The Experience

of Chief Nurses

in Military Operations Other Than War

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Abstract

The purpose of this research was to describe the experience of chief nurses in military operations other than war. The study is significant to the profession because nurses will continue to provide care in humanitarian operations, peacekeeping missions and disaster relief efforts. Inquiry into the experience will lead to an understanding of the foundations of the global caregiving community.

Hermeneutic phenomenology provided a description and thematic interpretation of the meaning of the experience. Purposeful sampling yielded thirteen participants, eleven women and two men. Duration of the deployments ranged from 3-7 months. Sites included Saudi Arabia, Oman, Panama, Cuba, Somalia, Guam, Croatia, England and Turkey. Purposes of the missions varied from peace keeping to humanitarian relief. Interviews were conducted using core questions developed as a guide. Audiotapes were transcribed and analyzed using procedures adapted from Colaizzi (1978), Van Manen (1990) and illuminated by Ray (1990). Significant statements were identified in the text, meanings were formulated then gathered into 60 interpretive clusters. Reflecting and rereading led to the emergence of the themes which constituted the fundamental structure and the essential themes. Three metathemes and the unity of meaning in the experience were identified.

The fundamental structure of the experience was the deployment trajectory with five themes: preparing, arriving, living, working, and leaving. Further analysis revealed five essential themes: paradox, leadership, caring, knowing and the true military. Lifeworld existentials of space, time, body and relationship were used as guides for reflection and development of a comprehensive description of the experience. The metathemes were authenticity, imaginative awareness and pride. The unity of meaning is

expressed in the metaphor, The True Military: Performing Live Theatre.

This phenomenological study captured the experience of the chief nurses. It revealed the challenges of leadership and tremendous pride in getting the job done. These nurses were proud of their participation in an authentic experience where imaginative awareness enabled them to identify and respond to the challenges they encountered as nurse leaders.

Further areas for research suggested by this study include topics in nursing practice and nursing administration. Several examples are presented which reflect individual, operational, multinational and multicultural issues.

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Chapter I
Introduction

Everyday there is news of social unrest and violence somewhere in the world. Additionally, there are reports of disasters resulting in huge numbers of casualties and losses of both property and human life. These scenarios have several characteristics in common. They disrupt and destroy the health and well being of many people in a very short time. Military medical support teams are often deployed to provide care to those who have been affected.

The United States is committed to defending regions throughout the world identified as critical to the national interest. At a time of increased social unrest and upheaval throughout the world, military nurses are being mobilized more often than in the past to provide health care for the men and women deployed as peacekeepers or to provide humanitarian relief. These deployments are known as military operations other than war (MOOTW). The nurses will continue to be part of an interdisciplinary team designed to ensure that care is available when and where it is needed. The teams have a senior nurse assigned as chief nurse. This position carries the responsibility for the delivery of all nursing care and the welfare of the nursing staff. Before deployment, the duties of these nurses may or may not be primarily administrative. Because the lived experiences of chief nurses in MOOTW are unknown phenomena, and understanding of the experiences would contribute to nursing's body of knowledge, the study was undertaken.

Research Question

The specific aims of the study were to (a) obtain a description of chief nurses' experiences including challenges of patient issues, staff issues and leadership opportunities during military operations other than war (MOOTW); (b) extract significant statements from the descriptions, formulate

meaning of the experience from the perspective of the chief nurse, and create interpretive clusters; (c) organize the interpretive clusters into themes and integrate them into a comprehensive description of the experience; and (d) arrive at a unity of meaning using the process of intuition.

A descriptive, exploratory approach was used to address the research question: What is the experience of chief nurses in military operations other than war?

Background

There is an urgent need to develop nursing knowledge relevant to the health of the global community (Meleis, 1993). Others argue that given the global society in which we live, nursing is at a critical juncture in its development and faces the challenge of becoming globally relevant (Ketafian & Redman, 1997). Gaining an understanding of the experience of serving as chief nurse in MOOTW is relevant, significant, timely and of interest to the discipline of nursing. This was the first study in a program of research. The goals of the research program were designed to gain an understanding of the ethical concerns and problems of the chief nurses and describe the choices and decisions made by chief nurses.

This study was also a beginning in meeting some of the challenges posed by the American Nurses Association (1985) and Jennings (1995) regarding research in nursing administration. It also addressed several of the research priorities identified by the American Organization of Nurse Executives (1997). These priorities include investigating the role of nursing leadership and management of cultural and workforce diversity.

The absence of research in nursing administration has created a void in knowledge development for the discipline. Nursing administration research includes inquiries into factors that influence effective and efficient organization and delivery of high quality nursing service (American Organization of Nurse Executives, 1987). Nursing administration research can

be used to influence health care policy and the academic preparation of future nurse administrators. De Pree (1994) discusses leadership and moral purpose. He asks “is moral purpose essential to leadership competence?”, and “how are we doing in acting as stewards of the environment?” (p. 134). Jennings exhorts us to redirect nursing research efforts to studies which look at the environment in which nursing is practiced. The purpose of this chapter is to introduce the phenomenon of interest, provide background for the study, explain the significance of the study to the profession of nursing, present methodological assumptions and limitations, and explicate the presuppositions of the investigator.

Disasters

A disaster can be defined as a destructive event that claims so many victims that a gap arises between the number of victims and the capacity of systems to provide treatment (Rutherford & de Boer, 1983). Similar events on a smaller scale, when the capacity to treat the victims is adequate, are known as accidents. Floods, earthquakes, droughts, epidemics, war, and armed conflicts are examples of disasters. The United States military has many specialized resources required for effective disaster response. Among them are strong leadership, a highly organized structure, state of the art equipment and advanced technical skills. These resources can potentially provide solutions to a wide variety of problems (Burkle, Frost, Greco, Petersen, & Lillibridge, 1996).

Recently, military activities have included humanitarian assistance, disaster relief, control of civilian disturbances and other activities unrelated to fighting a war. These activities were authorized by Titles 10 and 32 of the U.S. Code. Strategy for relief operations originates and is controlled by a policy decision of the government (Burkle et al., 1996). Military support is provided when directed by the Secretary of Defense and the National Command

Authority (NCA) through the Joint Chiefs in response to a request from the Department of State. Burkle et al. described the phases of the operation which include formulation of policy by the Department of State, with development of both a mission statement and concept of operations by the appropriate Commander in Chief. The role of the military, the scope of services, and a time line are addressed in the concept of operations. Ryals and Baker (1996) stated that the United States' response to humanitarian emergencies is an important instrument of foreign policy and the projection of a positive American influence throughout the world. Däniker (1995) explains changes in military thinking and practices. These changes reflect a widening scope of operations: disaster relief, conflict prevention, and a flexible and multifunctional force.

Sharp, Yip, and Malone (1994) acknowledged the controversies surrounding the use of the military for humanitarian assistance, but suggested that for the United States' national interest, the military should be involved in the post cold war era. The assistance contributes to peace, security, and stability in today's world. Advantages and limitations of military assistance were described and both pose challenges for nursing leadership. For example, transportation and logistics provide needed supplies, but the arrival time is often unpredictable and the actual supplies may differ from those the staff is expecting.

Command, control and communication (C3) are advantages that depend on clearly defined organizational structure and a commitment to common goals. A major responsibility of the chief nurse is maintaining C3. Another advantage is field hospitals that provide trauma care, treatment for acute illnesses, and preventive health care measures in austere and remote environments. Each of these interventions requires cultural awareness and flexible adaptation of established policies and procedures.

Limitations were well described by Sharp et al. (1994) and included

minimal basic supplies, lack of training in problems which occur in refugee and displaced person populations, management of chronic diseases, public health interventions, limited focus on redevelopment, poor coordination with local health professionals and suitability of supplies. These limitations may be sources of moral conflict for all concerned. They also pose challenges during pre-deployment, deployment and post deployment. Pre-deployment preparation is an ongoing problem since staff members are deployed on a rotational basis. This deployment pattern also contributes to the recurring lack of experienced people in the field. Another difficult situation is the coordination of services with other agencies. This requires the chief nurses to understand the multiple and diverse agendas of the other organizations involved in the organization. Sharp et al. offered recommendations to improve the quality of the military's response while keeping in mind that national defense, not humanitarian relief, is the primary focus of the military. Among the recommendations are clear definition of the mission, a collaborative role with other aid organizations by developing an understanding of their agendas, improved preparation of those who deploy through multiple field experiences, and development of better teaching materials. These recommendations deserved further study in order to expand the knowledge base on which nurses base their practice.

Humanitarian Missions

Humanitarian missions are usually associated with regional conflicts throughout the world that threaten the interests critical to the United States and are known as military operations other than war (MOOTW). Secretary of State Designate Albright (1997) in her statement before the Senate Foreign Relations Committee said, "we recognize that our interests and those of our allies may also be affected by regional or civil wars, power vacuums that create targets of opportunity for criminals and terrorists, dire humanitarian

emergencies and threats to democracy." Then, quoting President Clinton, she said, "The United States cannot and should not try to solve every problem, but where our interests are clear, our values are at stake and where we can make a difference, we must act and lead." Continued participation of the United States in humanitarian missions is expected in the foreseeable future. This participation becomes a readiness tasking for military personnel assigned to established bases. These deployments require new skills and different application of previously learned skills. Leadership challenges abound in an environment of unfamiliar stressors and dangerous conditions. The national security strategy of the United States acknowledged that while we no longer face the single defining threat which dominated our policy, budget, and force structures, multiple threats to our security still remain. During the Gulf War it was demonstrated that we cannot be sure when or where the next conflict will arise. Regions critical to national interest must be defended and the world must respond to straightforward aggression. The United States remains the nation whose strength and leadership are essential to a stable and democratic world order. (The White House, 1993)

Until 1990, the military medical mission was primarily the support of an extended, declared war. The stated mission is now "the mobility and deployment of medical support for contingency operations world wide" (Air Force Medicine, 1996, p. 7). Various situations throughout the world have elicited a response from the United States that included deployment of medical teams. Recent examples are the humanitatian operations in Haiti, Iraq, Bosnia, Zaire, Indonesia, Guam and Honduras. Medical teams were also deployed to North Dakota following the floods.

Frequently, during Joint Force operations, medical teams are made up of active duty and reserve members of all three services: the Army, Navy and Air Force. From the perspective of nursing administration, selection and preparation of the team members to participate in humanitarian operations is

of concern since the facilities, supplies, equipment and language are often unfamiliar. Potential danger and rapid response are compelling reasons for preparation that is useful in diverse situations, especially for those in positions of leadership. Increased responsibilities in the absence of professional resources and social support systems create an environment where fears and uncertainty are magnified.

Austere Health Care

Health care during disasters must be delivered under conditions in which the resources to provide that care are limited by the numbers, types and severity of the patients; the numbers or expertise of the medical personnel; and the health care facilities including equipment or supplies. This type of limited care can be called austere medical care (Dressler & Hozid, 1994). Frequently, austere care is delivered in a mass casualty situation. Examples include hurricanes, tornadoes, earthquakes, industrial accidents and situations occurring because of large scale political or economic constraints. Austere health care is best understood when contrasted with the perception of health care by those in the U.S. population who see health care as an entitlement and an unlimited resource.

Miltary operations other than war are often supported by the Air Force Medical Service (AFMS) in a cooperative effort with the Army, Navy and other governmental and civilian agencies. Recently there have been four major operations and multiple smaller operations supported by medical teams throughout the world. They ranged from classified locations to industrially developed countries to remote sites at the far ends of the earth. Examples of these were Operation Joint Endeavor, Operation Southern Watch, Operation Pacific Haven, Operation Provide Comfort and the crash of the Boeing 707 in Ecuador. Operation Southern Watch was supported by a 26 bed air transportable hospital (ATH) and an air transportable clinic (ATC). There was a 13 cot Mobile Aeromedical Staging Facility (MASF) in Tuzla,

Bosnia. There were similar units in Taszar, Hungary and Zagreb, Croatia. In Operation Desert Focus there was a 25 bed chemically hardened Air Transportable Hospital at Riyadh and another at Al Kharj. Operation Pacific Haven was implemented to relocate 6572 Kurds from northern Iraq to the U.S. territory of Guam. The duration of these missions was not pre-determined. This unknown factor was consistent with the concept of austere medicine.

Significance

The significance of this study is based on its contribution to nursing knowledge by advancing the understanding of chief nurses' experiences in military operations other than war. De Boer (1995) listed areas of interest to those who provide relief which have been well researched and areas requiring further research. Facets of human behavior such as panic, the counter disaster syndrome, and post traumatic stress disorder have been well researched. Areas requiring further research are organizational culture, treatment protocols and model development using both probability theory and chaos theory.

Nursing administration research can be used to influence health care policy and the educational preparation of future chief nurses. Jennings (1995) urges us to redirect nursing research efforts to studies which look at the environment in which nursing is practiced. Environment includes both climate and culture. Organizational culture is critical to health care delivery and patient outcomes. Because nurse executives influence the health care culture, it is an especially relevant topic for nursing research (McDaniel, 1995). Language barriers, cultural differences, and varying levels of medical expertise are some of the challenges encountered by deployed personnel. Resolution of these issues is being pursued, in part, by pre-deployment preparation and training (Stierle, 1996). The content of this preparation and

training must be based on research findings rather than on traditions or assumptions.

Ray (1994a) argued for research centering on moral experience. She stated that inquiry into the experience of virtues, values and principles of the community of carers would lead not only to understanding the foundations of choice making, but also to the understanding of a new ethic of shared responsibility. Knowing a patient is a central aspect of nursing practice. The possibility for nurses to know their patients can be limited by organizational arrangements and situations where it is impossible to engage in the informal discourse which leads to knowing. Chief nurses must create an environment where knowing is possible (Tanner, Benner, Chesla, & Gordon, 1993). Caring effectively for people of diverse cultures is frequently assumed to mean other cultures within the U.S., however the ideas put forth by Leininger (1994) are applicable to field nursing. Military nursing, as an emerging global profession, must focus on cultural care diversity in complex contingencies. Additionally, experiential research in the context of deployment can be used to illuminate the depth of the decision making processes and will communicate more clearly what it means to be human, responsible, caring and moral in these situations. According to Ray (1994a), this new research will embody moral reflection and moral responsibility. It has the potential to offer a clear direction for preparation and deployment of chief nurses in military operations other than war.

Methodological Considerations

In some studies the terms hermeneutic, phenomenology and hermeneutic phenomenology have different meanings and in other studies the meanings are the same. Van Manen (1990) explained the distinctions among these terms this way:

> Actually it has been argued that all description is ultimately interpretation. "the meaning of phenomenological description as a method lies in interpretation....The phenomenology...is a hermeneutic in the primordial signification of this word, where it designates this business of interpreting" Heidegger (1962, p. 37).
>
> It is possible to make a distinction in human science research between phenomenology (pure description of lived experience) and hermeneutics (as interpretation of experience via some text). Strict followers of Husserl's transcendental method would insist that phenomenological research is pure description and that interpretation (hermeneutics) falls outside the bounds of phenomenological research. (p. 25-26)

In this inquiry the terms phenomenology and hermeneutic phenomenology include both the descriptive and interpretive elements.

Assumptions

The following assumptions are adapted from Munhall (1994), van Manen (1990) and Benner (1994).

1. The investigator must turn to a phenomenon which seriously interests her and commits her to the world.
2. The experience must be investigated as it is lived.
3. Interpretation presupposes a shared understanding.
4. The phenomenon is situated in context and the context includes space, body, relationships and time.
5. The context changes with differences in space, body, relationship and time.
6. Perception, cognition and language provide access to meaning.
7. Reflection on lived experience helps distinguish appearance from essence.

Limitations

The following aspects of the study could be considered limitations:

1. The investigation is limited to the descriptions of the chief nurses who participated in the study.

2. The investigation is limited to the information provided by the participants.
3. The investigation is limited by the chief nurses' descriptions of their experiences while serving in military operations other than war.
4. Chief nurses' experiences during deployment cannot be isolated from their overall experience of serving as a nurse in the military.

Presuppositions

Presuppositions of the investigator about the deployment experience:

1. Notification of deployment and preparation for departure generate intense feelings, especially surrounding the issues of separation from family and adequacy for the anticipated responsibilities.
2. The work environment at the deployed location is unfamiliar and austere.
3. There are both similarities and differences in the duties of chief nurses in a deployed setting and chief nurses in permanent duty locations.
4. The deployment environment is physically challenging.
5. Professional relationships among the staff must be developed rapidly, especially building trust.
6. There are significant differences in the patient populations and the standards of care in the deployed setting.
7. Military operations other than war which include peacekeeping, peacemaking, and humanitarian efforts are appropriate components of United States military strategy.

Chapter II
Review Of The Literature

The purpose of this chapter is to clarify the dimensions of the phenomenon of interest and as recommended by Morse and Field (1995), to critically examine previous work and use it selectively as a guide in focusing the study. Care was taken to keep the literature from influencing the investigator during data collection and data analysis. Selected for this review were experiences of military nurses, leadership challenges for nurses, and potential moral conflicts. The context included embedded ethical issues, a description of response operations, the delivery of health care during and immediately following various military and civilian operations and challenges for nursing leaders in these same operations. The literature review described what was present and what was missing through a careful analysis which included scope, content, and methods of study. The scant amount of available literature with related content provided both military and non military perspectives.

This literature review was written to enrich the investigator and the reader in preparation for turning their attention to the phenomenon at hand.

Military Nursing Experiences

There were numerous anecdotal and historical accounts of the practice of nursing during war and natural disasters (Holm, 1982; Kassner, 1993; Marshall, 1988; Martin, 1967; McVicker, 1985; Odom, 1986). Macdonald (1978/1993, 1980/1984) presents over 600 stories of men and women, soldiers and nurses, who had been in World War I. Their experiences were interpreted in the context of the events which took place as the battles were waged. Norman and Elfried (1993) described the experiences of nurses in the Philippines during WWII:

> Nursing Leadership was strong ... she checked the patients and the nurses ... she demanded steadfast work and provided the nurses with security and a sense of the group. Prisoners and civilians also needed their care. The work was hard but it was the profession at its most basic, caring and saving lives. These nurses also add to our understanding of valor ... heroism is not two dimensional .... they quietly persevered. They were scared, they wanted to live. In short, we learn that true heroes are also very human. (p. 122)

This description refers to administrative duties as well as clinical duties. Barger (1991) interviewed 25 flight nurses who served in World War II. Specific coping situations identified were demands of living conditions to include communication, food, hygiene, living quarters, care of patients on air evacuation missions with lack of supplies and equipment, patient safety, demands of training, appearance and inactivity, concern for family members back home and for those missing in action, and finally, the death of patients and colleagues. Most of these are primary concerns of the chief nurse and require strong leadership for resolution.

Although the experiences of chief nurses were not directly addressed, situations were described that would demand the attention of chief nurses. McVicker (1985) described the condition of the wounded, long hours and daily living concerns:

> The number of casualties received during heavy periods of fighting, the troubling memories that nurses report ... routine work schedules in many hospitals were twelve hours a day, six days a week, ... multiple casualties were being received during prolonged fighting, personnel worked longer periods, sometimes going for days with only catnaps to sustain them .... personal supplies were extremely limited or absent. (p. 27)

Odom (1986) addressed operational requirements and living conditions:

> We are practicing setting up and taking down expandables, which are metal boxes that become lab, OR, and XRay facilities, and inflatables that make up the receiving area, postop ward, and holding units ... most of the seven nurses are new to Vietnam; only a few have had any experience with combat casualties. (p. 1036)

Norman (1989) did a qualitative study to examine the experiences of military nurses during the Vietnam War. Interviews were conducted with 50 women who served in Vietnam in the Army, Navy and Air Force Nurse Corps. Experiences shared by these nurses related to: "reasons for volunteering, professional stresses and moral dilemmas of wartime nursing, and positive aspects of service in the Vietnam War" (p. 222). Examples of moral dilemmas included issues surrounding triage:

> Decisions were mechanical, impersonal, necessary but anathema to professionals who had worked in stateside facilities where injured people were treated immediately .... nurses also faced the moral dilemma of caring for enemy soldiers who were patients in the same wards as American soldiers. (p. 224)

Scannell-Desch (1996) did a qualitative study using a phenomenological approach to study the lived experience of female military nurses who served in Vietnam. Three of the seven metathemes identified were: facing moral and ethical dilemmas, giving of oneself, and improvising. Concannon (1992) used a grounded theory approach to study nurses deployed in support of Operation Desert Shield / Desert Storm. Among the categories identified in her work were: camaraderie, morality issues, patriotism, leadership, personal growth, mortality, loss of identity, spiritual support, information seeking, and feeling alone. Similar themes emerged from a phenomenological study published by Stanton, Dittmar, Jezewski, and Dickerson (1996). They interviewed 22 nurses who had served in the Army in WW II, Korea, Vietnam, and Operation Desert Storm. These studies all emphasize the leadership challenges and the moral and ethical concerns for those who experienced deployment.

Leadership Challenges for Nurses

Literature has few recent studies about Chief Nurse Executives and

leadership behavior (Adams, 1990; Borman, 1993; Kelley, 1996; Schank, Weis, & Ancona, 1996). Chief nurses in top organizational positions find themselves in the midst of a mix of professionals. Cooperation may be difficult because it requires trust and understanding which are difficult to build quickly. These nurses are the policy makers who set the terms and conditions for everyone else (Buerhaus, et al., 1996; Johnson, 1989). Building trust and establishing the conditions are the work of the chief nurse in a deployed facility. The climate of the organization is influenced by the chief nurse. This, in turn, influences the decisions of the nurses who are providing direct patient care. Borawski (1995) addressed ethical dilemmas identified by nurse administrators. They included staffing / staffing mix; standards of care; rationing of resources; incompetent physicians and termination of employees. The outcomes of ethical decisions were also of considerable concern and presented leadership challenges for nurses.

Challenges Identified

Ethical dilemmas for nurse executives were identified by Camuñas (1994) in a survey of 315 nurse executives. They were (a) allocation and rationing of scarce resources, (b) staffing level and mix decisions, (c) developing / maintaining standards of care, (d) treatment vs. non-treatment, (e) incompetent physicians, (f) access to care, (g) employee relations, (h) incompetent nurses, and (i) diversification of services. She also identified resources used to resolve ethical dilemmas: (a) personal values, (b) administrative colleagues, (c) nursing colleagues, (d) institutional ethics committee, (e) Patient's Bill of Rights, (f) American Nurses Association Code for Nurses, (g) CEO / board of trustees, (h) hospital chaplain, (i) friends / family, and (j) personal spiritual counselor. These 315 responses were returned from a random sample of 500 nurse executives. This high (63%) return rate suggests that this was an important topic for nurse executives. The issues they

identified are also important for nurses in the field, however some essential resources used to resolve ethical dilemmas are lacking.

Camuñas (1994) also identified ethical conflicts in role obligations. Societal ethics and organizational ethics were both addressed in her study. Of particular interest were these items: 86% agreed that concern about ethics is growing; 96% agreed that people encounter ethical dilemmas at work; 76% agreed that ethical concerns can be empowering; 48% said there was pressure to compromise personal standards to meet organizational goals; 70% agreed that although individuals are responsible for their actions, organizations define and control situations in which decisions are made; 91 % agreed that authorizing subordinates to violate rules is unethical.

Camuñas' study was limited to peace time, civilian organizations. Williams (1996), however, provides some insights into ethical decision making during the Gulf War by giving examples of the dichotomy between the roles of nurse and disaster manager. His moral conflict was grounded in the desire to do the right thing in an impossible situation with patients exposed to chemical contaminants. Williams reflected upon his decisions and the implications for future policies and procedures in similar situations.

Chief nurses in the field supervise community health nurses. Samuels, (1997) who served in Cuba as a community health nurse with 50,764 Haitian migrants, addressed the need for communicable disease surveillance, discharge planning (from field hospital to camp) and public health education. She experienced frustration and misunderstanding and felt the migrants mistrusted those in military uniform. The leadership challenge for the chief nurse, as supervisor of these nurses, is enormous. Issues include identification of resources, support of individual strengths, and counseling and teaching to meet learning needs.

Military nurses have directly and personally witnessed the immediate catastrophes of war: death, trauma, disfigurement, grief, psychic

disintegration, infectious disease and displacement of persons. They have also faced combat related problems of poverty, interpersonal and family violence, rape, disability, suicide and uncontrollable fears associated with wounding/killing and being wounded or killed (Hall & Stevens, 1992).

Physical exhaustion was frequently mentioned as an experience of those providing care in these situations, but it is only one of many challenges or stressors. Dahl and O'Neal (1993), in their survey of nurses deployed to Saudi Arabia, identified many issues, but the single most agreed upon stressor was lack of leadership and organization of command. Also noted were lack of information sharing, poor communication, and conflict in the roles of nurse and army officer. Military nurses spend many days training under field conditions in preparation for deployment to care for the victims of disasters and other catastrophic events. These nurses receive their basic education in colleges and universities across the country. Upon entering active duty they are assigned to a medical treatment facility with duties that are comparable to the duties of nurses in civilian facilities. Opportunities for deployment occur sporadically during the assignment. These opportunities are dependent upon a variety of factors such as experience, time on station, scope of tasking and concurrent requirements of the home base facility.

Decision Making

Jennings et al. (1993) described the deployment, setup and operation of an air transportable hospital (ATH) and participation of assigned personnel as medical augmentees to Kurdish refugee camps treating 13,000 individuals. Nursing activities described in the article reflect the decisions made by the chief nurse. During the first 20 days, three quarters of the staff participated as augmentees to field units and civilian relief agencies. They also collected morbidity and mortality data on refugees. There was severe strain on the ATH personnel due to infectious illnesses and fighting between Turkish

military units and Kurdish insurgents.

Decisions on appropriate application of resources to the care of patients must be given the same emphasis as the decisions on organization and triage. In humanitarian efforts / disaster relief and military operations other than war, there is always a shortage of resources compared to health care needs. This dissonance is more evident when diseases are combined with trauma injuries. Limited care is generally accepted by the American public as a temporary situation with the expectation that ultimately, definitive comprehensive care will be made available regardless of expense. Dressler and Hozid (1994) stated that based on the analysis of WWII injuries for planning purposes, it has been assumed that victims will be distributed into categories as follows: immediate 20%, delayed 20%, expectant 20% and minimal 40%. This ratio has not been found in natural disasters or terrorist attacks. Instead, many deaths and minimal injuries characterize these situations. “There is the customary tendency not to critique mass casualty care events to the fullest for fear of offending the dedicated workers or of possible political ramifications” (Dressler & Hozid, 1994, p. 197). Current taskings require preparation for multiple levels of austerity rather than the previous simple level response of austere versus standard non austere care. Experience is therefore the best preparation for providing mass casualty or austere care; training and exercises are poor substitutes.

Dressler and Hozid (1994) proposed a model of austere care delivery that would serve as the foundation for planned medical responses in mass casualty or disaster situations. The levels they proposed are Level I, a determinate situation where the outcome is highly predictable and temporary, minimal austerity is practiced. Level II is less determinate due to unknowns and shortages. In Level III unknowns and severe resource limitations exist to the extent there is major doubt as to the outcome. Level IV is indeterminate; there is no predictable outcome or foreseeable solution;

maximum austerity must be practiced at this level in this model.

Rationing and prioritization are emotionally charged words and using them makes discussion of austere care difficult, especially in MOOTW which tend to be longer in duration than disaster / humanitarian missions. Dressler and Hozid (1994) further stated that implementation of such a program would require a societal consensus on the ethical, cross cultural and economic concerns. Societal consensus on the Unites States' involvement in MOOTW, disaster relief, and other humanitarian roles is difficult to achieve. The four levels make it easier to see the options to an "all or nothing" approach for United States policy makers and for those deployed. Health care personnel's previous participation in Level I or Level II situations is valuable preparation for Level III and Level IV situations. Guidelines for allocation of resources using trauma scores, coma levels, severity levels and triage were based only on individual patient needs. The levels of the Dressler-Hozid austerity model balance patients' needs with available resources.

Moral Conflicts

Examples from the literature illustrate potential moral conflicts (Dahl & O'Neal, 1993; Etherington, 1995; Harris, 1995; Laube-Morgan, 1992; Peterson, 1995; Rozmus & Wollaber, 1995). The scope, cultural differences, sensations and challenges combine to create an understanding of these experiences. "When we first saw the area, there were around 1,000 refugees. At it's peak two weeks later, there were estimated to be over 10,000" (Harris, 1995, p. 36). In Cambodia:

> Children were blind because of the lack of vitamin A in their diets for months or years .... outside a hundred thousand people waited patiently in lines .... Many cholera patients used their last ounce of strength to make it to our makeshift bamboo hospital. It was impossible to run enough IV fluids into them: the most we hoped to do was ease their dying. (Etherington, 1995, p. 14)

Cultural factors and their impact on care givers were vividly described in the literature. In one case, a missionary nurse was assigned to work with native nurses in their local hospital. An elderly man with ascites was admitted to have fluid drained from his abdomen, “No one bathed him or changed his clothes during his stay. Once a day the kitchen staff would bring him a plate of rice and meat. He had no water at his bedside.” One day she bought some juice and crackers for him, he drank the juice but the next day there was a screen around his bed, a signal to not get involved in his care (Petersen, 1995, p. 505). Culture shock can sometimes be frightening. “We traveled by car to the border, there were guard towers and barbed wire, we were met by soldiers who took our luggage and walked us across the border” (Rozmus & Wollaber, 1995, p. 17).

Personnel in disaster health responses assess the threat and articulate the needs (Burkle, Frost, Greco, Petersen, & Lillibridge, 1996). Training of the personnel must be improved to familiarize them with internationally accepted assessment protocols, international law and conventions regarding humanitarian assistance. The moral conflict inherent in this global view is the limited availability and unequal distribution of resources.

Sensations are physical and emotional. “How do you respond to children who have seen homes destroyed, loved ones and neighbors killed, raped or taken away? How do you help parents get beyond bone deep weariness, depression and hopelessness so they may again parent their children?” (Etherington, 1995, p. 15).

Characteristics of a humanitarian relief worker are described by Slim (1995). Among the more obvious characteristics of negotiation, conflict management and commitment, he added that a relief practitioner must be something of a moral philosopher to successfully function in the new environments. This ability is needed to deal with multiple moral conflicts

including the choice between neutrality or solidarity. Duffield (1996) in his discourse on developmentalism suggested that humanitarian aid may actually fuel conflict in unstable situations. This idea has been supported by others (Perlez, 1991; Roberts, 1993). He invited research that explores neutrality, power and information in disaster relief efforts. Each of these topics resonates with the concept of moral climate and challenges the chief nurse as she creates an environment for practice.

Ryals and Baker (1996) reported that military units will treat women, children and the elderly. These units will be less like combat support hospitals and more like community health care clinics. The emphasis will be on primary care and public health. Standards of care will have to be adjusted to the level of the host nation's capability. This adjustment is another potential source of moral conflict for chief nurses.

Chapter III
Methods Of The Study

A descriptive, exploratory approach was used to address the research question: What is the experience of chief nurses in military operations other than war? In this chapter the specific approach of phenomenology as philosophy and method is presented. Procedures for sample selection, data collection, and data analysis are described. Protection of participants and trustworthiness considerations are also presented and discussed.

Phenomenology

Disclosing Lived Experience

The word phenomenology means the study of phenomena, and has come to mean the system described by Husserl and his followers that stresses the careful description of phenomena in all areas of experience; it is also the study of essence—what makes something what it is (Ray, 1990). An expanded definition is provided by van Manen (1990). He states, phenomenology is the study of lived experiences; the explication of phenomena as they present themselves to consciousness; the study of essences; the description of the experiential meaning as we live it; the human scientific study of phenomena; the attentive practice of thoughtfulness; and a search for what it means to be human. The aim of phenomenology is to disclose lived experience, but it is recognized that the closest one can come is disclosed perception (Oiler, 1986). And finally, the purpose of phenomenology is to seek a fuller understanding through description, reflection and direct awareness of a phenomena to reveal the multiplicity of coherent and integral meanings of the phenomenon (Ray, 1990).

Worldview assumptions. Leininger (1981) described the way individuals or cultures grow, perceive, and know the world around them as a world

view. Worldviews are defined by and built upon assumptions. The influence of a paradigm or worldview is important since it structures the questions which can be asked. The worldview which supports the human sciences and phenomenology is subjective and has the following assumptions: reality is multiple, constructed, and holistic; knower and known are interactive, inseparable; all entities are in a state of mutual simultaneous development making it impossible to discern cause and effect; inquiry is value bound (Lincoln & Guba, 1985; Streubert & Carpenter, 1995). The natural science, objective or positivist view is based on different assumptions: reality is single, fragmented; duality exists between knower and known; context free generalizations are possible; inquiry is value free (Lincoln & Guba; Streubert & Carpenter).

Worldview characteristics. Both worldviews can support research questions and both contribute to nursing knowledge (Cameron, 1991). The natural sciences seek causal explanations, predictions and control whereas the human sciences seek understanding and interpretation (Munhall, 1988; Ray, 1990). They also have different characteristics. The natural sciences are deductive, and use statistical techniques while the human sciences are inductive, and descriptive (Ray, 1985). Human science offers a philosophy and a way of being with others. Research in human science does not attempt to control or manipulate events and individuals for they are concerned with the changing or dynamic nature of reality (Cameron, 1991). Gaining an understanding of experience is the aim of phenomenological inquiry.

Phenomenology As Philosophy And Method

Phenomenology is a philosophy as well as a research methodology. It is a dynamic movement that has been evolving and changing since its inception in the early part of this century. It grew out of the Humanistic tradition and began as a response to Cartesian dualism which is the belief that our human

existence is divided into two parts, body or matter and mind or consciousness (Fjelland & Gjengedal, 1994). This history has been presented numerous times in the literature (Cohen, 1987; Ray, 1990, 1994b; Speigelberg, 1984 Streubert & Carpenter, 1995). In this section a brief overview of the key contributions to the phenomenological movement are presented as reflected in the work of the philosopher / authors who have most influenced this study. Spiegelberg (1982) divided the phenomenological movement into three phases: the first (preparatory) phase, the second (German) phase and the third (French) phase. These phases built on each other as the students of the philosophers refined and redefined the elements of the system. The first phase began with Franz Brentano (1838-1917). He first wrote about phenomenology as a method of inquiry and is credited with two major contributions, inner perception and intentionality.

Inner perception and intentionality. Inner perception is the immediate awareness of our psychological phenomena while maintaining our attention to the external objects (Mezquita, 1994). Intentionality means that all thinking such as imagining, perceiving, and remembering is always thinking about something. Intentionality, as a concept, continues through phenomenological questioning and theorizing to describe the inseparable connection of human beings to the world (van Manen, 1990).

Scientific rigor. Carl Strumpf, a student of Brentano, first demonstrated the scientific rigor of phenomenology (Spiegelberg, 1982; Streubert & Carpenter, 1995). The father of phenomenology was Edmund Husserl (1859-1938). He, with his student Heidegger (1889-1976), were the major figures during the second phase. Husserl believed that philosopy should become a rigorous science and in addition should have a new humanism (Ray, 1990). He did not accept the traditional thinking of dualism and believed the foundation of the natural sciences should be rethought to correct the mechanistic view of the world (Fjelland & Gjengedal, 1994).

Essences, intuiting and reduction. The philosophical concepts of essences, intuiting and phenomenological reduction were developed by Husserl and his students. These concepts remain in the foundation of phenomenology today.

Essence, a concept developed during the second phase, means the inner nature or true being of a thing. Essence is that which makes a thing what it is (and without which it would not be what it is) (van Manen, 1990). Intuiting is an accurate interpretation of what is meant in the description of the phenomenon under investigation (Streubert & Carpenter, 1995). Intuiting requires the imaginative varying of the data until a common understanding is achieved. Phenomenological reduction or structured reflection, allows the researcher to describe with scientific exactness the life of consciousness in its original encounter with the world (Ray, 1994b).

Intersubjectivity and lifeworld. Intersubjectivity was another concept that arose out of Husserl's work (Cohen, 1987). This concept is related to transcendental subjectivity described by Ray (1994b). This philosophic activity involved bracketing or holding in abeyance one's presuppositions or theories. The last concept to be developed by Husserl and discussed here, was the concept of "lifeworld", the world of lived experiences. According to Husserl, the natural sciences presuppose the lifeworld. His works are an attempt to describe the structure of the lifeworld (Fjelland & Gjengedal, 1994). This idea influenced Heidegger and the French philosophers who successfully integrated phenomenology with existentialism (Ray, 1990).

Heidegger, also a part of the second phase, approached the development of knowledge of the world through an ontological perspective, the perspective of what it means "to be" (van Manen, 1990). His main work "Being and Time" describes the basic structure of the lifeworld. The lifeworld has meaning whereas the scientific world, for instance the world of physics, does not. "Unarticulated" or "tacit" knowledge are the terms used for our

knowledge of the lifeworld which is not articulated (Fjelland & Gjengedal, 1994). According to Heidegger, man is helped to understand his Being in the world as he discovers himself in his engagement and involvement in everyday matters (Kelly, 1994/1995). For Heidegger, the meaning of an object was not in addition to its physical properties, rather to regard something as an object presupposes an assumption of it's use (Fjelland & Gjengedal, 1994).

