

**Shipboard Nursing on Aircraft Carriers:
The Lived Experience of Twelve Navy Nurses**

**A dissertation submitted in partial fulfillment of the requirements for the degree of
Doctor of Philosophy at George Mason University.**

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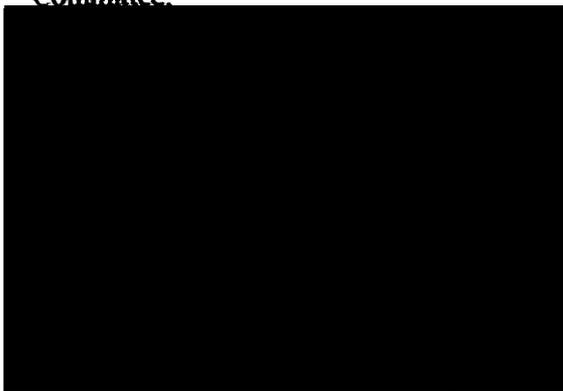
**SHIPBOARD NURSING ON AIRCRAFT CARRIERS:
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Catherine Wilson Cox

A Dissertation
Submitted to the
Faculty of the College of Nursing and Health Science
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of
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Fairfax, Virginia

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Dedication

Firstly, I dedicate this dissertation to the twelve exceptional Navy nurses I interviewed for this study. I wish I could tell you their names because if you were to cross paths with them, you would be the first to say: "A job well done!"

I also dedicate this dissertation to my family because without their love and support, I would never have come this far. My husband, Gerry, pushed me to pursue my dream of becoming a scholar despite the fact that he spent many nights and weekends as a "George Mason Widower" (his expression). I thank my children, Alexander and Caroline, for sharing their mother with George Mason University and I am grateful for the occasions when they enticed me away from the computer. I thank my parents, Shirley N. Wilson and Henry O. Wilson, for never allowing me to think that I could not achieve the impossible. Also, I owe my mother enormous gratitude for looking after my children on countless occasions during my studies – who could ask for anything better than having your children loved and cared for by your own mother! And finally, I dedicate this dissertation to my brother and his family, my sisters, my grandmother, my aunt, my mother-in-law, and my brothers-in-law and their families for always expressing interest in how my research was going and for giving me encouragement when I needed it most. I would be nothing without my family!

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Lastly, I would like to note that the information, content, or conclusions expressed in this dissertation do not necessarily represent the official position or policy of, nor should any official endorsement be inferred by, the TSNRP, USUHS, the Department of the Navy, the Department of Defense, or the U.S. Government.

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ABSTRACT

SHIPBOARD NURSING ON AIRCRAFT CARRIERS: THE LIVED EXPERIENCE OF TWELVE NAVY NURSES.

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George Mason University, 2001

Dissertation Director: Dr. Jeanne M. Sorrell

The purpose of this study was to describe the lived experience of shipboard nursing on aircraft carriers. As of Spring 2001, the Navy had twelve aircraft carriers in operation. Each carrier's medical department includes just one Navy nurse assigned to directly care for over 5,500 personnel. Currently, there is no research that describes what it is like to be the only nurse available to a patient population in the thousands. Using the principles of phenomenology, twelve Navy nurses previously stationed aboard aircraft carriers were interviewed to explore their experience as ships' nurses. Six of the participants were female and six were male. The participants were asked: "What was your experience as a nurse on an aircraft carrier?" Husserlian phenomenology provided the theoretical framework for this study and Streubert's methodological approach was chosen to analyze the phenomena. The primary data collection strategy was the use of tape-recorded, in-person interviews. Prior to the start of the formal interview, informed consent was

documented and demographic data were obtained in order to fully place the data into context. The interviews were conducted until data saturation occurred and were transcribed prior to data analysis. Organization of the data was supported by the use of a computer program entitled NVivo. All twelve of the participants verified the formalized, exhaustive description of the phenomenon and after some minor changes, they agreed that it accurately reflected their experience as the ship's nurse on each aircraft carrier. Shipboard nursing on aircraft carriers was best described by the following essences: experiencing the best but toughest job the Navy has to offer its nurses; ensuring operational readiness; being one-of-one; operating constantly in an environment of uncertainty; having two families; and making the job better for the next generation. The findings of this study have implications for operational readiness and will assist Navy Nurse Corps administrators with making appropriate assignments for nurses seeking these carrier assignments. Finally, since there is a paucity of literature on this topic, the results have given a public voice to this extraordinary experience of military nursing.

CHAPTER 1

Introduction

The purpose of this phenomenological study was to describe the lived experience of shipboard nursing on aircraft carriers. As of Spring 2001, the Navy had 12 aircraft carriers in operation. Each carrier's medical department included just one Navy nurse assigned to directly care for over 5,500 personnel. There was no current research that described what it was like to be the only nurse available to a patient population of several thousand on a ship; therefore, 12 Navy nurses previously stationed aboard aircraft carriers were interviewed to explore their experience as ships' nurses. The question guiding this inquiry was: "What is the experience of the ship's nurse on an aircraft carrier?"

This chapter includes the following sections: (a) the background and significance of the study, (b) phenomenological inquiry, (c) definition of terms, and (d) the chapter summary.

Background and Significance of the Study

Aircraft carriers are deployed worldwide in support of the United States' (U.S.) interests and commitments. They can respond to worldwide crises in ways ranging from peacetime presence to a full-scale war. In fact, the Navy's surface forces are built around battle groups with aircraft carriers as the centerpieces. Frequently the focal point of U.S. military, diplomatic, and geopolitical strategy, aircraft carriers represent the cornerstone of

Navy operational readiness. Each aircraft carrier is as tall as a 24-story building; weighs approximately 97,000 tons; contains over 2,700 compartments and a flight deck over four and one-half acres in area; and carries a crew of 5,000–6,000 (Cooke, 1997). An aircraft carrier has an airport control tower; holds over 80 aircraft; and features a movie theater, television station, library, chapel, gym, and medical and dental wards. The significance of studying shipboard nursing on these floating cities is that each ship's nurse has enormous potential to impact the health care of the carrier's crew and the operational readiness of both the ship and its battle group.

There being only one nurse assigned to each aircraft carrier brings to mind several questions: What is it like? What can one learn about this type of operational nursing practice? Do these nurses think that they were prepared for this role? If not, should the Navy provide special training prior to assigning nurses to these jobs? What are the nurses' experiences with treating, holding, transporting, and evacuating patients aboard aircraft carriers? Do Navy nurses make a difference in the health outcomes of the patients stationed on aircraft carriers? Given the integration of women on board Navy ships, what is the experience of aircraft carrier nurses with women's health issues?

This study could not build on previous research because the phenomenon of interest – nurses' experiences while stationed on aircraft carriers – had never before been explored, analyzed, or described in the literature. Because there is absolutely no research-based information available on shipboard nursing on aircraft carriers, the findings of this study provide valuable insight into nursing practice in a service unique environment and describe issues related to operational readiness. The findings may also assist Navy Nurse Corps

administrators with making appropriate assignments for nurses seeking these carrier job positions (billets). Finally, since there is a paucity of literature on this topic, the results give a public voice to this extraordinary experience of military nursing.