The Work of Merleau-Ponty

The third phase described by Spiegelberg (1982) is the French phase. Maurice Merleau-Ponty (1908–1961) was one of the leaders along with Jean Paul Sartre (1905–1980) and Gabriel Marcel (1889–1973). Merleau-Ponty wrote in the preface to Phenomenology of Perception:

> Phenomenology is the study of essences . . . But phenomenology is also a philosophy which puts essences back into existence . . . It is a transcendental philosophy which places in abeyance the assertions arising out of the natural attitude . . . but it is also a philosophy for which the world is always 'already there' before reflection begins—as an inalienable presence . . . It is the search for a philosophy which shall be a 'rigorous science', but it also offers an account of space, time, and the world as we 'live' them. It tries to give a direct description of our experience as it is, without taking account of its psychological origin and the causal explanations which the scientist, the historian or the sociologist may be able to provide. (Schmidt, 1985, pp. 35–36)

Embodiment. A critical consideration in the phenomenology of Merleau-Ponty is the recognition that consciousness is in simultaneous contact with the world and with ones self (Munhall & Oiler, 1986). The concept of embodiment explains how this unified relation of subject and object occurs. They continue:

> The concept of embodiment informs us that consciousness is diffused throughout the body and finds expression throughout it. We are our bodies. Bodily position in space and time, bodily movement and action shape experience by giving consciousness access to the world. There is in experience, then, a unity of the perceiving subject and the objective world. In experience there are no inner and outer realities. (p. 52)

Benner (1994) explains that Merleau-Ponty built on the work of Heidegger:

> . . . by discussing how the body is sentient and responds to meaningful situations. One's ways of being in the world are characterized by certain postures and gestures, habits and skills. The social and lived body reveals long term habits, meaning and comportment that allow us to be in the world and be shaped by it. (p. 120-121)

Perception. Perception is another concept found in the work of Merleau-Ponty. He believed that people experience the world around them by perception and that perception is a totally unique, individual experience that depends on context and stimuli (Parker, 1994). Munhall and Oiler (1986) provide further explanation:

> We now see that perception is the appearance of phenomena, and the perceived world is reality. This is not to be confused with truth. As access to truth, perception presents us with evidence of the world, not as it is thought but as it is lived. . . . It is this evidence that is considered to be the foundation of science and knowledge. Beyond this, there is nothing to understand. (p. 57)

Bracketing. Phenomenology as a method seeks to describe and unfold the phenomenon. To accomplish this, any preconceptions, presuppositions and assumptions about the experience or the meaning of the experience must be explicitly acknowledged by the researcher. The researcher must be open to the phenomenon as it presents itself. This process is called bracketing. The purpose of bracketing is to reduce the bias of the researcher during data collection and data analysis. This can be facilitated by writing down personal and theoretical assumptions before data collection begins. Although bracketing was addressed by Husserl, the idea was refined by Merleau-Ponty with a slight change in emphasis. It is better understood by looking at the entire process of phenomenological reduction. Van Manen (1990) explains

the levels or types of reduction:

> First, reduction involves the awakening of a profound sense of wonder and amazement at the mysteriousness of the belief in the world. This fundamental amazement animates one's questioning of the meaning of the experience of the world. Next, in the reduction one needs to overcome one's subjective or private feelings, preferences, inclinations, or expectations that would prevent one from coming to terms with a phenomenon or experience as it is lived through. Third, in the reduction one needs to strip away the theories or scientific conceptions and thematization which overlay the phenomenon in a non-abstracting manner. Fourth, in the eidetic reduction one needs to see past or through the particularity of lived experience toward the universal, essence or *eidos* that lies on the other side of the concreteness of lived meaning. (p. 185)

Lived experience. Lived experience is a final concept from the work of Merleau-Ponty that figures prominently in the work of many phenomenologists today (Cameron, 1991; Ray, 1994b; Riemen, 1986; Scannell-Desch, 1996; Watson, 1985). It is described as the focus of attention of phenomenology. Lived experience is always determined by one's history and in this sense is layered with meanings that are brought into relation of being-in-the-world. This corresponds to Merleau-Ponty's idea of the appearance of a horizon and figure-ground relation (Munhall & Oiler, 1986). Human experience is actualized in the four lifeworlds identified by Merleau-Ponty which are space, time, body and human relation (Mezquita, 1994; van Manen, 1990).

Achieving balance. The influence of Merleau-Ponty is seen throughout the work of van Manen (1990). He states:

> that lived experience is the starting point and the end point of phenomenological research and that the aim of phenomenology is to transform lived experience into a textual expression of its essence-in such a way that the effect of the text is at once a reflexive re-living and a reflective appropriation of something meaningful: a notion by which the reader is powerfully animated in his or her own experience. (p. 36)

To accomplish this is difficult since complete reduction is impossible and full, final descriptions are beyond reach. The effort spent in coming close to full description is worth it since the alternative is giving up altogether (van Manen, 1990).

A dynamic interplay among the methodological activities described by van Manen (1990) allows the researcher to pursue phenomenological human science research. Elements of the activities include turning to a phenomenon of interest, investigating an experience as lived, reflecting on the essential themes and then describing the phenomenon through the art of writing and rewriting. The act of remembering lived experiences and reflecting upon them gives them significance.

Phenomenology is not solely interested in the particular nor the universal, rather it consists of achieving a balance between what is unique (ontic) and what is essential (ontological); it aims at establishing a renewed contact with the original experience (van Manen, 1990).

Rationale for Phenomenological Approach

Phenomenology is a well respected and often used method of inquiry in many disciplines including philosophy, sociology and psychology. Recently it has gained recognition as an appropriate approach to study phenomenon of interest to nursing. Professional nursing practice is enmeshed in the life experience of people, thus phenomenology as a human science research method is well suited to these inquiries (Streubert & Carpenter, 1995). The study of chief nurses serving in military operations other than war was undertaken using a phenomenological approach because that approach promised to accomplish the goal of the study, which was to examine the lived experience of these nurses and the meaning of that experience from the nurses' points of view.

Research Approach

Sample Selection Procedures

The population consisted of nurses who had been deployed as chief nurses to MOOTW and permission to access them was granted through the offices of the Air Force surgeon general and the directorate of plans and readiness. These were the offices responsible for the deployment of troops to support our national objectives.

Criteria for selection. Purposeful sampling was used to ensure that the participant interviews would result in rich descriptions which would illuminate the research question. Experience with the phenomenon under investigation and the ability to articulate, suffice as criteria for selecting subjects (Colaizzi, 1978). Participants met the following criteria:

1. They were assigned as the chief nurse within the last six years in MOOTW.
2. They were able to recall and talk about their experiences.
3. They were willing to participate in the study.

Selection strategies. Several purposeful strategies, as described by Patton (1990), were employed. Each strategy is independent of the others and was selected to provide the richest description possible of the deployment experience. Extreme sampling provided participants for the study with a unique focus due to the location or tasking of their deployment. These chief nurses had been deployed to humanitarian and peacekeeping missions in Somalia, Cuba, Panama, Guam, Turkey, Saudi Arabia, Oman, England and Croatia. Diversity characterized the missions and the locations.

Intensity sampling was used to provide participants for the study who had had an intense experience. These nurses were referred by others who knew of their deployment experiences.

Maximum variation sampling was used with the expectation that it would yield high quality, detailed individual descriptions and important

shared patterns that would be significant because they emerge from the group experience.

The final strategy used was snowball sampling. This approach involved asking senior nurse corps officers who were familiar with recent deployments to recommend nurses for participation and asking participants themselves to recommend others who had served before or after them. Lists of potential participants were gathered from the command nurse executives. Additionally, a request through e-mail asking for contacts resulted in several referrals and volunteers.

The sample was selected from the population of Air Force nurses to gain contrasting views of the phenomenon, since diversity is valued in phenomenological research. Patton (1990) argues that there are no rules for sample size in qualitative research, but Ray (1990) suggests that five to ten is thought to be an adequate sample. In this study, similar clusters and themes began to emerge at the ninth interview. However, in order to gain the perspective of chief nurses from several significant missions, thirteen nurses were invited to participate.

The sample was purposive and resulted in a group of nurses who had been deployed to nine different humanitarian and peacekeeping missions. The selection process was deliberative to assure representation of the desired perspective. These decisions were made after consultation with the investigator's advisor and an experienced nurse researcher. The final sample was thirteen chief nurses who had, within the last six years, served as chief nurse in MOOTW; there was diversity in rank, years in service and professional nursing experience.

Data Collection Procedures

Interview preparation. Initial contact was made with the participants by the investigator. Each nurse was contacted by phone or e-mail. The purpose,

justification and participant welfare considerations were explained. When interest was expressed and the criteria were met, the nurse was included in the sample. Each nurse participant was then contacted by mail with a letter explaining the project, the data collection and data management procedures. The letter was followed by a phone call and when the nurse agreed to participate, an appointment was made for the interview. All thirteen nurses who were invited to participate agreed to be interviewed.

Interviews were conducted in an office or another private place, usually the office(9) or home(2) of the participant, at the current base of assignment. One nurse was interviewed in a meeting room at a restaurant and one in a hotel room. For each interview the goal was to establish an environment conducive to good interpersonal engagement and development of a trusting relationship. Conducting interviews in the participants' familiar surroundings was important (Oiler, 1986).

Interview process. The interview strategy selected for the study included flexible, open ended questions. The specific questions were not as important as the interview in its entirety. Additionally, this method required a relationship with the participant built on trust and respect. According to Colaizzi (1978) the researcher must be present to the participants in a special way, the participant is more than a source of data. The full richness of the experience can be contacted only by being present with the entirety of personality and the totality of being. Active listening and an engaging presence helped to establish rapport with the participant. The researcher took quiet time to become centered before each interview and to intellectually override presuppositions. This activity, which is a modified form of bracketing made active listening easier. Silence on the part of the participant was also recognized as a vehicle to communicate feelings or ideas which could not be captured in words.

Upon arrival at the site for the interview, telephone contact was

established with the participant to arrange for review of documents, photographs and other supporting materials. The time and place of the interview was confirmed. At the time of the interview, brief introductory conversation helped to establish rapport, consent to participate in the study was obtained, and the demographic sheet was filled out by the investigator. Following this preparation, the tape recorder, using a lavaliere microphone, was turned on and each participant was requested to describe the experience of deployment with as much conversation, feeling, and thought as possible while staying within the context of the deployment experience.

Core questions. Core questions were used, if needed, to guide the interview:

1. What was it like to be the chief nurse in _____?
2. What kinds of challenges did you encounter?
3. Tell me about a difficult decision you had to make.
4. Tell me about a particularly meaningful experience.
5. Can you tell me more about that?
   - what else was going on then?
   - a patient issue?
   - a staff issue?
   - an issue with the executive team?
6. Tell me how you were feeling
   - the climate
7. Any thoughts for next time?

Additional considerations. Each interview lasted from 60-110 minutes. The average was 85 minutes. The interviews ended when the participant indicated they had nothing to add to the description. Participants were contacted following the interview and invited to add any additional reflections or thoughts. Five participants chose to add anecdotes or points of clarification to their transcripts. Review of supporting materials included

videotapes, slides photos, notes, memorabilia and after action reports. The reviews took between 2 and 18 hours with 5 being the average. Handwritten and audio recorded notes were taken during the review process.

Data Analysis Procedures

Transcript management. The analysis of data from each interview began within 24 hours of the interview, thus the first phases of analysis took place concurrently with data collection over a period of four months. Following each interview, the interviewer reviewed the tapes (within 24 hours) and made notations. The tapes were transcribed verbatim by a professional transcriptionist during the following three weeks. Upon receipt from the transcriptionist the transcripts were read by the investigator while listening to the tape and corrections were made. The verbatim transcripts were edited to remove names, locations and distracting grammatical phrases such as “ahh”, and “um”.

Approaches to analysis. Data was analyzed using procedures adapted from Colaizzi (1978) and van Manen (1990), and illuminated by Ray (1990). These procedures have been used in other studies (Caliandro & Hughes, 1998; Kalb, 1993; Kirschbaum, 1993/1994; Scannell-Desch, 1992). Colaizzi’s approach to analysis has as its aim understanding phenomena within the human experience. The steps of the method are flexible and by no means definitive. It is also important to note that analysis is not a linear process nor can the activities be performed in a rigid sequence. The lifeworld existentials described by van Manen (1990) guided the comprehensive description referred to in step 6 below. The existential themes are lived space, lived body, lived time, and lived human relations. A unity of meaning was identified using the process of intuition described by Ray (1990).

Procedural steps. The procedural steps are listed, followed by the specific techniques used at each step. Presuppositions continue to be bracketed.

1. **Read the transcript to acquire a feeling for it.**

   Each transcript was read in its entirety, without interruption, to acquire a feeling or sense of what was being described. End note summaries were written.

2. **Return to each transcript to extract significant statements pertaining to the phenomenon.**

   The next reading was done with highlighter in hand. Significant statements pertaining to the phenomenon were highlighted. Repetitions were eliminated since significance does not depend on the frequency of statements occurring in the text.

3. **Formulate meaning using creative insight to get from what is said to what is meant. Care must be taken to preserve the connection with the statements.**

   Margin notes were written reflecting what the participant was describing rather than the interpretations or conclusions of the investigator. Careful effort was made to go beyond the data while at the same time staying with it. This was done by continually referring back to the entire text.

4. **Repeat with each transcript, then organize the formulated meanings into interpretive clusters. Acknowledge and accept the ambiguity or contradictory nature of the clusters. Refer back to the text to validate the clusters.**

   The interpretive clusters which emerged from the significant statements were organized from formulated meanings which were documented in the margin notes. Reflecting, re-reading the statements in context and re-writing the clusters began to reveal the themes. There were 162 clusters identified initially and 45 remained after combining some clusters and eliminating others due to their incidental rather than essential nature.

5. **Organize the interpretive clusters into themes and validate them by referring back to the original transcript.**

   As interviews were completed the themes were compared with the themes from the previous participants' transcripts to ensure that the attributed meanings were consistent. Care was taken to make sure there was nothing in the transcripts that was missing from the themes and that nothing had been added to the themes that was not in the transcripts. Some interpretive clusters fit into more than one theme and were therefore included to provide the richest description possible.

6. **Integrate themes into a comprehensive description of the phenomenon.**

   This was guided by the four existential theme categories described by van Manen (1990).

7. **Formulate a statement that identifies the fundamental structure of the experience.**

   Based on the interpretive clusters and the themes which emerged from the text, conclusions about the experience were formulated into a statement which identifies the fundamental structure of the experience.

8. **Reflect and re-reflect on the descriptions of the experience (the text) and use the process of intuition until the unity of meaning is apprehended (Ray, 1990).**

   Reading, writing, and quiet reflection were engaged in, using the process of intuition during all phases of analysis. Deep reflection on the text and themes previously identified, and interpreted led the researcher to an intuitive grasp of the whole.

9. **Validate the findings with the participants.**

   Findings were shared with the participants with an invitation to

comment on the accuracy of the essential themes, the fundamental structure and the comprehensive description as a reflection of the experience. Letters were mailed to each participant with attachments that included the comprehensive description, tables of themes and the discussion of the findings. A stamped envelope and reply card were included for easy response.

Trustworthiness

Trustworthiness, in human science inquiry, is established in order to convince the reader that the study merits attention and that the findings of the study deserve consideration. The construct of trustworthiness which includes credibility, transferability, dependability and confirmability, is appropriate for qualitative studies (Lincoln & Guba, 1985). In some ways trustworthiness parallels the familiar terms of quantitative studies: reliability, objectivity, internal validity and external validity. Both paradigms address truth value, applicability, consistency and neutrality (Lincoln & Guba, 1985; Sandelowski, 1986). In this study several techniques were used to achieve trustworthiness through demonstration of credibility, transferability, neutrality, dependability and confirmability.

Credibility

Credibility addresses the truth value of the data and was demonstrated by prolonged engagement with the culture of the participants, building trust, guarding against potential distortions, persistent observation, triangulation, peer debriefing and member checking.

Prolonged engagement and trust. Prolonged engagement provides scope to the study. The investigator has been on active duty with the Air Force for twenty two years. All assignments were in health care facilities and two assignments have been overseas. Exposure to mobility responsibilities and

training exercises introduced the researcher to the deployment experience. Successful completion of Air Command and Staff College and Air War College provided extensive grounding in most facets of military operations other than war. Trust was established with the participants through personal interactions and a reputation for competence, superior achievement and a commitment to excellence in previous assignments.

Potential distortions and persistent observation. Potential distortions by the participants were minimal due to reassurance of confidentiality, explanation of the purpose of the study and inclusion of the interests of the participants. Persistent observation is used to identify relevant characteristics and elements in a situation and then to focus on them in detail. This provides depth (Lincoln & Guba, 1985). This was accomplished by writing, consulting with the research advisor and expert consultants and most importantly listening to their advice. Rewriting, reformulating and reorganizing were the activities of this process of tentative identification and detailed exploration.

Triangulation. Triangulation of sources was used to further demonstrate credibility (Brink, 1991; Lincoln & Guba, 1985; Patton, 1990). Ten of thirteen participants shared meaningful data from sources other than recollection and memory. Photographs, mementos, videotapes, logs, letters and scrapbooks were reviewed to gain a richer feel for the experience. This triangulation of data is acknowledged by Colaizzi (1978) to deepen the understanding of experience.

Peer debrief and participant check. Peer debriefing took place during conferences with colleagues who were experienced with this methodology, experienced with nursing during humanitarian efforts or experienced with military nursing. Participant member checks took place as the analysis progressed. It was done informally and continuously throughout the period of data collection. Interpretive clusters and tentative themes were presented

to participants as they were identified. In several instances this process resulted in differentiating incidental themes from those that were essential. Participant confirmation is an important aspect of study credibility (Appleton, 1995; Sandelowski, 1986).

Other Elements of Trustworthiness

Purposeful sampling and the widest possible range of information contribute to a thick description (Lincoln & Guba, 1985). This description is provided to enable the reader to make a conclusion about the possibility of transfer or application of the findings in another situation.

Consistency or dependability is established when enough examples from the text are used to enable the reader to participate in the validation of the findings. The investigator, the research advisor, and methodological nurse expert agreed the data was adequate to support the themes, the structure, and the comprehensive description of the experience.

Neutrality, a criterion of Sandelowski (1986), is achieved not as objectivity but as integrity of the text in representing the phenomenon. Multiple, direct quotes of significant phrases were used to establish neutrality in this study.

Confirmability, according to Lincoln and Guba (1985), is best accomplished through an audit trail. This trail has been laid throughout the study and includes but is not limited to the tapes, the transcripts, annotated transcripts, printed drafts of interpretive clusters and themes, mind maps of the organizational process, field notes, notes taken during consultation, written comments from the advisor and other reviewers. Data was managed using QSR NUD•IST (software for qualitative data analysis) and the body of the text was prepared using Corel Word Perfect (word processing software), thus iterations of the analysis were stored electronically.

Final Review

Final comprehensive review with the advisor and the committee included the tapes, the protocols, field notes and decision rules. Additional considerations for analysis were described by Morse (1994). They included asking questions of the data by identifying values and beliefs and using lateral thinking. This process established links to descriptions of the experience in other sources. Writing the phenomenological text was the object of this research process (van Manen, 1990). Writing and rewriting led the researcher through the steps of Colaizzi's method. Recontextualizing occurs at the end of the process and it places the findings in the context of other established knowledge. Grasping the whole of the experience by expressing the unity of meaning as a metaphor brings the process to an end.

Human Subjects Considerations

Permission was obtained from The University of Minnesota Institutional Review Board: Human Subjects Committee (June 1997) and The United States Air Force (January 1997). The human subject considerations included informed consent, both verbal and written; confidentiality of materials by maintaining the tapes and the transcripts in a locked cabinet in the office of the investigator and limited anonymity in presentation of the findings through deletion of names of individuals and references to particular missions or facilities.

Chapter IV
Findings of the Study

This chapter will present a description of the sample and the analysis of the data. The findings include interpretive theme clusters, fundamental structure, essential themes, and a comprehensive description of the experience.

The findings of the study are presented according to the procedural steps described by Colaizzi (1978). The themes were identified from the interpretive clusters. The fundamental structure is described with examples of significant statements and interpretive clusters which illustrate each of the themes that make up the structure. The essential themes are presented in the same way. The clusters within each theme are listed and briefly described with examples of significant statements from the transcripts. Following this presentation there is a comprehensive description of the experience of chief nurses in military operations other than war. This description has been derived from a synthesis of the formalized meanings found in the interpretive clusters, the fundamental structure, the essential themes, and the existential life theme categories of van Manen (1990).

Description of the Sample

There were thirteen participants in the study, eleven women and two men. All of them had been on active duty in the Air Force when they were deployed to military operations other than war. Twelve were still on active duty at the time of the interview and one had retired. At the time of deployment, two were colonels, six were lieutenant colonels and three were majors. They had been on active duty for an average of 18.2 years with a range of 11-28 years. Their ages at the time of deployment ranged from 37 to 51 with 42.6 being the average.

The duration of their deployments ranged from 3-7 months; two had been deployed more than once. Sites of deployment included Saudi Arabia, Oman, Panama, Cuba, Somalia, Guam, Croatia, England and Turkey. Purposes of the mission varied from humanitarian relief to peace keeping.

Previous experiences for all of them included clinical nursing, with specialties in pediatrics, mental health, obstetrics, medical-surgical, gerontology and unit management, five had had flying assignments and three had been assigned as chief nurses. All were masters prepared. Seven had degrees in nursing: three in human resource development, three in administration / management and one in gerontology.

Fundamental Structure

The fundamental structure of the experience had five themes which, when viewed together, constituted the deployment trajectory. The five themes were preparing, arriving, living, working, leaving. These themes were identified from 28 interpretive clusters (see Table 1).

Preparing

Notification. The nurses described their experiences in much the same way. Each of the thirteen nurses identified events at a moment in time that marked the beginning of the deployment for them. Though many of them were assigned to mobility and therefore understood the possibility of being deployed, it was the actual notification and recall which marked the beginning of the deployment. Memories of where they were and what they were doing are remarkably clear.

> So I was on leave, believe it or not, at the time when the tasking finally did come down. My chief nurse called me at home about three days before my leave was ending and she said to me that we had gotten the tasking and we had to send a 46A3, nurse administrator.

Table 1

Interpretive Clusters and Themes that Constitute the Fundamental Structure Of The Experience

Deployment Trajectory	
Interpretive Clusters	**Themes**
Notification Urgency, packing and gathering information Picking people Previous experience	Preparing
Getting there Initial arrangements Natural and hostile environmental factors Orientation and setting up First casualties	Arriving
Communal living Daily living and elements of life Humor and little luxuries Boredom and problems from home Opportunities Cultural differences Human responses and danger	Living
Challenges and language barriers Daily routine Logistics and improvisation Additional duties and staffing mix Population diversity and patient conditions Dangerous environment and bunkers Practice standards Competency and translating into different environments	Working
Looking back Saying goodbye and closing down Lessons learned and next time Going home	Leaving

That was also the summer we were having an HSI [Health Service Inspection] visit. So about the day that the HSI came, that's around the 27th of Aug., we got our tasking order to deploy.

So we went over sometime early in January. They deployed us like ... That's another thing—here we are fat and happy in our homes, we're talking to the commander and he says we will never be deployed because they have this big medical center and we can't go. And then, on Friday, he says you are all on standby alert because there is a possibility that we will be deployed but, “I'm going to talk to the generals, and I'm sure they won't send us.” So we went home with this feeling on Friday night .... So I'm thinking can this be reality? And of course,the general is telling us that we aren't going and he is going to get this straightened out. So we go home on Friday night and I'm thinking if we leave this weekend, I have a house, I have two dogs, and I'm by myself—you know, I've got to do something.

Well first of all when this whole thing ... When the deployment occurred or was going to occur, it was a shock .... Just almost like going to ... To Desert Storm. I mean, like we're here today and then tomorrow we find out we're all going to be deployed and it was like an unbelievable sense of "This can't be happening." And my first impression was "See if I can't get out of this." Because they first told me ... They said, "Well you're going to have to go because you're a Lt. Col." and I asked why even though we had a major here who was well experienced in the ATH [Air Transportable Hospital] and she was the chief nurse of the ATH here. And for a while, they said, "O.K. nothing's going to happen" and they called back and said "No you don't have to go." So the whole deployment happened .... Sunday night I got a ... I received a phone call, ah ... Saying pack your bags, possible deployment. Really didn't think that ... "Oh yeah sure." And went to work on Monday and we had a meeting for everybody to meet and it really sounded serious, like this probably really was going to happen but we really didn't have a lot of information on what was really going on. I think they might have mentioned that there were some evacuees and possibly they were going to take them to Guam. But we really didn't know if we could possibly be going to Iraq or Turkey or where we were going to go, if this really happened,.. And I think all of us left that day and thought "Well we'll know something in a couple of days." Well we got a phone call very, very early in the morning, at 1:00, and were told "Need to be here in an hour."

The deployment to Somalia was a very, very short notice for me. I came back from a mission, air-evac mission, at 4:00 in the afternoon. I was basically told "pack your bags." This was about the 3rd of December of 1992. "Pack your bags. You're going to be deployed. You're going to be linked up with an air lift control element. You're going to go to McGuire. We don't know where you're going from there. We don't know when you're coming back.

I was real excited about finding out I was going. I mean, I wasn't in any way dismayed. I was glad to have the opportunity to, you know, have a break from the regular routine for a while.

Urgency, packing and gathering information. For some there was immediate shock and denial especially for those who had never deployed. For all of them there was a sense of urgency, a need to move quickly as they gathered information, packed personal belongings and made arrangements for their families, pets and other personal affairs. Short notice deployments left little time for adjustment.

> So I did. I left everything, I checked the hospital, and everything was still status quo, still on alert, and just waiting to hear. So I got up there to deliver the dogs and called back and they said "you have to go in and mobility process and you must be there in an hour." I said, "What?" So I give them the dogs and I rush back down the road and I packed everything to go now for, I ended up being there 3 months, in about 5 minutes. I just stuffed everything in the bag. I called somebody who I knew wasn't going and said "I'm leaving my house, everything is like it is, and could you check on it?" Christmas decorations were up and everything else. So I went in and we spent all night processing and then the next morning at 10:00 we left. I have never in my life done anything that fast. All these years in the Air Force, I knew this was possible.

> So it was very, very quick. To pack your bag. In fact, the morning When they called me, I had all my mobility stuff all together and, um ... And it hit me, "This is for real. I guess I need to throw in some sweats and everything else." So that's really how I really wasn't prepared mentally. Throwing some shorts, tennis shoes, sweats, and, um ... Just those every day, day to day clothes, because I didn't want to live in my BDU's [battle dress uniform] the whole time.

> So one of our big tasks was actually to get everybody in and we actually planned briefings for them with as much information as we could give them at the time, as much as we knew, to try to prepare them for Panama. We did the medical intelligence briefing for them as a group from public health, those kinds of things, so we actually did spend a lot of time trying to prepare them as much as we could. And then we needed to prepare our family members, you know the people who were going to stay behind, and try to get the support from the family members started so they'd feel as comfortable as possible with their people leaving.

> My boss said "Do you want to go?" You know, and then, of course, she addressed the ... "What are going to do with your daughter? Is she going to stay with her dad?"

> That was one of the issues we spent a lot of time... trying to get people prepared to be able to deploy and take care of their families.

> And about three weeks before we actually deployed, the executive team, the group that had been chosen to be the executive team at the deployed location, took a trip to the deployed location. And we spent three or four days. We had briefings at the headquarters in Germany which was like the headquarters for the U.N. forces.
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> And one of the things we always do before we deploy is really go over the country, what goes on there, and at least understand.

Picking people. Members of the deployment team were selected in several different ways. Some teams were pre-set—they had been assigned to mobility and had trained together; some teams were formed based on the particular requirements of the mission and used both volunteers and those who were assigned to mobility. For three chief nurses the ongoing requirements of the home facility had to be considered, leaving staff members at home who could keep the place running. Uncertainty about patient populations and the complexity of patient care made selections difficult. The possibility of the staff nurses facing extreme horror and monumental challenges hovered just at the surface of their consciousness.

> It's an enjoyable experience but the preparing for a deployment is very stressful because one of our jobs is to pick the people who are deployed.
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> I tried to figure out how I'm going to keep the medical center going and how am I going to run the contingency hospital so I did take a very select group of nurses. I knew the nurses well. I chose everybody I took. And it was a real hard decision because I have a lot of loyalty to the med center and to be able to sustain that hospital and yet I knew the horror facing us and the young nurses I was taking, I took some that were very good ICU / emergency room nurses.
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> Because we solicited for volunteers, we took people whose clinical background was pediatrics and we knew that we were going to a place where that would not be our tasking so it was a little bit of a mismatch when you do that.
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> We had made up a list of things that we thought we would need when we actually went in the field. We picked all the people who were going to deploy with us except we didn't have enough people. We met every week until we deployed. The whole team together so we knew each other at our base and little did we know that

> it wasn't going to be just our base that deployed. So the day that we got all of our bags, and they told us to bring everything in, and we brought everything in our duffel bags, whatever those things are, the long green ones, we put it on a truck and let it sit in the yard out there. And it stayed there for two days because we didn't get to go. And then we decided that we were going to do some humanitarian relief efforts down there so we started getting things for the babies and that's when we looking at the TA / table of allowances and there was nothing for children nor pregnant women or anything else on there so... We got extra vaccines and everything else and took it down with us, put it on the pallet, and took it. I have a computer and, of course, I put my computer on the pallet and took the computer with me.

Previous experience. The question, can I do this? was answered by reflection and recollection. The nurses reflected on their previous experience as they prepared themselves and their team members for separation from family and for the task ahead. Topics covered in training exercises were recalled and pieced together to form a picture of what was before them. The feelings they expressed ranged from exhilaration and excitement to reservation and uncertainty..

> I had not been one of the primaries. I had been an alternate so I really hadn't been involved in all the bag drags or, And she told me that "You're it. You're the chief nurse." So we had a big exercise. We had to set up the entire ATH and also we had a big readiness exercise. All within probably like four months. So that was the breadth of my experience. And I learned a lot with setting up the ATH. But again, I hadn't had a lot of experience.

> I literally pulled pieces of paper off the fax machine from headquarters and studied those on the way over.. It was kind of deja vu because I had been through this a couple of times before in my time at Pope... So it was not a distressing point in my life but it was a point where I realized that I was again going to miss the holidays.

> I never had to go to Desert Storm but.. I had my bag under my desk for months. And every other day, they were calling me and saying "Well we think we might need you." And one time, I even got to the plane, I went out told my wife "bye" and everything and went through all that emotional upheaval and then that night I came home.

> I was the chief nurse of the ATH and we had been practicing for I guess about what two years before we actually went over. Every year we set up and lived in...

Actually lived in the tents as we inventoried all the equipment and supplies.

I think we... Just the experiences that you have in managing your units and all that give you the experience when you move into those roles.

One thing that I felt uncomfortable about is the fact that I had been prepared as far as possible.. I had done a little two day Red Flag exercise, you know. And I was thinking to myself, those really did add up, even though, you know, you used to whine about playing out and having to do the portalets and all that kind of stuff. I thought, "Well this has helped" because it's not such a shock.

I wish there was a school that I could have gone to for a couple of weeks or something.

Arriving

Getting here. Arriving at the site of the deployment produced multiple responses. It was an intense time with incredible amounts of information to be taken in and many, many decisions to be made in a very short period of time. For some the arrival was a welcome end to a tedious journey filled with sleep deprivation, hunger, confusion and uncertainty. Although everyone got ready in the beginning, for some what was to have been the beginning continued for days and weeks. Being ready became the task and it proved to be a frustrating task when the expectation never became reality.

We left and we went to... Actually went to Spain and stayed there in a huge hangar at Zaragosa. Stayed in a huge hangar there for a day. And there was a light and you couldn't cut out the light so... We were supposed to be resting for the second half of our trip but we really never rested. We should've all stayed together but we didn't. And we got to Turkey, off loaded everything, and then whatever you brought it was up to you... You had to figure out how you were going to carry this stuff with you. So... I had all of this luggage, this computer that I had insisted that I couldn't live without, and all the reference books and everything else and they didn't have any place for us to rest. We ended up in the Rec. Center. So the next morning we got up... It was the night, we were on the pool table and it was two of us on the pool table and one of the girls, I don't know what she did but she fell off the pool table, and its like everybody in the whole place woke up, the lights were on, and here we all were wandering around. I'm sure they wanted to shoot us.

Initial arrangements. Living arrangements were an initial concern. For

those who arrived at a site that was already operational the arrangements were not a problem. In one instance the accommodations were almost resort like in location and amenities. For those who arrived at sites where no preparations had been made the experience was considerably different. The teams ranged in size from four or five to several hundred troops. Finding accommodations was challenging but often it was just the beginning of a very complex task. Communication, transportation and privacy were just a few of the problems that surfaced. These issues had to be considered in the context of the bigger and more pressing issues of the mission itself.

> This was family housing and we had to move all our nursing staff into these little tiny family housing units. The house in American standards would probably fit 3-4 people and we were putting like 12-15 nurses in there, on cots, you know, on the floor or whatever, and it was also 10 miles away from where the hospital was. We had no communications. So, the initial problem of getting there was trying to figure out where we were going to be, how we were going to get people back and forth to the hospital and it was a terrible logistics problem.

> The first priority was to get everybody a place to sleep and that was a real problem because we had people all over. Initially, they put us in an officer's club/barracks at this place 10 miles down the road and we didn't even have the buses contracted to move people back and forth, we didn't have a car, and so initially we were all at this base 10 miles away and yet we were supposed to be up here starting to activate this hospital. So it was a logistical nightmare. We did contract some buses. Then there was a dining hall where everybody was going to eat, which again was 2 miles from where they were living. So, we had to get them on a bus, take them to the dining hall, feed them, and then get them out to the hospital. Then, once we were at the hospital, this hospital had no dining hall, the plan was to put a tent up and cook the food for the patients and not the staff. So, we had to have MRE's at lunchtime and then at supper we could be bused back down to that dining hall. So, just the idea of getting people a place to sleep, a place to eat, and how to get back and forth was our biggest problem and it took us a while to work that out.

> Finally, got someplace to sleep but it was a real problem as far as one bathroom was outside, one in the house, and here you have 12-15 women living there trying to get to the bathroom. I mean, you don't even think of these little things.

> Our team of four people including the commander, the administrator, and some loggies [logistics people] went down, two loggies, they had not made any

arrangements for billeting for these 125 people, no arrangements, there were no arrangements... There were really minimal arrangements for where we were going to put the ATH or how much room we needed for an ATH .... So what we had to do was our group that was just coming together as a team, Just as we're coming together as a team, they decide that they're going to split us up and they can only find places so that we have to split in three different groups, two on one side of the canal and one on the other side of the canal, So the surgeon, anesthesia, the SGH, the commander,... the team that had to be closest to the hospital stayed on The ATH side of the canal. And then the most senior, this is how I decided, the most senior of the techs that I could trust the most and knew the best would stay in a converted ward in the Army Hospital. It was "One Flew Over the Cuckoos Nest" revisited. It was unreal. And it was like one block away from the Red Light District, so that's why I couldn't have the youngsters in that environment. Then, I took the rest of us over to the base and we were in another dorm similar to the facility that we had in the old dorm that had to be renovated. But I had all the youngsters, the most young of the youngsters, inexperienced nurses and techs, young, challenging.

10 days here, we're out of this hole." And it really was... You know, we had bottled water, no showers, sleeping out under the stars, open pit latrines, MRE's, and so for the first 10 days it was pretty nasty in there.

The senior nurses were in a tent together and then the doctors were two doors down in another tent. And the other nurses and technicians were actually like three rows over in another tent, separated from us, which they liked very well because we couldn't keep an eye on them.

But by the time we got there, they knew what was going on and they had everything fixed for us. Like I said, I went right to my room, I had no problems or anything like that.

And when I got there,..they had rented... an ocean liner And people were living on the boat... it used to be one of the luxury liners. .. there was a little gym there. And I lived there first before I moved into billeting which was they were extremely small accommodations. I can remember having a candle when I first got there and the people that cleaned my room, took it out.. Without permission. I wasn't allowed to have that. And there was only one electric outlet So I had to use my curling iron someplace else and I ironed down the hall. And.. I was really feeling closed in. I could never have been in the navy. But we lived on the ship for two weeks before I got into billeting.

Natural and hostile environmental factors. The environment was a significant variable at the time of arrival. Characteristics of the natural environment were noted as well as the more immediate concerns of the

political and cultural climate. A unique situation for everyone who experienced it was the presence and use of bunkers.

> It was very scary initially. ...we got there right at the beginning of it and people would... You'd be driving down the street and you don't know what's going to happen. And you're in the vehicle and what we had to do was... We had to wear the helmet, the whole bit.
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> It was kind of unnerving.. We had to load the weapons and had to hold them up so that people could see that we would shoot them if we had to.
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> And you saw people with their guns and it would scare you to death.
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> There was a lot of animal life when I first got there. There were turtles swimming. Huge, huge, mammoth turtles come from the water. And there were... Banana rats. Which were big mice that were kind of like from the monkey species.
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> I don't know if you've ever been in there but these buses are not like American buses. So we got on there and this driver... He was driving as fast as he could and up these mountain roads and we were hanging on to the seats, just praying that we'd get there... That we'd just get there.
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> Everybody had an assignment, a bunker assignment. So we all knew, if you're in the housing area, this is your assigned bunker, this is the closest. If you're on duty, we also have hospital bunkers so you could go to the "hospital bunker" and that's where we would evacuate patients and our ourselves. So it was very important that we knew that right away. And it's fortunate that we did.