The significance of studying the phenomenon of nurses' experiences while stationed aboard aircraft carriers came to mind during several social conversations I had with nurses previously assigned to aircraft carriers. Some of these nurses shared a desire to be more senior (at least an O-4 or O-5) for this type of tour. They also voiced a desire to have personnel management classes prior to assuming this duty because they found that their role changed from critical care nurses to division officers immediately after they transitioned to the aircraft carrier. Those stationed aboard nuclear-powered aircraft carriers wished they had more radiation safety preparation prior to reporting to this assignment. Finally, at least one spoke of the need to increase the billets of nurses aboard aircraft carriers from more than one because the demand for directing quality nursing care to over 5,500 shipmates was an impossible goal for just one nurse. To determine whether these comments were representative of shipboard nursing aboard aircraft carriers, 12 former aircraft carrier nurses were interviewed in order to identify their lived experience in this role.

Prior to data collection, the Navy Specialty Leader for Operational Nursing was contacted to ascertain what life was like for nurses on aircraft carriers. Commander C. McLarnon (personal communication, August 6, 1999) wrote that a typical day entailed supervising inpatient care, conducting training, attending planning meetings, setting up and executing medical training drills, and conducting quality improvement activities. The

ship's nurse did not have any direct subordinates except for the corpsmen who were assigned to the inpatient ward when the aircraft carrier was underway. He or she also coordinated the Medical Training Team (MTT). When the ship was underway, the ship's nurse was on-call 24-hours a day, seven days a week (24/7). Unlike the six or seven medical officers who shared call and had duty every six or seven days, the nurse was always on-duty. If there was a critically ill patient on the inpatient ward, the nurse handed the patient over to one of the medical officers for a short sleep break, but other than that, it was up to the ship's nurse to provide nursing care to that patient. Many carrier nurses reported shifts of 18-to-20-hours for several days at a time when providing critical care nursing. Additionally, since the carriers did not have respiratory technicians, the nurse was usually the resident expert on ventilator operations. Also, some nurses had to leave the carrier for one to five days at a time in order to provide nursing care to critically ill patients during medical evacuations. During these occasions, nursing coverage to the aircraft carrier or carrier battle group was interrupted until the nurse returned. As for other inpatient care, the corpsmen performed most of the duties. The corpsmen also conducted most of the training throughout the ship; however, the ship's nurse was ultimately responsible for all training exercises.

The qualifications for the ship's nurse were as follows:

1. Preferably a senior lieutenant (O-3) or lieutenant commander (O-4)
2. Completed at least two tours of duty
3. Two years of critical care experience
4. Certified in Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS)
5. Some teaching experience (e.g., as a BLS or ACLS instructor)

6. Some administrative experience (e.g., as a division officer) as well as other collateral duties such as quality improvement activities
7. Possessed a strong performance record that demonstrated good leadership and interpersonal skills
8. Met physical fitness standards

Regarding what day-to-day life is like on an aircraft carrier, U.S. News & World Report (The Big, Mean War Machine, 1994) did a cover story on a six-month deployment with the USS America. The article portrayed life at sea as a hardship. Sailors were separated from their family members for unreasonable periods of time. Many started distancing themselves from their families weeks before departure in an attempt to make leaving easier. "They know that while they are gone, babies will be born, parents will die, Christmas and Thanksgiving will come and go, cars will break down and wives will give up on Navy life and leave their absent husbands" (p.31). During the timeframe of the article, 85 wives gave birth at home while their spouses were at sea. The one thought that helped these new fathers at sea was the Navy tradition of allowing them to be the first off the ship upon homecoming. Life was hard for those who spent the deployment beneath the flight deck – away from fresh air and sunlight. There were no portholes and the spaces were claustrophobic. A week could go by before a sailor even attempted to climb the steep ladders to the flight deck to get a breath of fresh air. The galley's menu served as a calendar to some (e.g., pizza for dinner so it must be Friday). After an arduous six months at sea, the transition to home began with Navy counseling teams joining the carrier to remind the crew that their loved ones had changed and had grown independent since they left port. The crew was reminded that they needed to learn to be fathers and husbands

again. For this deployment, the America lost no sailors at sea. However, two sailors went on to die in a late-night automobile accident on the day the ship returned home.

An exploratory review of the literature regarding nursing practice in service unique environments (which included several non-fiction military nursing books, various military Internet websites, and over 90 military nursing journal articles) revealed the following themes (in no particular order):

- Operational readiness
- Hardship and emotional pain
- Battle fatigue
- Austere environment
- Flexibility/Adaptability/Improvisation
- Humor
- Camaraderie
- Pride and patriotism
- Paraprofessionals
- Remembrance of special patients
- Job satisfaction
- Role expectations, conflict, and stress

Only one article had a discussion regarding what it was like to be a nurse on an aircraft carrier (Poyner, 1992). Poyner's article described some of the duties involved with being a shipboard nurse; however, the article was devoid of a majority of the themes discovered in the exploratory literature review.

This study was consistent with the Navy Nurse Corps' Strategic Plan. The Plan's Mission stated that the "Nurse Corps actively supports the Navy and Marine Corps Team and Navy Medicine with a community of active and reserve component professionals focused on accomplishing the readiness and health benefit missions," (Nurse Corps Strategic Plan, 2000, p. 1). Its Scope of Nursing Practice read as follows:

Navy nursing is unique in its responsibility for professional nursing care in peacetime and wartime. Nurse Corps officers share an historical camaraderie of caring for others under ordinary, extraordinary, and often unusual circumstances. As professional registered nurses, they voluntarily assume an additional role as Naval officers which mandates the successful integration of compassion with discipline, individuality with conformity, and wellness promotion with wartime readiness. As collaborative participants on the health care team, they freely share nursing expertise to accomplish the health services mission. Navy nurses are life-long learners, dedicated to pursuing quality education and training to foster personal and professional excellence. Leadership is every Nurse Corps officer's responsibility. As role models and mentors for other nurses and Hospital Corpsmen, Navy nurses must apply their experience, education, and training to be both military and nursing leaders. (p. 1)

The goals of the Navy Nurse Corps' Strategic Plan pertained to the qualifications of leadership, operational readiness, and professional nursing practice. Because aircraft carrier nurses incorporated all three of these characteristics into their job, this study supported the goals of the Navy Nurse Corps.

Phenomenological Inquiry

This phenomenological inquiry was grounded in Edmund Husserl's perspectives. Husserl proposed a number of steps, most notably epochè, as well as a number of methodological devices (e.g., intentionality, phenomenological and eidetic reduction, and intuiting) in order to isolate the central essential features of the phenomena under study (Moran, 2000). The goal of Husserlian phenomenology is to describe the meaning of an experience from the standpoint of those who have had (or "lived") that experience (Cohen & Omery, 1994). Because Husserl emphasized pure description, rather than finding hidden meaning, and the goal of this endeavor was to describe the lived experience of shipboard nursing on aircraft carriers, his phenomenological philosophy was selected to provide the theoretical framework guiding this inquiry.

Definition of Terms

Billet is the Navy term that characterizes a job position. A famous Navy saying is: “no billet, no body” meaning if there is no official job position (or “billet”), then the spot will not be filled (with a “body”).

Carrier Battle Group consists of warships that operate in concert with the aircraft carriers while deployed at sea.

The Commanding Officer (CO) is the Line officer in actual command of the ship. Regardless of the CO’s rank, he or she is always referred to as “Captain.” Although absolute responsibility for the safety of the ship and the ship’s crew ultimately lies with the CO, in actuality the CO delegates the duties of the ship to the Executive Officer (XO), department heads, and the Officer of the Deck (OOD) (Wedertz, 1978). Another nickname for the CO is “Skipper.”

The Executive Officer (XO) is the Line officer next in rank to the CO. All matters related to the crew, customs, and discipline of the ship fall to the XO. Any orders issued by the XO carry the same weight as those issued by the CO. If anything were to happen to the CO, then the XO takes control of the ship (Wedertz, 1978).

The Line Community consists of the war fighting community of the Navy such as the officers that man surface ships, fly aircraft, and operate submarines. The Line community is supported by the officers of the Staff Corps (which consists of nurses, physicians, dentists, allied health personnel, accountants, civil engineers, lawyers, and chaplains).

Medevac is an acronym for “medical evacuation” and involves transporting a patient to a source or site of definitive care (usually ashore).

Being One-of-One relates to the fact that Naval officers are evaluated by being compared to their peers. In a hospital setting, where there are many nurses, an individual nurse is ranked among a group of other nurses with similar seniority and experience (e.g., ranked number four of 15). On a ship, however, where there is only one nurse, the single nurse is typically ranked one-of-one.

Operational Nursing is defined as nursing outside of traditional Navy hospitals in support of Navy operations.

Operational Readiness is defined as “the ability to deploy personnel and equipment in an expeditious manner to any part of the world in support of military operations” (Tricarico, 1998, p. 41).

Underway occurs once the aircraft carrier is no longer docked to the pier and the ship becomes its own entity. This period may last from hours to days to even months at a time.

Part of the deployment cycle of an aircraft carrier is participating in Work-Ups. With work-ups, the carrier undergoes multiple testing phases to prepare the ship for potential combat.

Chapter Summary

This study describes the lived experience of shipboard nursing on aircraft carriers. In this chapter, the background and significance of the study, phenomenological inquiry, and definition of terms were identified and described. Chapter II contains the review of literature relevant to this study.

CHAPTER II

Review of the Literature

The purpose of this study was to describe the lived experience of shipboard nursing on aircraft carriers. To accomplish this purpose, phenomenological philosophy and methodology were used to discover and gain insight into nursing on aircraft carriers. An exploratory review of literature is as follows: (a) nursing practice in service unique environments (b) aircraft carriers, and (c) phenomenological inquiry.

Nursing Practice in Service Unique Environments

A search of CINAHL, MEDLINE, and INFOTRAC, revealed no articles regarding nursing on aircraft carriers. Eventually, one such article (Poyner, 1992), which was not in any major computer database, was subsequently discovered and is discussed in this chapter. Therefore, the scope of the search was broadened to include all military nursing articles regarding nursing practice in service unique environments. This search disclosed that most military nursing articles fell into various categories: military nursing history; nursing during armed conflict (e.g., World War II, Vietnam, and Desert Shield/Storm); nursing during humanitarian missions; military nursing job satisfaction; military nursing practice models; military nursing recruitment articles; and miscellaneous topics (e.g., interviews with military nurses regarding their jobs or about their programs). None of these categories could be ignored so any article thought to reveal facts, thoughts, or

themes that could relate to being the ship's nurse on an aircraft carrier were evaluated. Eventually, several non-fiction military nursing books, various military Internet websites, and over 90 military nursing journal articles were deemed fitting and reviewed for this section. Incidentally, of the 90-plus military nursing journal articles reviewed for this inquiry, less than 20 were research studies (i.e., Dahl & O'Neal, 1993; Kennedy, 1984; LaRocco, Tetrick, & Meder, 1989; Maloney, Anderson, Gladd, Brown, & Hardy, 1996; McNulty 1994; McRae-Bergeron, May, Foulks, Sisk, Chamings, & Clark, 1999; Means-Markwell, Hawkins, Reichow, Gaglione, Holmboe, Malone, & Hyams, 1997; Puksta, 1995; Reineck, 1999; Robinson, Rodriguez, Sammons, & Keim, 1993; Savage, Simms, Williams, & Erbin-Roesemann, 1993; Scannell-Desch, 1996, 1999; Shusarcick, Ursano, Fullerton, & Dinneen, 1999a/1999b; Stanton-Bandiero, 1998; Stanton, Dittmar, Jezewski, & Dickerson, 1996; and Yoder, 1995).

The exploratory review of the literature regarding nursing practice in service unique environments revealed the following themes (in no particular order) and are discussed below:

- Operational readiness
- Hardship and emotional pain
- Battle fatigue
- Austere environment
- Flexibility/Adaptability/Improvisation
- Humor
- Camaraderie
- Pride and patriotism
- Paraprofessionals
- Remembrance of special patients
- Job satisfaction
- Role expectations, conflict, and stress

Operational Readiness

Operational readiness, including a soldier's individual readiness for deployment, was reported in the literature. Tricarico (1998) defined readiness as "the ability to deploy personnel and equipment in an expeditious manner to any part of the world in support of military operations" (p. 41). The concepts of readiness and training go hand-in-hand – nurses need to be trained to respond to the unique aspects of nursing when deployed. Stanton-Bandiero's (1998) study of nurse veterans from World War II, Korea, Vietnam, and Operation Desert Shield/Storm found that eighty-percent of the nurses surveyed felt that their training prior to deployment was inadequate. The majority of nurses in this study recommended that deployment training address leadership, critical decision-making, and field expedient methods for clinical intervention.

Fessler's (1996) book contained interviews from WWII military nurses. One of Fessler's participants commented on the lack of training received when caring for the soldiers in the Bataan Death March:

When I look back, we did things I never knew I could do and had experiences I never expected to have. Our training never included that kind of treatment. I wouldn't want to do that over again. (p. 55)

Scannell-Desch (1996) interviewed 24 nurses who served in the Vietnam War and discovered that their advice for the next generation of military nurses was for operational training to be intensive, realistic, and focused on trauma care without the use of sophisticated equipment. Scannell-Desch (1999) recommended that the training of military nurses emphasize lessons learned from past wars and disasters. Norman's (1990) Vietnam nurses cautioned the next generation to be prepared – that war is no game.

This advice was echoed in Reineck's (1999) article where Reineck discussed how operational nursing differed from traditional nursing. In the operational setting:

- The nursing role switched from being a specialist to becoming a generalist
- The technology changed from high to low
- The equipment tended to be manual versus automated
- The clinical nursing scenarios became much more diversified
- The environment tended to be austere
- The need for flexibility was heightened
- Nurses needed to be prepared to deal with confusion, psychological pressure, and stress in a chemical and biological warfare environment

Reineck's focus groups defined individual readiness as a "dynamic concept with dimensions at the individual, group, and systems levels, which, together, influence one's ability to accomplish the mission" (p. 253). The focus groups then identified six interrelated components of individual readiness and their corresponding ideas as being:

1. Clinical nursing competency – included technical skills as well as physical assessment skills and trauma/triage skills
2. Operational competency – related to the ability to use skills in an operational environment
3. Survival skills – encompassed familiarization with weapons, tactical proficiency, and knowing how to live safely in the operational environment
4. Personal/psychosocial/physical readiness – involved courage, commitment, and integrity. Nurses need to have a healthy mindset and they need to possess the stamina to perform physical work in a hard environment
5. Leadership and administrative support – linked leadership with providing a favorable command climate
6. Group integration and identification – promoted teamwork

Reineck believed that the resolution of these six components was necessary to achieve and maintain readiness when providing nursing care in the operational setting. Other authors also discussed the need for operational readiness regarding humanitarian missions (Baker & Ryals, 1999; Samuels, 1997; Smith & Smith, 1995; Vermillion, 1996); air combat

command medical personnel (McRae-Bergeron et al., 1999); and the air transportable hospital (Tricarico, 1998).