Orientation and setting up. After assessing the situation and making plans to adapt to the daily living needs of the group, it was time for orientation to the operations if they were already established, or time to set up if the mission was just beginning. When the deployment site had previously been used for another purpose and was now abandoned, the creativity and imagination of the team was put into play as buildings were assigned new uses and space was reconfigured to accommodate the equipment and supplies for patient care. Familiarity with the equipment

helped a lot but for some the equipment was unfamiliar and presented an immediate training challenge.The terrain was not always user friendly and the tents frequently had to be reinforced or moved. The physical labor was demanding and turned out to be an opportunity for developing unity. The consequences of the intense effort were best treated with “Vitamin M.”

> We're hurrying up, trying to get this place ready to accept patients we were just looking at old buildings / barracks, asking how are we going to set up our hospital.
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> You see these trenches here? They put us on an old parking lot and we had to change the configuration because we did not have the room needed to configure the ATH the way that they're supposed to be. But this was a parking lot and there is no drainage when it rains. The flooring was actually floating and so we were the ones that dug the trenches to try to keep the water from the ATH.
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> The area used to be a shooting range for tanks and guns. So I mean it's out in the middle of no where and they have put the cement slabs up for all the tents and put the tents up. So they were building the camps at the same time that we were building the hospital and the same time that we were building our sleeping tents. It was a maze of activity and things changing rapidly.
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> It was really interesting, just trying to get things going. Anyway, then, of course, I thought "oh we'll have these three shifts," well that went away the first day. We ended up dividing it into two 12 hour shifts. We had to get buses in the middle of the night. We felt like we had the team of people, enough people there, to do the two shifts and then have them be able to orient them and start getting ready. Our biggest whole preoccupation the first month was being ready for casualties.
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> I knew the equipment was like the old Bird respirator and I knew the E.R. nurses had never even heard of the Bird. And when we showed it to them, of course, we heard "What is that thing?" But we did have one M.A-I. and a Bennett respirator. So we focused on a lot of training in the first couple of weeks. People at least knew some of the basics, as far as the equipment we had. We had equipment that had been in moth balls. We had to take everything out, wash it, you know, get it ready. We were devising ways because we had no call system and everybody is used to a call system. We had no little bells. So we were figuring out - an IV pole, you put a flag up if you had an emergency and that meant everybody run but, you know, we were just trying to devise our own methods.
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> We got there and it was... We were putting up the tents and trying to figure out where to put these tents and where we could have a helicopter landing pad

because there was nothing there at the site. It was an actual wheat field that we set this thing up in. And everybody worked together, even the people that were new.

I remember... Thank God for Motrin, Vitamin M. ... without Motrin I wouldn't have survived.

First casualties. All of the intense preparations and anxious expectations upon arrival were totally eclipsed by the arrival of the first patients, the first casualties.

We had... We were on the ground 42 hours and we had our first military patient. The migrants arrived... Started arriving about the... In country about the same time that we did. Now, there were four different camps and I think they were supposed to take up to 2,500, would that be 10,000? They were supposed to take up to 2,500 folks and we got up to about 8,600.

They showed us where the bunkers were..... So it was very important that we knew that right away. And it's fortunate that we did because we got there on the 1st of August, the other folks left the afternoon of the 3rd, and the next day there was an offense about 20 miles from Camp and we could hear some of the activities going on and we knew that the planes,... we could hear them taking off early, early, early in the morning so we knew something was going on. Well, like I say, within three days of being there, the little war broke out. That was when a couple of the sectors launched offensives against one another. And two days after that, we started getting casualties.

I mean, we got off the bus working and then scrimmage happened and then for 11-12 days after that things were really, really, really, really busy. I mean three patients on ventilators and... None of us... None of us would have ever anticipated that we would have that type of patient or clientele, at least not all at once, and at least not so sudden. I mean, the idea was we'd get there, we'll have to have to train, we'll lay it all out, you know. No time to train.

Because I knew at that point that as soon as I landed there were going to be disease, non-battle injury patients, who had to be evacuated from theater.

We landed in country. They invaded on the 10th of December. On the 13th of December, I'm standing on the flight line in with one other nurse, two med techs, and the flight surgeon who had gotten lost already. And, uh... We immediately linked up with the advance marine medical element that had landed there. Our hospital on the scene was the U.S.S. Wasp that was steaming up and down the coast line. .. in the harbor and found out that we already had casualties on the

ship and we needed to get them out of there. Literally within 12 hours, we had our first air-evac mission using a nurse and a technician, leaving me, a nurse, and a tech in the theater with about 15,000 military now on the ground and the flight surgeon, It took about 10-12 days of... It literally seemed 24 hours a day, seven days a week, before the rest of the air-evac element came into country and we were hanging on. Those four or five of us were hanging on by our... Our nails during that entire period of time.

A humvee [small truck] that had gone over a land mine that had been planted for the humvee. It ended up killing at least one, I think killed the driver or the passenger,and severely injured the other occupant of the vehicle ... was air lifted out to the U.S.S. Wasp and stabilized there, if you could stabilize it in that environment, and then we had to coordinate getting the patient helo'd in from the Wasp to the flight line, unloaded onto a C141 with our air-evac crew, and then flown up to Germany. We, by that time, had the beginnings of an air transportable hospital establishing at the refueling stop for the C141's. So that was literally the mission that we had within about... Just a few... It was probably 36 hours, it seemed like it was, you know, 1 hour from the time we landed there. We did successfully transport the patient. ...was probably one of the most seriously injured patients that we had in the entire time that I was there and it was the one that was there right at the very beginning.

Living

Communal living. Living in community became a reality for everyone who was deployed. The communal aspects of the deployments evoked many complex and contradictory responses in each member of the team. The surroundings provided a backdrop for an increasing awareness of the differences between desires and needs and gave new meaning to the word luxury. Rhythms of the camps and bases were recorded into the consciousness of the troops and they became a source of stability in the particular kind of chaos in each of the deployments.

The climate out there was either hot...or When we first got there, it was during the rainy season. And there was this red mud and... You know, those vases they make out there? The ones that they find. You can tell why they are still together because this mud is almost like clay. And so you wear your boots and you walk across from your tent to the hospital and you could not walk... You had to take off your shoes and clean the mud off of your boots before you could even walk. It snowed some while we were there. And then at the end, it was miserable... Miserably hot. It was very, very hot out there. And so we worked six hour shifts. And everybody would have to rest. It was mandatory that people rest and they had to drink water. We had all of those fevers. We had all these diarrheal diseases. And none

of our people actually came down... None of us were actually sick out there except for the one person who went back early.

Daily living and elements of life. The activities of daily living had their own peculiar influence on the daily routine. Living, all by itself, took time. The most basic elements of life, water, food, transportation and the natural environment became significant to the troops and previously ignored activities or those taken for granted became a central focus of the unfolding story.

I want you to know that at 12 o'clock every noon time, you have a torrential down pour, o.k.? The skies open and you are drenched. Now, factor that in.

We deployed up to a place out in the middle of nowhere. It... It was the darkest place I've ever been to in my entire life at night. There was not a light anywhere. It was out in the middle of the desert.

I saw the big iguanas. They would just be walking around. And the navy was so serious about not injuring those things or not hurting them. I guess they're endangered. And there's $10,000 fine if you hurt one of them or killed one of them ... And they'd just walk in our tents. You'd just be sitting there and then here one would come in, we would give it an apple or something, and it just kind of walked out. No snakes there so we never had to worry about that but ah... those other little rodent things, those banana rats, which really weren't rats but they looked like they were kind of rodents..... hundreds of them. You could just see them all over the place at night and just about dark.

And it was very warm there. Very warm... And very sweaty because we were on the water. Salty water. Not nice fresh water. And when I got there, they still had barbed wire around the area.

It made sense to have the hardened facility especially because of their rain. They have lots and lots of rain, and also typhoons. ... it turned out, we did have a typhoon that came through and we had to take down the whole ATH.

The only thing that was real annoying right before I left, probably because it was right before I left, was, the electricity would go out because the heat was getting so hot and then the water, the bathrooms wouldn't work, and that got real annoying very quickly. When you couldn't wash your hands because ... you'd have to use the bottled drinking water to wash your hands .... Some places, depending on where

you were on base, you had to use the portalets and had to go find water because, of course, they didn't have water so you had to go find water to wash your hands with. So, I mean, it was just an adjustment type thing. You had to go back to the basics and remind people to take showers every once in a while.

But we had minimal support. We did not have running water in our hospital until December when some air force folks saw our situation, were thankful for the care they received during the riots and put in a couple sinks for us. The O.R. didn't have running water—5 gallon buckets and hand washing stations. But we didn't have any infections either.

The only shower facilities that females had during this deployment was the shower point. There was 1/2 hour we got it in the morning and 1 1/2 hours at night. That's all we had for sinks, showers, for everything for 44 females. So, Showers became very important. And in the evening time, you know after you'd sweated all day... When it was the shower hour for the females, we'd practically drag the males out of the shower stalls when it was... When they were in there past their time. And we got real nasty with them, to get the heck out of the shower because we were... It was our time!!!. But it was just... I mean, just the basics. You know, Maslov's hierarchy needs.

My shirts.... they look like tie-dyed 'cuz there was no cold water, they only had warm water, 'cuz the water was kept in the bladders outside and it would be so hot... In fact, you couldn't shower in the middle of the day, you could only shower first thing in the morning or in the evening because it would be too... You'd get scalded if you showered in the middle of the day because it would be too hot just from the sun, not even from the water being heated up.

Eating in an army chow hall that they served ham and two other unidentifiable meats for lunch. I ate ham for three months straight for lunch 'cuz that's the only meat I could identify. uh... We were really into basics. Their breakfast recipe always started with a glob of lard. And you drank bug juice, you know koolaid, that was what you got to drink but... You were so thirsty, you would drink anything. You even drank tap water out of a stinky old canteen because you were so desperately thirsty.

We like milk. There was nothing for milk. So, it wasn't even the first week that they immediately went out and got a contract for food. And they bought coffee pots and made us coffee, they got whole big things for milk and cereal and some of the things we eat instead of the beans and sausage - I mean we couldn't live on that kind of stuff for breakfast. So once they got that really good contract, the morale went up... I mean, little things. You know, even orange juice, fruit - we wanted fresh fruit, you know we demand a lot of things. So, they did a bang up job. Essentially, I only ate once per day because where I was living we didn't have any kind of facility. We had a stove in our little house there. ... all they did was take an empty government house and hand it to us. So I just heated hot water and cocoa or

something for breakfast. Then lunch, we had MRE's [meals ready to eat]. Then supper, we ate our main meal. And it was a great time and a morale builder to eat a real nice meal down there in the dining hall.

A prison tray...You know, it's kind of like a metal T.V. dinner tray. And that's where they put the food, directly on the prison tray. That was a shock the very first time. And then new people would come in and they'd be like "Huh!" and it would be funny because you'd realize "Oh a couple of weeks ago that shocked me too".

We got a lot of things that we wouldn't automatically get from the different services. They had MRE's. The French had the best MRE's in the world, it was like having a gourmet meal or something. So we would get their MRE's and everybody shared. Whatever you got, you shared with everybody else. So we had everything.

The big problem for us was transportation. Because all the things that were going on the island, catching the transportation... We were doing long shifts, we had to get there before the beginning of the report started. So we would put in... It was not unusual to put in 14 hour days just trying to catch the transportation back and forth. It was probably 30 miles. So,.. That was a big issue. The administrator ended up getting his own vehicle. The commander had his own vehicle. They would offer me rides, but I felt like I needed to go on the bus. I needed to feel how people were doing and be a part of the group. In very, very rare situations I would use the truck. When the administrator was off, he would give me the truck to use so that I could run around and check on people on the compound.

The commander had a car, a staff car, and there were two vans. And we all just took turns using those or walking. I hitch hiked to work a lot and rode in the back of a truck... Or you could take the shuttle but that took a long time.

Then I got a bike handed down about the last month I was there so I rode my bike a little bit but it was pretty hot for riding a bike.

I thought that was a little bit of an adjustment. I think especially because in that climate the temperature averaged 110 degrees every day. Yes, by 11 o'clock, it was just unbelievably hot, you couldn't even sit in the tent if the air conditioning went out, you just couldn't do it and so you would go find an air conditioned tent.. or shade.

Humor and little luxuries. The combination of resources and requirements created some unusual situations and the details that made up the situations took on new meaning. The definition of luxury expanded to

include trivial items, especially those that were in short supply. Humor made living easier and much like other professions which deal with stressful and profoundly sad events, a humor evolved to release the tension and to help keep things in perspective.

> I walked every day to the hospital which was probably 1/2 mile. We did get one car between the four of us but usually the commander drove the car and I lived in a house with three guys, by the way. Because I was the only female in the house, I got the bedroom with the bathroom and they all had to share another bathroom but I lucked out and had luxury accommodations.

> I'm trying to think. ... I just packed BDU's [battle dress uniform] and civilian clothes. And a lot of all that other stuff that people generate. You know, your [electric] cords and your... You know, your clothes lines. And, you know, all that... Things that make things easier for you. The one thing that I would have died for and I pack it now in my bag, are hangers. And, you know, they would say, "Is there anything you need?" I'd say, "Just buy me some hangers." We had a microwave and stereo and refrigerator and ironing board.

> They didn't realize that there was a BX [base exchange] and a movie theater and all kinds of places to eat. ...but there was a lot to do there. They had movies every night, everything was free. Movies to mail. Even to mail letters was free.

> I hate to say that this is a positive but it always comes out that way. The concrete floors were horrible and we were in combat boots but I got... I told them to bring sneakers. That was a big issue. But they only could wear them while they were on duty .... Believe it or not, little things like that mean so much. So they could wear their sneakers. ... while they were at work, they could wear sneakers. When they went out of the work area, they had to put their combat boots back on. You know, you're standing 12 hours, those combat boots are murder. Our soldiers have a terrible time with it but that was a real morale builder, real positive.

> But what we did is the executive team used that white jeep so when you got your days off to go back to base and stay in the Q [temporary quarters] then you got the jeep. So he would get back sometime around 10:00-11:00 on Sunday morning and I'd leave and then I'd be back by Tuesday at 7:00 in the morning. So 1-1/2 days. You know, I'd get back to the rear. Those were good days. I mean, you got to go in a flush john, flush john, air conditioning, privacy, phone, all those wonderful things. So it was nice to do that. I mean, you really took a shower in a shower.

> After wards, we restocked the facility, the E.R. area. We would talk about what happened and how everybody was feeling and how we were going to handle the

next group that came in and who was going to be ready. We found a lot to laugh about even though there wasn't anything really funny, we laughed because somebody had done something really silly or reacted a certain way and we would laugh about it. And it sort of helped the person get through, and to see it's o.k. to be like this.

So they made vanities. The supply and maintenance guys, whatever they were, made vanities, mirrored vanities with chairs so that all... And one for each women's tent.

The General came down to visit. It was when... We had just had an incident. We had cleaned up... We were cleaning up... I was on my hands and knees at the front of the ATH, mopping this floor, and I looked up and I saw these boots and that's the only thing I saw was boots. And I didn't see anybody else. And I said, "Well you'd better get back outside and get those boots off before you step inside of this building." And you could hear silence. I looked up... Even as I looked up... And there he was. "Oh Sir I'm so sorry." He said, "O.K." And he went and took his boots off.

They put up signs near their tents. This is when we got there, they put "No fishing allowed." Well obviously, you're in the middle of the desert so there was a sense humor that people had.

So we went to the bathrooms and the bathrooms were... Actually they were buildings but they had a hole in the ground in the cement so all the females... You could hear everybody laughing and we did what we had to do and we got back on the bus, got to camp late that night. We got off and there were tents as far as you could see. We carried all of our things off the bus.

And you know what gets you through? Humor gets you through and people get you through.

Boredom and problems from home. The lack of productive activity while waiting for patients generated boredom for days at a time. The absence of usual leisure pursuits and the companionship of friends and family magnified the boredom and provided opportunities for unhealthy and sometimes destructive behaviors to evolve. In addition to the boredom there was a felt helplessness in meeting individual responsibilities at home. Letters and phone calls brought news of family problems and there was little that could be done to help.

We had... It... It varied. Ah... Drinking... There wasn't a lot to do in camp other than they had little night clubs that had sprung up out of nowhere, just because the camp had been there forever. And we were in Europe and drinking is prevalent. .. we had, ah... little BX's and package stores that had liquor and it was fairly inexpensive. And so, when one was not on duty and had a lot of time on their hands or when we didn't have hardly any patients, which for days we would go where it was very, very slow, people had plenty of time. And drinking was prevalent. So we did have some people who got into trouble because of drinking.

I don't know, maybe... This may have been their first deployment... You know, they were very young, 20, 21, 22, a lot of them... And they'd meet up with these people from the other contingents and those... Those people are used to drinking. I mean, this is Europe, you know. And some of our young airmen would get pretty drunk.

We also had people who... If your personal life is not real secure and tight at home, it affects you in your deployed location. And we had some folks whose family life was somewhat shaky when they left and... And being gone does not help a situation like that at all so we had some personal problems with, you know,spouses back home and so forth which ... It affects people's duty. It really does. Thank goodness we had a good social worker. I keep saying that because he was always there to listen and he helped a lot of people, helped a lot of people through some very difficult times.

And was there problems at home. Like we had one person that was married ... and he had some real big concerns about her 'cuz they had one sick child and she was pregnant. And so you're hearing all the problems from home, you know, and the issues, you can't deal with them when you're not there and, you know, you can only do so much.

But the typical problem is everybody got bored and there wasn't anything to do. We were supposed to have more R&R type things and we never got any videos, we never got movies. We did organize some parties, They were great, wonderful. We had a couple of parties where they had some dancing and some skits and stuff. But on the whole, the doctors got crazy. Then what happened is how do you control doctors who aren't working and they were sort of going off and doing their thing, then my nurses wanted to do it, I couldn't do that, so we started really having a lot of disciplinary problems. You just had to think up things for them to do just to fill the boredom. The last month, it seemed like it was so hard to keep everybody involved. It looked like they were starting to disintegrate. I mean, you could just do so many things. We started doing unannounced exercises, just to keep ready. So we would do this about every other day practically or sometimes every day, just to give them something to do. ...and we were just trying to think of things constantly to keep people busy and out of trouble. Very frustrating.

I found that the nurses stayed very busy because I think nurses tend to find things for themselves to stay busy. And I found that for the technicians I needed to find a

couple of things to do like sandbag detail... I volunteered them. You know that sort of thing.

Boredom. The boredom and the day to day entertainment. They want to do things for a while and it's exciting and then every day is the same with nothing to do. So you work... We always worked 12 hour days but then there was nothing to do for the 12 hours after and people just started getting on each other's nerves.

And so then the atmosphere,.... as it dragged on and not much was going on, people would get tired of it and want to go home.

The days went by, I thought, very fast. There was always something to do. You know, we would... We would go to the intel briefings or if there was something that the entire American contingent was involved in, we'd detail people to that. There was always something and... And if people say they got bored, I don't know how because I never had a dull moment over there.

Opportunities. For some the slow pace and lack of work translated into opportunities for new experiences and adventures. There were lots of new people to meet, and when allowed off base or out of camp, many new places to visit. During the longer deployments or when there were permanent bases nearby there were activities set up by MWR that included movies, sports and parties.

I got invited out, a number of us did, to a wedding, this was in town And, The women, the young women, 20 year olds, were so... We were in a separate area with just them and they were just like our young women in the states. I mean, some of them were teenagers and 20 year olds. and they would wear blue jeans and things like that. And they would just yak. You know, just like women do in the states. But then when we went in where the men were... or When a guest would come into the house, they would all make this noise like (noise)... Like that and they all do it. And so it just raises the excitement. You know, that's just the culture... And then when they get with the men, they all put their abayahs on and they were all complaining 'cuz they had to wear their... Cover their heads and they were going to mess up their hair.

There was a school there for the kids. And, you know, once I got to know those people in the short period of time, they'd take me to different people's houses and certain villages where they worked and show me beautiful art work and that kind of stuff. And then you'd sit down with them and sometimes tell stories.

> This wasn't a typical deployment, we didn't have to put up tents, there was really no hardship, people were getting certified in scuba, there were lots of opportunities to do various things, and there were no hard hours whatsoever. They did their job but it was not a hardship TDY except for the fact of being separated and for some of them, the housing. There was also the cruise ship. A lot of the people were billeted on this cruise ship. You got three unbelievable meals per day. Many people had an extremely good time during their 90 days.

Cultural differences. Living in another culture required various adaptations on the part of the troops. Examples of these adaptations included dress, food , drink and getting around. Most of the individual adaptations were acceptable because they were perceived as being for a limited time and required minimal inconvenience. Cultural differences were also apparent in the populations in the camps and among the patients in the Air Transportable Hospitals (ATH) on base. Observing these cultural differences encouraged reflection and a kind of respect for both the individuals and the people as a whole.

> We became a whole community. There was a mayor, a man who spoke Kurdish who became the mayor. They had a chaplain there. They had security police. It was amazing to see this place transform into a community with walls and order and everything else. ... initially, they had all these tents set up where they would eat. Well, they don't eat our food. And they would eat up the loaves of bread. But, The food that we were making was just going to waste and so what they decided is they got together with their leaders, talked about what kind of food did they want, and they ended up that every morning, the men would go and get their bushels of food, loaves of bread, and their cabbage, and, you know, all the different requests for different vegetables and different food .... so that worked out much better than us trying to prepare their food.

> Initially with the uniforms, we were so hot, but we had to keep our sleeves down in respect for their culture and not show a lot of skin. And eventually, we were able to get a waiver but we always had to wear a BDU jacket, we couldn't just wear a T-shirt. You know, it was too revealing.

> You know... The other issue was the abayah. The women had to wear the abayah if they left the base.

> I guess the other thing that was difficult was when you did cover up and you were

> out there, they'd have the religious police that would come and they had these sticks. And if you were not covered up right, they would hit you in the ankle. The other thing that they did, which was kind of different for me, but it didn't make me upset, is that when you ate, they would have a separate room that they called the family room, ...the men could just go and eat in the normal front room but it would be a nice room, it would maybe be on the side but separate where the women and children would go and eat. So you couldn't eat in the other room because you were a female. So that was a little bit different.
>
> I bought an abia, a fancy abia there. You know, we got the ones that were issued but I bought one that had sequins and stuff. I thought, "If I go out, I want to wear something different."
>
> I guess it was just so interesting how the culture differences... Where they set up a rec center for them And one day I went over there with the mayor and it was all the men and all the boys. And the women are all at... home, You know, that... That separation of the women and the boys and the men. And ...How if they were in the clinic being seen, it was the man that talked, not the woman.
>
> They were bus drivers...and they would just stop. Two of them right in the middle of the road and sit there for 10 minutes and talk, with everybody waiting, blowing their horns, and they were just talking ... So you kind of learned to say "O.K. don't get excited." You know, after a while, you don't get excited 'cuz you know you're not going anywhere. "So what if I don't get home at 6:30. It doesn't really matter." ...there was nothing there anyway, you know.
>
> We were able to practice our own religious... The only thing we couldn't do, even like Christmas, we could not put lights out. That bothered me. People were so excited 'cuz they got lights from home and they wanted to decorate their tents, we were not allowed to do that. we were restricted and it wasn't because of a safety issue so... I can't remember exactly why but I remember it was a cultural thing.

Human responses and danger. The responses of the chief nurses to living in danger, living in community and living with deprivation were varied. The variation occurred among individuals and within a single individual during the deployment.

> Somebody had caught a scorpion. They had those quite a bit. A little blond scorpion, little ones. And it was in a jar. . So they had it there on this table or something. And people wrote a note, "Let this thing go." You know, "Let this poor... Either kill him or let him go." Okay? And then somebody wrote a note saying, "No he's going to suffer like we have to suffer." And I thought that was so

bizarre.

You know—deployments do different things to different people.

And some of the people were scared, to be honest.

It was just a really unique environment. People learned... You sort of meshed with people 'cuz you were all in the same circumstance and you worked a lot of long hours. Couldn't cook in your room so if you didn't make meals, you didn't eat although you could go over to the club. But you worked all day so it was just go in, take care of business, and leave. Mail service was real slow. That... I think that was probably the worst thing. I would try to beef up the mail system. I mean, we wouldn't get mail for weeks and then we'd be flooded with mail. So that was probably the worst thing.

Maybe they think, "Well I may never live to get out of this again so I'm gonna let my hair down" but people tend to get a little promiscuous when they're deployed. So you had a lot of that going on. You know what I mean? And then you live in such tight quarters and you see each other all the time so... So there... There was a certain amount of that going on, little romances.

You know, every once in a while, you would have a fear that something was going to... That something could happen to you, you know. That fear that I would think, "Well somebody..." One day, I was over... And it would only pop up a couple of times to me,, ah... It was late when I went over to the shower tent and was taking a shower and I was the only one in there. They're open showers. You know, just one big tent... And I thought, "What if somebody came in here and..." You know, "A terrorist came in here." And so a little fear came up. And I thought, 5,500 people, and we had security. We had concertina wire and burns. And they had a tight security around our post but then I thought, "Gee," you know, "That could happen." So that kind of fear came up and then you would have your scud alerts but those didn't bother me too much but many people, were very fearful of that. The old stories of people running out of the showers with their towel... that kind of thing happened because of their fear. I wouldn't... I'd go in there, I'd say "If it happens..." it happens." I wouldn't run... I just continue because what are you going to do. So I just kind of adapt. I'm like a chameleon. I'll adapt immediately to the environment I'm in.

I guess I kind of look at it as "If something happens, it happens." I don't know, I just kind of... I guess you've got to die of something. Die of that or something else. I don't know what my thought of life is. But I just didn't worry about it. If it happens, it happens.

Another time, I was a little fearful because they had a dining facility. And I

thought, "Do I really want to go there to eat because all the Americans are in there eating and it would be a perfect environment for a terrorist to get us." But I went and ate. My stomach overwhelmed my big concern.

That's the other thing... I homestead, like I said, and I brought a lot of civilian clothes. And a lot of people don't do that. I packed a nice... Something that is a little more dressy and I brought junk stuff and jogging stuff and all that.

I just... homestead... I unpack, get settled, and I'm going to be staying there a while. You know,I'm just gonna make it home. So whatever I need to make myself comfortable, I'm gonna do it.

Working

Challenges and language barriers. Like the living experience, the working experience was filled with challenges, many of them due to cultural differences. The daily routine of each chief nurse was tailored to meet the particular requirements of the mission. The duties were similar in some respects to the duties of a chief nurse at a permanent base. These duties included organizing the work force, creating a practice environment and managing resources. There were many additional duties which over time became part of the routine. The peacekeeping missions presented the team with a very different population than the populations encountered during the humanitarian missions, both populations had unique problems requiring innovative solutions and particularly sensitive approaches to care. Individual health, family health and community health were all part of the mission requiring a wholistic approach including nutrition, disease prevention and treatment, parenting, and psychosocial support. In both environments there were dangers for staff and patients and this was an ongoing concern for the chief nurses. Besides the safety issues there were numerous issues related to standards of care. These concerns were further complicated by language barriers, environmental factors and cultural preferences.

We ended up creating a community hospital but it did take us some time. The

psychiatric population was one of the biggest challenges in the world. It became very evident that if the medical patients didn't have a diagnosable psychiatric disease, they had psychiatric overlay to their symptoms that were presenting. On top of that, their culture is much more... Appears to be much more demonstrative and, you know, their arm movements and their voices, the level of their voices, you can't really tell if they're having a disagreement when sometimes they're just discussing something. It's a different culture and how they present themselves. So we weren't used to that on top of the fact that there was a lot of psychological overlay to the illness presented.... in fact fairly early on, probably October or November time frame, we started what we called our chronic disease list. What a mistake. Because everybody then appeared to have a chronic disease of a psychiatric nature. That's when people started swallowing rocks, swallowing anything they... Bullet casings. Whatever they could find, they started swallowing as a way to perhaps get to the United States. Not only did the patient go but the family members went also and that required an Immigration and Naturalization physical for everyone in the family.

Language was one of the real challenges of this deployment because we only had so many interpreters; if you couldn't speak Spanish, you were at a real deficit because in order to communicate with any patient at any time, ...virtually none of them spoke English, so that was really an obstacle, it was very tough.

Now you have to remember, they didn't speak English so with each person we sent out there... I mean, nurse triage and technicians and physicians, we had to have a translator. And those were multi-service also. And so sometimes we used... Sometimes we used the migrants themselves to translate, some of them spoke very good English. And there were physicians and nurses and teachers that were in these groups of people living in these tents.

So we really were seeing patients almost immediately. The first kind of nationals we were seeing were the workers that were working to set up the camp, and those were emergent situations only that we could deal with. It became apparent that one of the things that we really needed were linguists because we only had one Spanish speaking person in our entire group so you can't much deal with chest pain, with psychiatric problems, when no one speaks Spanish. So that was one of the biggest things, that's one of the biggest lessons learned, you don't go anywhere without your linguist or call ahead for a linguist or something but that was a major problem for us.

There were some... Initially, we had a lot of patients with dehydration. And because the clinic it was really..... Like a duplex house so when you walked in there was your living room, that became the big waiting area.... When they come in to be seen, they'd bring their whole family, all eight of them, all eight kids. So the waiting area would just be filled. And actually it was good that they brought in the other kids because if one had pin worms, they all had to be treated for pin worms. If one had dehydration, probably all the rest were leaning towards dehydration. And then there was the communication problem. We didn't have translators first...

> Right away and there were different dialects. They... You know, spoke different languages. So we had to really work the translator issue.
>
> You had the other issues where whole families were put with other families. And some families were from one cultural group and some were from another. And they didn't like being with each other so you had fights, you had tensions. Because these houses were two story houses and one family might get the... There was nothing, no furniture in these houses at all, they just put cots in there and they had a working washer and dryer and a stove and a flushing toilet. They were actually pretty nice but they had no furniture. .. A lot of them didn't know how to use a toilet. So when they would use the toilet, they would throw the toilet paper in the basket right next to it instead of flushing it. And.... It was very, very hot when we were there. They would turn on the air conditioner and open up all the doors. Or they'd turn on the heat and open up all the doors. So those were kind of issues that came up to us and we had to let base support know to start educating the families and help us out. I think the innovative thing and the really, really neat thing that we started doing was home visits.

Daily routine. Making rounds was by far the most common element in the daily routine. Gathering information about the requirements for care and planning to meet the requirements with the available resources was a responsibility of each of the chief nurses. For those in flying units the routine was dependent upon the flying schedule.

> But the problem with making rounds is you had this hostile environment between the two locations. So, you couldn't just arbitrarily get in your vehicle and go down there, you had to go and... You had to go in at least two vehicles, you had to go with six guns, loaded weapons. So, for me to go down there and see my troops, for instance, it involved like 9 people and 2 vehicles, minimum, and we all had to carry loaded weapons and flak vests, the whole nine yards.
>
> And so for the next 60 days, life got pretty good because the initial push was out of the way, the initial injuries had been taken out of theater, and we were really beginning to establish some routine missions. We created a milk run that went through the theater, picking up patients out of some of the other outlying deployment locations, And we would pick them up and they might have malaria, they might have other contagion, they might have injuries, but we would bring them back to the assembly point because by that time we had a full up marine contingency support hospital there which could hold the patients.
>
> I hitch hiked to work. Sometimes I made rounds at the different clinics. Sometimes, we were short people and I'd just go out and work and triage people. Sometimes, I did paperwork. I usually visited the camps. Sometimes, I made rounds in the

> adolescent unit. A couple of times, I went out to the TB area. So just depending on what was going on. Some times I'd eat lunch and sometimes I wouldn't. And then the day ended about 5:30 or 6:00 and we'd go back and...eat dinner and then... I'd usually just work on OPR's [officer performance reports] or wrote home.

> I would start... I would arrive just before 7:00, made rounds. I would get with my SGH [director of professional services, the senior physician], like I said we kept the old structure and he and I shared an office space, my desk here, his over there, so good cross talk back and forth across the room. We would make rounds together starting with the E.R. first and then back to the close observation room and then our multi-service unit and then on back out and around. That was between 7:00 and 7:30. I would pick up the 24 hour reports from the staff as I went through. The E.R. had provided us with a log of all the folks that they had seen in the last 24 hours. I would look for trends or any infections... Things that you would want to know.

Logistics and improvization. Working in an environment with little logistical support complicated the implementation of the usual policies and procedures. In some locations there was an enormous demand for computer support to accomplish the paper work associated with the Immigration and Naturalization Service physicals and there were no computers; many of the buildings that were adapted for use as clinics or inpatient care areas had narrow doorways and no elevators making transport of patients, meals and supplies very labor intensive; additional clinical services were available at nearby base facilities but transportation was limited and communication to arrange it often nonexistent. Equipment needed to administer IVs and equipment needed to apply traction was not compatible with the supplies which were stocked in the ATHs so the staff learned to improvise.

> One of the other patient issues was that ah... You ran out of supplies really quickly. We had bathrooms. outside.. All these patients were having diarrhea. We had the bathroom and it was on the other side. The ground was a wheat field but it was really rocky. So the patients who could get out of bed to go to the bathroom had to roll their IV pumps all the way through this rocky field, that was the only way to go to get to the bathroom. We had these bed pans... Had this bed pan hopper that belonged to the ATH. It was like a bathroom. But you had to have water and everything else to go with that. We rigged up these things with bottles of water that we would carry from the well and put over there so everybody would have hand washing. We had sinks but we didn't have any water to hook up to

anyplace. We had bathrooms inside the ATH for the patients but you had no water to flush it with. So that was interesting. And so, you're not really prepared. . I don't know how you would be prepared for everything that could happen and would happen.

And even feeding the patients was going to be a real problem because, remember it is being cooked in the tent, pushed in a cart, and then the staff had to haul it up the steps because we didn't have an elevator, It was really difficult.

We could not track the patients. And we had experiences with our own people. We had one of our... Our folks, he was an O.R. nurse, who had to go for an evaluation, he needed beyond what we could do. I mean, he was ambulatory outpatient evaluation. So we put him on a plane and he would go.. ... we put him in the air evac system and when he got to his location, an army... field hospital or whatever, he was basically just dumped off on his own. And so he found his way to his appointment but then he wasn't given billets, he just kind of bunked up in a waiting room. They had no tracking... And so we ended up... we gave them ...cards with our addresses, return addresses, and told them when they get to where they're going, to write us back where they are and what's happening to them.

The first incident was over narcotics. We didn't know they weren't going to work. But the patient who had his legs amputated, we kept giving him this Demerol and the patient kept saying "Well I'm not getting any relief, can you please give me something. Give me something." And we didn't have anything to give him. We kept giving him all this medication and we thought "Well this patient isn't getting relief from this medication, something must be wrong with the medication." And then you think, "Well where's the medication been." It's been sitting in a Conex, even though it's cold, the sun is out and it gets warm, it gets really hot. The medication has been sitting out there for almost two weeks so is no good in the direct sun. And so we had some Tylox and we gave the patient some Tylox, we sent the patient with the medication on the air-evac., just enough for a day because we didn't have a three day or five day supply that we were supposed to give them, so we just sent what we could, any supplies that we could possibly give these people.... So it was really interesting. The nurses who were on the med-surg unit didn't know that they were supposed to count the narcotics, keep a count of these narcotics, so they said "Well we're in the field so we don't have to keep any kind of narcotic..." I said, "Well this is a place you need to keep the narcotics and know what's in there because if you don't know what's in there... First of all you need to know what you have on hand and second of all you need to know if somebody is taking them or, you know, because we're all under stress out here and anything can happen in the field.

The Army were the best people out there and the Marine Corps... They gave us medication.

In this day and age, which is certainly different than World War II... We were going

to have parents coming over to see their kids... if they were casualties. What were we going to do with parents? So I worked hard with the Red Cross, Family Services, and I quick took a little landing area outside of the ICU, because we decided that a parent looking at our ICU would have a heart attack, because you know you're looking at 200 beds lined up. So we said, we can't ever show the parents Johnny sitting out there in the middle of this chaotic mess. So my idea was that we were going to roll the bed into this landing and I got a couch, a lamp, some curtain screens, and a rug and I was going to bring the parents up there and let them visit with their sons and not let them get into the ICU. But even where we were going to have to house them and all this, you know, we were sitting there planning it with the Red Cross trying to figure out how we were going to handle parents because we knew that the minute they heard their son was coming someplace, or daughter, that they would be on a plane over there trying to see them. So that to me was going to be a real problem - of what we were going to do with parents. And I did not really have the facilities to try to figure out how we were going to accommodate them real well. And that was a stressor.

It was a constant getting contracts, getting laundry. I had a little book for standup every morning to bring up issues. ..all the logistics of getting going really took so much time and so much coordination. And also the limited budget because nobody wanted to untie purse strings if you really didn't have casualties so it was very interesting,... we had to be ready... And every day command would call and say, "Are you ready?" And we would say how many patients we could operate on and what our status was. And yet, none of the money was released to buy any of the equipment to do it with. So, you know, it does something to you brain when you work under those circumstances. Same with pharmacy. That was a big issue because we needed drugs for our ICU and IV solutions.

Ah... I-VAC's [electronic IV pumps]. They weren't the most modern, the kind that we had back at home and we found that the tubing that we had was incompatible with our I-VAC's and they kept popping apart. It was, I guess, too much pressure and so the first few days there that was a challenge. Taking care of patients with long limb fractures or amputees, we did not have the best orthopedic equipment as far as trapezes. Now it was very, very difficult to try to take care of a patient adequately like that without a standard bed.

Now, we processed, I think, over 1,200... 1,200 to 1,500 INS physicals that required seven pieces of paper during the time we were there with no computer support. Hand written, seven pieces of paper on these people. The other thing we had to do with the ATH's. We held clinics. Orthopedic, cardiac, all manner of clinics so we had to uproot logistic supply folks out of their area and had to have another tent in the back for them because we needed that for our clinic area. That's not in the original plans for an ATH. Anytime they went to the army clinic, they had to go with security police and our staff, driving in these rickety vans that the army had given us, all of them had been in wrecks for sure. You'd be driving down there and the van would have the window up and water would be streaming in through the cracks and the leaks.

But that was one particular case and there were numerous ones, patients with... With bacterial infections in the eye, spitting cobras in the eyes, poison and venom in the eyes. And we had times when, instead of putting a patient on a C141, we put him on the very first KC10 mission that had ever been run with an air-evac patient on it. We put them on civilian planes that were on the ground there. We put them on KC135's. We put them on C5's. We used anything that had wings to move patients, we broke literally every regulation that was ever written and afterwards received praise for, having the courage to make those decisions to use the regulations as a guide, not use them as the bible. And we did that, putting ourselves in jeopardy.

Once the scenario stabilized and you no longer were bringing lots of equipment and bringing lots of crew... Lots of troops in the theater, then the flow of air craft shuts off and you start to have problems and you need to get patients out and there are no planes to get the patients out of theater. So that then became a challenge for us.

So we had that front room and then if you went to the right, there was like a little separate dining room, small kitchen, and then the kitchen with the counter. We turned the kitchen into like a satellite pharmacy and that little room right off to the side of it became our acute care clinic and we put up a sheet as a curtain on both sides of it to have some kind of privacy.. And then if you turned left when you first came in, there were three rooms, one was a larger bedroom that was the master bedroom. Actually, it was four bedrooms. It was the master bedroom and then there were three little tiny bedrooms. And we put a cot down and set up all the little different equipment for each of those rooms and that's what the physician used to examine the patients.

The number of drugs that we were giving out was just amazing. Now again, thinking that they explained to them how to take these medications and then you'd go to their house and there they'd have the medication still sitting there. They hadn't been taking the medication. So If they had an infection, they had to come to the clinic every day. If they were on meds t.i.d. or q.i.d., we told them "These are the times you need to come to the clinic" which wasn't a problem, they didn't have anything to do. They would come to the clinic and we'd actually give them their antibiotics. So if it was medication that was p.r.n., we gave it out. Our pharmacy techs... They worked so, so hard. They really, really set up a really, really good system. Everything labeled, just like in a real pharmacy... We decided to set up the whole ATH, the different sections of it, to flow : "Here would be immunizations," "Here would be drawing lab"..., "This would be where the physicals were done," "This is where the chest x-ray would be done." So we kind of broke up the ATH so that it would flow.

The ATH, all the supplies that they used... You know, that they have in there, are not always right for a humanitarian mission.

Additional duties and staffing mix. Additional duties were identified and assumed by the chief nurses from the very beginning of the deployment. Caring for the staff was just as important as caring for the patients. Two forces were evident in the additional duties needed to run the ATHs and clinics. The first was the vacuum created by the lack of support staff, particularly housekeeping. Keeping the place clean was a major undertaking especially given the austere environment: no paved roads, open netting instead of windows, winds that blew dust everywhere and rains that created mud on a daily basis. The second was the staffing mix which was unevenly matched with the requirements of the mission. There was little flexibility in gaining more staff or in transferring patients when care requirements exceeded the capacity of the assigned staff. In response to both these forces staff members pitched in to cover the gaps and to relieve those who were over worked.

> And we had duties that we had to do, we had to go around and pick up our tent, pick up the paper, and the butts, and everything around our camp and the commander would get right out there with us and do the same thing that everybody did and nobody complained. He would help mop the floor. We'd get down on our hands and knees and he would get down there with us and help mop the floors. Dust was always a problem. I mean we were, at least twice per day, wet mopping the floors and, of course, you provided your own housekeeping, you know. Dusting and sweeping. So dust was always a problem. You worried about that from an infection control stand point.

> And it was really bad. So our tent was set up correctly. We had ditches built around it, had floors put in. The whole time we were there, we were working on that ATH. I mean, they were moving tents, they were replacing them, they were making more permanent wiring for the electrical service. They built showers for the patients and a break room for us, a tent just for us to have for a break area.

> A significant point. The CRNA's [Certified Registered Nurse Anesthetists] came out and helped with the ventilators. The CRNA's came out, they pretty much stayed at the bedside too. So they came out, they managed the respirators, which they are very good at doing. Anyway, the O.R. nurses came out and worked on the floor. You know, on the unit, because a couple of them had been floor nurses anyway before they cross-trained. So floor nursing was not new to them. So, yes we did get help that way.

> I would coordinate with the people who worked down at the UNPROFOR [United Nations Protection Force] headquarters because we provided people to do a lot of training. As a matter of fact, I worked very closely with... And she was an English nurse but she worked at UNPROFOR headquarters and, ah... To provide her on two to three days a week manpower, technicians and nurses to teach, to teach BLS. They taught self aid and buddy care. So they'd be there for like half a day. For the most part between like 9:00 and 1:00. Every U.N. troop who entered that country had to go through two or three days at the headquarters and part of that included self aid and buddy care. And we... We were the manpower to do the teaching for that.

> The flight line was on the other side of the island, we had to take a ferry to get to it so we had to leave way early for the flight to get to the other side of the island where the flight line was. It was on the cove and we had to go across that. There were mountains there so you couldn't get to the other side of the island.

Population diversity and patient conditions. The chief nurses had to address health care needs at multiple levels. In the deployments where there were very large numbers of people, the health care needs were population based. This included availability of water for washing and drinking, availability of food that was nutritionally adequate and palatable/culturally acceptable, toilet facilities which were clean and properly used, access to first aid and transportation to higher levels of care. Many individuals within the populations had special needs or required additional care in some way. There were people of all ages in the camps, families and individuals without families, some of whom were children. There were prisoners, and groups who saw each other as the enemy and thus had to be kept separated in the clinics, on air-evac flights and in the ATH. The medical conditions of the patients were, for the most part, familiar to the staff. What was unfamiliar was the concentration of patients with a single diagnosis which resulted in the equivalent of large wards. Psychiatric diagnoses, AIDS, TB and dehydration were examples of these patient populations. OB was also represented in several of the deployments creating a need for services which were not ordinarily part of an ATH.

We had an... epidemic of sand fly fever. All these soldiers would be on maneuvers and the sandy... Sandy and dusty and whatever else. And they would come in with these high fevers, like 103_, and you were wondering... Well we thought the patient maybe had a cold or something. . But we saw, I think... We saw almost a thousand of those guys. What it necessitated was us putting up another tent and actually having like a hospital where those people went in and they had to stay. They stayed there for like three days and if... After three days, the people were pretty much good if they got Cipro and all of that stuff that we gave them. But they were in the tent and we had the Marine Corps and the Army that actually came in and augmented our group to provide care for the people. They also... The doctors pulled call, the marines and army. They would pull call with the docs and the corps men who were all LVN's and there... Those people that were deployed with the marine corps and the army were the best prepared technicians that I have ever seen. Most of them were LVN's in the first place but they were really good.

It expanded... I mean, there were over a thousand of them in the detention center. Horrible conditions. And who do you suppose had to do the aid station for the detention center? The ATH. So that was another tasking we had is to have around the clock detention center medical aid station... also Severe psychiatric patients. Strait jackets, sedated, shackled. Really a traumatic time for our staff ,we had to go help with them.

We had to man a 60 bed ATH. Uh... Of course, they would be the United Nations troops so we would be taking care of people from various nations, many different nations, and 38 different languages spoken. We took care of any U.N. troops. If they had a U.N. I.D. card, they were eligible for care. If they didn't have a U.N. I.D. card they were not entitled but we didn't turn anybody who was emergent away.

The war kicked off apparently very, very violently and we ended up with... If I remember the number correctly, 6 prisoners of war, wounded. And they went to our mobile air medical staging facility that was in that area. . We had been running air-evac missions all along but they were all disease, non-battle injury, soldier jumped out of the back of the truck, sprained his ankle, got to air-evac him back to the states, that's what we had been running. This was the first air-evac mission that we were going to have with enemies... The enemy.

We met some of the members of a terrorist group who were friendly to the Americans so they brought their people in in helicopters to be treated and there was another group and I can't remember what the other terrorist group that they were fighting and we were working with both of them. So they came in at the same time and we had to actually get one group out and put them on the other side of the hospital to make sure that the other group never even came any place close to each other so they wouldn't find out that we were treating both of them. And that was very interesting. That's the first time I've ever seen any political thing like that in my life.

A lot of the people that were the refugees or the migrants were professionals. And they had been persecuted in Cuba so they wanted out. And then we had people who were hardened criminals, who were murderers, who were in a camp that was triple barbed wired and marine guards and loaded weapons and that kind of thing, who were absolutely criminals. And those people that they knew, they put them in Camp X-ray. That was X, Camp X. I went out there to Camp X-Ray several times to deliver some medical care and they always had guns on the patients while we were out there with them. And they told us, you know "Don't have anything that they could take away from you. Any kind of thing that they could use for a weapon or something."

There were even some old folks there, in their 70's, that had gotten across the bay. And there were a bunch of kids that didn't have parents that had gotten across the bay. And that was... So that was the camp in itself. And that was kind of interesting 'cuz it was kids taking care of kids.

We had a jail there. I had a nurse that I put over there and he used to do medications at the jail... Or institution. Which was really run by the Army and it was a very tight... We had some folks come in who had tried to commit suicide, slashing their wrists or trying to hang themselves or stabbing themselves with plastic spoons and things they had and um... What else? It was just a really unique environment. People learned...

And the problem was the population that came to us #1 when you think about OB they were non... None of them were supposed to be pregnant.... None of them were pregnant supposedly. Well about a 8 month pregnant woman showed up very quickly. But we had to get an exam table and an ultrasound to deal with the pregnant population that we had. The political concern about that was that the president of the country said we would not have any migrants having babies. . They fought about where these ladies were going to deliver. And I just laughed because the ladies were going to deliver. You know, they were going to deliver so, I mean, what's the big deal, it's not a political decision, the delivery is going to happen. But none of them did deliver they were shipped back in fact to Texas and that's where they delivered. But, I mean, the OB concerns. ... the health risks about not getting the prenatal care that you needed. But we had the pregnant women and then we had the... I think 75-80 was the top age in our population. And the internal medicine kind of concerns that that age group brings you. The cardiacs that we had, Diabetics. Patients with seizures. Um... We were not set up originally to take care of those people so we ended up actually setting up on one of the wards sort of SCU if not an ICU, an SCU, to take care of those patients

But they decided to keep our patients to the very last and the psychiatric patients were the very last of the very last. We ended up developing a 30 bed psychiatric annex right next to our facility and it had in it the most severely psychologically, psychiatrically involved patients I have ever seen in my life. The psychiatrist who was with us, had never seen such severely affected patients. The doses of

medications that he used in Prozac... I mean, it was like water. The doses he used to just keep them calm would make us unconscious. But supposedly in their country people can get Valium over-the-counter. You know, their tolerance much have been built up. But he really... He learned a lot from his time there. But we had acting out. We had... We had more leather restraints on a routine basis. ....in addition to chemical restraints. What a population of patients.

I learned a valuable lesson. If you were to do psych patients, you'd almost have to have a facility where you could lock them in or somehow secure them. And I don't think you can do it in a tent. I mean, in a tent, how do you secure the man? So you... We would have had to use a hardened structure to really be able to provide that type of security. Or if you ev... Like restraints, which is a big deal state side. How would you restrain? What would you restrain them to? I mean, those cots you can almost pick them up and walk off with them. It... It would be a challenge. It would be a challenge.

And the issues she had were just unbelievable with education and working with patients with active TB, patients... We had a whole camp just of TB patients. And a whole camp of HIV. And then when we had the chickenpox outbreak, we had a whole camp of chickenpox.

So there was a tremendous amount of fake illnesses and self-mutilations that went on constantly. I have slides of people who had swallowed batteries, swallowed glass, and intentionally injected their legs with diesel fuel to get scars and cellulitis. We had people with fake chest pain constantly coming into the clinic and also with fake seizures. There was a lady who had an Alka-Seltzer tablet foaming in her mouth.

All the OB was done on our side and that was one of the most pleasurable things, to see those babies born. And we had so many babies.

And then we had the ones that were really sick. ... the little kids who had really bad things wrong with them. We had an arrest of a little girl. She might have been 2 or 3 years old. An active TB patient , she had a respiratory arrest and almost died.

Most of our patients were just typical air evac type movement patients, ambulatory, and, you know, broken legs, bones, and stuff like that. After you come from a medical center, this stuff was easy stuff. And you had the most expert people there to take care of them and they didn't have anything to take care of. I mean, they were wishing things were wrong with the patients so they could take care of them. So, you know,to treat 70 patients over that period of time was really nothing when you think of how many we had at the medical center.

We had, ah... A number of people with migraines. I had some of my own staff with

migraines. So I get real sensitive when we talk about deploying people and doing profiles. I go, "People with chronic migraines, why are we deploying them in an environment like that?" .....you got them in a warehouse, you're supposed to keep it quiet and you're medicating and trying to break the cycle and we're in a warehouse where half of the warehouse you've got forklifts going and all this and it's... You know, that makes it hard when you're trying to treat those types of conditions.

Dangerous environment and bunkers. Dangerous conditions were present at one time or another in every deployment.

We carried loaded weapons, the whole nine yards, we wore... We had flak vests, and everything.

And inside the camp, they had some army troops but they didn't have night sticks. They had no weapons at all. But they were army, they were in uniform, and they were identifiable. So there were some homemade weapons and rocks. And they actually stoned the army troops that were in there. I mean they actually rushed them and stoned them. They burned some tents and they burned their cots. So there were no major injuries. I mean, there were really no... I mean, there were no guns. So there were no really major injuries but there was a lot of injuries. A lot of broken, fractured, sutured, little suture... Little cuts here and there that needed suturing. So the first afternoon, they were actually... The ar... Young army troops, young army troops, that came in quickly through our area for suturing, for bruises, for breaks, those kind of things. But luckily there were no guns.

Quickly, the um... Army became armed with night sticks. .. Like when you play baseball, the shin guards, you know. And that's actually what they were. They went to a sports store and that's the kind of thing they got. And then shields, the plastic shields that you have seen the security police. And then they had the face thing to. So they actually were armed. The second day was most all day that we had some uproar. I think it started in camp 1 and then... I think it was maybe the second day, they actually rolled over some vehicles,... Pushed the gate down and escaped into the jungle. In flip-flops, shorts, into this horrible jungle. Yes, yes. Snakes, big time snakes. Um... But they escaped and they really trashed... They got into the camp computer room and trashed the computer room. Later on in the day, they did a sweep of the tents and found Molitov cocktail kind of things, weapons, crude weapons that they confiscated. So that really kept us very busy.

But what was very interesting for me who had not been exposed to military operations is, they shipped in many more military to act as guards and the real environment changed. There was no country club anymore. They actually had APC's, armored personnel carriers. That... They would run up and down the roads starting at 3:00 in the morning. I think just to let everybody know that they were there. So intimidation factor I'm sure was used. They parked one of those things right outside camp 4. We were right next to camp 4. There was like the ATH compound where we slept and then camp 4. And they parked one of those right outside the... The one gate of camp 4. Uh, the security police had night sticks. You

know, they were prepared. They actually had guns at sometimes, outside the camps, not inside the camps, outside the camps. There were more drills and things like that that happened. So the environment really changed.

And so our concern was what if... What if at 3:00 in the morning, airman so and so at the front desk of the E.R. gets a call and says "We have soldier who has been in a car accident, come get him." What do we do? You know. 'Cuz nobody knows how to get there, 'cuz we don't go there. You know, it's supposedly a hostile area. We're not supposed to go down there, especially in the night, but we were responsible to take care of all the soldiers and we were... On paper, it said "You will go get them, if something happens." So do you call the security police for an escort? You know, how do we even get there 'cuz we don't normally drive there? Are we going to get lost in the night?

The bunkers....Some of them were under the ground. Some actually were containers, navy containers, that were partially into the ground but... But the front part was not. You could... If you could... If you could envision part of it being under the ground and the front part, where you entered, was not.
It was equipped with bandages, IV's. Just about anything and everything that you would need to get you through... Through the time you were in there. IV pole and those types of things. No medications. O.K.? It wasn't equipped with medications. But it did have supplies, bandages, and so forth. A stretcher.

We stayed three hours the first time we went in. Three hours until we got the all clear. The one down by where we lived was mostly under ground but not totally under ground. Somehow, I felt more comfortable in the ones that were more under ground than the ones that kind of set above the ground. The bunkers were equipped to hold 40 people. The first night when we had to evacuate, it was like at the end of a duty day, the time was approximately quarter to six, so most of the folks who had worked a normal duty day had already gone home. Ah... And then, of course, the people who were still on duty were still on... You know, on duty. We didn't have... We had... The 7 o'clock shift had not come in yet because it was only about 6:45 when we got the word that this was for real and we all had to evacuate patients and everybody. So we... Thank goodness, we knew where our bunker... Which way to head. And the nurses on the inpatient units, they got the patients together and he was... We used pretty much our, ah... Our beds were not much better than a litter anyway but they were able to get him onto a litter, a NATO litter, and rolled him into the bunker and then we were able to transfer him over to, you know, one of our litters and a litter stand when he got inside. We had additional oxygen tanks that were kept in the bunker so we had additional oxygen, 02, ah... For him. And we just took him and his family and kept them calm. And they were in there laughing and joking as if they had been through it before, perhaps they had but... It was new to us. Like I say, we stayed in the bunker for three hours the first night.

The bunkers that were built for 40 people down by the housing area when the alarm went off, 80 people scrambled into this one bunker. I mean, they're... They were in like sardines. Needless to say, there was standing room only. And after it went off, people had to take turn sitting. I mean that's... Because it was three hours. And so one person would sit for a while and then give somebody else an opportunity. I wasn't in that bunker, I went to the hospital bunker 'cuz I was still at

> work when it happened. So we had plenty of room in our... In our bunker but when the siren goes, you have to get to the nearest and that's what they did. And 80 people scrambled into a bunker built for 40. 'Cuz that wasn't just our little group of people, it was all of Camp. We had no idea how long or for that matter what was going on around us, you know. We tried to keep people occupied and busy.
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> So we get them on the plane, we get air borne, and then I get on the PA system. I said ". We've got six prisoners of war. You guys, you know, do you have your weapons." "Yes we've got our weapons." "You know, this is the furthest forward now that we have sent an air-evac mission and I'm not real sure what we're going to find when we get on the ground." Well we got on the ground.

Practice standards. Given the wide range of diagnoses with the usually prescribed plans of care, it became a challenge to establish and meet a standard of care in the austerity of the deployment environment. Constant effort to apply standards from the homebased facilities produced creative solutions and revealed a deep and clear understanding of the intent of the standards. The most universally challenged standard was infection control. Lack of running water made handwashing a real event in almost all deployments. There was an understanding that doing the best possible job was all that was expected except when there were incidents with adverse outcomes. In those situations the standards were more rigorously applied.

> Sometimes when the helicopters were trying to land to bring us patients, we would have these... All I can say is dust storms. Carried dust and wheat... And it would come through there and everything in the whole tent would be covered with dust, patients, everything included... Anything that got in its path. The beds, everything else. So we would be cleaning out the place again when it got dusty. And I had this policy that that was the only place on the compound that was going to be clean, it was going to stay clean. I just had this need.
>
> We weren't going to do anything sophisticated, that's for sure. Keep them alive and prevent infection. So, anyhow, I think when you have nurses who are so used to being in an acute care hospital and put them in a place where they have nothing, they have a hard time in their minds figuring out... They just can get the concept of how to do some real basic things with patients. You know, it is such a different world than the real world.
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> There's a difference, there's a perceived difference in doing emergency surgery and

the standards that are required when it's more elective surgery and was the Conex or was the O.R. really to the standard that it needed to be to be able to do elective, more elective kind of surgery on nonmilitary patients. So what we ended up doing is actually having a staff assistance visit from the O.R. crew at the base who tried to give us some ideas.

But I do know this that, ah... Any time that one is deployed and this I had to learn myself because I didn't know it. You always have to maintain the same standard that you would have maintained state side. And I think that that was not the going in thought. It was kind of like, you know, "We're not covered by the Joint Commission because how can you be." You know, in a tent environment, how can you be...? How can you do Joint Commission standards? But I can... I can... I can attest to the fact that if anything ever goes wrong and somebody came in to look at you, they use the Joint Commission standards. So it would be wise to use them.

I mean, we even had to set up... We built a wall with sand bags and all to... Because we had to bring our x-ray unit inside but we had to have it... I mean, we researched. It had to have so much of these sand bags and what... You know what they put in it to... You know, because of the x-rays and all this.

But I thought it was going to be real hard for them to see the type of wounds in casualties and how they are going to operate without that fine modern medicine that we have back in the states but it was drafty and infection control... That's another thing, infection control. There were very few sinks. We had them, on the spot, put in a toilet and two sinks in the ICU and that was it for hand washing for 200 beds. They were not going to do anything like they did back in the states.

We had restraints. A lot of these guys were combative, they were psychotic, Big problem and so we got the restraint policy from home and implemented it, how we were going to do it here.

There are a lot of rules in air-evac and all that, but when you... When the rubber hits the road and you're really in a combat deployment, we... My people were taught to do whatever they needed to do.

So that was our first mission with these prisoners of war. We ended up having several after that. Our General refused to have prisoners of war on the same missions as our soldiers or our allied soldiers so we had to run a whole separate air-evac system to pick up the prisoners of war. We ended up using other C130's which were magnificently equipped air-evac planes.

Competency and translating into different environments. Standards related to competency and scope of practice were addressed and heroic efforts

were made to keep the staff current and comply with these standards. Staff Development officers assessed learning needs, created inservice and continuing education programs and documented attendance so learning needs would be met and staff members would not fall behind in their requirements for licensure. Documentation standards were adapted successfully after some trial and error in developing forms based on familiar computerized equivalents.

> We... Our technicians weren't all EMT qualified and we needed to have... If we were going to maintain the same standards of an acute care clinic as we did... You know, and we figured we were on U.S. territory, we needed to have two EMT's on day shift and night shift. The army corps men that came in, none of them were EMT's. When we were transporting them to the navy hospital, a lot of them didn't have their ambulance license, so we set up a course to do ambulance training. Several people, their CPR expired. So I was a CPR instructor and so was one of the other technicians, we gave a CPR course. Um... One of the doctors expired as far as her ACLS so found out the navy was going to have a course, sent her over there, um... What was some of the other stuff? We tried to maintain... You know, you were talking about the different standards. We tried to maintain that this was an acute care clinic, a crash cart, we had to get a crash cart over there that we were going to have in the inpatient ward. Trying to maintain as much as possible the same high standards 'cuz we felt like we were on U.S. territory, we were a clinic that had... Had to meet the same standards as if it was a military clinic or a military hospital.

> It was called AIDS in the work place. And everybody Air Force wide was required to get this AIDS lesson so I had gotten the trainer course at home before I left and so I thought, "O.K. while I'm over there," since I have been trained to be a trainer and there were three of us total who had been in the group that deployed, well I said, "I'll take care of getting the 128... Making sure these 128 get done." 'Cuz we had a deadline to have it all done Air Force wide by the end of 1995. So I took that whole program and we put on those classes. We did a lot of training.

> As a matter of fact, it was an additional duty for one of my first lieutenant nurses and she did a very, very good job. As a matter of fact, she kept records. When I... When we left, ah... We got CEU's [continuing education units] for all of the, ah... Ah... Grand Rounds because the docs would put on Grand Rounds and we'd have like an hour's lecture on various things and they'd always try to pick a topic of something that had either just happened or possibly could. Like in the fall, as we were nearing winter, they talked on hypothermia and what to look for and the different frost bite things and that was excellent. Gun shot wounds and high velocity injuries and so forth, that type of thing, and fractures, you know. So they'd almost try to tailor it around something that we had seen a lot of or

whatever. We got CEU credit for that.

> The way we run our lives translating it into a different environment, it's interesting to see what pieces of paper they eliminate, which they leave behind, because we're deployed and we don't have to do that.

Leaving

Looking back. Many of the deployments ended as suddenly as they began. Some teams went home early and some had to stay beyond their planned departure date. Closing down the operation was a final task for those whose mission was ending, others just tidied up and turned the camp over to a new team. Leaving together was also important; for the chief nurses it was unacceptable to leave anyone behind and too daunting to stay behind themselves and build relationships with a new team. Saying good bye was difficult even though they were looking forward to getting home. Looking back on the whole experience right through to the homecoming events evoked a lot of emotion. Reflections on lessons learned ranged from the very practical to the philosophical. Every single chief nurse was willing to go back, just maybe not tomorrow.

> Well you went out and you were a kid but you left there... Even if you left there... The first group left after the first 30 days... You grew up.

> We... We really grew, as I said, grew as a team so much so that we finally, uh... Things... Troops were pulling back out, there were... Gosh I would say the presence was about 8,000 U.S. troops there when I finally left, about the end of March. All during that time, as I mentioned, the reserves would come in on 30 day increments. And we would see them come and we would see them go and we would see them bitch and whine and moan because the green tents weren't quite what they expected and, you know, those kinds of things and it... And we had a turnover of... It was finally our turn to go and the crews that came in reserve to relieve us, the commander of that, felt like they really weren't prepared yet to take it all over. And they were as prepared as they were ever going to be. And so we were going to miss our one chance to... To get on a flight. If we didn't catch a flight, we were going to be stuck there another week. And I can remember just sending him a message that said "You're at the helm, we're out of here." And insisting that we came and... You know, that group came together and we left as a group. I wasn't going to leave anybody behind, nobody was going to stay and fill a slot. If we all

couldn't go, no one was going to go. And we ended up all leaving and ended up coming home to a luke warm reception and that was the end of that.

That is about when they announced suddenly that we were all going to go home. They had the plane there and quick everybody had... We came over like we went home. They said we weren't leaving for like another three to four days and all of a sudden somebody had a plane available, they called, and within two hours everybody had to be out of there. So after the scramble, running around and trying to find everybody, because some people were in the village and I was going around in the car, yelling to "Get back. We have to catch a plane," and then we had to go around afterwards and I had to send many things back on an air evac. plane and stuff because they left it behind. I mean they were in such a scramble to get out of the houses. Some people had clothes in the washing machine that were wet, they packed them in their suitcase. It's funny but it wasn't funny--it was horrible. It was real chaos. I mean it was almost worse to go home that fast. You know, if they would have... A lot said if we had a day we would have gotten ready. But, you know, here's the plane, shut it up, and they said "Oh Oh, you're going in 2 hours." And then, you know, the biggest problem was finding all my people.

The people at home couldn't possibly understand what we had gone through. So I could come back and tell my husband or my friends or my family but it wouldn't have the same meaning to them that it had to me. So there was some bittersweet when we left.

I was assigned. We could've... I could have gone home if I had wanted to but I decided that I wanted to do that. I really thought that I was there and I thought that I was going to see this to the end. In fact, I could have stayed and... Until it closed. But the whole group was leaving and I didn't want to do that.The Col asked me if I would stay and I told her, I said, "Well I will stay if somebody else stays." But nobody else would stay so I decided I was leaving. Then it was a whole new group of people.

Saying goodbye and closing down. Long awaited departures were characterized by feelings of accomplishment, unfinished tasks, and reaching closure.

And we were treating all these soldiers. And what I did was I kept... One of these days, when I have time, I'm really going to... I kept every one of the records of every patient we treated in the ATH, all the diseases, everything... I have a copy of all of those... All of that. And one of these days, I'm gonna to look at it. I have all of those records. Every one. And in the end we treated... Admitted, treated, ah... 3,000, ah... 7. And I kept them all. So I'm going to go back and look at those when I get a chance.

The leftover MREs... we donated that to the local church. As we were cleaning up and leaving the place, we had to get rid of a lot of stuff. And luckily, we started to do that kind of when we knew the war was over and we were starting to put things back together again. We at least started doing that because if we had that two hour time frame to get out of there, still trying to clean up the place, It would have been terrible. But our people went back and we stayed another week there to finish cleaning up and make sure that everything was back to the right place and we also left people from logistics who were there another 5 months or so to try and straighten out the inventory.

So when we left, when my group left, we took down the entire MASH. It had been up, like I say, for 3 years by the time we left 'cuz the first group went in in 1992. And when... When my group left, my group was the one that dismantled and took down the MASH. That's what it was called, the MASH.

Very close associations. So you kind of thought "Wow. Lasting friends but now it's time to say good-bye." You know? So that was kind of bittersweet as we were leaving.

I like to think that we went down there and did some good but I'm not sure that we really did. You just wonder with the political end of it. I know there are people that we helped. And those ones that we really did help, it was wonderful to be able to do that but... Again, we're not sent there to make a political statement.

Lessons learned and next time. Wanting to share the lessons learned was an earnest desire to reduce the stress and alleviate some of the hardships for those who will deploy next time.

Yeah. Yeah, you do. But there are certainly a lot of lessons... Lessons to be learned out there and ah... Folks that I think are willing to tell the story and, ah... We need to try to capture it if we can.

And so this is going to be a generation that has no familiarity with war or casualties. And the training aspect I'm not sure. When I first went in the military, we had to go to training once a month. So I got a lot of the basic first aid, casualties of war and all that. Of course, the scenario is different from World War II and that was all based on that. And now, they are writing this training which they have finally reinstituted and I think that was great that they did because for years we had a gap in military where there was no readiness training. You know, they just kind of forgot that issue. And we're in the hospital taking care of patients and forgot about the war. And now, I know they do the fields and they try to look at it but, you know, whether they will be able to change for futuristic prospects, I

don't know, that's something that we are going to have to keep guessing about.

With that job over there, I think it should be at least 120 days. Because by the time you figured out everything and got into the groove, yeah, and you were like on coast, it took you a good 30 days to feel comfortable and know where you wanted to go and what you wanted to do so... Adjust to the heat.

They need to read all the lessons learned from the previous ATH... And that's the problem. We do not use the lessons learned. We spend hours and hours writing up our lessons learned. I'm not sure that they were used. We do not use them. That's a... A real problem. I would say to have an extremely clear idea of who tasks you and what was their expectation of the ATH because it was a real surprise that we were to be a community hospital,, in two weeks of hitting the ground. ..... Have a linguist wherever you go. ..... The deal about send an avant team ahead of time, even though, you know, perhaps the army would know more about what the air force is like, will become more like the army probably, but, um, you just really need to... To understand... Whoever is receiving you understands about you and what you can and can not do. And if I... I should have read... I should have done a literature search, didn't have a lot of time, but a literature search of the culture because, you know, 10 years before the one I went to, the Cubans had the Mariel boat lift. And if you looked at the literature, they had the same problems, medical problems, that we found - cardiac, psychiatric, some of the same concerns. Uh huh. They went into camps like Indian Town Gap, Pennsylvania, and I think did they put one in Arizona and Georgia, I don't know. And they actually had camps in the country for them. ..... after we left, they took down the tents, they sold all the... They sold everything they could, uh, and there is nothing there probably but the cement slabs 'cuz, you know, the fences are gone, the trash is gone, everything is gone.

Well... My thoughts for next time would be to take people who are assigned to mobility. I would take every standard, every reference, every OI, every procedure I had from my facility and then try to apply them to the ones there. You may never need them but if you ever did, you'd wish you had them. I would, ah... We did a lot of training but I would say training prior to getting there. More emphasis on training prior to getting there. Our plan was we'd have plenty of time 'cuz they've got a lot of slow time, which they did, we can train and... But you never know that day 1 you get there may be the day you need to apply it and, you know... Our folks did do o.k. but, ah... I guess if I ever had to do it again, I would make sure that they'd know what equipment to expect because number one our people going over there... I don't think that they knew what equipment we really would have to work with. They knew it wouldn't be like home but I don't think they were expecting 1960-1970 technology either. You know what I mean?

Going home. And finally there was the homecoming.

> We got off the plane and got on a bus, "There's going to be some people here that they, you know, they want to welcome you back." And we went and they had, I have some pictures of it, they had a big yellow ribbon around the tower. And we... You're kind of oblivious. I mean, you hear about this stuff and we saw CNN tapes and stuff when we were there. But when we walked in, they had massive crowds that were there. I'm going to get emotional. I'm still emotional about it, it's so silly. But they were... It was like we were heroes. Emotional. But it was... It was just amazing to me. And we didn't do anything, you know. I don't know why I'm getting emotional about this. I guess, we had an opportunity to do what Americans should do and it was... It was overwhelming and it still is.

Essential Themes

There were five additional themes identified as essential to the experience. These themes represent the essences of administrative nursing and the essences of military duty. By looking at each of them, one at a time, the whole experience is revealed from different perspectives (see Table 2).

Paradoxes

High tech / low tech. Paradoxes or incongruities were evident, though frequently not recognized as such. Traditional boundaries were blurred making decisions more difficult. Contradictory messages and stark contrasts combined with extreme variability in available resources to create a unique environment.

There were paradoxes in the structures, processes and outcomes of the experience. When information about the deployment was not available through the usual channels, one nurse turned to the Internet and found a website describing the facilities and activities on the site. Another nurse described patients pushing electronic IV pumps across rocky fields to get to outdoor bathrooms. Turning an officers club into a burn unit and, at another location, having computers perched on crates on dirt floors in tents were other examples of the contrasts they encountered. Beautiful beaches seen

Table 2

Interpretive Clusters Which Yielded the Essential Themes Representing Nursing and Military Duty

Interpretive Clusters	Themes
High tech / low tech Luxuries and necessities Irony and parallel realities	Paradox
Greater than the sum of the parts Role identity and role confusion Coming together and building trust Concerns for the welfare Living in community Helping to understand Responsibilities Communication Staffing Making decisions Pride	Leading
A way of being Being present Compassion Supporting each other Support received Lack of support Doing their best Profound experiences	Caring
Ways of knowing Previous knowledge Uncertainty Possibilities and probabilities Moral distress Understanding	Knowing
Fullness of two professions From rehearsals to opening night The big picture and defining moments Willing to go again	True military

through barbed wire remained in the mind of one nurse as a powerful image of the stark realities of deployment.

> They were all barracks. The ICU used to be the officer's club. So it was like a big ballroom / dining hall. And, what we did is we took all our beds and it was an all open ward, just beds. The burn unit was a building. We had already fixed that up.

> I found Prince Sultan Air Force Base... Somebody knew that there was a web site so I found Prince Sultan Air Force Base on the web and then wrote to the hospital.

> The floors were dirty and dusty, there were crates everywhere that we used for desks and storage of stuff. Every desk had a big computer... when we left, every single one had to be packed up and sent home.

> They knew it wasn't going to be med center technology but they weren't expecting the 1960-1970's either...We had telemedicine set up over there, can you believe it?

> We had bathrooms... All these patients were having diarrhea. We had the bathroom but it was on the other side from the tent. The ground was a wheat field but it was really rocky. So the patients who could get out of bed to go to the bathroom had to roll their IV pumps all the way through this rocky field that was the only way to get to the bathroom.
>
> So when I got there, there was still a bunch of wire and they were enclosed with a gate. They could not leave or go anyplace to include outside in the water. They could only see the water and the beaches through the wire but they couldn't go there.

Luxuries and necessities. The significance of these juxtapositions was the fact that they didn't follow the hierarchy of needs usually applied in building a living / working environment. An amazing result of this confusion was the redefining of luxury and purposeful / intentional reasoning about the seemingly contradictory occurrences. Coat hangers, flush toilets, hot meals, paved roads, clean water, and telephones were greatly appreciated when they became available. Sometimes two standards of care were available in the same geographic location, one in the deployed site and one in the fixed facility. Another truly unexpected occurrence was the presence of family

members at or near the deployment site. Families of patients visited when there were no accommodations for them and families of staff members visited in country or even vacationed nearby.

The most difficult situation for many of the chief nurses was the lack of running water for washing and drinking in the presence of high tech equipment. Also noted as lacking were means of communication, like phones or a call system, in the presence of air conditioning and cable news.

Transportation for staff and patients was minimal as was transportation for distribution of food, equipment and supplies. This was in contrast to the sophisticated aircraft coming and going and at one site, a helicopter pad just behind the tents.

> Because we were so close to our home base, families would come out to visit. Now, some people couldn't afford to have their families come out to visit and I really had mixed feelings ...my husband talked about coming and I said, "I don't think its right. We're deployed." Some of these airmen, their wives couldn't afford to come out or their husbands couldn't afford to come out. You know, they couldn't afford a commercial ticket.... And there were some people that also left the area... .. There were some issues that weren't right. . Those are probably some things that need to come down from higher up ... "When you are deployed, you are deployed. No matter if you're two miles away from your family. It's a deployment."

> Initially we saw everything....over a hundred patients a day. They were doing huge numbers of consults over to the navy hospital and the navy hospital was feeling overwhelmed. If you sat down and talked to the physicians...they wondered "Are we here to treat acute problems or are we here to treat chronic problems?" Like undescended testicles, there was a huge number of patients...well should it be surgically taken care of? Is it a problem with potential for higher risk of cancer?

> So it just wasn't organized very well. And so... In our new tent city, we put roads in, asphalt down, because they didn't have any roads. So it was... It was austere but you still had air conditioning, electricity, and all that.

> They issued me a jeep. And for one or one and a half days I'd get back to the rear. Those were good days. I mean you got to go in a flush john, you...yeah, a flush john and air conditioning, privacy, phone, and all those wonderful things.

> And half of the warehouse was still a warehouse with forklifts moving equipment and everything and the other half was our ATH set up and...you know...it had one

bathroom in there...this hospital was set up in the warehouse.