Hardship and Emotional Pain

The theme of hardship and/or emotional pain was evident in the reviewed articles. One had to learn to endure hardships when placed in the operational setting (Fessler, 1996; Forster, 1996; Ganas, 1994; McRae-Bergeron et al., 1999; Norman, 1990; Reineck, 1999; Sterner, 1997; West & Clark, 1995). Emotional sequelae of catastrophic events experienced in the operational setting can leave one with a lifetime of painful memories (Barzoloski-O'Connor, 1998; Scannell-Desch, 1999; Stanton et al., 1996). One of the respondents in Scannell-Desch's (1996) study cautioned:

I think when you join the military, you must join with full knowledge that it is a 24 hour-a-day job and if there is a war, you can be called for that. We didn't join because we wanted a nice 7-to-3 job, and, of course, it may involve making the ultimate sacrifice, your life. (p. 122)

Battle Fatigue

Battle fatigue is a term used to describe the negative responses that can arise from stress in the operational setting (usually combat). It is a normal reaction to an abnormal event. The signs and symptoms include:

- Profound personality change
- Hypervigilance
- Fearfulness
- Anxiety
- Irritability
- Grieving
- Loss of confidence
- Loss of faith
- Fatalism

- Depression
- Insomnia
- Psychosis induced by lost sleep
- Exhaustion
- Apathy
- Loss of skills
- Impaired speech
- Misconduct in combat (e.g., drug and alcohol abuse) (Worthington & Titus, 1995, p. 22)

These symptoms may occur in those nurses who work long hours, with no free time, under uncomfortable and dangerous situations (Gianas, 1994; Hale, 1998; Hale & Collins, 1995; Reineck, 1998; Shusarcick et al., 1999a; Stanton et al., 1996; Vermillion, 1996; Wise, 1998; Zdrodowski, Dekker, & Vogelsang-Watson, 1996). The treatment for battle fatigue is rest.

Austere Environment

Working in austere environments was mentioned in a number of articles. Stanton-Bandiero's (1998) respondents felt that military nurses needed to learn how to cope with the austerity of the military combat environment (e.g., even performing simple hygiene measures is complicated in this type of setting). West and Clark (1995) conducted 90 oral history interviews of personnel who served on a humanitarian mission in Somalia in 1992 – Operation Hope. The authors wrote that the deployed personnel had to adapt to difficult living conditions including filth and blowing sand. Other authors said that military nurses needed to realize that operational nursing may not occur in ideal circumstances and that nurses need to be prepared for this (Barzoloski-O'Connor, 1998; Hale, 1998; Hale & Collins, 1995; May, 1996; Reineck, 1999; Stanton-Bandiero, 1998; Stanton et al., 1996).

Flexibility/Adaptability/Improvisation

Having a flexible attitude, being willing to do new things, and being adaptable to changing situations are important deployment strategies, especially in austere environments (Reineck, 1999). Jonas' (1991) Gulf War nurses used improvisation to get around shortages and limitations (e.g., utilizing tent boxes as work tables and making their own 12-lead EKG tracings – because they lacked a 12-lead EKG machine – by manually moving the V-lead on their cardiac monitor for each lead). Scannell-Desch's (1996) Vietnam War nurses learned to make do with whatever equipment they had available to them. Zdrodowski's et al. (1996) humanitarian nurses had to adapt their operating room equipment for even the simplest procedures. Forster's (1996) mission to Haiti had a rough start when the nurses realized they had no toilet facilities; whereupon, they used empty milk cartons as latrines. Other authors also addressed this subject matter in their articles (Barzoloski-O'Connor, 1998; Scannell-Desch, 1999; Smith & Smith, 1995; Stanton-Bandiero, 1998; Stanton et al., 1996; Stowe, 1992).

Humor

Humor was a coping strategy that emerged in some of the articles (Dahl & O'Neal, 1993; Scannell-Desch, 1999; Smith, 1993; Stanton et al., 1996). Hale & Collins (1995) wrote: "The ability to find and create humor in the frustrations and absurdities and willingness to laugh at oneself are vital" (p. 94).

Camaraderie

Another theme reported in the literature was camaraderie. Operational nursing breeds camaraderie whether it involves flight nursing (Brannon, 1998); nursing during periods of

armed conflict (Armstrong & Unkle, 1992; Barzoloski-O'Connor, 1998; Bennett, 1991; Fessler, 1996; Gianas, 1994; Hale, 1998; Hoogendorn, 1991; Kelly, 1991; Norman, 1990; Scannell-Desch, 1996, 1998; Stanton-Bandiero, 1998; Stanton et al., 1996; Sterner, 1997); nursing during humanitarian missions (Zdrodowski, et al., 1996); and general military nursing (Fillion, 1991; Vescovi, 1998). Dahl and O'Neal (1993) and Gardner (1991) felt that a strong sense of camaraderie led to decreased stress in their combat support hospitals. One nurse in Fessler's (1996) book commented on the sense of family this participant experienced when working with nurses while taking care of prisoners released from Camp Dachau at the end of WWII:

We both realized we would not be seeing each one another again, and it was sad to leave people who had become as close as members of my family. (p. 190)

Pride and Patriotism

A sense of pride and patriotism was reflected in articles written by military nurses regarding deployments during the Vietnam War (Scannell-Desch, 1996; Wise, 1998); Desert Shield/Storm (Duval, 1991; Galvin, 1991; Kennison, 1991; May, 1996; Mefini, 1991; Thornton, 1991; Worthington & Titus, 1995); Hurricane Andrew (Krause, 1993); Somalia (Early, Drost, Lomax, & Kutzner, 1994); Haiti (Forster, 1996); and the Korean airline crash (Topley, 1998). Despite many hardships, these nurses (including the nurses who returned home from the Vietnam War and were ostracized by the American public) felt an enormous sense of pride and patriotism in providing service for their country.

Paraprofessionals

The military's use of paraprofessionals was considered in several articles. Barzoloski-O'Connor (1998) reported that one had to rely on delegation when there were too many duties for just one nurse to handle. Hale and Collins (1995) and Scannell-Desch (1999) cited the clinical expertise of paraprofessionals as being outstanding – both articles had discussions regarding the use of the team approach in the delivery of health care to troops in operational settings.

Remembrance of Special Patients

One theme noted during this review was the remembrance of special patients. Scannell-Desch's (1996, 1999) phenomenological study regarding Vietnam War nurses revealed relationships that were characterized by a deep bonding with patients. Barzoloski-O'Connor (1998), Fessler (1996), Ganas (1994), Mailey and Topley (1999), Norman (1990), and Sterner (1997) all discussed specific patients in their publications.