Irony and parallel realities. Simultaneously the rehearsals continued as the performance began. The boundaries kept shifting, requiring a tremendous flexibility and understanding of the concurrent priorities needed to successfully achieve the short term and the long term objectives. Staff members with hi-tech abilities were in a situation that required lo-tech care.

Requirements and obligations accompanied the nurses to their deployments. Taking books from the hospital library elicited the usual admonition from the librarian to be responsible and to return every single one of them. Expiration of certifications like CPR and ACLS and other forms of qualification used to demonstrate current competence was a concern for the chief nurses. Implementation of programs for smoking cessation or new programs on AIDS education were accomplished just as they would have been stateside. Inservice classes and continuing education programs were designed, taught and approved for credit so those deployed would not fall behind in meeting their requirements. Recent nurse graduates were unable to use the old equipment. Only the most senior members of the staff recognized the old technology and it fell to them to do the training.

Additionally, there were other agencies who came to the sites to conduct research.

> I went to the hospital library and the librarian was very helpful. I ran down there and I picked books. We took two big cartons of books on the plane with us...med-surg, ICU, electrolytes...those kinds of books. And of course the librarian said "This is your responsibility and I want every one of them brought back." "Yes, M'am."

> And everybody Air Force wide was required to get this AIDS lesson. Since I had been trained I said "I'll take care of getting the 128...making sure these 128 get done." Cuz, we had a deadline to have it all done, Air Force wide, by the end of 1995.

> The CDC came down and... Actually did a study... we collected information and data for them and gave it to them. And we got to go out with the CDC to take samples and see what was going on out in the field. I haven't read that paper yet. I have never read it. But I think it's time that I do that. That was really interesting because it was the first time... And for the first time, I was very interested in what they were doing and how they were ensuring that the information they got was valid. We developed this little form that we gave them with all the information they wanted. When was the onset of symptoms? How long? What were the presenting symptoms? That was really interesting to me. To just go out with them. We went out into... Some of them went up into the... Into the camps with the CDC and worked with them. Did vital signs. Did whatever else they needed us to do. But that was very interesting to me.

> I was so worried about the training and the nurses who were going to be functioning without the wonderful medical center equipment... We had lessons in counting drops and going back to the old ways. I had been exposed to that era of nursing but none of these people were exposed and I thought "How can I take the modern nurse and move her back twenty years and not have the equipment and still expect her to give this outstanding care."

Like Tevya in Fiddler on the Roof who reflected on the paradoxes in his life "on the one hand ... on the other hand" focusing on the mission enabled them to achieve balance amidst the many paradoxical situations of the deployment.

Leading

Greater than the sum of the parts. Leadership was clearly a factor in achieving the goals of the mission. Chief nurses had a clear sense of identity and reasonably well defined roles. The responsibilities were theoretically similar to responsibilities at home but operationally they were quite different. Establishing and maintaining a team to accomplish the mission was the prime directive. Subordinate to that were concerns for the personnel and personnel issues not the least of which was helping the staff to understand the mission. Chief nurse responsibilities included staffing, performance evaluation, training and other duties as required. The scope of responsibility expanded until things were running smoothly and then expanded again as rough times were encountered. Making decisions was a familiar task for

everyone but the magnitude of the decisions was at times awe inspiring. Communicating, a key tool for leaders, was a challenge in almost every way. Requirements for multi directional flow of information pushed the communication resources to their maximum capacity. Just sitting around talking or going for a walk were some of the more effective communication strategies The chief nurses took great pride in their own accomplishments and even more so, the accomplishments of the troops. Growth of the troops as individuals and growth as a cohesive team were the real sources of their pride.

> And it takes sometimes a different type of leader in that kind of environment than it takes in a peace time environment and that's why the folks like..George Patton and McArthur do well in war time but are hopeless in a peace time setting. And I think..... I personally felt that way. I felt like... You know in an operational setting, I was very, very, very effective. In a peace time setting, I'm not so effective.

> But then we had another guy that we called Spaghetti Man. This was a national troop. And he had gotten blown up with this land mine. Both of his arms were amputated... .. right below the elbow and all of the tendons and everything were hanging down and actually looked just like spaghetti... That's what it looked like. Well we took him back there and everybody would come around .... You'd have all these people in play so... I didn't mind the medical people but all of the commanders, our wing commander, everybody else would come in there so... It became an issue, "Well you can't go back into the tent. You need to clear out and we'll come and give you some information." And, of course, that was left to me. And they would look at me. And you could see... I could feel the eyes on me. Everybody was looking at me to get these people out of there. So I would say, "Could you come with me?" We would go into... ...into the primary care area or administrative area. And I would sit down and brief them about the patient, what was going on, and what we were doing. .....This guy... We started all these IV's and used all this fluid. And then, I finally said, "You know, if we use all the fluid and supplies on one person, we're not going to have any left." So at some point you start not really rationing but you start saying how much fluid you can give which was really crazy because we did the 99's and that's the inventory where you can get fluids and you're supposed to be able to get anything, like supplies, in 3 days but out there it doesn't work. ..... You can order as much as you want but it gets there when they decide to bring it to you. So this patient, since he was a national, we took him downtown.

> And we had ambulances. We sent out people in ambulances. We didn't send any guards or anything because we didn't know that we needed to do this. But they

took this patient down there and the ambulance was surrounded. And it was really frightening for the staff. They weren't really... I don't think they were really going to do anything to them but they were just wanting to see what was in the ambulance and I guess the ambulance... They were rocking the ambulance backwards and forward... And so when the techs got out and took the patient out and got ready to come back, they were blocked out from leaving the area. Finally ..... Somebody came and got them out and they got back there. We never sent... ... We didn't send anybody else off base to take patients or anything else. If they wanted to take the patients off base then they had to provide a way to get them off because it was just really... The area was unstable. It was just too unstable to do that so we never did it anymore. We had a kid, he was burned. . We got him out by our air-evac system to a large hospital ..... so he got there. That was really hard for the nurses also to treat this kid because I guess he was so young. And the thing that really bothered them is we... We're gonna send him back someplace but where do you send him back to and what kind of help... What kind of care is he going to get... after they get back there.

Role identity and role confusion. Identity and role definition were clear from the beginning for some of the chief nurses, for others the assignment came as a complete surprise and they had doubts as to their ability to function in the role. Most came to terms with the role soon after arrival.

I was on mobility. I had an assignment on mobility as the chief nurse of our ATH. And we practiced with the ATH.

And there were other majors but I was the chief nurse and it was just never disputed.

So as the chief nurse, I think I got... It was a lot of respect. The British called me sister or matron. That's what they said. I was the matron.

I was the den mother. I started out immediately being the den mother.

"Oh we have to set up the ATH and train." Being a chief nurse in a fixed facility or at air transportable hospital, to me, is the same. You're just working in a different environment.

I was somewhat leery. I had not been a chief nurse all by myself before but I felt like I had, you know, a good background, that I could do that, and had been around the Air Force for quite a while.

> I didn't have the foggiest clue as to what my role was. So I got there the first day and I went to the command tent assuming that I'd be in the command tent or in something like that. And I got in there and realized that there was no spot for me there.
>
> I'd be doing patient care ... Not that I couldn't do that but there was a lot of role confusion.
>
> I was perceived as being one of the staff nurses, ... I didn't feel like I could be the chief nurse, I was one of the nurses.
>
> I had been a nurse manager. And I had just stepped into the role of flight commander so I had just a little bit of background as far as administration but not... I certainly didn't feel prepared to be a chief nurse.
>
> And what I found was that wasn't my decision alone whether or not to proceed with the urgent [flights] and once I started going around and asking, ... because we have a flight surgeon assigned, that he had his portion and I had my portion and then I knew exactly the lines as to what my responsibility was because I wasn't quite sure. I thought I was starting to get into medical decision making as opposed to my understanding of the job. So as soon as I started talking with the other folks that were supposed to help me make this decision, then I understood, "O.K.," what my role was.

Coming together and building trust. Coming together as a team was one of the main concerns of the chief nurses. It started at the time of notification and continued throughout the deployment as new staff members joined the team. Sharing information, planning, packing and traveling together helped people get to know each other and to build trust. There were a few situations that were counterproductive to building the team and a few challenges in merging staff members from different bases into a single unit.

> The toughest thing... Which is what I told the nurse who took my place. I said, "The toughest thing of this whole thing" was not the mission, it was the people. It was to make them all happy, to make them a team, and not for them to be bickering, whining, and to keep them productively employed.
>
> I guess, I felt good in that we were going to be deploying, all of us from our hospital

for the most part so it meant that we wouldn't have to, ... learn a whole new group of people

A month or two prior to our actual leaving, the executive team met regularly so you already started the... The bonding and the association and so forth.

Well I felt real... I think being able to tell them what to expect, many told me that they were very grateful that I did that because they had no idea. They had absolutely no idea. So giving them the preview with the videotape of where they were going and telling them as much as I could about it was real helpful. And I think you bond a lot closer to the group if you're going to say "Well we're all going to hell together." And, you know, I was so worried about the training and the nurses who were going to be functioning without the wonderful medical center equipment.

Everybody had to come to our base. They came to us and we all went together. So while we were doing a few other things, we were actually getting everybody in. They couldn't house them on the base so they actually had to be downtown, we had to keep track of them, where they were in their facility, some of them came with shorts and no other provisions, some of them had no money, some of them were not as well prepared as they should have been for this deployment, some were very well prepared.

When we went,we actually stayed to begin with on a base in an army, old army barracks, a horrible place .... it was a Ritz compared to where we ended up living because it had flushing johns and a shower ... actually,very sparse conditions but we actually started coming together as a team because we all lived in this barracks.

We all got together and left ... but we went on a C 5 and the avant team, all of the senior people were in the front and we were there in the low cockpit. We were actually separated from the troops so... And I think that was probably a mistake. I think we should've all stayed together but we didn't.

There were nurses from different bases throughout Europe. So it was really interesting when they got there because we... All of us were a group... A cohesive group in fact. And then these other people, it was sort of hard not to look at them as intruders because we'd done all the training and we knew everything.

We tended to get along well but keep in mind we planned the whole mission together and we'd worked together as a group beforehand so... There was a core of us that went out almost all the time. So we got used to working together and we really would have a good system set up.

I really enjoyed working with people from all the different bases too. We had one

or two coming in from all different places. And we had the boat or the plane that came in on certain days of the week, every week, and we knew to... You know, expect somebody or somebody was leaving. So there was always a lot of joy that somebody finished their 90 days and they were going home and then we had to support the people that were coming "It's going to be o.k. It doesn't last that long..... there are things to do here.

And then we had to wait. Half of our group went and then the C5 that was to come and get up sort of broke down several times and so there was a delay of, I think, 3 days between the first half of our group with C5 and the second half and that was a problem to begin with.

Then the nurses were... They started competing with each other because they were from different bases. And after that first incident, I think everybody started working together as a team. One of the things that happened, I think we were there for maybe three weeks, and there was a car accident. .....all these guys were burned, like third degree burns, but this guy I will never forget. He walked into the ATH with his arms out and his face was just covered with all of the burns, the skin is just dropping off of his face, and all he was saying was "Help me. Help me. Somebody please help me." So we got him back into the E.R. and started doing all the IV's, getting IV's and everything else in him.

And you know what gets you through? Humor gets you through and people get you through. The good people get you through and what you have to do as a leader gets you through. ...you can not not survive because there is too much to do and there are too many people depending on you. And you learn that real early. But, without a sense of humor... And you get so close to those folks, you really do. I mean, when you're out there digging, digging in the rain together, and... It didn't matter. I mean, we all got out there and did it. It did not matter. You know, it was not, "Well enlisted you go do this." Uh uh, we were all out there doing our share. I remember... Thank God for Motrin.

This is what happened. They didn't all leave. What they did leave us behind was... And I can only best describe it as the misfits... The unit went back because they had an ongoing training mission and they had gear to repack, to get ready for the next war, and they left me with folks that had the reputation for not being stellar performers and... And I was concerned about it, I addressed it with the commander, but his decision stayed. So they ended up leaving me with, I think, about 20-22 active duty folks, and then by that time we had about 15 reserve crew members who were there. So we, as the active duty, served as command and control, then the reservists who came in for 30 days stints were the air crew members that went with the patients. I'd say that was the low point of my tenure there. And I remember standing on the flight line seeing these 70 people that had come in after me get back on the plane, seal up that plane, and they went on home. And it was just emotional, you know. Personally it was an emotional experience. But I took that as a personal challenge ...to take the folks that really had been labeled the misfits of that squadron and to build them into a cohesive team. And,

> you know, to make a long story short, 90 days later that was the best air-evac control center team.I'd go with them anywhere, to any conflict. I mean, I remember those folks to this day and they just became cohesive because we were all kind of stuck there together. ... personally... I think it was a growing experience. I really got a taste of what leadership was under adversity.

Concerns for the welfare. Concerns for the welfare of the staff persisted throughout the deployment, they included safety, emotional well being and living conditions.

> Some people started protesting and marching outside our gates. So we put camouflage netting up, all around the compound, as much as we could, so people couldn't see what we were doing inside. And then we had to start talking more about terrorist problems. That worried me and especially when we went back through the airport and they inspect you and there is all this security You realize then that this was unfamiliar. You have this terrorist threat because in the United States you don't have to go through that. And then, of course, I think while we were there one subway got bombed down in the city. So, you get in your mind, your thinking, it is not your most important thought, but you're thinking well this might be an obstacle that you're not expecting so we had to really start talking to our people about being careful and that the threat of terrorists was there. But we're Americans, supposed to be safe. And the one base where I was in that barracks, living in the officer's club, that was one of the ammunition bases, , and one of the things I was told was that they brought us in there thinking then that the terrorists wouldn't attack that base and that didn't make me feel real good. And, we tried...to tell our people this because I think, you know, Americans they kind of do their own thing and we were afraid that somehow they would put themselves at risk. And so then we told them that they couldn't walk around in their camouflage uniforms, we gave them parkas, and they could wear civilian clothes with parkas, but they really shouldn't be in their military uniforms running around town. Again, that was something unexpected. I guess that would be it. That we didn't know that was going to happen. And I was not comfortable. And they really checked and searched everybody when we came onto this base, where the munitions base was, and we were thinking, "Boy, I hope they don't decide to attack here at this clinic."

> Am I willing... You know, if they die, is it my fault .... my chief would spend nights worrying about... If something happens to him, it's his fault because he put him there, and I said, "No it's not your fault," and he said, "But I picked him," and I said, "But you pick them based on the needs of the mission."

> I tried not to... And I know a lot of people I talked to tried not to get emotionally connected to any of this. We just really got to the point .....you know the little girl has AIDS and she's probably going to die but you can't dwell on that. You can't let that.... we had nurses there and techs who wanted to adopt kids. They tried and their government would not agree to it, our government would not agree to it. There was no avenue to try to help.

My first shirt and I would always go and meet people at that boat.... the first week there, I wanted to go look at housing. And, the commander said "Well that's a waste of time." I said, "I need to know where my people live." So I would go through the housing area. Sometimes, I'd ride my bike and ride around. .... so even after work, when I was actually done with being out in the field, if you will, I'd come back, I'd get on my bike and go visit. And people would invite me to their houses.

And then it blew up in his hand. ... A number of my people really... they almost were fainting out there. It really shook them up. And I was concerned, "How are they are going to deal with it when the war hits and we're going to get..." ....I was imagining Vietnam in my mind. "How are they going to be able to deal with that if this one..." It was a very controlled injury. it's one half of a hand.

I wish I could have protected them better because I think a lot of them were really young, immature nurses, and they were probably away for the first time and came up against some very aggressive, very persuasive people who were pursuing them. Alcohol and the stress of being TDY... I'm not so sure that they were adequately prepared. They really weren't prepared at all. They had no lectures on what it would be like, what the migrants were like, some of the cultural things. I think some of that would have helped. They were such a demonstrative people, a very warm and friendly people. It really would have helped to have understood some of the situations. I think we could have been... a little bit more sensitive, ...what we would experience.

We had a lot of different problems. There was no alcohol, no shorts, no bathing suits. .... all of our nurses had bathing suits and the nurses from other countries had bathing suits but they particularly chose if they were going to sunbathe... They sunbathed nude. And they had blankets around these tents so you couldn't see anything. But you know how guys are. They can find a way. So we got into trouble. Several of the nurses got into trouble for wearing bathing suits.
And I thought "Well now the only thing they're doing is they're in their bathing suits, they're behind the ATH, nobody can see... You have to make a concerted effort to get behind, all the way behind where they were to see, and what were you doing back there anyway." I mean, yes, they needed some way to relax and that was one way that they could relax, after working all day or after working all night or after an incident would happen, and so I really thought nothing was wrong with that. They weren't getting into trouble. They weren’t doing anything. They weren't walking around the compound in their bathing suits or anything, they always were fully clothed, and so I thought that was o.k. but our commander and all the other people didn't, so it was like a battle. And any way we won it, they pretty much just sort of left me alone. And I said, "Well, you know, I'm not really going to do anything to them about going out. They're there. They're protected. Nobody should be back there anyway. They're covered. And so what? They're not bothering anybody. So that's one of the little things. We have other things to worry about."

Living in community. Personnel issues were mostly minor things that were dealt with immediately, informally and successfully. Health, behavior and interpersonal conflicts topped the list, the latter probably secondary to living in close quarters. The resort like atmosphere of one deployment was no more or less prone to problems than were the more austere environments. In addition to counseling and disciplinary action there were promotions and other recognition programs.

> The bottom line is how you take care of your people because the people do the mission.
>
> Well, you know, when you're busy... When you're busy working with... On the executive team, you really spend most of your time worrying about your folks rather than how you personally feel.
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> There were many, many personnel problems.
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> We had an NCOIC who had a drinking problem. He was sent over there with the drinking problem and it did not resolve. We found him passed out in the bushes and had to intervene on his behalf. We had to get him into treatment.
>
> Some of the challenges were getting the people to take the fact that they were deployed seriously because it was so much of a party atmosphere. We had a very active officer's club, we had steak dinners outside on the water. I walked in one day to the med.-surg. unit, right in the little back room, I found one of the nurses who was hooked up to an IV. I remember just sitting there thinking, "What are you doing? Are you sick?" Of course the nurse, being a very honest person, said, "No. I just partied a little too hard last night, I'm hung over, and I'm just getting a couple liters of fluid." I just did not react at that time. I didn't get angry right there. I just left, went and called her nurse manager who ended up giving her a really strong letter of counseling. I was really disappointed because I could not believe... Not that they wouldn't party but that they just weren't taking it seriously. On their own, without a physician, felt they could get somebody to start an IV and get a couple of liters of fluids and this was fine and acceptable. I don't think it would be acceptable at home in a day-to-day operation, to be hung over and need some fluids even though I am on duty, so it was not acceptable to me in a deployment setting.
>
> I tell this story because it was just unbelievable. So the nurse yelled because she hadn't been sleeping for 2-3 days because she had been working. She worked hard,

there is no question... It was like 6 o'clock in the morning and she had come off of a 12 hour shift because she had to cover nights. So she is in her bed and this Second Lt's alarm clock goes off. So she got up and yelled at her and said, "You know you have to get a new alarm clock!" So the Second Lt. goes running out of the tent, starts crying. Then I come in at 4 o'clock, after the day, and she says "The Lt. has been in and out, grossly upset, I tried to apologize to her, she won't listen. She's going to sleep with the guys in the other tent." And of course you can't do that, that is one of the rules. You know, you do not sleep with the men in their tent. So I went to her and said, "Oh I'm sure we can work this out. We'll move your bed. We'll get you a quieter alarm clock. You can't sleep with the guys in their tent, that's not allowed, even though it is a deployment." And she's going, "Well then I won't sleep with them, I'll just sit out on the couch outside." In a little rest area,... And I was like, "Well you can sit out there but I'm telling you you've got a bed. I'm sure we can work this out." And she just started crying some more and threw her water bottle around. I said, "You can't act like this. You can't be throwing your water pitcher around. This is not the way to behave." I said, "We're trying to help you here and I realize you're upset," And basically she was only there for 3 weeks and she slept out on our couch because she didn't want to sleep in our tent. I think there was another underlying issue there. I think she had a problem... My thought was that she must have missed an appointment or something because she was so paranoid about her alarm clock and waking up. I think that was the issue and then when the nurse fussed at her because I kept saying, "This is not a big deal." And then she had to go back to the states for something and she didn't return.

One of our nurses, probably was having an affair with an enlisted member ... Lots of supposed dating between enlisted and officers, mostly officer nurses and enlisted techs, who were, Well, some of the officers were married, some of the enlisted were married, it was just a combination. Some were both single, some were... One was single, one was married. Some of them were both married.
The thing I... could do, and we did it very early, is to let them know that this is not behavior that is acceptable. You know, its a general kind of a briefing about acceptable behavior at any time in the military. You are still military. This is a military deployment. These are the behaviors that are not acceptable and that's fraternization.

I remember calling her in there and just having a talk and just saying "You know, you've been somebody I could count on every step of the way. And you came in... You came in two months after I did. And you remember all those things we've been through." And I said "And I understand you're verbalizing that you're gonna get out of here before the rest of us."And I said "Well ,I just want you to read my lips. If I hear you say that one more time, you are gonna be the last person that I allow to leave this theater and I don't ever want to hear it again. You're poison in the well here. And I expect more from you." It straightened her out, I never heard another thing, best team player again for the remainder of the three months.

So I went over and I took that nurse out in the back, someplace quietly, and I just had a little conversation with her about "This is what's come to my attention. This is all informal. I'm strictly telling you this 'cuz it's time to play by the rules." And,

of course, she denied the whole thing. I said, "I don't want you to deny it or not to deny it. I just want you to fix whatever the problem is. And if I hear about it formally, this is what will happen and it will not be pleasant." And I never heard anything else about it.

My headaches and my stress the whole time I was there was 90% involved around this one individual. He was a... He was junior in rank in but he had prior enlisted time and he had a lot of experience and he kept thinking that he should be given more responsibility. I didn't involve the executive staff with this because... Except for to let them know at one point that, I was having a problem with him.

That's another thing I would suggest to people, and I have it in my ditty bag, is rank. Because you have promotions, you have all those other things that normally occur, and so I throw in these camouflage ranks, so I throw that in my bag now.

Helping to understand. The missions came first; always, always it was mission first and that was hard. Understanding not only what they were doing but why they were deployed took lots of explaining.

You care about these people but yet the mission has got to come first and I think that's the hardest thing.

Initially, I would say we saw everything. I mean, we would see... It was not unusual if we saw over 100 patients in the clinic a day. And sometimes our numbers were even higher than that. So initially, you could see that the physicians were really getting burned out...we had a morning meeting always every day, giving report and we also had an evening report. And so would always ask, "Are there any issues? Are there any concerns? Are there any problems?" And that was one thing that eventually,... If you sat down and talked to the physicians, they just felt that "What are we really here for? Are we here to treat acute problems? Are we here to treat chronic problems? And how many of these...?" They were doing huge numbers of consults to the navy hospital. ...everybody wanted to do everything they could for these patients and eventually we just able to come up with "These are the things that we will refer. These are the things that we will not refer."

It's very hard for to tell young people to understand why they're spending three months in an environment that's hostile. They say, "Well if we're there to protect them and they don't like us..."..... whatever your feelings are, you have to put that aside.

"Why are we even taking care of these people?" I had to deal with that a lot and we talked with them about the kind of situation that we were in. Many of those

> people actually saw their families eaten by sharks or drown at sea because they were out in flotillas, in homemade boats, bathtubs, boxes, anything that would kind of float, and a lot of them never made it.

> I would try to talk to them. And I said, "Why do you think...? Why would they send us back after we've been here, acclimated to the desert for three/four months? Why are they going to send us back now only to bring brand new people in to rotate us?"

> They may not still like the reason why the U.S. is there but I think if they can at least buy into part of it and not understand completely what goes on.

Responsibilities. There was tremendous variation in the enormous number of requirements confronted by the team. Success in meeting the requirements was complicated by environmental factors. Functions that ordinarily had assigned offices of primary responsibility (OPR) were assumed by the chief nurses. Teaching and training, tracking personnel records for promotions, resource allocation and work flow issues all fell to the chief nurse. Additionally, the basic tasks of site maintenance had to be shared by all. This participation served the greater purposes of earning the respect of the troops and building a cohesive unit.

Multiple requirements and taskings and the ever present concern about capability were overwhelming at times. Performance evaluations and promotion cycles could not be ignored, neither could the budget. Funding of the deployments was certainly not a straightforward process. Procuring supplies and planning expenditures was done with minimal guidance. Occasionally it was after the fact that an accounting took place. Training was a major responsibility and the stakes were high so there was little resistance to participating in classes and exercises.

> I tried to figure out how I'm going to keep the hospital at home going and how I'm going to run the contingency hospital so I took a very select group of nurses.

We were assaulted on many sides by the requirements we had and what was required officially in our capacity as the ATH. It was an assault. It was really. Because when you're worried about where you're going to sleep and you have to set up your own tent and you have to organize to be at a certain point every day because the skies open up, the skies open up and drop torrents of water, and you're out there with little shovels digging trenches to try to keep the water from having the darn thing float away.

I was finished working redeployment issues and resupply issues and I then focused more on what I saw as traditional nurse roles. One of them was to put together a guide book for all the mobile air medical staging facilities and the air crews on what to do in various situations. What do you do with a death in flight? Well, you know, you're in a foreign country, how are you going to deal with that? So we put guidelines in place for that. Guidelines for handling enemy prisoners of war. How do you transport those patients and what are the rules of engagement as far as arming the air crew members. ... what were the rules of engagement as far as wearing the Red Cross arm band for the air evac crew members or any patch that had a red cross on it. And so... That really became the focus of my duties.

You know, you just get the work done. My biggest concern, my biggest worry, was we weren't going to be able to take care of the injuries that we saw. That was my big concern. I was not worried about safety for us, I just didn't get that sense from the patients that we took care of. They realized that we were trying to take care of them as best we could,... They didn't dislike the hospital. We were o.k. So I wasn't worried about our safety but I was worried whether we could step up to the challenge of taking care of whatever came in the door.

The nurses, they were still rated from their nurse managers back at home. They were sending me OPR's through the computer and it was wild. You know what I mean? PRF's [performance recommendation forms] had to be dealt with the same way.

Initially, there was no budget. The Navy hospital would give us anything we wanted. The clinic would give us anything we wanted. And then, all of a sudden, they realized that there was not a real... good accounting of the supplies. Turned out to be a big, big problem. Because they would write something on a little scrap piece of paper and somebody would keep that little scrap piece of paper. . When they told us how much we were charged, for immunizations, then I went back to..And luckily I had put the right person in immunizations and he was able to show all the slips of paper and how many kids actually got immunizations and we were able to show the Navy that they had really over charged us and we saved the ATH mega bucks. That's probably a lesson learned, that you need to set up your accounting system right from the very beginning.

It wasn't something that was really, really discussed but I felt responsible for all of the physicians and the nurses. I was the... They brought me all the problems

because our commander was very, very busy going to all of the meetings with the general and working out different things. The administrator was someone that was very, very good but he was not one that made rounds in the ATH.. I thought that he really kept us organized and did all of those things. I guess I really looked at everybody. looking at the morale, how are things going, talking to everybody, making rounds. I also took a big role in the INS physicals, really supporting the social worker down there and helping out with the paperwork and then going up to the clinic and making sure that they were doing o.k.

I was always teased about it... dog and pony shows. I ended up pulling about five air crews into the air evac control center, bringing them in for training. We trained them on the equipment, sent them out to the five main hubs, had them train the crews and we all had to do that in a matter of just a few days. So those were kind of the challenges that we faced. We had to train the mobile air medical staging facility folks and again these were folks... I believe we had at one point about 22 mobile air medical staging facilities scattered all through the country up along the border and down in the southern areas. Towards January, we were getting folks that had just gotten out of flight training, they didn't know what a mobile air medical staging facility was..... so we had to train those folks. And they came with very, very little confidence. .. we developed a training site and we would bring these crews in and we would deploy them up to a place...for training.

We did some day operations and some night operations. And we would take folks that on Sunday were timid, didn't know how to put up a tent, and by the next Saturday, those were motivated, pumped up troops, ready to do the job. And that's what we did. We turned through about... about six or seven teams. You know, of 30... 21 person elements that went through that particular training.

I was... I think well respected there... Maybe because of my rank but also because of my performance. I was able to... I was doing the things that I needed to do. The people there knew that I would help and I would work. I cleaned potties and latrines just like everybody else did. I was continually reminding them about the infection control things. We had a real problem with keeping the place clean. It was just an unending chore and a lot of times they'd just say "Well I don't think we need to mop this place" and I said "Oh no. It's going to be mopped every shift." When it was really bad and wet, if it rained or... You'd turn around the next day or two and it was real dusty.

Communication. Open communication helped to solve problems and it was a good way to share information, even though there were times when the executive team didn't really know any more than the troops did. Commanders Call gave everyone a chance to clarify expectations and control the rumor mill. Coordination of patient transportation was a communication

nightmare since there were so few available phones. Getting together to talk either formally or informally was therapeutic for individuals and for the group. People gathered together in lots of different ways just to chat for awhile. Most everyone who was deployed had used e-mail and beepers at home, it didn't take long for them to create low tech equivalents; not quite as convenient but they worked.

> I think that it was real important to be able to leave communication open and to have a really good flow. I was proud that I was able to keep them together,and to try, as best I could, to look at their problems and try to come up with some answers. Also, to stand up for them against the docs sometimes, as far as who was getting what.
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> And there were times when we didn't know anymore than they did. And you know if there is not information passed, then rumors will be developed. And that was one of the things that we recommended... The executive team recommended to the boss was "Please we've got to do this. We've got to have. Stand up.." And it's not to see how many people have their shoes shined, it's to get this information out as soon as we can. And then we'd ask, "What rumors have you heard today?" So...it's Critical. Critical because they do come up with the most bizarre rumors and information that they think is the God's honest truth and it's not.
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> We just, every once in a while, had a little commander's call and we talked about fraternization, professionalism, and how we're going to do business and what's expected.
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> Keeping people informed because the rumor mills were just going wild. So communication was really important.
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> Anyway, so that was a big requirement to coordinate the clinic visits realizing that the camps didn't have phones. We could get to the camp aid station but the patients didn't have phones so you had to coordinate... You had to coordinate their clinic visits. Somebody had to go get them in their tent and I forget how many... I want to say 6,800... No, no. 68,000 clinic visits during the time we were there, it was terribly busy.
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> We did things like,.. One time we took one of the physicians along and went down to the Navy hospital and we met with the commander, we met with the chief nurse, and we talked about "What can we be doing better.What are issues that are that are frustrating for you. Here are some of our problems." So I felt like the communication was really, really good. We tried to work things out and not just

talk about people.

But most of them are extremely reasonable. The O6 marine was great. We saw things the same way. We used to sit at the bar every once in a while, drink water, and talk about things. .....he was great. I started going to some of the army meetings because those were the people that ran the camps that could talk about what the problems were. And I'd say, "How can we help you?" And you know what, they always knew the answer or they always knew what they wanted.

We are not going to fail. ...it also comes down to, with those kind of people together, you get through it. You know, there was somebody that I could talk to to deal with these issues. And then, there's God. You know... You do. He watches over us. Well, you know, tests you, I'll tell you. I was never in such a situation as feeling like they were ready for us to fail, encouraging us to fail, putting us in a position where we could easily have failed.

We'd just talk and... We had a little thing where we'd smoke cigars. And we'd just sit around and just talk.

Communication is a big thing. And what we had done initially is just put butcher paper up along the.... we had these divider walls dividing the hospital from the rest of the warehouse. And we would just write with markers to relay the messages, our E-mail over there. And that worked really well. And I was able to catch up on things.

There were no phones so I had to sleep with a brick [radio] and there was a brick at the base and then there was a brick at the other facility and then, of course, they had communication at the ATH. But I slept with a brick for communication. So that lasted about 2 weeks.

Staffing. The challenge of staffing was matching the staff members with the work to be done. The tasking often changed or expanded during the deployment requiring people to work outside their normal scope of practice. Getting to know the abilities of each member took time and sometimes their preferences were very different from their abilities. Flexibility was the key to getting the job done.

And then I was staffing it. And, in fact, I took a pediatric nurse practitioner and put her in charge of triage which worked out real well you know, trying to use abilities of the people that we had. Our ICU and burn unit though were our two

biggest problem areas, trying to get them up and going. And then, we had also psych and. I think I brought two psych nurses but... On our staffing plan, had no psych. and luckily I brought two. And, I don't think we had a psychiatrist. I think we had a sociologist or a psychologist. So, we had to worry about getting some mental health texts and then again work together trying to get them ready to handle a psych unit.

And our first sgt. was not a real first sgt. He was a master sgt. but he had never been a first sgt. and his... To some degree, his cup was always half empty, not half full. he tried hard but he just wasn't the man for the job. You really need to have a first sgt.

So what we did and what I did, is I got cards, 4 x 8 cards, and I had everybody write down what experience they had, and things that they liked and disliked. And sort of collected all those cards and I kept all those cards.

Merge the three into one and not knowing your staff, to try to get, you know, ward set up and not having any idea who these people were.

Most of our people were excited to go. It's interesting, you pound yourself into the ground making the decision about who would go. And not only for us who would go but what job you would have.

We had a very, very young group of people who did not know each other, that was one of my big concerns as a nurse, as chief nurse. I knew the folks from home, it was a small enough facility, I knew their strengths and weaknesses. I did not know to be able to assign people that came from the other bases, a big contingent. What I did was, because we were the ER package and that's what we came as, that's what we were to be assigned. Those were the emergency room staff and I left it the way it was because everybody wanted to work the emergency room, nobody wanted to work the wards. So to begin with to get into full operation as quickly as possible, I left it that way because I had no idea, I did not know these folks at all. I identified the most senior... The most senior person was a captain. Luckily, I had a major from the other base who had deployed to Operation Desert Storm, who was wonderful. I don't know what I would have done without him. But I identified their most senior person and that's who I tried to work with and work through. But I know that gave some people some real heartburn because they all wanted... They wanted to do what they wanted to do and work where they wanted to work.

So I looked at my social worker ... there was not much social work to be done. She eventually... We utilized her in the home visits. She went out to the homes and listened to their stories with the interpreters and everything. So she became my charge person of the INS physicals and did a fantastic job. ... The mental health tech who was in charge in immunizations. We took the dietary tech and put him in charge of admissions and trained him. We used a lot of our personnel that

> weren't... deployed in this kind of a role but we didn't have that role... They weren't full-time employed. We put them to use in other roles and it worked out well. They really, really, really stepped up to it. In fact, they were excited because it was something different and they felt like "This is neat. I really feel useful."
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> There were probably 30 nurses under me. And their issues were quite significant too. They didn't want to work where we wanted them to work. We had several O.R. nurses show up, well we didn't need O.R. nurses. We needed nurses in the camps so I had to assign them to camps. And I'm sorry. We don't need 15 nurses in the O.R. when we already have an O.R. crew there."

Making decisions. Decisions were seen as part of a process that started with gathering data, listening to other people, making the decision and then reflecting on the outcome. Gathering data was difficult because there was so much uncertainty, counsel from others was available locally but the usual support systems of these nurse leaders were geographically separate and difficult to access. After the decisions were made, the executive team reflected on the awesome responsibility of decisions that put the troops in harm's way.

> I've always been a person who was not afraid to make a decision and I think that's an important thing especially for a nurse and an officer to be able to do.
>
> And the Colonel and I... We confided in each other a great deal and we really had felt like we had signed those people's death warrants.... that we had sent them up there....that that was going to be the end of them. You know, we made a purposeful visit to go up there about a day or two later to see them.
>
> The difficult decision was really trying to find a place for the Anthrax patients and trying to figure out who I was going to put over in that horrible place to work. Oh, here's another one. In this day and age which is certainly different than World War II. We were going to have parents coming over to see their kids... if they were casualties. What were we going to do with parents?
>
> Yes. I think the one that was most difficult. When they came to us and we had to re... We had to deploy a small group of people... It was the decontamination team. And had to send medical technician support to a forward location. Now, when we moved up..., you knew that you were still removed from where any of the activity... ... Even though we had scud alerts, we were really out of the range of the scuds. . You sometimes say "Well maybe it can get out this far." ..... you believed what you want to believe and they would say "Well we're really out of range" but

we still would have scud alerts when they would shoot them off and... So when we had to select that team and send them forward, I didn't know if I was putting them into danger. So that was... I made the decision but it... You know, you get kind of... You kind of wonder if you're sending them off to... to their death. So that was difficult.

Then, when you get all the pieces together, then you realize that the situation may not be what you thought at the beginning. So there was a lot of using other folks to help you make decisions.

Pride. The chief nurses were proud of the growth of individuals and proud of the growth of the team. Seeing this growth renewed their confidence in their ability to handle the mission.

I had to hand pick who was at each station, what teams were at each station, by name. It was wonderful. But that second day, we got through that, pretty tiring. But that's when the staff, the youngsters, everybody, just worked magnificently. They just were wonderful. I was so proud of them. They were wonderful people. They really... They really did their best during that... those days.

If you would keep those people busy and they knew they were doing something that was worthwhile and they could see the results of their activity, you know immediate feedback, immediate gratification, they would do anything. I mean, I would take that group of 125 or 130 people anywhere to do any tasking. I would. I trust them.