Job Satisfaction

A number of articles reflected different aspects of job satisfaction. LaRocco et al. (1989) compared the differences in perceptions of work environment, job attitudes, and health beliefs among military nurses, physicians, and dentists. The authors found that nurses reported the least amount of job satisfaction among the three groups. Robinson et al. (1993) compared perceptions of selected aspects of work life between military and civilian nurses and discovered that although the military nurses were pleased with their pay and fringe benefits, civilian nurses reported greater job satisfaction, peer cohesion.

supervisory support, decision making, autonomy, task orientation, and innovative opportunities.

Maloney et al. (1996) evaluated and compared the work environment of a large Army medical center to other military medical centers. The authors discovered that nurses in higher positions experienced a greater feeling of autonomy and support than did their subordinates. Also, men and women had similar perceptions regarding their work environment. Finally, the military facilities differed in their ratings of peer cohesion, supervisory support, sense of autonomy, supervisory support, and work pressure. The authors recommended that senior nurses be sensitive to the work environment and how it affects their staff's morale and job satisfaction. Yoder's (1995) study suggested that the perception of importance, as manifested by a "coach" taking an interest in one's professional life, favorably influenced job satisfaction.

Norman's (1990) nurses expressed job satisfaction when they experienced so much professional autonomy while serving in Vietnam. When returning to the United States (U.S.), they found that they could not professionally function the way they had in Vietnam. In Vietnam, their nursing skills had been appreciated. In the U.S., the nurses saw their role shift back to being a "handmaiden" (p. 128).

Puksta (1995) conducted a descriptive, correlational study among female Navy nurses in the age group of 40-60 years old. Puksta discovered that daily hassles (e.g., not enough time to do things, too many things to do, troubling thoughts about the future, concerns about weight, too many responsibilities and interruptions, and the health of family members) and work-related hassles (e.g., concerns about retirement, too many meetings,

concerns about decision to change jobs, job satisfaction, and concerns about job security) were the most significant predictors of quality of life. McNulty (1994) also studied female Navy nurses. McNulty wanted to determine the prevalence of eating disorders and identify the factors that might predispose one to exhibit an eating disorder. The author found that eating disorders were widespread across all ages and ranks in the Navy Nurse Corps and that one of the variables that predicted eating disorders was job satisfaction.

Some Navy nurses were actually excited about their work environment (Savage et al., 1993). These nurses valued the variety, leadership and management experiences, and the opportunities for teaching and learning that Navy nursing had to offer. Puksta (1995) confirmed this by writing that the Navy Nurse Corps offered diversified opportunities that most of its members viewed as having a positive effect on their career. Savage et al. listed six points of frustration, which mimic some of Puksta's hassles, with Navy nursing:

- Understaffing
- Inappropriate staffing
- Not having enough time to accomplish work
- Lack of communication between physicians and nurses
- Lack of communication between nurses and administration
- Work not getting done that should be done (pp. 153-161)

Role Expectations, Conflict, and Stress

Role expectations and role conflict in military nursing was another theme mentioned in the literature. Adams (1988) wrote that a role included the expectations held for one's behavior when working in a particular position. Role conflict occurred when there were contradictory expectations for the role occupant's behavior. Adams reported that a military nurse (in this case, an Army clinical head nurse) held three roles: officer,

administrator, and registered nurse. The author advocated three recommendations for avoiding role conflict and stress:

1. Maintain clinical expertise
2. Become thoroughly familiar with the rationale for military policies and procedures
3. Develop a managerial theory and style from which to operate in [one's] organization (p. 50)

Austin (1993-1994), Dahl and O'Neal (1993), Kennedy (1984), and Shiffer (1990)

also addressed role conflict in their articles. Shiffer's essay was particularly important because Shiffer believed that the concept of being both a military and nursing leader might lead to role stress and strain. Shiffer reported information that pertained to the role of the Navy nurse as both an expert nursing practitioner and naval leader. Shiffer wrote:

The ultimate Navy nurse role would be described as the Nurse Corps officer who is known to be an expert nursing practitioner and simultaneously [meets] all role expectations as a naval leader. Unclear or inaccurate expectations regarding the traditional Navy Nurse role may originate from expectations of peers or superiors. Role stress and strain results when role expectations are not or cannot be met, which may lead to loss of commitment and professional values both as an officer and as a nurse. (p. 208)

Shiffer's article suggested that role stress and strain may occur in those nurses on board aircraft carriers because once they reported to these assignments, they were no longer hospital-based nurses. They were now division officers who no longer reported to a senior Nurse Corps officer but rather to their Senior Medical Officer (SMO) and, ultimately, the Commanding Officer (CO) of their ship. Therefore, they became part of the Navy Line community.

Miscellaneous: Persian Gulf Crisis

A number of articles were available regarding the Persian Gulf Crisis (perhaps because this event occurred within the last decade). In two of the articles, it was reported that women and men differed in their responses to life events, stress, and coping when deployed on the hospital ship – USNS Comfort – during Operation Desert Shield/Storm (Shusarcick et al., 1999a/1999b). Other articles reflected the stress of this event (Dahl & O’Neal, 1993); offered personal accounts of military nurses deployed during this time (Bennett, 1991; Bowdoin, 1991; Gardner, 1991; Hoogendorn, 1991; Jonas, 1991; Kelly, 1991; May, 1996; Rhoads, 1991); described the role of the nurse executive in an operational setting (Smith, 1993); or detailed the functioning of their respective organizations during the deployment (Armstrong & Unkle, 1992; Hale, 1998; Hale & Collins, 1995; Ochsner, 1992; Ochsner et al., 1992).

Stowe (1992) offered an optimistic formula for the successful deployment of Stowe’s nursing organization during the Persian Gulf Crisis:

- Maintain a positive attitude
- It is best if all of the nurses come from the same hospital/organization
- Provide a strong nursing education department which offers such topics as trauma support, handling mass casualties, and preparing for chemical and biological warfare
- Develop a departmental philosophy as soon as possible
- Select the right people for the job
- Foster a climate of command support
- Plan for the worst case and be flexible (pp. 49-53)

In summary, the exploratory review of the literature regarding nursing practice in service unique environments revealed themes that could relate to being the ship's nurse on an aircraft carrier. In the next section, an overview of aircraft carriers is presented.

Aircraft Carriers

When the scope of the literature review was expanded, over a dozen articles that reflected aircraft carriers were found (and are discussed below). During the last 75 years, the Navy's ability to launch and land aircraft at sea has been a powerful aspect of American foreign policy. Currently, there are 12 aircraft carriers in operation. These aircraft carriers are defined by their class and are either nuclear-powered (CVN) or not (CV). The Nimitz-class carriers are the largest warships in the world and they consist of the:

1. USS Nimitz (CVN 68), homeported in Norfolk, VA
2. USS Dwight D. Eisenhower (CVN 69), homeported in Norfolk, VA
3. USS Carl Vinson (CVN 70), homeported in Bremerton, WA
4. USS Theodore Roosevelt (CVN 71), homeported in Norfolk, VA
5. USS Abraham Lincoln (CVN 72), homeported in Everett, WA
6. USS George Washington (CVN 73), homeported in Norfolk, VA
7. USS John C. Stennis (CVN 74), homeported in San Diego, CA
8. USS Harry S. Truman (CVN 75), homeported in Norfolk, VA (Public Affairs Office, 2000)

The Enterprise-class carrier is also nuclear-powered. However, it requires eight nuclear reactors as opposed to the two of the Nimitz-class carriers (Public Affairs Office, 2000). The lone Enterprise-class carrier is the USS Enterprise (CVN 65) and it is homeported in Norfolk, VA.

The John F. Kennedy-class carrier also consists of just one carrier: the USS John F. Kennedy (CV 67), which is homeported in Mayport, FL. The last two carriers are Kitty

Hawk-class carriers: the USS Kitty Hawk (CV 63), homeported in Yokosuka, Japan, and the USS Constellation (CV 64), homeported in San Diego, CA. The main difference that distinguishes the last three non-nuclear aircraft carriers is the composition of their power plants (Public Affairs Office, 2000). Incidentally, one of the existing carriers will be retired once the Nimitz-class USS Ronald Reagan (CVN 76) is fully operational.

CVN 77 (still unnamed and currently being built in Newport News, VA) will be the last Nimitz-class carrier to be constructed. In 2006, a new line of aircraft carriers, known as the CVX-class, will go into production. A debate continues as to the final shape and design of the new carrier model; however, several factors will be taken into account during the building of the CVX-class. Because the average cost of building a Nimitz-class carrier is about four billion dollars, and it costs two billion dollars a year to operate, one thought is to build a smaller ship. Thus, the Navy is looking to downsize the 5500-man crews of Nimitz-class ships by increasing its use of automation. For example, an automated bomb-handling system would replace nine sailors with just one to accomplish the job. A study by a nonprofit think tank estimated that if the personnel on an aircraft carrier were reduced by 1,500 sailors, the Navy could operate 15 carriers at the current cost of operating 12 (Jaffe & Ricks, 1999). Incidentally, the sticker price for an aircraft carrier does not include the 80-100 seagoing aircraft, or the escort destroyers, cruisers, and long-range supply ships that must accompany the carrier when deployed (which drives the cost of a carrier from four to ten billion dollars) (Wilson, 1998; Wright, 1996).

Another anticipated change is making the ships last longer. The current aircraft carriers can last 30-50 years. The CVX-class is being designed for a 55-year life span.

Another concept being explored is the elimination of nuclear reactors in the power plants. The alternative to nuclear power may be advanced turbine-electric power plants that drive super-conducting motors (Wilson, 1998). Finally, the obsolescence of aircraft carriers will constantly be debated because they are vulnerable to long-range missiles, are less effective than amphibious assault ships, and with the collapse of the Soviet Union in 1991, "there is simply no blue-water enemy to sink" (Wilson, p. 59). However, from a self-interest standpoint, it would be difficult for Congress to reject a proposed aircraft carrier because it is "90,000 tons of prime pork. The things take forever to build, and subcontractors in at least 40 states get fat slices of the action" (Wright, 1996, p. 44).

What does an aircraft carrier consist of? Cooke (1997) described the USS John C. Stennis as weighing over 97,000 tons, having over 2,700 compartments, and containing a flight deck that is over four and one-half acres. It is manned by a crew of 6,000 and its height is equivalent to a 24-story building. It is powered by two nuclear reactors and carries an air-wing of over 80 fighters and other aircraft. The hangar deck offers such sports as weight lifting, jogging, and basketball. Television sets are located in both the workspaces and the sleeping areas. Meals are offered four times a day and the ship's stores sell snacks and other goods in between meals. Smoking is allowed in a small number of designated areas but alcohol consumption is prohibited. Pollock (1992) wrote that the USS George Washington is an American city at sea because it has a hospital, a barber, a daily newspaper, and a 3,200-book library that is hooked up to over 250 shipboard computers.

Medical Department

How is the medical department staffed on an aircraft carrier? Bohnker (1995) wrote that it is composed of six physicians, a physician's assistant, a registered nurse, and 40 enlisted hospital corpsmen. There is one operating room, a 3-bed intensive care unit, a 50-bed inpatient ward, other patient care areas, and other ancillary spaces that provide radiography and endoscopy services.

Bohnker (1995) also reported results from a one-year study whereby the medical department was called upon to support a broad spectrum of medical care for 260 days while the ship was underway (during work-ups and an extended Mediterranean deployment). The average length of stay, for 417 ward admissions, was 3.1 days. Bohnker admitted that the criteria for admission was less than that for a shore-based admission given that a lot of the patients had nutrition, hygiene, and rest requirements not guaranteed by their sparse living conditions on the ship. The medical department saw over 75 elective surgery cases, a large outbreak of gastroenteritis, and a psychiatric diagnosis for almost ten percent of the inpatient population. Bohnker's experience was consistent with others who reported on surgery (Fisher, 1990; Fontana, Lucha, Snyder, & Liston, 1999), diarrheal disease (Bohnker, 1996), and psychiatric diagnoses (Bohnker, McEwen, Blanco, & Feeks, 1992) aboard aircraft carriers. Eighty-two percent of Bohnker's (1995) admissions during the Mediterranean deployment were returned to duty on the aircraft carrier. The remaining eighteen percent required medical evacuation (medevac), which proved tricky for some during specific ship movements and/or tactical situations. Bohnker

(1995) concluded that an aircraft carrier's medical department must be prepared to handle serious medical problems in unpredictable patterns.

Derderian and Blood (2000) examined medical admissions for five different deployment groups aboard aircraft carriers. Their retrospective review revealed that peacetime deployments to the Mediterranean theater produced a larger proportion of total admissions for accidents and mental disorders. Those deployed to the Western Pacific (West Pac) theater were admitted more for infective, respiratory, and skin disorders. The authors attribute the disparity to the climate differences between the two theaters.

The remaining articles related to medical care on aircraft carriers included effort thrombosis (Mitchell, MacGillivray, and Almond, 1991); dermatologic and venereologic diseases (Vidmar, Harford, Beasley, Revels, Thornton, & Kao, 1996); and injury patterns (McNiesh, 1989). In passing, both McNiesh and Bohnker's (1996) articles emphasized the need for a strong preventive medicine program to combat preventable conditions. Also, Mitchell et al. (1991) reminded us that the sailors on board aircraft carriers are exposed to harsh, strenuous, and often dangerous working conditions. Even though most are young and healthy, the severe work environment yields to a wide variety of both *common and uncommon illnesses and injuries*. They reiterated Bohnker's (1995) experience that the movement of patients to a better-equipped medical facility may be hampered by the isolation, distance, and danger involved with deployed aircraft carriers.

McKenzie and Boren (2001) discussed environmental issues pertinent to nurses on hospital ships. Although the mission of a hospital ship is not the same as an aircraft carrier, the preventive medicine aspects are. The authors discussed the need for

decontamination rooms aboard ship when working with patients exposed to lethal toxins, gases, and microorganisms; annual mandatory tuberculin testing and up-to-date immunizations for all crew members since they are potentially exposed to infectious agents when deployed to developing countries or during port calls; periodic evaluations of the air quality of the ship to minimize the risk of air contaminants; management and monitoring of the potable water supply to decrease the risk for contaminants and diarrheal diseases; personnel assigned to food services to be properly immunize and to remember that food can be a primary source of potential contamination; and the ship's wastes to be disposed in accordance with official policies.