We just all had to do. The nurses came through with shining colors. They just really... I... I learned one valuable lesson. That when we are put to the test, we really can perform and perform they did. Everybody did an outstanding job. When they had to evacuate the patients to the bunker, they did it without thinking. I mean, they just... They just acted. And they acted very, very, very well.

I'm proud that I didn't have any major disciplinary problems with nursing. I think it was one of the hardest things to figure out what you do with boredom and how you keep people challenged, focus their energy in a positive way, because they could have disobeyed me, they could have done lots of things, they could have gotten into lots of trouble. I think we spent so much energy training... I met with them. And that's another thing. I conducted night meetings and day meetings and just let them talk about their frustrations.

It was after the riots, it was after the riots, that's right. We didn't have any help. So we actually had to open our 30 bed psychiatric facility with one major who has

not had any psychiatric training... ...., any more than any of us who did not work psych. He volunteered to do that for us and then he got volunteers because that's the kind of guy he was and we had come together as a team and there were people who volunteered to do that for us and so that's the group that opened the psych unit. And it had to open quicker than later because of the riots and we filled up the rest of the hospital so the psych patients had to get into the tent earlier. We, of course..... Our psychiatric unit was two GP large tents. So you have these very involved patients in tents, on cots. That's what everybody slept on.

Well to the credit of a lot of the techs and the nurses, they actually did learn Spanish very quickly and they communicated well but... I mean, that was one of the areas that we had to have as soon as we could get some... Some interpreters, the volunteer interpreters, or the Army troops, or whatever, our one airman from home that spoke Spanish was well used. I mean, it's a wonder he ever got any rest. He was our... One of our two dietary ... Dietary techs too that went down with us so... You know, and ended up, the one.... The other dietary tech really got the brunt of the dietary work load because we needed him to do interpreting.

That's it. They would do anything for you. You know. They just did it. And they... They were these babies, that started out to be babies, that you just wanted to say "Grow up." And, you know, they were just wonderful people. And they did grow. I mean, one nurse, one lieutenant., I just wanted to strangle her when we were having to move to our second home. And I was trying to find rooms for everybody in this place and she wanted to know where her linens were. But she turned out to be a real good kid, grew up. Yeah. So I would say probably the proudest I am is how the kids grew and came together as a team.

So he started out as a meek, mild mannered guy who was scared of his own shadow and didn't have the confidence to really do very much of anything. And I watched... I just watched him grow over three to four months into... And... And I can remember just like it was yesterday, getting on the C141, and he was in charge of making sure that the reserve air crews that came in the theater had that plane configured the way it needed to be for the patients that we had and then he would go out and give them the report on the patients and he'd get the patients loaded up on the plane. And I remember one time a load master was just being a butt, wasn't configuring the plane like we wanted, and I watched him rip that guy a new asshole and I just said "Great."

"Well there goes that exercise. Goes to show we can really do it when it's real world 'cuz we did it."

Caring

A way of being. A broad range of caring behaviors and intentions was revealed by the chief nurses. Supportive interpersonal relationships were established, intentional therapeutic interventions were performed, and the moral imperative of respectful care of the dead was applied in practice. The distinctly human trait of caring was manifested in the language and presence of the chief nurses in multiple situations where their beneficent actions relieved suffering in those around them.

> There had been an accident. One of the French troops was decapitated and they brought the body in first and then they brought the guy's head in. Well one of the nurses... She was a captain, a brand new captain at this time. Somebody had to help with this guy and she was the only person that was not busy doing something so she was the one who went in and helped with... Helped the dentist do this..he had to take x-rays of the head for identification purposes.... And so I was looking at her when she went and I knew she was really having a hard time and there was nobody else... I mean there was literally nobody else to go and help at this point. And I knew that she was having a hard time but we... There were three other guys that were burned, the one that walked in was the most critical but there were three others, that we were trying to take care of. So I got busy trying to help with these other people and getting supplies and getting everything else there. And it's like being the chief nurse, you're really chief nurse but you actually have to do... We had to do clinical work because the other people were really young. Some of them were very young nurses so I was helping out and trying... Looking over the back of my... Looking around to see where the nurse had gone and so I didn't see her. But I asked, "Did you see her?" And they said, "No. She was in there to finish the x-ray and we don't know what happened to her." So I said, "O.K." and I just left it at that. And I had to fill out all this paperwork and do all these things, talk to this guy from the other service. I was talking to him. I went and I said, "Well I need to find her to find out what... I'm going back to the tents and I'm going to find out what happened to her." So I went in the tent and she was there on the cot, rolled up in the fetal position, just rocking backwards and forwards, and I thought "Now what can I do with her? What am I going to do with her?" We had mental health but actually I didn't even think about the mental health people. I sort of went over and put my arm around her and just held her for a while and then they said "Well we can get a helicopter to come in to take this guy with the burns out of here." And I said, "Oh that's good." I said, "K, I need you to get up and get your things together and I want you to go out on the air-evac with this patient. I need you to take this patient back to Germany." She said, "Well, I can't do it." I said, "Yes you can do. You have to do it. You're the only person that I have here that can do this today." So she... And she did. She got up and she got her things. And I said, "Well do you want me to wait here with you?" Then I said, "Well I'm going back and I'll make arrangements. And just come back over to the hospital." And she came back over to the hospital, she got on the helicopter, and she went out with that patient. But I

> just felt that she needed something to do. I mean she saw the death and now she could at least have some part in at least saving this other guy, feeling useful, she would be o.k. And she was. She went to Germany.

Being present. Those who cared for others by their presence made a difference in many situations; terror was relieved in the bunkers and new mothers were reassured. Caring expressions succeeded when language barriers prohibited verbal communication. Aware that presence made a difference, one chief nurse noted missing opportunities by not being present.

> I tried to be a good role model, I think, and I, you know, tried all the time and tried to make an appearance or have these meetings when I could... They knew I was there. I think that was fine, I felt really good about it.. I was very positive about my staff and I was very positive how the Guard [Air National Guard] nurses came and became part of our staff. I think nursing was very strong.

> A smile and a friendly face and gestures worked and that's how we were able to get through the first couple of weeks though that was a challenge.

> In the bunker... We tried to keep people occupied and busy. We had some really innovative NCO's who had been deployed before and... And they just tried to take people... Now we had some people who were terrified. And you could see it. I mean, people were literally trembling like this. I mean, you could see the fear. Can you imagine? I mean, three days in country. We thought, "Oh this is going to be a long six months." And people were actually just shaking. And so, after we had been in an hour or so, folks started to relax a little bit. Believe it or not, they starting finding boxes of MRE's and saying "Well since we missed dinner," you know. And they somebody came up with some playing cards, a deck of cards, and so that's kind of how we tried to ease the anxiety and so forth. And I think at the time because we hadn't seen any injuries yet, we just couldn't envision it or have any idea of what was to come.

> In the small house where the new moms stayed with their babies... There wasn't any set standard of how long you could stay there. So some people had been there for 6-8 months with these new babies. So we kind of changed that a little, went in and put some OB nurses in there to do some teaching.... So putting two military nurses in there on a volunteer basis, they weren't actually assigned there, they just took turns going over there because they were interested and they cared.

> I got more involved doing INS physicals than I should have. I probably should have delegated more when I look back. Maybe then I would have... Because I didn't feel like... I felt like I knew what was going on in the clinic in my morning rounds, my

afternoon rounds, and I trusted my nurses but I really wasn't in the clinic a lot. And it wasn't until afterwards, when we'd sit down and we'd talk, I'd realize all the things that I was missing as far as the interactions with the evacuees and stuff. But I think, at the time, I was... I was doing the best with what I had.

It was so ideal. Because we were right there on the camp with them and it was such a great opportunity to go in there, see how they were cooking food. ... we had one guy that had a severe burn because he had picked up a can of soup, and he stuck the can of soup in a hot can of water. He didn't know he had to take the lid off. ... It was a great opportunity for the nurses,with the interpreter...just to talk to the new mothers, who had just had babies, because they didn't have their extended family. And in their culture, what usually happens, is after they had a baby, the mother-in-law, the extended family, takes over the care of the baby while she recovers. They didn't have that; many of them might have had four or five kids but they didn't know how to take care of a newborn because they always had had that extended family. ... Also,they were uncomfortable breast feeding when there were strangers in the house and what were they going to do? ..there were several families living in each house We had to really teach them... They had an extreme change in weather from where they had come from to the island which was hot and humid. They were dressed in all these clothes. You know, the women would be just in layers. Now the men had no problems with the short sleeves but the women wore layers and layers and layers. So... we treated a lot of women for dehydration.

They cooked in their homes which were the old base housing units. They had pots and pans and staff members went out there to show them how to properly use the stove because we had all those burns, they had to be taught how to use the appliances and that worked out much better. And when the nurses and physicians would go for home visits, it was just easier to go out to the homes,... The right thing to do when they offered you their tea or they offered you a bite to eat was to take some because that was their way of saying thank you to us..... it's just part of their custom. You know, when you come to our home, we feed you.

Compassion. Compassion went a step beyond the usual expressions of caring. Authentic personal connections that formed in the normal course of events reflected a balance between compassion and reason. The individuals involved were not necessarily patients but during this period of time shared in this incredible episode of the human drama which was unfolding. Unique circumstances also brought forth an imaginative awareness and a desire to do more.

The second day a land mine went off and they brought in a guy.....He was one of our troops. He was an American and his buddy said "Well he has a little... His

daughter was born today... Was supposed to be born today. And we're going to try to find out and maybe that will help him." And this was the most important thing to him, was finding out and trying to give this guy this news, and of course at that time of day we couldn't call back to the United States because it was in the morning. So the Marine Corps somehow found a phone and had him call back. And, of course, the baby was born, he came over and he told the guy. And whether he heard him or not... This guy... It was just such a relief just to watch this guy. I guess he had been talking about his kid all day ..... that guy went out air-evac the next morning, first, they took him to surgery, did the escharotomies,and we sent him out and we sent a nurse out with him.

In a way, especially the third country nationals (TCN's), we felt kind of bad for them. ...we knew that they were hired. And they basically were hired, from what I understand, for a year. And they were not paid anything until the end of the year. And they were guarded. So wherever they went... Like they would go to clean the toilets... Wherever they went, they had to have a guard with them, an armed guard.The host government paid them so we had no control over what was happening to them at all. They were somewhat amazing.

They had been on maneuvers and they were playing with the machine gun and this guy killed his best friend, shot him through the heart, and he brought this guy to us. ... I mean the guy was really dead but we decided that we could do something. We took this guy and did open heart surgery. Dr. W. did open heart surgery in the E.R. there to try to save him, we didn't, he died.

But at the same time that was happening,..... One of the French troops was decapitated and they brought the body in first and then they brought the guy's head in. And so we were in the middle of trying to take care of those burn patients and everybody was really busy and somebody came in and said "We need to identify this guy and we need to get a... To see about a... We need to do a dental examination. We can do dental examination." We had this dentist there who was really good. So they took the head and set it on the x-ray table, away from the body, and x-rayed the head. ... The next day, we took him out and put him in the Refri-Unit, first time I had ever saw one of the Refri-Units, one of the refrigerators that they have in the dining hall used to put people in. So we put him in this unit and put the head in and everything else. We were very careful to make sure that every part of it... This was really interesting for the whole time we were out there... Just made sure that every piece of that person was together... Somehow we just didn't want to leave anything laying any place. So we got him together and we had a funeral. We actually had a funeral. It was one of the most beautiful things. It was very touching. All the services. Everybody that was in camp, all of the services, all of the foreign nationals, all the troops came over and we were... They were standing in front of the ATH and they left from the ATH. It was one of the most beautiful, touching moments of the... That I have ever seen. When they started playing the music and everything... You didn't have to say, "You need to stand at attention," the whole... Everybody... All the services just automatically stood up and stood at attention. And then everybody saluted the coffin, You didn't have to say anything. Everybody just did it. It was automatic. And they put him in a

helicopter and took him off and... All of the troops were standing around and they were watching this helicopter until it just completely went out of sight, didn't even see it... Couldn't even hear it anymore. But nobody moved. It was a really good experience.

Probably one case that I really, really remember is when... When I went out to the hangar to see how it all worked, there was an elderly gentleman who had white hair who was having chest pains and the story that we were able to get from the interpreter was he had to leave his whole family and he had seven or eight kids. He didn't know when he was... He did not want to get on that plane but pretty much was "If you don't get on the plane, you're going to get killed" and so he didn't know when he was going to see his family or when he would see his kids again, he really had real mixed feelings about being there.

We had many missions that we started flying ,taking prisoners of war and we took a lot of them out to Jetta. And we took patients that had been horribly injured and took them out to Jetta. I remember... You know, when I mentioned the one patient we ventilated... I remember a nurse ventilating a patient for 12 hours while we flew him out to Jetta so he could be out there with his family and then they could terminate the ventilation and let him die there with his family. So we had lots of missions with the prisoners and saw the same kind of professionalism, compassion, from our crews as you would see towards our own soldiers. Just tremendous caring. You could see that nursing coming out in those folks once again. Yeah... The caring.

I got to know the Canadians. The Canadians were going doing humanitarian relief efforts up into the hills. And so I talked the Colonel into letting us go. I told him, I said "You know they really need help up there and we are all nurses and..." We had trauma but it wasn't steady, it wasn't every day. So I said, "You know, these people who go up there and we could do a lot of stuff. We have all these vaccinations and everything. We can go up and help take care of some of the people up there..." He said "Yes. Only thing is you have to have an armed escort." So we went out with the Marines or the Army.

Well to make a long story short, the patient expired. We brought his wife in to be with him. She was at his bedside. You know, he was brain dead, they disconnected the ventilator, did all those kinds of things and it was a real emotional time for the folks in the air-evac community because we had really worked so hard to try to save him.

Supporting each other. Giving and receiving support was another expression of caring. Caring for the staff so they could care for the patients was an incredibly powerful dynamic which permeated the camps. It started by helping new troops feel welcome upon their arrival to the deployment site

and making sure that basic needs were met. The support continued into the professional realm and was especially appreciated when it came from the senior ranks.

> We didn't know where we were going to stay, the food was a little chancy, just mail,.... we had to get set up, and communication. You really don't do well until you get the basic things taken care of. Really pretty solid. How can you worry about your patients? How can you give them what you need to, when you're not sure about yourself? So it was Maslov's hierarchy of needs, that is the truth. ... we were into, where are we going to sleep and eating in a army chow hall that only served ham and two other unidentifiable meats for lunch. I ate ham for three months straight for lunch because that's the only meat I could identify. We were really into basics.

> We made her bed for her. We were doing nice things. You know, when people would come in, we would make up the bed and have the tent all arranged nicely so at least when a person would come in they would feel a little bit welcome.

> We had our executive team where we all knew each other because we were from the same base. I would not have survived if it were not for the SGH. He was a Lt. Col. family practice doc. He had been a helicopter pilot in Vietnam as a 19 year old and had gotten out and,.... He was a D.O., ...then came back in at some time. But he instilled... As we were setting up the facility, he was the leader, you know, he knew how to put things... But he really was a leader in setting up and during the riots it was very comfortable having him there to figure it out. He's a real down-to-earth kind of person.

> I would talk to her on the autovon every day and say "Col, you know, I've got patients here. I've got to get them out of theater. I've got to have aircraft to do that." And to her credit, and I admire her to this day... In the past, every time I would talk with somebody from command and say "You know, you really need to come over here and see this situation that you're trying to support."... we couldn't get people to come in theater ... but she said "You know you're right. I do need to get over there to see." And bless her heart, she went nonstop all the way, she came, spent about two days with us, and after that... We had tremendous support after that. She really could understand. She could not believe the environment that we were working under. It's a green tent and it's a cot and it's a hole in the bottom of a gallon bucket that you shower under and that's basically the environment that you're operating under. So, when she came over there she was really sobered by the experience and went home with the message that "Whatever those people need, get them because they deserve it. Those guys are going through some really pretty nasty experiences.

> And that was because I had a great first shirt. I mean, he literally picked those

people up, took care of them, and made sure they had what they needed. And I didn't really hear about anything unless he felt a need to tell me. And most of the time, he just told me after he handled it.

But my right hand person was my staff development officer, she was a major. And so she deployed. She was the chief nurse until I arrived for the couple weeks.

And see I... One nice thing about going out in the field, you meet generals and admirals and everybody else. I mean, we met everybody. Like the Marine general,he's just... He's one of those, he just wants to know what you're going to do for his troops and just do it. He didn't want pomp and circumstance. See and that's what I like. You get out in the field and lets just do our job. We had a two-star, wonderful general down there, and one time he asked me, "Do you have a problem with anything?" And I thought, "Well I'm not used to telling a general," but I just said to him, "Yeah, _____ isn't supporting me" and he called them right in front of me, and then later he chased me down to find out if the problem was fixed.

And the General seemed to like what we did, he came over and visited us, and thanked us,...I feel like he probably remembers that to this day.

The air lift control commander was a general and he was a great guy and he, wanted you to do the mission, he wanted you to do it safely but he supported his folks being innovative .. coming up with solutions.

Every issue that came up, he never failed to stand by me, to back me up. And I can't remember really an issue where I did anything where I probably shouldn't have.

And actually there was a Colonel who was an 06 marine that was the commander of our ATH and he ran all those camps. And I used to walk around with him every once in a while because he would go out there and do the same thing. And it was great .... we'd walk out there together and we'd talk about stuff like cold water and showers and the women who were pregnant.

Support received. Support came from outside sources as well. Families and friends at home showed support by sending traditional care packages. The host facilities near the deployed sites also provided both moral and material support.

In fact my local church sent me a care package, First one I have ever had in my life, with goodies in it, you know. A box full of stuff. And they sent it off to troops in the gulf because they knew I was over in there and I was from the community.

The people from the United States, the different organizations and companies, wanted to help us so they would send things and we'd get truck loads of stuff I know we got some of this lemon medicine... you have to mix it in hot water. And nobody had any hot water, they just had cold water there. And they don't like hot water. They liked everything cold.

I made sure I communicated on a regular basis with the Colonel so that she could check on the spouses. So that was one thing that she did... and she was out there to see us off in the morning ...she said, "Take care of your people. If there's anybody that's having problems that you identify, let us know, so we can check on the families."

There was an outpouring of letters. The Retired Nurses Association ... I was going through the letters. I still have them. I kept all that stuff. They were great. And they said just tell us what you need. Getting decorations for the different holidays meant a lot to people. So the outpouring of support was wonderful.

I think, personally, I mean it's a great opportunity to have been through that. If you have everything set up personally, like with your family and all, which I had a great support for my family and I don't think there's any ... I mean, there's not any residual effect. In fact, my daughter was very proud. ... she tells me that, at the time, when she saw all the bombs going off and,everything happening in Iraq that she was thinking I was there with the tanks and all that. ... she remembers that. Now, she's 13. She tells me that she recalls that but she said that she was real proud that her mom was over there.

The disconnect was what we were expecting we were going to do and what the local base expected of us... A saving grace was that nursing at the local base was wonderful. They were very supportive of me personally and I didn't see a lot of them but I just knew they were there. They sent me four people to help when we had the riots in December and they stayed out there with me for... Until things calmed down.

The Navy still maintained their hospital there which was a small hospital. They had ortho and OB and surgery and a few other services. So if we had a bad case that we needed to do a real extensive surgery on or something, we'd take them up there to that hospital. We got our care at the Navy hospital too except we really got some of our care at the ATH.

I felt like the nurses from the local base who came to help us came to me and

> shared their concerns They had to work really long... They were really surprised at the long hours that we demanded from them. And some of them had personal issues like one was going to school Some of them didn't have vehicles or really good vehicles to get to the other side of the island. So I ended up meeting with the chief nurse, ... She really, really supported me. ... right from day one we talked. I always knew that I could call her and ask her "What do you think?" She would come to our morning meetings,. She introduced me to the chief nurse over at the Navy hospital so that I would know her, I could talk to her about some of my concerns and some of the issues ,and she was the senior nurse exec there,...she was really, really supportive. Really shared things with me.

> Wanted to make sure that, um... That... That the wonderful work that the Navy had done and the wonderful support that they gave us and her support and her staff's support, it was there. I mean we really, really backed up. And they really did a lot of the initial set up those first couple of days. But she was always there and I could always talk to her.

> She was, excellent, excellent support. I didn't feel like I was all alone. I could share some different things with her.

Lack of support. When there was a lack of support it was unexpected and a source of loneliness.

> I have never felt as unsupported and even more than that, they were out to get us to some degree. They really wanted to help us fail. And I don't see that in most people, I really don't. But in this ..., I have never been in that place. In my life, I have never been in that situation.

> I was my own support system, there was no one else that was going to be going with me, and I was going to be working in the air lift control center with the air lifters and had to be the credible voice for patient evacuation out of the theater. It was an exhilarating point.

Doing their best. Doing their best was another expression of caring, and when doing their best wasn't enough they felt guilty and asked what could we have done differently?

> And my main thing was, I want to do a good job and get my folks back home all in one piece. You know, bring them back like we left, everybody safe and sound and intact and so forth. That was a big concern.

But the point is, I think you give us a mission, to do it we have to do the best we can so my people knew... They knew what the rules were but they also knew that patient care came first and you did whatever had to.

But I'm a generalist nurse so I guess I'm used to making the best and just going out there and doing it. .... my feeling was, "The air frame is an air frame" but you should be qualified on something.

It was possible in a contingency situation that we wouldn't be able to send our patients off base, that this would become a lock down area, and we just need to have this, to do the best we can do with what we've got."

We worked on building up a lot of sterile bundles, sterilized sheets, and getting ready. The O.R. was a big nightmare but everybody worked really hard trying to figure out how they were going to make it manageable. It was downstairs from the ICU....just an open area... they cordoned it off and made it a restricted area ...they did the best they could. There was a lot of air coming in around the windows and they went out and put plastic around the windows trying to make it more air tight.

I just tried to take some more senior nurses and tried to do some basics and then have that expert come in and give us some lectures ... we got a hold of a book and said "we're going to do the best we can," try to prevent infections, just some of the basics.

And I think the way they whipped the place in shape...I think they did a fantastic job. If we had causalities, I imagine that we would have all done the best that we possibly could. They had a lot of anxiety. I was constantly telling them, "We are going to do the best we can. We can only do what we can do." They had so much anxiety that they weren't going to be able to handle the load. And even the ICU nurses,were stressed about that. I tried to tell them some of my experiences with Vietnam casualties, you know. I said, "I changed the dressings. I gave them baths. I fed them. I tried to do basic nursing care to maintain comfort and then give them something for pain." I said, "You know we are going to have to do the best we can with the facility we have and the equipment" and they had a hard time getting that concept in their brains. And I don't know, if it had happened, how I would have managed. You know, I just kept trying to stay as strong as I could.

That same patient did commit suicide while under our care which really, really was very traumatic to all of us.. Of course anytime when something like that happens to a patient that is under your care, you always think what could I have done differently. You know, if I had had this in place, perhaps this wouldn't have happened. So it always leads one to second guess. You know, what... What could we have done to avoid it? You... You have the feeling of guilt.

Profound experiences. Profound experiences were imprinted forever in the memories of these nurses. Extraordinary effort in extraordinary circumstances demonstrated without doubt that human caring raises us ever closer to our full potential.

> And then I went up to... Went on this helicopter and went up to... this mountain? It was a very famous mountain. So they let us off at the top of this mountain and said "All you have to do is walk up the hills to the camps themselves." We got up to the top and saw that the rest of it was up another hill. You walked up to that one and there was another hill. .... I got up... I walked up there, I sat down on the ground because I was so tired and I was not in physical shape. I mean I was totally out of shape at the time. I had a back pack with supplies and everything in it. So I got up to the top of the hill, sat down on the ground, and a man came by with a donkey and he wanted me to ride the donkey but they had told us that we were not to get on any animals, to stay away from them. So I got up to the top of the hill and when I got up to the top of the hill, this man said, "We were watching you, you almost stepped in this land mine." And I thought I was going to faint. I just stood there and I started trembling. I said, "Are you kidding?" He said, "No." This man had weapons all over his shoulders. He had a Russian gun and he was standing there. And we saw them all there. We got up to the top of the hill and you could hear this wailing. You could hear it when we got off the plane and we thought it was like the wind or something, we didn't know what it was. We got to the top of the hill and it was this conglomeration of national troops, aid agencies, and everyone else who had come there to give medical care to these people. ... we went across this little pond and it was about... 12". They had water falling around this pond that had cholera. All these patients had cholera. ... we went in and most of them were kids and most of them were dehydrated. They had a measles outbreak and they had all those people in close proximity. And I'm thinking, "Well the ones that don't have measles are going to get measles because it's going to go from one to the other." But actually it didn't. They used good infection control techniques.

> The patient who committed suicide...I think that that one incident was probably the absolute hardest that any of us ever, ever had to deal with....it was such a painful and trying time for everybody that... Even those who were the least involved felt... Felt the emotion and the impact of it all. It was very traumatic.

Knowing

Ways of knowing. The chief nurses experienced personal knowing, ethical knowing, aesthetic knowing and empiric knowing. They learned from sensory encounters, decisions and choices they made, individual engagements, and seeking personal clarification. They developed understanding despite multiple challenges to their established base of

knowledge and the pervasive uncertainties which confronted them on a daily basis.

> There was a hospital, a local hospital, that we actually went to visit. we were just going to visit. When we got there, you'd see these guys standing up on the hospital with machine guns all over and you'd know that ..... This was for real. Then we walked inside the hospital, they let us in. We went in there, into the hospital, and they didn't have traction. So what they were using was ropes with IV bags. I guess they were weighing them, 5 lbs weights, to keep this traction in place. There was one bed but the bed was really not like a twin bed that we have in the states, it was smaller than that, and the patient was on that, the whole family was in there with him, taking care of the patient. There were some nurses and doctors but most of them had left the area because of the war. So the families were really taking care of the patients. Then we went into this room... where they had the medications and all of that. Well, the medications were in all different languages - French, Italian, some English, it was just a conglomeration of everything that you could think of and the doctor had requested that the nurses, if we could, would sort out the medications for them. And I thought, "Well we can do that. Does anybody speak French?" "No." "Does anybody speak Turkish?" "No." So what we did is actually ask one of their people who knew how to speak English and knew how to speak these other languages...to help. It took them about a week but the nurses from the ATH and the technicians actually went and put their medications and everything together like it was supposed to be put together. And they worked other places in the hospital. They also provided care for some of the patients and that was the most rewarding thing that they did.

Previous knowledge. The chief nurses had a broad knowledge base when they were selected for deployment. This base had been built from previous management experiences, clinical experiences, professional military education, academic coursework at the graduate level, and readiness training exercises. Immediate information about the specific deployment was gathered in many different ways including site visits, teleconferences and the internet. For some the particular facts about the deployment were classified and the information would be revealed enroute or after arrival at the location.

> After the preview visit, I came back to the Medical Center, I got all the nurses together and I showed them the videotape that I had made of the buildings and how the wards were going to be set up, and kind of climate, how cold it was going to be, what they should wear, and everything. Luckily, I did that because they had some other expectations.

I didn't really feel a big challenge, I felt like I was well able to do my job from my past experience. If I hadn't had those experiences... I think the exercises helped a whole lot. .... anytime you can get some kind of education or experience in what you are going to do before you do it, I think is really helpful.... I think the experience of being the chief nurse as well as being an assistant at a large medical center makes the management of people a lot easier. ... you've almost seen it all, not quite. ... you get to learn all the problems associated with managing people. And so that was very vital.

I didn't know exactly what I was getting into... And I thought it was really helpful, especially because right before that job, I got to be the interim chief nurse for 3 months and I thought that was great.

I felt I was fairly well prepared. I didn't think I really had too many difficulties.

But I think some of it is just experience and learning and it takes short time to learn... You know, you make all these mistakes and you don't have time to recover and press on. I'd do it again though. I'd go back. I'd go back and a lot of people in the group have said that they'd go back if the buses were lining up.

We had a planning visit and that was good because it was better to have seen it and know what to expect ... then you could come back and tell the troops. We had pictures and intel. We also had weekly teleconferences with the group that was already there. So it really helped. It really, really helped. So when we went into it, we kind of knew what we were going into. We knew the layout of the camp. We had talked to the others and we pretty much had a good idea for what the patient load would be like. And we knew what the layout of the facility was like and the manpower that was already there.

They told us it was classified where we were going. So we didn't know where we were going. So that's kind of a challenge when you're the troop commander and you're just trying.

So it was very difficult before we went because there was no direction. There was no direction from anybody.

I got the nursing service people together..... then what happened is everybody else kind of ended up joining in our meetings because nobody else was having meetings either and everybody was worried and frantic about what should we do. .... so many questions. So then as we got E-mails in from my counterpart, we got some answers.

> And you know, the one thing that the nurses had a lot of concern about was... "We can't take care of these patients." We had a bunch of OB nurses. We don't all have the training.

Uncertainty. Despite having learned many things before and during the deployments, the chief nurses encountered many uncertainties. Questions about the magnitude of the mission, the types of casualties and the capability of the staff were asked frequently. Many of the teams were deployed for an indefinite period of time and for some the duration changed after arrival. Because of the political influences directing the missions it was often unclear exactly what the scope of the mission included. Information arrived from multiple sources and the situations changed rapidly as activities in the region changed. Rumor control was an ongoing challenge.

> So we were trying to figure out... I think one of the things that I got the most upset about... Number one, about how young nurses were going to handle all the casualties; I had been working in an ASF in Vietnam so I was used to casualties. We were told that biological warfare agents might be used and I had no experience with that. I called the Colonel at command and said "Have you got anything on Anthrax. I mean I don't know anything about it." And nobody seemed to know what we were going to do. So, then we talked about it and decided that we would take one of the old bunkers that was on the base if we had anybody who came in with a biological problem, like Anthrax or whatever, but we would just make a kind of a black dungeon area and then I wondered who was going to go over there and man it, that was the other big question, I mean, these are things going through you mind. You know, what ifs? I think I was very frightened ; if we had to deal with biological warfare what were we going to do?, that got to be a real tough issue. And nobody had really had any experience with it either.

> A pediatric nurse.....She was very good and she worked out well but she was a little concerned and said, "You know, I'm used to little people and these are adults."

> Little things, you know. Nurse-wise, they were tremendous and all the other nurses they sent were excellent. Some of them were real scared because I had to put them in the burn unit and that is a disconnect, in a way, because most of the air force or army burn patients go to Brook Army burn center so we never take care of them. So the idea that we were going to be a burn unit for casualties coming from the gulf and yet none of my people were trained for that or even the facility, we had to do a lot of fixing up of the facility. We put money up front trying to get that place ready for a burn center. And it was a real problem. And then we got the burn

expert in and he talked to our people and tried to just give them some real basic principles, how they were going to handle them for the first few days until they could air evac out. We were still hoping that a lot of them would go to the burn center back home.

We thought we were going for 3 months originally but that's not how it worked out. So it was a very busy... Very, very, very busy time getting everybody ready to go. ....When we were down there..... We actually were not under the control of our command. When you deploy, you are in the theater of operation and whoever's that command is.....they were the ones who decided we would stay 180 days.

It could have very easily been a week [in the bunker]. We had no idea how long or for that matter what was going on around us.

And we had to screen every migrant that came in to the country. Now, this wasn't on our tasking order either. So it was like things changed on a daily basis about what was required of us and we had to, figure out with our staff how we were going to manage all of our taskings. This was sort of a fun kind of thing because everybody's attitude was real... really sort of positive about going to the new camp. The happy team, we called it the happy team, they were just glad to be there, because instead of being at the old camp where everybody was so crowded, there was going to be some breathing room. ... that was our happy team.

I think more than anything else, we lacked structure and direction from the higher echelon. I mean, "What are we doing now? And what's the truth?" The truth changed from day to day depending on what was going on in politics.

The thing... The one issue that was real critical to our deployment is when we first got there and so much information ... So many things were happening. And what was truth in the morning was not necessarily the whole truth at night time because of the situation changing. ....the camp was going up so fast and our area was going up so fast. What we ended up doing was having a morning and an evening stand-up for the entire camp to come together and say, "Folks this is what we know at this time." You know, just so they could understand or realize that we were trying to give them as much information as we could, as quickly as possible. And there were times when we didn't know anymore than they did. And you know, at those times, that if there is not information passed, then rumors will be developed. And that was one of the things that we recommended... The executive team recommended to the boss was "Please we've got to do this. We've got to have stand up" And it's not to see how many people have their shoes shined or whatever, it's to get this information out as soon as we can. And then we'd ask, "What rumors have you heard today?" So... it's critical. Critical because they do come up with the most bizarre rumors and information that they think is the God's honest truth and it's not. So... That's critical for any deployment.

> We would go and get weekly intelligence briefings and they would come to us and keep us updated so we knew when things were heating up and you knew when you could afford to relax and you knew when you had to be at heightened awareness. So that always helped.
>
> And then the commander in turn would give us the latest information that he had gotten from, ... When he would go to the meetings across base because he went... almost every day to some kind of a meeting over there. So they would kind of let us know what was happening..... For the American contingent at least.... things that applied to us.

Possibilities and probabilities. Uncertainty was expressed as “What if?”, “What am I doing here?” and “What’s happening?” Discussions about possibilities were tempered with discussions of probabilities and a certain detachment came with realization of the cold reality that was occurring elsewhere.

> This is what we kept talking about. What are you going to do if...? What are we going to do if there is a big accident? This was the other thing that the nurses were worried about and that I was concerned about.
>
> One time particularly where I said "What am I doing here? This is absolutely insane." And that was when we were... We were on the compound right downtown, the air-evac control center, and it was getting... We knew the war was going to kick off. We didn't know within the hour but we knew within the next day or so.
>
> You could see the smoke and you knew something had happened so we were all actually standing out, looking around to see what was going on, to see if we could see anything, and we never really got a call to come and get the patients. We didn't have any way to go get them anyway so they had to bring them to us but we didn't get any call or anything until this guy walked in and then we knew what had happened.
>
> They came just like... The nurses and the technicians too came just like we did. They were not prepared for what was going to happen. They didn't know what to expect.
>
> We were there four months. But we didn't know what we were... What was going to happen. We set up a full... 50 beds in the warehouse. This was a big warehouse.

> So the uncertainty was difficult, I think, for the staff. It wasn't... That's why I say, people respond in different ways to deployments.

> Well I think it was painful because you... You go along and you talk about these things and you just think "Now what would've happened?" Like one time we were there and it was towards when we were going home. The whole field... We don't know what they were burning but it was like a whole field and it was like a roll... It looked Agent Orange if you saw it on T.V. That's how it looked, it was these rolling flames over on the field. And at night they were doing the tracer rounds, shooting over the tents. We were in between the terrorist groups and the police station that they wanted to take out so... And we were directly in the... In the center. So all of us were standing out there watching these tracer rounds and all of these rocket fires go off over our heads into the police station. And um... We were really scared. And I was thinking to myself "What if somebody gets killed? How am I going to tell this person's mother?" I've heard about having to do that. Now why would I be the one to have to tell the person's mother? But I felt like I had a responsibility to do that since I was out there with that person. And I... I just felt that.. It was so strange and... And I mean all of us... The executive committee talked about it and we all felt like that. It was just like a theme that ran through us that whole night. We sat there and watched for about four hours until it got over with. I thought "Well if they hit the tent, we don't have a chance" because we had all these fuel bladders that were sitting out there. If they had hit one of the fuel bladders, the whole thing would have gone up so we were doomed... It was so interesting. I thought that was the most fascinating thing. Now why would I think that I would have to go and do all of this when they have all these branches of service to do that?

Moral distress. Chief nurses were in a position to make difficult personal choices from among alternatives which were ambiguous and grounded in uncertainty. The consequences of these choices were very hard to predict and acting on the choices frequently gave rise to moral distress. Principles which successfully guided the nurses' practice at home were often in conflict with the realities of the austere deployment environments. Knowing the principles and recognizing the conflicts was both an immediate and a long term concern. Issues arose around duty, privacy, kindness, fairness, doing harm, personal autonomy, and respect for autonomy.

> We would get them on an air-evac flight to the states. So as soon as one diagnosis went out with a certain thing, then you automatically had copycats throughout the camps of the same type of injury or disease. So this created a real problem in terms of sensitivity with the staff, with the physicians, nurses and the techs because they

were seeing how we had what was called a "litter patrol" and there would be seven migrants bringing this person in. It got to the point where a lot of times, they were giving placebos of saline and the saline worked every time.

Fix them, because that's what I have to do. And if I send them away, I can't be guaranteed that they're going to get care. If I say go to your doctor downtown, are they going to do that?" You know, knowing the conditions that they were living in. So that was a real big ethical dilemma. Where administration was saying "No you can't take care of these people." And the docs sort of just kept doing it. It was very difficult. It was a very difficult situation.

The privacy, you don't have good privacy for the patients, and that sort of thing. So those kind of patient care issues.

One evening, when I was on duty because everybody else was at a dining out, a man, TCN, third country national,... Who we're not supposed to take care of... came in with heat...
he was totally disoriented... You know, classic. This man's going to die if we don't, you know, really take care of him.
We started an IV..... Finally his own company came and got him. ...we don't know if he got seen. ... we don't know if he got care after that. We have no guarantee of that.

The real issues with us. We got to the point, after you were there for a while, that you see that you're being taken advantage of. It was really frustrating because we knew these people were not sick, they were not having heart attacks, they were not... But that's what they came in with and we had to respond.

Talk about difficult issues. They really were wanting to help somebody. Wanting to take somebody back to the states or wanting to make sure that somebody got where they needed to be but you couldn't help even though you tried... you tried to disassociate and say "O.K. I can't help this one person out of 30,000 people." but we all got attached to people that were there for a while or we knew that they were genuinely sick. That was the bad thing... When you started talking to somebody. When you started talking, then you started finding out "Oh boy. This is bad. I wish I could help. I wish I could do something. Can I give you something?" but you can't. You can't do that.