Integration of Women

The decision to assign women to combatant vessels was mandated by Congress in the early 1990s. The USS Dwight D. Eisenhower (also known as the "Ike") made Navai history when it received its first complement of women during the first six months of 1994. Its selection seemed logical because the aircraft carrier was already in the shipyard (a circumstance known as "drydock") undergoing a major overhaul and refitting. Thus, the privacy modifications required to accommodate a mixed-gender crew were accomplished, at a cost of over one million dollars, without delaying the Ike's deployment schedule. Its first cruise as a mixed-gender crew proved to be a success in that it suffered no decline in operational readiness (Komarow, 1994; Waller, 1995; Yacavone, 1996).

Some morale and discipline problems did occur with the Ike's integration of women on the ship (e.g., dating among the crewmembers, including one couple who decided to videotape their escapades). Certain adjustments were almost comical. Women learned

not to send their lingerie to the ship's laundry because the machines had no gentle wash cycle. The crewman received so many lectures about sexual harassment and fraternization that they were afraid to even talk to their new female counterparts. The ship's barbers had to be trained to cut women's hair. The mess-hall menu offered few low-fat items since it was geared towards young, starving males. Foul language was toned down. Eventually, a comfort level emerged that allowed for a "smooth sailing" (Waller, 1995).

Do the health care needs for women differ from those of men? Yes! Recognizing the need to address women's health needs in the operational setting, the Navy (Hughey, 1999) and the Army (Davis, Scherr, & Parsons, 1997; Vara, 1999) have information that addresses the unique needs and considerations of female warriors. Meanwhile, Means-Markwell et al. (1998) found that during sea deployments, women visited the medical department at significantly higher rates than men. In their study involving the crew of four Navy ships, both women and men had similar medical problems except for some minor gynecological conditions. The most common reason for clinic visits among women was for upper respiratory complaints and for birth control pills requests. For men it was both upper respiratory complaints and accident or injury. The authors concluded that because of the high standards of health and preventive medicine efforts of the medical department, most medical problems encountered by shipboard females are not serious and can be managed by routine medical and gynecological care.

Schwerin and Sack (1997) interviewed 36 health care providers aboard various ships regarding their perceptions of health care of women on ships. They found a variety of responses; however, perceived limitations fell into two categories: general health care

limitations (related to the unique nature of the shipboard environment and a limited access to specialists when deployed) and practice-specific limitations (e.g., limited supplies of contraceptives, pregnancy tests, and sexually transmitted disease testing kits).

Yacavone (1996) and Parodi (1997) authored the only publications regarding woman and their health care needs when stationed aboard aircraft carriers. When the ship was in drydock, Yacavone's medical department created female exam rooms and a female section of the hospital ward. Yacavone felt comfortable providing a new category of medical services; however, Yacavone was concerned about the treatment of sexually transmitted diseases, pregnancy, and birth control (not only because they were medically challenging but because they were "politically [sic] 'hot potatoes'" [p. 590]). Yacavone's department concluded that pregnancy was incompatible with service on a warship; therefore, during the deployment, 14 women were sent ashore due to pregnancy. Other than this reason, no women were medically evacuated for a "female problem." Several women did require emergency surgery; however, it was for the same conditions experienced by men (e.g., appendicitis and trauma). Yacavone concluded:

The presence of women contributed to our performance. That's the real story. The Ike team, both men and women, spent 141 out of 180 days at sea. Ike performed more than 150 operating room cases, saw over 8,500 outpatients, and admitted more than 200 patients to the ward. The entire cruise illustrated what's best in both Operational Navy Medicine and the United States Navy. (p. 591)

Parodi's (1997) dissertation research discovered many similarities between female and male subjects reporting to the medical department on an unidentified aircraft carrier; however, Parodi also found that women had an extraordinary reported rate of abnormal Pap smears and that the women crew members expressed concern about the turnaround

time for receiving results of both and Pap smears and mammograms. Parodi concluded the dissertation with strategies for Navy Nursing to improve the overall health and well being of its deployed forces, including the recommendations to add three more general staff nurses to each carrier – to case manage the health care of the ship’s crew – and to provide a formal training curriculum for nurses reporting to the carriers.

Nurse’s Role

An article that discussed the nurse’s role on a Merchant Marine vessel (not on an aircraft carrier) was located. Aboul-Enein (1999) reported that this role, which advocated preventive medicine strategies, included:

- Surveying the overall cleanliness of the ship
- Maintaining the first aid boxes and eye wash centers on the ship
- Testing the water periodically for consumption
- Surveying the preparation of food
- Conducting sick call
- Stabilizing patients until they can be medically evacuated

Poyner (1992) authored the only article that discussed carrier nursing. Poyner reported that nurse anesthetists were the first Navy nurses assigned to aircraft carriers during the 1980s (a fact confirmed by Sterner, 1997). With the shrinking of the nurse anesthetists’ pool in 1988, and the addition of collateral duties that required more of their time than those duties related to their specialty, the decision was made to replace them with general duty Nurse Corps officers. By the mid-1990s, general duty nurses were aboard all of the carriers. Poyner listed 11 possible collateral duties of the ship’s nurse:

1. Weight Control Officer
2. Quality Assurance Coordinator
3. Family Advocacy Officer

4. Medical Training Officer
5. Patient Contact Representative
6. Medical Waste
7. Security Officer
8. Credentials Coordinator
9. Maintenance and Material Management (3-M) Spot Checker
10. Zone Inspector
11. Preventive Medicine/Occupational Health

The most time-consuming job was that involving medical training. As medical training officer, the ship's nurse interacted with many departments on the carrier. Conducting a mass casualty drill involved the coordination of many departments. The ship's Medical Response Team (MRT) was its "ambulance on foot" (p. 17). Five of the members strapped life-saving equipment to their backs when responding to the scene of an emergency. Because an aircraft carrier is so vast, and the goal of a four-minute response time to any emergency was a must, MRT training was constant. Marines augmented the MRT by acting as stretcher-bearers. Poyner also offered some recommendations for Nurse Corps officers who were seeking a position as a ship's nurse on an aircraft carrier. Poyner concluded the article with the comment that shipboard nursing was arduous; however, it was highly satisfying.

This one and only article regarding shipboard nursing on an aircraft carrier (Poyner, 1992) posed some problems in that it was devoid of a majority of the themes discovered in the exploratory literature review regarding nursing practice in service unique environments. Also, Poyner's article was written for an obscure journal that was not identified in any of the major computer search engines; thus, it was not easily accessible to the general public. Finally, the article was written in 1992 – two years before women

joined the ships. Had the integration of women on ships affected the role of the nurse on the aircraft carrier? These disparities will be addressed via the findings of this study.

In order to gain an understanding of the phenomenon of interest of this study – nurses' experiences while stationed aboard aircraft carriers – phenomenological philosophy and methodology were employed. In the next section on phenomenological inquiry, a historical overview, with a focus on Husserl's phenomenological philosophy, are presented.