And there were a lot of pregnant women. And there was an area there where we took care of pregnant women. And if you had some problems, you got to stay in, a building that was... That had an actual bed in it and was air conditioned. So people tended to stay there for a long time. And, of course, their spouses or significant other could also stay with them. And they were staying there forever so we kind of set in motion a plan for how long you could stay there.

These were people like you and me who could have come over on a boat to find liberty, it would be like you going to a football game and you're enclosed in this area for months ... six to eight to ten to a year. ...some people had been there a year. ....when I first got there, they were still disfiguring themselves, pouring gasoline into their wounds, because,if you had a bad enough problem, you would be sent to the U.S.

Sirens would go off and the nurses had to get the patients to the bunkers and some of the patients they weren't able to get to the bunkers, they would stay with them, but they would put them under... they would get out of their cots and then stay under. So that was difficult for my nurses to deal with because they felt that they couldn't provide the maximum safety for their patients .....so that was difficult for them to deal with. Because you're in a tent, ...that's not going to help you. ... then the others, they would get over there if they could but there were some that just couldn't be moved, whether they were in traction or whatever, so it was difficult. They stayed with them. But that was a little traumatic for them.

A child. He was about 7... He was 7 years old... 9 years old. He was 9 years old. He was a local child. And the thing that really bothered the nurses is we're going to send him back someplace but where do you send him back to and what kind of help... What kind of care is this person going to get... To receive after they get back there. We sent him back home ....what could you do with him. But there was nothing. Their infrastructure, especially. for the hospitals... They had hospitals and they were still standing but there weren't any personnel to work the hospital. So what do you do with this person? You can't keep him. You know for political reasons, we couldn't keep any of those patients there. So they had to go someplace. So we sent him back and you always wonder what happened to these kids.

Learning large lessons. Learning new things continued throughout the deployment. The lessons reflected the enormous horror of the activities surrounding the camps and the sadness within the camps.

They had these live land mines planted. And we had already been told ..... usually on a land mine the first person who was in the lead is usually killed, the second person is really critically injured, and then the third person will have a chance to survive. So we already knew that. But meanwhile it was about 6 o'clock and just getting night and it was dusky and you'd hear these helicopters and we didn't know... What if nobody had called in and said we were getting a casualty or anything but this helicopter landed and they brought in this patient.

And I went up to one of the prisoners of war that was there and they're handcuffed. I said "Do you speak English." And he said "Yes I do. I do speak

English." And I said "Really." And he said "As a matter of fact,I studied at..." some university, I don't remember where he told me, but he said "I've been to the United States." And I said "Really, you have?" And he said "Well..." And he asked me "So where are you from?" And I said "Well I grew up in the state of Oregon." And he said "I've been to Oregon and it's a beautiful... It's a beautiful place." And you get to talking with these guys and you find out that they're just some poor schmuck that was told "You've got a choice. You can either take a bullet in the front or you can take a bullet in the back but you're not retreating one step from this front line." So that was our first mission.

Understanding. Perception of the mission as a whole and careful discernment about the events, relationships and roles of the team led to understanding. Understanding contributed to the increased awareness and expanding consciousness of the chief nurses and a realization that these deployments were in fact a true military experience.

Trying to get my people to understand what you're doing there because sometimes the mission was lost because you .... And you really didn't know and then you get there and what were we doing? Were we invading into the middle of ...their problems?

O.K. you understand that the biggest problem is reconciling why the military are there in the first place. See and that's what you run into when it's not an out-and-out war. You know, is it a humanitarian mission or is not? Well, to be honest, where we were .....it was hard to tell.

But it's hard when you're carrying out decisions made by people who really and truly you know don't know ... about being out in the field. And until you've lived out in the field with people and seen what they go through.

We were to take care of the migrants and we knew that. But we were also there to take care of... Well the migrants and the military personnel that were assigned out on the range, out where we were in the camps, to take care of the patients. So we had ended up with 8,600 in the camps and, I think, I want to say it was like 12... I want to say 12,000 military by the time the mission was up ..... there was a big increase in numbers after the riots, a huge increase in the ratio of military to migrants it really changed dramatically.

What a standard ATH is to do is to take care of the wounded, you know do the necessary surgery, and ship 'em. Ship 'em, ship 'em, ship 'em. They're healthy people that are injured in some way in war. That's what we're there for. We are not there as a community hospital to take care of newborns through 80 year olds. So

there was a disconnect in what we were set up originally to take care of and what we were required to take care of. So we became a community hospital but it did take us some time.

So it was going to be adult... We were specifically told in our briefings that we... Our mission would not be to take care of children so we were not to do humanitarian work. And we were not to operate outside the confines of the camp.

So, you know, emotionally I... I still get emotional. There were events that took place .....that were very emotional and, you know, felt like I really... Really could appreciate the hardships of predecessors from the years before us in those kind of environments.

People were really, at that point, we had been in theater probably for about 90 days and we were all really questioning why... Why we there and what we were doing and... And I think that that really, ... solidified in our minds, you know, why we were there, it really helped, and it helped kind of give us our second wind, to keep right on... To keep right on trying.

They were great. They were tremendous experiences. Not... I shouldn't... Won't say great but they were... They were defining moments.

So we sent 57 groups of a, nurse and 2 techs. Some of the doctors went also. We'd send them up to the different camps. ...And they would take care of the people. There were illnesses that you would never... They had cholera. They had everything. Phlebotomus fever. They had a measles outbreak. Kids were dying from hunger right across from us, about a mile from us, and you could actually see the tents from our base. They had... They were doing immunizations and we went over and did immunizations.

There were nurses from Ireland and they were... They were really into infection control. And so every time they touched a patient, they would wash their hands. Anytime they... They had on these little... little jackets. And they were changing these jackets .... They were washing them all the time, hanging them up so that they could get dry. We saw some patients with hemorrhagic fever,I had never seen that before. And just walking down, just watching these people, and they ..... They would always be saying "Take me home with you. Can you help me?" And you knew you couldn't do anything .... when they died... When one of the people died, they would take them out in the back and that was the wailing that we heard. It was a line. I want to say 1/2 mile long because people were taking these people to these... Just common massive graves. They were ... They were burying all these people. And so I was standing up on top of the mountain and... And all the trees, all of the leaves... There were no leaves on the trees and that was what struck you first. There were no leaves, there were no birds singing, there were no animals, you couldn't see anything. But I was standing there and I took a picture of this tree and

I could never figure out why... Why I took the picture of this tree. Even when I got back, I kept looking at that tree and saying "Now why did I take a picture of that tree." But I was looking at it about 1-1/2 years later and it had the foliage that was starting to come out of this tree. And so it was like a rebirth. Even with the all the death, things were starting to be reborn again. And I saw that, it didn't register in my mind at the time, I just took it, but it did later on. We came down off the mountain .....they had no water, no nothing, and to find out that we left that evening and the terrorists came into camp and killed almost all of the people that were in that camp. And you just think... You know, just by the grace of God, not I.

Because we had just left. I mean we could hear the gun fire but you could hear gun fire all the time. But we never knew until about a week later. M came back into camp and told us what had happened and um... That was very interesting. . They did not kill the people that were helping. I guess, you know, they kept those people so they could help. There was one person killed but we could never confirm who it was and it was not American but it was a nurse. So... We came back down, came back to the camp.

Those were the kind of issues. And then you'd try to think "O.K. this is why they're so desperate. This is why they're willing to tell lies and injure themselves or do whatever they have to do to get to the states."

Some people got angry about being ..... Being female and being restricted. ... We had to wear an abayah. They issued us abayahs, the females, because when you left the base you had to wear abayahs. And you had to have... You couldn't drive. The women couldn't drive off base. And they couldn't... And you had to have a male..... If you wanted to do an exchange of money, you had to have a male there. That didn't bother me because we're in their country.

I found it very interesting, we had, a French R.N. and he was with the French contingent and they had French M.D.'s and so forth but he was the only R.N. He had his technicians, our equivalent of 4N0's. Their mission was convoys ..... they actually went into these places near the skirmishes ... Part of the convoy was the medical detail on the end and they provided medical care and support in case there was somebody hurt or injured on the convoy. So they always had to accompany it. ... what I learned in talking to him is that nursing the world over is not that different... we found it so fascinating, we said "Tell us what nursing is like in your country? And what I learned is that there were more similarities than there are differences. More similarities again than differences. The same thing I learned from my interaction with the English R.N. that I dealt with a lot..... more similarities than differences. So what I learned is that nursing the world over is pretty much the same. Pretty much the same.

True military

Fullness of two professions. For those who were deployed it brought an end to years of being ready. Thinking, planning and forever imagining what it might be like to bring nursing to the field. The expectations were realized by multiple realities that were exciting, frightening, and rewarding. In spite of the difficult decisions that had to be made about managing personal commitments and the painful goodbyes as families were separated, they all went willingly, some to fulfill a commitment and others to participate in an adventure.

> All these years in the Air Force, I knew this was possible.

> There was really no difference in who went because of our family commitments and you don't not go because reality is there and it's not convenient and I haven't done that my entire career so I'm not going to start at 22 years. So, I really was pretty well organized to go.

> In the 19 1/2 years that I had been in, I had never ever ever been deployed. I didn't get deployed during Desert Storm, you know. And so, one of ... the better experiences that I can say that I've had.... To get to work with, number one, those joint forces. You had your army people right there on the base, you know. You had... A small contingent of navy, not very many, a few. For the Camp, our deputy commandant was a marine. So I mean it really was... It really was joint force. And it really was United Nations.

> They did go and solicit for volunteers. So I started mentally preparing myself. I guess, I felt good in that we were going.

> You'd find most of the people in my unit wanted to be where the action was because that's what we were trained to do.

> So, preparing for it... I mean, I get excited by it, to be honest, because to me that was the true military. You know, you sit in a hospital your whole career but it's not... We're wearing a blue suit, basically doing the same thing that could be done on the outside, just a little bit different. But there in the field, it's the real military.

> You know, they need caring people and people who want to do it. I had some

wonderful nurses who just... They lived to go out in the field.

From rehearsals to opening night. Training exercises and lectures in classrooms were part of the preparation for deployment throughout the careers of these nurses. During these exercises realistic scenarios were designed to help achieve the learning objectives. Sometimes there were no notice drills to simulate the expected demands of being in the field. This kind of training continued after arrival to help them become familiar with the specific demands of the situation. They envisioned different possibilities as best they could and then made ready to respond. Crossing the line from practice to reality brought forth everything they had imagined as well as the sobering realization that this time it was for real. Moulaged volunteers were replaced by real patients, cardboard cue cards announcing that you were under fire were replaced by live ammunition, the noise and chaos of choreographed / staged disasters were replaced by unrehearsed activity.

> The 7 o'clock shift had not come in yet because it was only about 6:45 when we got the word that this was for real and we all had to evacuate patients and everybody. So we... Thank goodness, we knew where our bunker was.

> I think that if you wear the uniform that the opportunity to go and practice your profession in a... In a war time setting or a conflict is probably the purest form of practice and it is clearly a defining moment, I think in any professional's career.... it certainly was for mine. And I strongly encourage folks that have the opportunity ...to put their arms around it, embrace it, and relish the moment. Not that in any way, shape, or form it's going to be pleasant, going to be enjoyable, it's going to be very painful, it's going to be very lonely but it is going to be truly an experience where you're going to get to know yourself better and you're going to get to know the folks that you work with so much better than you ever thought you would.

> During the air war, you know, not a paralyzing fear but just the sobering fear to say, "You know, we're in this for keeps. This isn't... This isn't the movies that are playing here. This is really... People are gonna get hurt."

> I was fearful, it was just, again, sunk into me how dangerous the profession of arms really is and how close you can come in an instant to having an unfortunate outcome. So those were probably two of the incidents that I remember vividly as

times when you knew you were playing for keeps and this was dangerous.

> We were just going to visit. When we got there, you'd see these guys standing up on the hospital with the machine guns and you'd know that you... This was for real.

The big picture and defining moments. Beyond the immediate awareness of the local activity was the awareness of the global nature, timelessness and universality of the deployment. Being part of a complex mission, with joint forces, in a multinational effort was a defining moment. The sense identity was larger than self, it was a national identity articulated not with words but with the American flag.

> Because we all billeted together and all that. I mean, you ate together and you partied together and so I think it really got people to know the air force... And the reserves... Big reserve components. We were dealing with the reserves. So I think from that aspect, it's great. When these deployments come up now, I just... That's why I say, I don't need to go, I've been there and done that, we need to send the other people and... You know, to have them have that experience because it's wonderful. That's what makes the air force unique.

> Not everyone. But people would get... start talking ... And say, "Well when are we going home?" And they want to know when we're going home. And there was a discussion of rotation occurring and, ah... But we never knew. And my thought was... when you think in World War II and the other wars... you could be there forever. I never thought when I deployed, "I'm gonna be here for 90 days and go home." You know, "This is the real thing people.". But people... It was on the very forefront of many people's minds and some more senior officers.

> What bothered me the most... In fact, it really bothered me a lot, but we got it resolved finally, thanks to our JAG officer... Was we could not have the American flag flown. And that... You know that bothered me.

> So we lost people but yet you couldn't fly the American flag in the open. In the open. I mean, you could do whatever you want inside your building but you couldn't in the open. That was the rule. That they wouldn't allow you to do that. So that part of the policy bothered me more.

> So you get some mixed feelings because you're leaving a very unique experience. I think the hardest thing was when the planes left ...we were all out there ... the planes left before we left and the hospital stayed there. So you see the planes, you

know, and you'd get really close to the maintenance...and other people. Talk about bonding. You get... You know, you get involved in things operationally that you never got involved in...the people interfaced so much with the operational side. Well... It was amazing to me that when I deployed... When I first got there I hadn't even seen an F15E. I didn't know what our planes were. And I thought, this is... And when I got back, I said, "We're going to do tours over there to the flight line." ah... Because I thought that is terrible that I don't even know my own mission's airplanes.

Willing to go again. Some felt called to serve as a military nurse, some saw it as the purest form of practice. All of them would go again. It was a unique experience that was exciting, rewarding and sometimes overwhelming.

I would go back. You know, I think... I told somebody else this yesterday. With the military... The nurse corps changing like it ... Like it has. I think I would... I would really enjoy just going out there.. Because that's how I saw it. I got a chance to really do my job. It's one of the most rewarding experiences that I have ever had in my life.

I'll tell you, I'd go tomorrow because I'm a people person. Because I think I'm of use in the field.... Because I care about my people and I spend a lot time. And I think if I've got that quality and I like it,... why not use those skills because I'm willing to put my life on the line, I just... I really... My best times were in the field. I much prefer that. But I really do... I think let people who really want to deploy, deploy. Set up the army system and let... Have quality people who are ready to go do it, know their mission, and go out and do it.

I looked at it as "This is what I'm called to do and it's humanitarian." And we did get a medal ... by the way. We got two or three medals. So that was nice that they recognized us for that. But really... I think it probably was an important thing to do and I'm glad that I went but I wonder what the out... Why... You know, what the whole outcome of the big picture would really mean. In the end.

I don't know why I'm getting emotional about this. I guess, we had an opportunity to do what Americans should do and it was... It was overwhelming and it still is.

Comprehensive Description of the Experience

This phenomenological study explored the structure of the lived world as experienced in everyday situations and relationships. The complexities and

qualities of each person's lived world differ one from the other. The lived world of the chief nurse had different qualities from the lived world of the staff nurse or other members of the executive team. There were different lived worlds at home and in the deployed setting. At the most general level, the universal themes of the lived world are the existential themes of lived space, lived body, lived relationships and lived time.

The Existential Themes

Lived space or spatiality was felt rather than measured. The physical spaces occupied by the chief nurses affected the way they felt and was described as " having a sense of..". Other aspects of the lived space were environmental factors such as the weather, the terrain, distance and the configuration of the camps.

Lived body or corporeality alludes to physical or bodily presence in the world. It was the felt response of the chief nurses to personal factors which included exercise, fatigue, and hygiene.

Lived other or relationality refers to the relationships maintained with others. The chief nurses' experience of others in the local community or in the larger global community provided a sense of purpose.

Lived time or temporality was the subjective experience of time. Qualities of this existential were referred to in descriptions of duration, acceleration, deceleration, frequency, recollections and visions of the future.

This comprehensive description of the experiences of chief nurses in military operations other than war takes its shape from the essential themes and the fundamental structure previously identified. Van Manen (1990) suggested weaving the phenomenological description against the existentials of space, body, relationship, and time as a way of manifesting an intricate unity which is the lived world. The trajectory of the deployment experience and the essential themes of paradox, leading, knowing, caring and the true

military allow the meaning of the chief nurses' experience to emerge.

Lived Space

Lived space or spatiality was felt rather than measured. The physical spaces occupied by the chief nurses affected the way they felt and was described as " having a sense of..". Other aspects of the lived space were environmental factors such as the weather, the terrain, distance and the configuration of the camps.

The spaces occupied by the nurses shaped their experiences in many ways. They all arrived to find spaces that were unfamiliar in appearance, structure, function, and purpose. Creating spaces to meet the requirements of all the people was accomplished by erecting tents or other structures and redefining function of existing structures. When that didn't work they developed new processes to best use the available spaces.

The initial impressions / perceptions of the environment influenced their understanding of the magnitude of the mission. Transforming wide open spaces into camps that would accommodate 10,000 people was an awesome undertaking as was creating an acute care hospital out of an abandoned base. **(Leading, Arriving, Knowing, Working)**

Characteristics of the natural environment like midday downpours, typhoons and tropical storms made the absence of hardened facilities and paved roads glaringly apparent. Mud that sucked your boots off and water flowing through the tents, floating the floors and equipment, made ditch digging a mandatory skill. Shelter from the sun and relief from the heat were necessities and even with shelter the dangers of dehydration and heat exhaustion were ever present. It was amazing to them upon arrival that a trip to the bathroom required a rest period. **(Caring, Knowing, Living, Working)**

> A huge composite wing with all different aircraft....it was beautiful when you went out there and drove around out there at night with all the landing lights and

everything. The desert is a beautiful place. I... I thought it was, you know, really.

The military presence permeated the environment with patrols of armed guards and rumbling vehicles, camouflaged netting and barbed wire around the perimeters, and the sounds of missiles, gunfire and fighter planes taking off in rapid succession. Fires and smoke in the distance raised questions about incoming casualties and prayers of gratitude that the fires weren't closer. With this cacophony of sounds and kaleidoscope of sights the nurses settled into their living space. **(Knowing, Living, True Military)**

The people that were not far from us... You know, we could hear them taking off early, early, early in the morning so we knew something was going on.

But meanwhile it was about, ah... I guess 6 o'clock and just getting night and it was dusky out and you'd hear these helicopters and we didn't know.

You could not leave the base. You could only walk in a circle. The base was about the... It wasn't very big. It was probably from... Where you basically could not leave the housing area or wherever you worked which was basically in the same area. So it was probably about the size of the flight line...it was about 1/4 mile. It was 1/4 mile because you had to walk around it four times to make a mile. Right. So it was about 1/4 mile.

Since everything was unfamiliar and to some degree austere, the perception of hardship varied with the location and the mission. Spaces taken for granted at home frequently occupied their thoughts when deployed. Bathrooms were the most problematic. Lack of running water and lack of privacy made toileting and showering events of daily living rather than mere activities of daily living. Additionally, the facilities were often quite far away so getting to and from them consumed both time and energy. Limited availability provided an opportunity for a new kind of team cooperation, taking turns in the showers. Time limits were set and it was with great enthusiasm that one group was thrown out and the other group took possession. Fear, which was ordinarily not associated with taking a shower,

occasionally surfaced and resulted in the humorous sight of towel wrapped wet bodies fleeing to safety. **(Caring, Living, Knowing, Leading)**

The spaces used for meals varied from large open mess tents to makeshift dining halls; at some locations the officers clubs were also available for meals. The distance from the eating facilities made eating an event also. Transportation to and from meals could take up to an hour each way by bus or it was a 30-40 minute walk. This created a scheduling nightmare for those trying to provide continuous patient care. Gathering together for cooked meals was a welcome change from eating MREs but sometimes the togetherness was too much. **(Leading, Caring)**

Communal living arrangements are usually entered into on a voluntary basis. Sacrificing privacy and one's own personal preferences required a great deal of discipline and a positive attitude based on a commitment to the common good. One of the most successful attitudes was described as "homesteading". This attitude enabled the nurse to define as "home" whatever personal space was assigned. This space was then a safe retreat from the work environment, a place to relax and be yourself. The range of assigned quarters was enormous, from sleeping on the ground under the stars to a cruise ship called into service to support the troops. There were 12-15 people assigned to housing units designed for 6-8 and there were tents built for twenty that had 4-6 people assigned. Sharing sleeping space for those used to privacy was a challenge throughout the deployment. Serious effects were noted like sleep deprivation from hearing the noises of others or worrying about wildlife roaming around the tent. Living without furniture was another challenge in the living spaces. Those who were handy with tools and scraps of wood made furniture that was used by the maker and then handed down to the next residents as rotations occurred. **(Caring, Paradox, Living)**

> I worry, how are they going to work out there because it's one thing to work for 8 hours and go home with your family, it's another when you're with the same people

24 hours a day.

> And that's how... When they planned it, it was much better ... the females were all in the two rows, officers were all grouped, and then the enlisted, and then over on that side were the bathroom facilities for them and then the rest of the hundreds of tents for the rest of tent city were over that way and then the male showers and facilities and bathrooms were up here. Completely separate.

Office space and patient care space was created to fulfill multiple purposes / functions. Considerations in assigning space were based on the same theoretical principles used to assign space at home. These included safety, traffic flow, privacy, communication, and accessibility. Operationally these principles generated additional considerations in the field: water drainage, winds, rocky soil, proximity to running water, patient populations who were enemies, and level of noise. Fixed facilities were used whenever possible. This meant caring for patients in warehouses, empty airplane hangars, officers clubs or abandoned housing units. In one unit the kitchen became the pharmacy and the bedrooms became examining rooms, at another location, calculations were carefully done to determine the number of sandbags needed to make a safe barrier around an X-ray machine and then they built the wall. Transforming space was extremely difficult in situations where associations with the previous use or the intended use was emotionally charged. At one location rooms which had been used as a morgue were assigned as sleeping space.

Bunkers were the ultimate in safe space but they presented numerous problems: minimal equipment, standing room only, limited activities and only MREs to eat. Fear and uncertainty were palpable forces within the closed space, it was reduced by the calm demeanor of the senior folks and a few decks of cards. **(Working, Caring, Knowing)**

When fixed facilities were not available, temporary structures were erected. Civil Engineering provided support for the larger missions and eventually roads were paved, floors were laid and plumbing was installed.

Physical labor was required of everyone on the staff to create the space and then to maintain it. Besides putting up tents, unpacking, digging trenches and carrying supplies there was a lot of walking. Walking was the way most everyone got around. The open air, the exercise and the opportunity to visit as they walked along made up for the inconvenience.

Transportation was limited for two reasons, first there were few vehicles and second there were few good roads. In addition to these factors was the danger in hostile environments. Making rounds for two chief nurses was done in convoy wearing full gear and carrying loaded weapons. Because of the danger there were limitations on traveling off base or outside the camps, when the danger passed the restrictions were lifted and people were able to travel about freely. **(Caring, Living, Leading, True Military)**

> But we do have some pictures....it was quite a... Quite a set-up. Quite a set-up. It was pretty impressive, you know, to see what we could do in a tent.

> We weren't allowed to go downtown. We were basically in jail with the barbed wire perimeter.

> I never once left the perimeter of that base in the 3 months that I was there. Not once. Never saw a tree. Never saw a child. Never saw a plate. We ate on prison... Prison trays. You know what a prison tray is.

> The other part about it is that we could go downtown and that helped people a lot too. Just to be able to get off of the base meant a lot to a lot of people.

Lived Body

Lived body or corporeality alludes to physical or bodily presence in the world. It was the felt response of the chief nurses to personal factors which included exercise, fatigue, and hygiene.

Caring for those who care for others was essential for the chief nurse. The chief nurses understood the need to develop and maintain healthy patterns in their daily lives as a way of taking care of themselves. They took

time off to get some rest and relaxation. This translated into a hot shower and a bed with sheets for some of them. For others it was time out on the water or a long walk. Writing, calling and using e-mail to communicate with those at home was also important. There were many opportunities to reach beyond the confines of the camps to participate in the local culture. Learning about the countries and the people who lived there contributed to their understanding of the mission. When there were challenges and the chief nurses accepted them and then succeeded in meeting the challenges there was a sense of pride. **(Living, Knowing, Leading, Caring)**

> I used to take Sundays.... They issued me a white jeep, you know regular jeep. All... The 06's, I guess, according to army protocol get issued a car. And they issued me a white jeep. And it was a stick... Standard and I had never driven a standard in my life so I had to learn how to do a standard... I guess proud of me is learning how to do a standard.

> There was a nice workout facility. They had a lot of exercise equipment. I finally started exercising for the first time in my life on a regular basis, got up at 5:30 in the morning and worked out almost every day.

> But I actually used the time a lot... I did a lot of reading. I did stuff that I can't normally do in my real life. And the... You know, even though I worked a lot of hours, there was always like an hour that I was free in the evening which I don't normally have at home. So I read a lot. I... I'm not a person that needs to have people... People were around you all the time.

> I said "Gee, you know, it wasn't so bad." But I always was glad to be there though. I enjoyed it when I was there, I enjoyed the parts of it that were good. You know, the privacy things of having free time to do... Not privacy, isn't the right word. We never had any privacy. But independence. Being able to be my own person and do what I wanted to do sort of when I had some free time.

The uncertainties and fears diminished as confidence grew. A confidence that came from knowing and understanding the expanding limits of their own abilities and seeing the same expanding abilities in their staff members. Some of the abilities were physical, some emotional and some were

cognitive. Learning in the field never ended.

Reflecting on the deployment and the underlying meaning was a valuable experience for the chief nurses. Responding to the call to serve their country they were grateful for the opportunity to be part of these special missions which are unique to the military. **(Living, True Military)**

> It sort of comes back as I think about it. I know even when I worked at a casualty staging unit during Vietnam, I repressed so much stuff there. I think because society had such a stigma for it. You saw some horrible, horrible things happen to people and I guess to live your life, you sort of repress some of that stuff. I don't think about it very often. But when I really do, then I get real sad.
>
> It was one of the best experiences of my life. I have to preface a little bit - this was not a hardship deployment particularly for the chief nurse.
>
> I'd been very fortunate to be assigned with some good leaders who, uh... you see the... The right way to do it. And sometimes the ones that you have been assigned with are not the good ones but you learn because that's not the way you're going to do it.
>
> And... I have to say that I depend on my family. And I guess lessons learned and what they've taught me. Regardless of whether its a military experience or a personal experience, I rely on family values... Um, the kind of honesty, hard work, those kinds of things. I don't know that everybody can say that they depend on their family quite so deeply but I've really attributed whatever success I've had to that.
>
> But it also comes down to, the SGH and my real strong nurses that did the clinics.... Those kind of people together, you get through it. You know, there was somebody that I could talk to to deal with these issues. And then, there's God. You know, you all... You do. He watches over us. Well, you know, tests you, I'll tell you.
>
> We came down off the mountain and I promised myself when I went up on that mountain that I would always remember the importance of physical fitness and I would keep myself in shape and anybody that worked for me would also be in shape because you never know where you're going to be. I would have never thought that I would have to walk up this mountain. I tell you, I'd never did any mountain, I'd never walked anywhere first of all. I do aerobics but I don't walk.
>
> We had a group... A core group of... You sort of picked people who were like you.

Which is really interesting. I would have never thought of that. I used to say, "No, no, no. You don't do that." But there was a nurse anesthetist, a doc and myself and... You know, we sort of matched and mixed out there together because we actually think alike in some respects. And so we would sit down, all of us... It was like a core group of like six of us who would sit down and we would talk about what was going on and how we were feeling um... After the incident .... we became real attuned to what was going on with everybody. And we would sit there at night... And we didn't have anything to do... And we would sit there and we would talk about everything that was going on, talk about our family life, talk about things that we wanted to do and how we were going to change. Everybody was going to change for their family. The family was going to become more important. And I don't think any of us did that actually when we came back.

But I think some of it is just experience and learning and its a short time to learn... You know, you make all these mistakes and you don't have time to... You know, recover and press on. I'd do it again though. I'd go back. I'd go back and a lot of people in the group have said that they'd go back if the buses were lining up.

We still had six weeks left in country but it... It really... I think it really brought a lot of people together and allowed a lot of us to do a lot of soul searching and so forth. And just to know how valuable life really is.

It was certainly a learning experience.

I had been in the Air Force... You know, when I came in it didn't take me long to be totally committed to the... You know, the calling. You know, you say why you joined the Air Force. I came in, it was do two years and get out because I didn't know what... I kind of wanted to go somewhere but didn't know what I wanted to do. And my sister, who is also a nurse, had suggested that we go into the Air Force. ...so I'm totally committed. You know, you can do whatever you want with me and I will do it for the Air Force ...not everybody feels that way.

Returning from the deployment, they appreciated a difference in themselves. For some it lasted and they acted on it and for others it disappeared and they did little differently. All of them would go again. **(True Military, Leaving)**

And the other thing that happens to you when you deploy is you become... When I came back, it was like I could lick the world, you know. You know, you get this macho type thing, you know, ah... I ran a marathon when I got back and I got an F15 incentive ride. And they said, "Oh you haven't been in an F15 yet. Well we'll get you in there." And... I went sky diving ... the people... A big component of those

> I was hanging out with out there,... They were sky divers and so my JAG officer... My roommate and I went and we went sky diving with them much to the chagrin of our spouses. So you come back thinking, you know, you could do anything... So that was... You know, now I think I was crazy. But, it's kind of a neat thing because you've been there, done that, and you've experienced a lot of things. I think... Oh, I would keep a journal. That's what I would do. I think everything I did before, I wouldn't change anything.I had a positive experience.

Lived Other

Lived other or relationality refers to the relationships maintained with others. The chief nurses' experience of others in the local community or in the larger global community provided a sense of purpose. The chief nurses established friendships with co-workers during the deployments as well as maintaining relationships with their families at home. **(Caring, Living)**

> I met a lot of people and a lot of nurses. Most of us keep in touch now, keep in touch with each other.

> The only thing I think... Any time when you are gone more than about 4 weeks... Is talking to your kids. And we used E-mail. My husband spent the $20 per mo. and talked on E-mail. So even though... You know, you're only supposed to make a phone call once per week. That was o.k. but talking on the E-mail was nice.

> I promised my son that... He was very worried. I mean I can't tell you how many times he told me... Now he was 8 years old. He said "Mom. All I want is a camel and 5 dollars of their money and for you to come back home alive." And he said this to me multiple, multiple times. He was very worried that I wouldn't come home. And... And so I told him that I would do everything I could do to try to make sure that I came home safe. And... And I probably could have gone downtown as one of the escorts at one of those times but I was so busy, I just don't think I could have fit that it. But I could have done it though. But... But I just felt like the safest place for me to be was on that base.

> We knew everybody. I have developed, I think, some friendships with some of the nurses that I was with now and we get Christmas cards and I send... Just this week, you know, I sent Christmas cards to them.

Most of the executive teams worked hard to develop trusting relationships so the mission could be accomplished. Common doubts, fears,

concerns and worries provided lots of material for discussion. Difficult decisions were made that much more easily when there were supportive people to encourage them. **(Caring, Knowing, Leading, Working)**

> This is going to sound a little weird because it was weird to me at the time. Ah... When faced with situations like that and people that see every day of your life. I mean, you eat with them, you sleep with them, you work with them, they're everywhere, because we all lived right there in the same little camp. I mean, you know, door to door to door. We all used the same rest room. You know what I mean. And we all... There was one place to eat. And... And so everybody ate in the dining hall. And there were only certain times so you always met up there together. You will not know what that does to a person, it just really bonds you.

> Me and... my friend, who... She retired this summer and I really miss her. But we'd go walking and... For hours and hours and hours. We got to be good friends because I... You know, after a while, you just have to talk about anything that you can think about.

The more senior of the chief nurses had an easier time with social relationships in the field. Fraternization was not a problem for any of them but the appearance of inappropriate relationships with subordinates was a consideration for some, and it limited their openness. Very strong bonds were built among those who shared the profound experiences in the field, many of them still keep in touch. **(Leading, Leaving)**

> It's kind of the typical chief nurse thing where you really can't be friends with people. I couldn't be friends with the Col.really because she couldn't be friends with anybody.

> So when... When it was time for us to go, even though we were all glad, we were also sad because we had made such interesting friends and we had gone through so much together, all of us as a group, that unless you were a part of that group, you couldn't possibly understand what we had gone through.

Storytelling and listening to stories led to understanding through getting to know one another. Soldiers from other countries had stories to tell and so did troops from the sister services. The patients also had stories to tell, stories

of family members who died at sea while trying to reach the camp and stories of the lives they hoped to establish in the U.S. The staff responded with genuine concern and that concern was the seed of a caring, healing relationship. **(Knowing, Caring, Working, True Military)**

> Believe it or not, not only did we get close to the people we deployed over there with, the people we met from the other contingents. Because there were, on Camp, probably 12 or 15 other contingents. And you'd... You'd... You'd... You developed friendships with them. I mean, we had close association with the French contingent and they had their own little medical, ah... First aid station .... The Danish group of folks there and the Swedes and folks from the Netherlands and you had your Russians and the Ukraines. I mean, you know, there were 10 or 12 other contingents on that base. After you'd been there a while, everybody'd eat in the same dining room and you'd see them around, they'd come to our hospital, it got to be not just our little family but a bigger family that people had developed very close associations. Very close associations.
>
> It really was joint force. And it really was United Nations. I mean, we had people from all contingents. And what you learn is that people really come together in times like that.
>
> There again, it was really bad... the interpreters came from the camps to help us, they were volunteers. And a lot of times, they were doctors or... They would tell us, you know, when you got know them, "You know, I was a lawyer" or "I was a college professor" and here they're reduced to asking for a coke and being an interpreter and trying to help us out.
>
> Some of them spoke very good English. And there were physicians and nurses and teachers that were in these groups of people living in these tents, like animals really. They were more like prisoners..... So, you know, we heard their stories and people really got attached. And although there was supposed to be no fraternization between Americans, no matter what service, and the migrants, in reality, there was some fraternization.
>
> There were some beautiful artists there, they could really draw. And they were very... Just a neat group of people. You know... So we got to... You got to know people personally.
>
> And they all had stories. And if you saw some of the paintings... You could tell how, there were paintings of people in chains and... They had lost boats and family coming across the water. And there were a couple of old boats that they had made and rafts that were just sitting off the back of the island where we were

> housing these folks. When I went on the boat, you could see some of this stuff.... and everybody had their story, who they had lost, what was going on, whose family was back home.

Lived Time

It started the day they came on active duty, some nurses wanted adventure and others answering the call to serve their country. There had been many exercises with phone calls in the middle of the night, hauling packed duffels over to the base to practice mobility processing, long lines to check immunizations and to verify information for next of kin notification. Time moved slowly—bag drags, days of training, many plans. They were always ready and never got a call. Twelve, sixteen, twenty two years later they were notified. It was time. **(Preparing)**

> When we got there for the actual deployment and the bag drag and all... And all the briefings, We actually were delayed so we... We really didn't even take off, I think, until 11 in the afternoon, something like that. It was a long time waiting and waiting and waiting. When we finally did get there, we got a briefing and then it was time to set up the tent.

This time after notification, they knew it was not an exercise any more. Hurry to pack, hurry to base, hurry to say good-bye and then they waited. Planes, buses, overnight delays...they were ready now, ready to be there, ready to start—almost.

A sense of urgency energized the set up and preparation for casualties. Everyday the same question, “are we ready yet?” Within hours some had an answer. The casualties started to arrive, the clinics started to get patients. **(Preparing, Working, Knowing, True Military)**

> I mean, here we are, we had been in the country for three days, the other group just left the day before, and all this was going on. So that was kind of our introduction. We really... We kind of came in when things were pretty hot and so needless to say we never had time to sit down and plan. I mean, all... It just happened so fast and this went on for at least the first two weeks.

> In the bunker...It... It could have very easily been a week. We had no idea how long or for that matter what was going on around us, you know.
>
> The people that preceded us departed on a Thursday, the 3rd of August. We had two days to overlap when we had flown all night long and we got there at 8:30 in the morning, their time, but, my goodness, no telling what time it was our time, it was like later on in the evening, 4:00, 5:00, or 6:00 our time but... When we got off, we went to work right away because we only had two days to overlap them and to learn everything we could from them. We arrived at 8:30 in the morning, they greeted us of course and took us to our room and put our bags down and some of us were already scheduled for 12 hours... To begin 12 hour shifts starting then.
>
> Some people were terrified. And you could see it. I mean, people were literally trembling like this. I mean, you could see the fear. Can you imagine? I mean, three days in country. We thought, "Oh this is going to be a long six months." And people were actually just shaking.
>
> So that was literally the mission that we had within about... Just a few... It was probably 36 hours, it seemed like it was, you know, 1 hour from the time we landed there. We did successfully transport the patient.

Uncertainty twisted time and slowed it down, “would this go on forever?” Patterns emerged: quick response, fast pace, no more patients, slow down, regroup; or a gentler, steadier pattern, a weekly routine in airevac, a daily routine in the clinics. Working had a rhythm and so did living. **(Knowing, Working)**

> See part of it is you're there... It takes a month to figure out what you're doing. I mean to even begin to really see what the problems are. And then it takes another month to sort of get... Start doing anything. And then it takes another month and you're getting ready to go. That was difficult too. You didn't have enough time to accomplish a lot. Now, they're going to be there 4 months and I think that will be better.

Activities of daily living were drawn out, stretched into the consciousness of the nurses. It took time to live. Tasks that were usually automatic had to be thought out, planned or done according to someone else’s schedule. Meals were served between the hours of... Showers were

available when it was your turn and it was always a long, long walk. Laundry was done by hand, mail was at the post office across camp, lines for the phone were long, getting a connection could be longer. Living took time. **(Living, Paradox)**

> I just tried really hard to make sure people were oriented so they had their expectations met and felt comfortable because it took an awful lot out of you just to walk down to the bathrooms. You know, because you had to carry everything, come back, and you were always sweating all the time. So I thought that was a little exhausting. You could see why folks didn't move very fast.

> But actually just to maintain yourself, just takes time. I mean, you're walking everywhere you go so that takes up time. You're doing your laundry by hand ...We actually did have some washers up where we were. So everything takes a long time.

Schedules for the chief nurses and their staff members varied considerably with the tempo of the mission. Time off was also governed by the availability of transportation to and from work. At some locations everything was within walking distance and at others there was a 10-12 mile distance over poor roads. When there was lots of work to do with an influx of casualties it was important to enforce a duty schedule so there would be a fresh crew for the next wave of patients. Some staff had to be sent off to rest. **(Working, Living, Leading)**

> We did a 6 days work week. I probably had 4 days off in the time we were there, on Sundays. I probably had 4 Sundays off where I just didn't go into work in the 3 months time.

> It was very busy. My... My staff was... They were working five and six 12 hour shifts per week. Oh, it seemed like there was never... When we were busy, there was never enough staff it seemed. And then, on the days when we weren't, of course, there was too many.

> We'd give them more time off and they really enjoyed that. But with time off came more chances to get into things that they shouldn't have been into. The SP's calling us that they were someplace where they weren't supposed to be.

> And we worked anywhere from 8-12 hour shifts with a day off at a crack or two days if you were lucky. And there wasn't a whole lot to do because we were on this little island.
>
> And we'd go to work about 5:30 and come home about 7:00. And we'd work seven days a week. And I cheated sometimes and took 1/2 day off if we could get a boat.

The days had light and dark to mark their passing but the weeks had no weekends, the months had no mid month pay and the year had no holidays. The familiar markers that time was passing were missing, so for some time stood still, for others time had bleeps where anniversaries and birthdays should have been. One nurse deployed in November and came home in February but for her the year never changed. The old year never ended and the new one didn't begin—the holidays were missing. **(Knowing, Caring, Paradox)**

> They didn't know what to expect. We were there, I think, at the worst possible time, right through all the holidays. We missed Christmas, New Year's, the January holidays... We missed all of the holidays. I... And there was no difference. We could... You could not tell if it was Christmas Day or any other day. It didn't matter because there was nothing happening, we had to go to work. We still worked our six... I was off every Friday and Christmas wasn't on Friday so I worked Christmas. I went there and it was just kind of like in a way all that didn't happen.
>
> The toughest part about being deployed was Christmas because we missed Christmas, Thanksgiving, and Halloween. I didn't miss her birthday because she's got a July birthday but Christmas was the worst day so... Probably being busy and having some responsibility helped. So that probably helped quite a bit.
>
> Well, Christmas was the worst... But we were busy. But Christmas was the worst for everybody. And then we... we heard that it would probably be Febru... Well, it had to be February before the March deadline. Um... We just wanted to get home. After Christmas, we wanted to get home. It was time to get home.
>
> We went at a time when we would have been there during the holidays. And I'm

> talking the most celebrated holidays You're talking Thanksgiving, Christmas, New Year's. Those are just widely celebrated and everybody was missing or the thoughts of not being home for those holidays weighed somewhat on our minds. But by the time we had been in country 40, 50, 60 days, we started... You know, started... We... We jelled pretty much as a family and that group... Became our family. So we would have activities and so forth with that group.

Everyone came home. For everyone the deployment is over. Some will retire so they will not deploy again. Some have duties that do not include mobility; they will not deploy again. The others are ready, waiting and they might get to deploy again.

Chapter V
Discussion of the Findings

This chapter presents a discussion of the findings. It includes an integration of the findings across themes and places the findings within the context of what is already known. The chief nurses' response to the interview process, the significance for nursing and implications are also discussed.

Integration of Findings

The purpose of this research was to describe the experiences of chief nurses in military operations other than war. Hermeneutic phenomenology, was used to provide a description and thematic interpretation of the meaning of the experience. Thirteen nurses who had served as chief nurses in military operations other than war were interviewed. Audiotapes of the interviews were transcribed and analyzed using procedures adapted from Colaizzi (1978) and van Manen (1990). The fundamental structure of the experience was identified as a deployment trajectory and it had five themes: preparing, arriving, living, working, and leaving. Further analysis of the data revealed five essential themes which emerged from 32 interpretive clusters. These themes were paradox, leadership, caring, knowing and the true military. Lifeworld existentials of lived space, lived time, lived body and lived relationship as described by Merleau-Ponty (1962) and van Manen(1990) were used as guides for reflection and development of a comprehensive description of the experience.

The presuppositions which had been identified and set aside or bracketed by the investigator during the data collection and data analysis processes were unbracketed at the completion of the presentation of the findings. Following additional reflection on the experience, as it was described in the fundamental structure and the essential themes, three integrative metathemes emerged.

These metathemes were authenticity, imaginative awareness, and pride.

Integration of Meaning

Authenticity. The chief nurses' experience was authentic. It was beautifully demonstrated by the chief nurses who were fully present as nurses and as officers throughout the deployment. To be an Air Force Nurse Corps Officer is a way of being in the world. In numerous instances they articulated that just being themselves was the most successful strategy for success. Nursing is one part of the dual profession of Air Force Nursing and caring is the foundation of nursing. A broad range of caring behaviors and intentions was revealed by the chief nurses. Supportive interpersonal relationships were established, intentional therapeutic interventions were performed, and the moral imperative of respectful care of the dead was applied in practice. The distinctly human trait of caring was manifested in the language and presence of the chief nurses in multiple situations where their beneficent actions relieved suffering in those around them. Those who cared for others by their presence made a difference in many situations; terror was relieved in the bunkers and new mothers were reassured. Expressions of caring succeeded when language barriers prohibited verbal communication. The integrity of the operation was, in part, dependent on the presence of the chief nurses. Aware that presence made a difference, one chief nurse noted missed opportunities by not being present. Presence was clearly a constituent of authenticity.

Leading is the foundation of officership. Multiple roles of a nurse leader were evident from the beginning of the trajectory. The chief nurses built high performance teams to accomplish the mission. They assessed the work requirements and then matched those who were best suited to get the job done. They understood that integrity, credibility and trust were essential for managerial effectiveness and that success depended upon the combined

efforts of each member of the team. The chief nurses understood, practiced and modeled self care to assure the highest levels of mental and physical energy would be available when needed. Discipline and good order was maintained, though at times there was creative interpretation. The most basic elements became significant and those usually taken for granted became a central focus. The chief nurse had to work with other members of the executive team to develop policies which would guide the behaviors of the staff when their loss of perspective caused problems. The role of counselor was added to the chief nurse's repertoire. Danger was an ongoing concern. In spite of the dangers, they made rounds. The chief nurses knew their presence was important. Identity and role definition were clear from the beginning for most of the chief nurses; for others, the assignment came as a complete surprise and they had doubts as to their ability to function in the role. Most came to terms with the role soon after arrival. From that time on, they were present as leaders.

Staying engaged was another constituent used to establish authenticity. Twenty four hour a day responsibility demanded their energies and focused their attentions on the health of the people who were living and working in the deployed setting. Living in community became a reality for everyone who was deployed. The communal aspects evoked many complex and contradictory responses in each member of the team. Autonomy and respect for autonomy were often the underlying principles invoked when seeking resolution of daily conflicts. There was an awareness of the differences between desires and needs, and new meaning for the word luxury. Humor made living in community easier by releasing the tension and keeping things in perspective.

Embracing responsibility was the final constituent of authenticity. They embraced all responsibilities even though the boundaries kept shifting. The responsibilities were theoretically similar to responsibilities at home but

operationally they were quite different. Meeting the requirements with the available resources was a responsibility of each of the chief nurses. Keeping the place clean was a major undertaking especially given the austere environment. They also had to address health care needs at multiple levels. This included everything from availability of water, food, toilet facilities, access to first aid and transportation to higher levels of care. The activities of the chief nurses as they carried out their responsibilities revealed the holistic and interactive nature of nursing.

Imaginative Awareness. The second integrative metatheme was imaginative awareness. This gave them access to the essential knowledge needed to inform their choices and decisions. They were then able to act freely or intentionally within the scope of their authority. Authentic personal connections that formed in the normal course of events reflected a balance between compassion and reason. Unique circumstances also brought forth an imaginative awareness and a desire to do more. The chief nurses experienced multiple ways of knowing. They learned from sensory encounters, decisions and choices they made, individual engagements, and from seeking personal clarification. They developed understanding despite multiple challenges to their established base of knowledge and the pervasive uncertainties which confronted them on a daily basis.

Maintaining perspective was a constituent of imaginative awareness. A pattern emerged and that was the simultaneous appreciation of the parts and the whole of the experience. This appreciation required the nurses to intellectually override the immediate concerns and to maintain a global perspective.

The meaning of space was another constituent of imaginative awareness. When the deployment site had previously been used for another purpose, the buildings were assigned new uses and space was reconfigured for patient care. This was significant since some of the deepest meanings shared

by humans are related to the use of space. A particular example was space which had been a morgue or was now being assigned as a morgue.

The chief nurses encountered many uncertainties. Questions about the magnitude of the mission, the types of casualties and the capability of the staff were asked frequently. Because of the political influences directing the missions it was often unclear exactly what the scope of the mission included. Information arrived from multiple sources and the situations changed rapidly as activities in the region changed. Rumor control was an ongoing challenge. Uncertainty was made more visible because of their imaginative awareness. Uncertainty was expressed as “What if?”, “What am I doing here?” and “What’s happening?” Discussions about possibilities were tempered with discussions of probabilities and a certain detachment came with realization of the cold reality that was occurring elsewhere.

Moral distress evolved as a result of their imaginative awareness. There can be no distress without awareness of what might be, what could be, or what should be. Chief nurses were in a position to make difficult personal choices from among alternatives which were ambiguous and grounded in uncertainty. The consequences of these choices were very hard to predict and acting on the choices frequently gave rise to moral distress. Principles which successfully guided the nurses’ practice at home were often in conflict with the realities of the austere deployment environments. Knowing the principles and recognizing the conflicts was both an immediate and a long term concern. Issues arose around duty, privacy, kindness, fairness, doing harm, personal autonomy, and respect for autonomy.

Recognition of particulars is the final constituent of imaginative awareness. Living in another culture encouraged reflection and respect for both the individuals and the people as a whole. Perception of the mission as a whole and careful discernment about the events, relationships and roles of the team led to understanding. Understanding contributed to the increased

awareness and expanding consciousness of the chief nurses and a realization that these deployments were in fact a true military experience.

Pride. The third and final metatheme was pride. The chief nurses clearly reflected a sense of pride when describing their experiences. Above all else, they were proud of the team. Establishing and maintaining a team to accomplish the mission was the prime directive. Coming together as a team was one of the main concerns of the chief nurses. It started at the time of notification and continued throughout the deployment as new staff members joined the team. Sharing information, planning, packing and traveling together helped people get to know each other and to build trust. They were proud despite a few situations that were counterproductive to building the team and a few challenges in merging staff members from different bases into a single unit. The chief nurses were proud of the decisions they made. Making decisions was a familiar task for everyone, but the magnitude of the decisions was at times awe inspiring. The chief nurses took great pride in their own accomplishments and even more so, the accomplishments of the troops. Growth of the troops as individuals and growth as a cohesive team were the real sources of their pride. Seeing this growth renewed their confidence in their ability to handle the mission. They were proud of doing their best in spite of the challenges. Doing their best was another expression of caring, and when doing their best wasn't enough they felt guilty and asked what could have been done differently? Profound experiences were imprinted forever in the memories of these nurses. Being part of a complex mission, with joint forces, in a multinational effort was a defining moment and a great source of pride. The sense of pride was larger than self, it was a national pride articulated not with words but with the American flag.

The Unity of Meaning

Through several levels of reflection, the metaphor **The True Military: Performing Live Theatre** emerged from the fundamental structure and the essential themes to express the unity of meaning. Military officers frequently use the term "theatre of operations" to describe the boundaries of a mission. It was as if these nurses were finally asked to give a command performance after years of rehearsal. Notification of the deployment was the invitation to perform. Each chief nurse had rehearsed multiple lead roles for several plays in this repertory theatre. It was unclear which play they would be asked to perform so they left prepared to perform in every role. The cast members were the rest of the mobility team, they required some direction but they knew their own roles. The sets and props were shipped with the expectation that they would be used just as they had been in rehearsal, but often they were incompatible with the open air theatre. Simultaneously, the rehearsals continued as the performance began. The performance went well, they returned home and some of the chief nurses are hoping to reprise the role. The unity of meaning was revealed and is expressed in this metaphor.

Context of the Literature

The findings are presented and discussed in the context of the literature. Many of the themes support and are supported by what is found in the literature.

Living, as a theme, was articulated by Stanton, Dittmar, Jezewski, and Dickerson (1996). They identified a total of five themes among nurses who had served in war and in MOOTW: (a) living in the military, (b) reacting personally, (c) nursing in the military, (d) the social context of war, and (e) visual images and sensations. The constitutive pattern of adjusting was also identified. All nurses in their study were young when they entered the military. This study revealed similar themes, especially the clusters related to

activities of daily living, travel to the deployment, sense of camaraderie, improvising to provide care, and the importance of support. This study added the dimension and perspective of senior nurses serving as chief nursing administrators to the perspective of staff nurses identified in their study.

The appraisal of environmental stressors was discussed by Norwood, Ursano and Gabbay (1997). They described two responses to stressors: challenge and threat. An individual experiences threat or challenge based on a balance among the environmental demands, the available resources and the person's ability to manage them. Both challenge and threat were identified in this study as responses to the cultural differences and hostile conditions in the environment.

Cultural differences in health care must also be recognized and understood. Wittich and Salminen (1997) note that with readily increasing military medical deployments, primary care physicians and specialists can expect to confront health care practices such as infibulation or female circumcision. They will be expected to treat these patients and manage them during delivery. Uncertainty surrounding cultural differences was identified in the study, as was the need for compassionate care in humanitarian operations.

Resources have been developed to help nurses understand similarities and differences among groups or populations. Topics include communication patterns, activities of daily living, food practices, symptom management, birth and death rituals, family relationships, spiritual religious orientation, illness beliefs and health care practices (Dibble, 1997). These resources address several of the concerns identified by the chief nurses. Understanding and communication in the presence of profound cultural differences were seen as desired outcomes in every deployment. Burkle, Frost, Greco, Petersen, and Lillibridge (1996) acknowledge the need for improvement in the training of military personnel in internationally accepted assessment protocols,

international law, and conventions regarding humanitarian assistance. Networking and communication skills must also be improved. These areas of improvement were perceived by the chief nurses as crucial to the success of future operations. Working under the threat of biological agents had additional significance for the chief nurses since the scope of their responsibilities included the multiple aspects of planning patient care units, selecting staff members to work in them and ensuring their safety. This study supports observations of Franz, et al. (1997) "that the hostile use of BW [biological warfare] agents would likely cause significant impact on the health care system. Patients would present in unprecedented numbers and demands for intensive care might overwhelm medical resources" (p. 399). Potential problems include availability of medications and supplies, physical protection for health care personnel and management of the bodies of patients who have died. This was a concern voiced by more than one of the chief nurses.

Leadership issues emerged as a theme for all the chief nurses in this study. In an earlier study van Wijk (1997) identified two factors needed to support military nurses in isolated settings. The first was regular and frequent contact between nurses and their supervisors leading to better information sharing and clarification of rules and policies. The second was the need for supervisors to convey support and interest in the welfare of the nurses. These factors were clearly articulated and sometimes dramatically demonstrated by the chief nurses as they donned full protective gear in order to get out to see their nurses in geographically separate locations.

The chief nurses in this study recognized the impact that leadership or lack of it had on the health and welfare of the staff members. The chief nurses often made up for weak leadership in others and openly acknowledged and supported strong leadership in other members of the executive team. In a previous study, leadership was shown to be a major determinant in the health of military members both in peacetime and in combat environments.

Training was also listed as a protective factor in minimizing stress of military members (Norwood, Ursano, & Gabbay, 1997).

Accepting responsibility, carefully articulating levels of authority and being accountable were just a few of the leadership abilities described by the chief nurses in this study. Leadership abilities are the first priority for executives in military health care according to Sentell and Finstuen (1998). They also mentioned effective interpersonal skills and the ability to manage complex relationships as essential to effective leadership.

The findings in this study are also consistent with the findings of Sentell and Finstuen (1998) who asked military health care executives to identify key issues and the skills, knowledge and abilities needed to deal with fulfilling the primary operational mission of readiness. Emphasis was placed on patience, listening, team building, conflict management, negotiations and motivational leadership, all of which were significant in the descriptions of the experience of chief nurses in this study.

This study corroborates the findings of Carmack (1997) who found that caregivers who balance engagement and detachment affect outcomes without needing to control the outcomes. These caregivers set and maintain limits and boundaries, monitor the balancing process and practice self care. The chief nurses not only accomplished the balance of engagement and detachment in their own lives but modeled the behaviors and encouraged them in their staff members.

When viewed as a whole, the fundamental structure and the essential themes reveal an experience with an enormous potential for moral distress. This finding is consistent with the work of Mann (1997). He describes the complex interactions among practice ethics, human rights and public health issues. These interactions become problematic in environments which are not dignity affirming. A lack of vocabulary to name and describe many of these situations limits understanding of them. He goes on to say that the

boundaries of health care blur when considered in the context of conflict, marginalized populations, human rights and economic consumption. The camps described in this study were certainly not dignity affirming. The chief nurses acknowledged the difficulties in capturing the magnitude of the human suffering in several of the deployment settings. Moskop (1998) confirmed this problematic pattern when he noted multiple obligations which can and often do come into conflict when delivering health care. The chief nurses specifically mentioned the moral distress they experienced in making decisions about staffing, allocation of resources, safety considerations and access to care.

Nursing administration and military leadership come together in a deployment setting. Higgins (1996) noted that historically, nursing and the military have been linked and that the obligations of nursing and the military are not opposed. She specifically addresses their ability to survive in adversity and attributes it to their education for responsibility during their nursing studies.

Chief Nurses' Responses to the Research Process

The presentation of findings demonstrated that the chief nurses were willing and able to articulate their experiences of serving in military operations other than war. Additionally, they were earnest and enthusiastic in their efforts to share their experiences with others. Many of them stopped at intervals throughout the interviews to confirm with the investigator that the information was relevant to the purpose of the study. At the conclusion of the interviews they offered to provide further information or clarification should questions arise later. They expressed an interest in how the information would be used and said they hoped that the information would contribute to the success of future deployments. They welcomed the invitation to participate in the study and communicated that having an

opportunity to describe their experiences was important to them.

Commitment to the Study

The chief nurses voiced gratitude for being asked to participate in the study. They were proud that their descriptions would contribute to the understanding of the deployment experience and the overall body of nursing knowledge. Many of them came prepared with notes, journals, tapes and scrapbooks and indicated they had reviewed these things in preparation for the interview. They indicated that review of these materials was beneficial to them and had given them the opportunity to reflect upon this significant time in their lives. Also, they said, it was an opportunity that they might not have taken otherwise.

Commitment to the Interview

The chief nurses expressed the intention to provide information that was both complete and accurate. Their openness and honesty was evident in the balanced portrayal of the experience as “work to be proud of” and “lessons learned”. It was of particular importance to them that experience of humanitarian operations be recognized as unique in the areas of clinical and administrative practice. They hoped that by describing the diverse patient populations they served, teams configured to deploy in the future would be better able to meet the challenges presented by the patients. They believed that sharing their experiences would benefit not only other chief nurses, but all the members of the executive team who would be deployed to subsequent military operations other than war.

Implications of the Findings

Significance to Nursing

This study extends military nursing knowledge and understanding through the specific focus on the experience of chief nurses. It also contributes to knowledge in nursing administration and the practice of nursing in disasters. The fundamental structure of the deployment trajectory reflects the unity of the experience. Particular aspects of the experience such as preparation, skills training, providing care in adversity, leadership and an ability to live in community clarify the experience and provide concrete opportunities for integration, synthesis and application of knowledge from science and the humanities. Insight into the transferability of knowledge as nurses move from traditional practice settings to the field emerged after reflecting on the paradoxes described in the text. The concerns of chief nurses encompass their own needs, the needs of the staff and the needs of the patients. Identification of the needs and understanding the challenges they present is significant to nurses in clinical practice, research, education and administration. The clinical specialties of trauma, maternal child health, mental health, perioperative nursing, medical-surgical nursing, community and public health nursing, patient education and gerontological nursing are all required in the field as well as aeromedical evacuation and the administrative specialties of middle management, executive management and staff development. Extension of each of these specialties is possible from the knowledge generated in this study.

Implications

The implications of the study fall into three areas: education, policy development, and administrative practice.

Education. Educational considerations include identification of ongoing, recurrent training issues; preparation of immediate, predeployment training

plans with content specific to the mission; and provision of information available on military support, permanent bases and fixed facilities in the deployment location.

Skills training must be done in such a way that the skills can be translated into a variety of situations. Especially important is learning the low tech equivalent of high tech equipment commonly used in health care today. Recent graduates are particularly likely to need extensive training since they have never learned to provide care “the old way”.

Efforts to improve cultural competence relevant to the particular deployment should include information on cultural aspects of the mission, translators and language teachers for longer deployments and creation of an educational program exploring moral concerns from various cultural perspectives.

Lessons learned from previous deployments should be critically examined for applicability and generalizability to other deployments. Appropriate content should then be incorporated into readiness training.

Policy Development. Those who develop policy should be mindful of issues related to the length of the deployment such as family situations, competency requirements, and consequences or impact of the absence of individuals from their permanently assigned base. A second consideration in policy development is the selection process used to determine those who are to deploy. Policies and procedures for family visitation to the field as well as policies for personnel absences from the field should be addressed.

Administrative Practice. Chief nurses should continue to give explicit support to the staff nurses for providing compassionate care. They should have the opportunity to discuss the influence of uncertainty on the staff and develop strategies to manage it.

Chief nurses could practice “making do” in a variety of scenarios based on the experiences of previous deployments. They could also explore

the full range of communication problems, and then practice creating viable alternatives. They must initiate and encourage open discussion of the realities of communal living and the expectations of conduct and behavior in the field. They must try to be attentive to their own exercise patterns and those of the staff while they are deployed.

Chapter VI
Summary of the Study and Recommendations

This chapter presents a summary of the study, including the research approach, research conclusions and recommendations for further research.

Summary of the Study

The purpose of this research was to describe the experience of chief nurses in military operations other than war. The study was undertaken because the lived experiences of chief nurses in MOOTW are unknown phenomena and developing an understanding of the experiences would contribute to nursing knowledge.

The study is significant to the profession because nurses will continue to provide care in humanitarian operations, peacekeeping missions and disaster relief efforts. Inquiry into the experience of these nurses will lead to an understanding of the foundations of the global caregiving community.

Research Approach

Hermeneutic phenomenology, a philosophical research approach, was used to provide a description and thematic interpretation of the meaning of the experience. Phenomenology was selected because, as a human science research approach, it promised to accomplish the goal of the study which was to examine the lived experience of chief nurses in MOOTW and the meaning of that experience from their point of view.

A review of literature was presented to clarify the dimensions of the phenomenon of interest and to enrich the investigator and the reader in preparation for turning their attention to the phenomenon at hand.

Purposeful sampling provided thirteen participants for the study, eleven women and two men. All of them had been on active duty in the Air Force

when they were deployed to military operations other than war. Twelve were still on active duty at the time of the interview and one had retired. At the time of deployment, two were colonels, six were lieutenant colonels and three were majors. They had been on active duty for an average of 18.2 years with a range of 11-28 years.

The duration of their deployments ranged from 3-7 months; two had been deployed more than once. Sites of deployment included Saudi Arabia, Oman, Panama, Cuba, Somalia, Guam, Croatia, England and Turkey. Purposes of the missions varied from humanitarian relief to peace keeping.

Previous experiences for all of them included clinical nursing. All were masters prepared. Seven had degrees in nursing: three in human resource development, three in administration / management and one in gerontology.

The interviews were conducted in quiet, private settings using core questions developed to guide the interview. Audiotapes of the interviews were transcribed and analyzed using procedures adapted from Colaizzi (1978) and Van Manen (1990) and illuminated by Ray (1990). Significant statements were identified in the text, meanings were formulated then gathered into 60 interpretive clusters. Reflecting and rereading the text and the interpretive clusters led to the emergence of the themes which constituted the fundamental structure and the essential themes. After deep reflection on the text and use of the process of intuition three metathemes were identified and the investigator was able to grasp the unity of meaning in the experience.

Research Conclusions

The fundamental structure of the experience was the deployment trajectory and it had five themes; preparing, arriving, living, working, and leaving. Further analysis of the data revealed five essential themes which emerged from 32 interpretive clusters. These themes were paradox, leadership, caring, knowing and the true military. Lifeworld existentials of

space, time, body and relationship as described by Merleau-Ponty (1962) and Van Manen(1990) were used as guides for reflection and development of an comprehensive description of the experience. The metathemes which emerged were authenticity, imaginative awareness and pride. The unity of meaning is expressed in the metaphor, The True Military: Performing Live Theatre.

This phenomenological study captured the experience of the chief nurses who were deployed to military operations other than war. It revealed the challenges of leadership and tremendous pride in getting the job done. These nurses were proud of their participation in an authentic experience where imaginative awareness enabled them to identify and respond to the challenges they encountered as nurse leaders.

The chief nurses understood the responsibilities of leadership and approached them with confidence. They lived with feelings of apprehension, uncertainty and fear, transforming them into pride, understanding and trust. When notified of the deployment they hurried to get ready for departure. Preparations included gathering information and making arrangements for family members. They responded to the responsibilities of leadership from the beginning by carefully selecting the individual members of the team who would deploy with them. The chief nurses sensed the challenges that laid ahead and in almost all situations transformed the challenges into opportunities. They faced austerity and a fast paced tempo of operations with creativity, energy, innovation and most of all their unflagging support of the staff. This support encompassed a concern for the welfare, safety, development and personal growth of all the nurses and technicians, especially the young ones, who were new to nursing and to the military.

The living conditions and working demands they encountered were a source of wonder, amazement, confusion and fatigue. Caring characterized their behaviors and attitudes in carrying out the duties of the role.

Uncertainty was openly addressed with monumental efforts to communicate and to become comfortable with ambiguity. They lived willingly in the immediate, local operations but had to be constantly mindful of the global dimensions of the mission. Throughout the experience they were truly nurses and truly officers in every sense of the fullness of the two professions.

Recommendations

Further areas for research suggested by this study include topics in nursing practice and nursing administration. There are individual issues, operational issues, multinational and multicultural issues.

Individual issues to be addressed are the experiences of other members of the executive team in MOOTW, the experiences of chief nurses from other branches of the military or nongovernmental agencies in MOOTW, risk behaviors of deployed personnel, and individual health issues related to deployment (health promotion and disease prevention). Investigations into the processes and outcomes of nursing care measures in an austere environment are also suggested by this study.

Operational issues that emerged from the current study include the effect of the new organizational structure on deployment functions, a description of the organizational culture of a contingency base or deployment setting, and the influence of the organizational culture on practice and decision making.

Because there are numerous opportunities for joint force deployment, studies should be conducted to look at the experiences, processes and culture of joint force operations. Further studies could identify similarities and differences in the cultures of the army, navy and air force, and identify and describe the integration process among the guard, reserve and active duty forces.

Multinational and multicultural issues that could be addressed are perspectives in global health care, the influence of culture on ethical

recommendations, and cultural interpretation of human responses to health and illness.

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Appendix A
Air Force Approval Letter

DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE

MEMORANDUM FOR COLONEL MARTHA TURNER
AFIT/University of Minnesota
651 Bridle Ridge Road
Eagan, MN 55123

5 Feb 97

FROM: HQ USAF/SGX
110 Luke Avenue, Room 400
Bolling AFB DC 20332-7050

SUBJECT: Permission to Contact Air Force Nurses Deployed as Chief Nurses in Military Operations Other Than War (MOOTW) (Your Memo, 2 Jan 97)

I support your request to contact nurses deployed as chief nurses in MOOTW in order to study their experiences. You may also contact the Command Nurses for names of additional nurses who may be willing to participate. I agree with your comments concerning the necessity of this research. We can expect ongoing deployment taskings and your study could provide a foundation for an ongoing research program in medical readiness.

It's heartening to hear that you're attempting to tap into a valuable resource - lessons learned form our deployed members. I wish you well in your proposal to obtain funding from the Triservice Nursing Research Council for this endeavor. Thank you for the consideration of focusing your efforts on readiness. Despite the many challenges in our present Air Force Medical Service, readiness remains job one and our primary mission. Again, you have my total support. Please keep me posted on your efforts.

LINDA J. STIERLE, Brig Gen, USAF, NC
Director, Medical Readiness Doctrine &
Planning and Nursing Services
Office of the Surgeon General

cc: Command Nurses

Appendix B

IRB Approval Letter

UNIVERSITY OF MINNESOTA

Twin Cities Campus

Research Subjects' Protection Programs
Institutional Review Board: Human Subjects Committee (IRB)
Institutional Animal Care and Use Committee (IACUC)

Box 820
D528 Mayo Memorial Building
420 Delaware Street S.E.
Minneapolis, MN 55455-0392
612-626-5654
Fax: 612-626-6061
E-mail: irbiacuc@ortta.umn.edu

June 10, 1997

Dolores M. Turner
651 Bridle Ridge Road
Eagan, MN 55123

RE: Experience of Chief Nurses in Military Operations Other Than War

Human Subjects Code Number: **9706E00040**

Dear Ms. Turner:

The IRB: Human Subjects Committee determined that the referenced study is exempt from review under federal guidelines 45 CFR Part 46.101(b) category #2 SURVEYS/INTERVIEWS; STANDARDIZED EDUCATIONAL TESTS; OBSERVATION OF PUBLIC BEHAVIOR.

The code number above is assigned to your research. That number and the title of your study must be used in all communication with the IRB office.

Upon receipt of this letter, you may begin your research. If you have questions, please call the IRB office at (612) 626-5654.

The IRB wishes you success with this research.

Sincerely,

Carol Siegel
Executive Assistant

CS/map

CC: Patricia Crisham

Appendix C

Letter of Invitation to Participants

Date:

To:

From: Martha Turner, Colonel USAF NC

Subject: Participation in Research Study

1. You are invited to participate in a study of the experience of being a chief nurse in a military operation other than war. I hope to learn what the experience was like and what meaning it had for you. You were selected as a possible participant because you were deployed to _____.

I am a graduate student in a PhD program in nursing at the University of Minnesota. My advisor is Dr. Pat Crisham.

2. The purpose of the study is to gain an understanding of the experience of serving as chief nurse in military operations other than war. It is the first part of a program of research to identify the ethical concerns and problems of chief nurses and to describe the choices and decisions made by chief nurses. This study is important because it will help prepare others for future deployments and once deployed enable them to better understand the experience. From this understanding it is expected that they will be able to create a climate and contribute to a culture which will be supportive for the practice of moral and ethical nursing care.

3. If you decide to participate, I will interview you at a time and place that are convenient for you. The interview will be audiotaped. It will last from 1- 2 hours. These are examples of the questions I will ask:

What was it like to be the chief nurse in Cuba, Saudi, Bosnia etc.?
What kinds of challenges did you encounter?
Tell me about a difficult decision you had to make.
Tell me about a particularly meaningful experience.
Can you tell me more about that?
- what else was going on then?
- a patient issue?
- a staff issue?
- an issue with the executive team?

Tell me how you were feeling.
- the climate.
- any thoughts for next time?

Additionally, I will ask you to provide some demographic information such as rank at the time of deployment, jobs prior to the deployment, area of clinical specialty, level of education and field of study, age at the time of deployment, marital status, length of time on active duty. There are no risks or benefits to being in the study other than your contribution to this body of knowledge.

4. The records of this study will be kept private. In any sort of report to be published I will not include any information that will make it possible to identify you as a participant. Research records will be kept in a locked file, only I will have access to the files. The tapes will be erased within five years of completion of the study. Any other materials you may choose to share will be maintained in the locked file and returned to you at the completion of the analysis. The other people involved in this study who will have access to the data are a transcriptionist who will transcribe the audiotapes, my research advisor and a research expert who will review randomly selected samples of the data and results to assess accuracy of the results. Confidentiality will be assured by assigning a number to your transcript and dropping all names of individuals you may refer to during the interview.

5. Your decision whether or not to participate will not affect your status or relationship with the University or the U.S.A.F. If you decide to participate, you are free to withdraw at any time without affecting those relationships or your status.

6. Contacts and Questions. The researcher conducting this study is Col. Martha Turner. You may ask any questions you may have now or later by contacting me at (612) 405-9692. You may also contact my advisor Dr. Pat Crisham at (612) 624-2972.

Dolores M. H. Turner
Colonel, USAF NC

Appendix D
Consent Form

You are invited to participate in a study of the experience of being a chief nurse in a military operation other than war. I hope to learn what the experience was like and what meaning it had for you. You were selected as a possible participant in this study because you were deployed as a chief nurse to _____.

I ask that you read this form and ask any questions you may have before agreeing to be in the study. This study is being conducted by Col. Martha Turner, USAF, NC; Graduate Student, PhD Program, University of Minnesota. Her Advisor is Dr. Pat Crisham.

Background Information. The purpose of the study is to gain an understanding of the experience of serving as chief nurse in military operations other than war. It is the first part of a program of research to identify the ethical concerns and problems of chief nurses and to describe the choices and decisions made by chief nurses. This study is important because it will help prepare others for future deployments and once deployed enable them to better understand the experience. From this understanding it is expected that they will be able to create a climate and contribute to a culture which will be supportive for the practice of moral and ethical nursing care.

Procedures. If you decide to participate, I will interview you at a time and place that are convenient for you. The interview will be audiotaped. It will last from 1- 2 hours. These are examples of the questions I will ask:

What was it like to be the chief nurse in Cuba, Saudi, Bosnia etc.?
What kinds of challenges did you encounter?
Tell me about a difficult decision you had to make.
Tell me about a particularly meaningful experience.
Can you tell me more about that?
- what else was going on then?
- a patient issue?
- a staff issue?
- an issue with the executive team?

Tell me how you were feeling.
- the climate.
- any thoughts for next time?

Additionally, I will ask you to provide some demographic information such as rank at the time of deployment, jobs prior to the deployment, area of clinical specialty, level of education and field of study, age at the time of deployment, marital status, length of time on active duty.
There are no risks or benefits to being in the study other than your contribution to this body of knowledge.

Confidentiality. The records of this study will be kept private. In any sort of report to

be published I will not include any information that will make it possible to identify you as a participant. Research records will be kept in a locked file, only I will have access to the files. The tapes will be erased within five years of completion of the study. Any other materials you may choose to share will be maintained in the locked file and returned to you at the completion of the analysis.The other people involved in this study who will have access to the data are a transcriptionist who will transcribe the audiotapes, my research advisor and a research expert who will review randomly selected samples of the data and results to assess accuracy of the results. Confidentiality will be assured by assigning a number to your transcript and dropping all names of individuals you may refer to during the interview.

Voluntary Nature of the Study. Your decision whether or not to participate will not affect your status or relationship with the University or the U.S.A.F. If you decide to participate, you are free to withdraw at any time without affecting those relationships or your status.

Contacts and Questions. The researcher conducting this study is Col. Martha Turner. You may ask any questions you may have now or later by contacting me at 612-405-9692. You may also contact my advisor Dr. Pat Crisham at (612) 624-2972. You will be given a copy of this form to keep for your records.

Statement of consent

I have read the above information. I have asked questions and received answers. I consent to participate in the study.

I would / would not like a summary of the final results.

SIGNATURE:

DATE:

SIGNATURE OF THE INVESTIGATOR:

DATE:

Appendix E
Demographic Data Form

Date:

Name:

Current rank:

Site of deployment:

Dates of deployment:

Job title during deployment

At the date of deployment what was your

- Age?
- Rank?
- Length of time on active duty?
- Job experience?

- Years in nursing?
- Area of clinical specialty?
- Level of education and field of study?
- Family status / deployment planning?

Appendix F
Followup Letter

Dear

Thank you for participating in my research project “The experience of chief nurses in military operations other than war.” Enclosed is a preliminary summary of the findings. The findings are presented as a comprehensive description which includes the fundamental structure of the experience and the essential themes. Also enclosed are tables of themes and a discussion of the findings. I welcome your comments, specifically on the extent to which the description/findings reflect your experience. I have enclosed some materials for mailing your response or you may use e-mail or phone.

Again, thank you for reviewing the findings and for participating in the study.

Martha Turner

651 Bridle Ridge Rd., Eagan, MN 55123
(612) 405-9692
turn0127@tc.umn.edu