Phenomenological Inquiry

Streubert and Carpenter (1995, 1999) wrote that science has traditionally been grounded in the quantitative approach; however, there are some phenomena that defy measurement. In order to capture the meaning of these phenomena, investigators have turned to qualitative research methods. Mason (1996) identified three common elements of qualitative research:

1. It is "grounded in a philosophical position that is concerned with how the social world is interpreted, understood, experienced, or produced" (p. 4)
2. It is rooted in "methods of data generation that are flexible and sensitive to the social context in which data are produced" (p. 4)
3. It is "based on methods of analysis and explanation building that involve understandings of complexity, detail, and context" (p. 4)

Therefore, as opposed to quantitative research where a key characteristic is maintaining objectivity, qualitative research differs in that it allows for subjectivity. Additionally, qualitative investigators may use multiple ways of understanding in their process of discovery. The following statement eloquently describes the qualitative research process that is discussed in greater detail throughout this study:

One undertakes qualitative research in [a setting] where the researcher is an instrument of data collection who gathers words or pictures, analyzes them inductively, focuses on the meanings of the participants, and describes a process that is expressive and persuasive in language. (Creswell, 1998, p. 14)

Qualitative researchers approach studies with basic ontological and epistemological assumptions that guide their investigation (Creswell, 1998). Mason (1996) recognized the ontological perspective as “what you see as the very nature and essence of things in the social world” (p. 11). Mason named over fifty examples that make up social reality. The examples that were applicable to this study included people, minds, psyches, emotion, thought, feeling, memory, understandings, interpretations, attitudes, beliefs, views, self, individuals, experiences, accounts, stories, actions, reactions, interactions, social processes, rules, morality, belief systems, and culture.

Epistemology is the researcher’s theory of knowledge. It is concerned with the principles and rules by which the researcher decides how social phenomena can be known (Mason, 1996). For this study, Edmund Husserl’s thoughts on phenomenology provided the conceptual framework for exploring the phenomenon of interest – nurses’ experiences while stationed aboard aircraft carriers. “Phenomenology is a science whose purpose is to describe particular phenomena, or the appearance of things, as lived experience” (Streubert & Carpenter, 1999, p. 43). Thus, Husserl’s phenomenological concepts allowed me to give a public voice to the participants’ experience of lived events.

In clarifying epistemology and ontology, Mason (1996) wrote, “your epistemology helps you to generate knowledge and explanations about the ontological components of the social world” (p. 13). Therefore, the thoughts, feelings, beliefs, etc. elicited in the

interviews were the ontological components of this study and Husserl's conceptual framework provided the epistemological element that assisted me in transitioning the ontological components into knowledge (epistemology).

The Phenomenological Movement

The phenomenological movement began around the first decade of the 20th century. Three phases define this philosophical movement: Preparatory, German, and French. The philosopher, Franz Brentano (1838-1917), and his student, Carl Stumpf (1848-1936), dominated the Preparatory phase. The concept of "intentionality" was the primary focus of this period. Intentionality is described as "consciousness is always consciousness of something" (Streubert and Carpenter, 1999, p. 45). For example, one does not hear without hearing something.

The German Movement and Edmond Husserl

The leaders of the second movement (German) were Edmund Husserl (1859- 1938), Martin Heidegger (1889-1976), and Hans-Georg Gadamer (1900-). In fact, most of what we know about phenomenology is grounded in Husserl's philosophical perspectives (Creswell, 1998).

Husserl was born to Jewish parents on April 8, 1859 in Moravia, Austria. He began his university studies in Leipzig but then moved on to the University of Berlin where he studied both mathematics and philosophy. He completed his doctoral dissertation in Vienna and then spent some time in military service in Berlin. Upon Husserl's return to Vienna, he attended lectures by Franz Brentano. Brentano's descriptive psychology provided Husserl with the intellectual stimulus to develop Husserlian phenomenology.

Husserl was inspired by Brentano's view that philosophy was an exact science. As a result, he decided to concentrate on the study of philosophy. In subsequent writings, he even borrowed Brentano's belief that mental acts engage in intentional relations to their objects. Husserl went on to complete another dissertation, under the guidance of Stumpf, whereby he united the concepts of mathematics and philosophy. Several years later, he published the first of many books (Moran, 2000; Natanson, 1973; Stiver, 1999; Welton, 1999).

Husserl first taught at the University of Halle (1887-1901), then the University of Gottingen (1901-1906), and finally the University of Freiburg (1906-1928). Martin Heidegger, a student of Husserl's who was also a great proponent of hermeneutics (Heideggerian phenomenology), succeeded Husserl as the chair at Freiburg. With the rise of Nazism in Europe, Husserl's Jewish status led to repressive measures. After his death on April 27, 1938, his works were smuggled out of Germany in an attempt to avoid their destruction (Moran, 2000; Stiver, 1999).

Husserl purported that phenomenology was not a natural science and could not be measured by methodologies associated with it. In his eyes, phenomenology was "a descriptive science of direct experience" (Stiver, 1999, p. 424). Therefore, his phenomenological method sought to describe the essence of "the things themselves" (Husserl, 1900-1901/1970, p. 252) as they are constituted in the consciousness. Key to Husserl's approach was his belief that experience is grounded in and gives meaning to knowledge (Koch, 1995). Husserl wanted phenomenology "to address the given, the

phenomena, the things themselves, in the sense of whatever immediately appears to consciousness in the manner that it so appears” (Moran, 2000, p. 108).

Husserlian phenomenology consists of some dominant concepts that are essential to its understanding: intentionality, essences, reduction (both phenomenological and eidetic), and intuiting. With intentionality, every act of thinking implies an object thought of. Objects are not real entities or events; they are whatever is perceived. The concept of thinking is the same as thinking about something; thus, it has a directional force. Phenomena are objects of intentional acts. Intentionality of the consciousness assumes that consciousness is always consciousness-of something (Natanson, 1973; Stiver, 1999). According to Husserl (1913/1952), intentional experiences are acts of the consciousness and every act of consciousness intends some entity or object (including mental objects such as memories).

“Phenomena may be appreciated as essences.... Essences are unities of meaning intended by different individuals in the same acts or by the same individual in different acts” (Natanson, 1973, pp. 13-14). An assumption of this process is that for any human experience, distinct essential structures (essences) make up that experience. These structures are crucial to the phenomenon being studied no matter which person experiences it. Essences compose the basic units of common understanding of any phenomenon (Moyle & Clinton, 1997; Streubert, 1991; Streubert & Carpenter, 1999).

The process of phenomenological reduction is necessary in understanding essential structures. Many terms have been used to transfer Husserl’s concept of phenomenological reduction (epochè): bracketing, reduction, suspension, disconnection, abstention, setting

aside, and canceling have all been applied. For consistency's sake, the term "bracketing" will be used throughout this study. Bracketing does not mean neglecting, rather it is simply accepting the obvious and is thus reflectively recognized "as a performance of consciousness and subjected to analysis" (Natanson, 1973, p. 59). Natanson wrote that few concepts in phenomenology have led to as much misunderstanding as the concept of bracketing and that even Husserl was not consistent with his writings on bracketing. Bracketing occurs prior to data collection, during data collection, and throughout the data analysis process. Seidman (1998) offered a very succinct description of bracketing:

It is important that the researcher identifies his or her interest in the subject and examines it to make sure that the interest is neither unhealthy nor infused with anger, bias, or prejudice. The interviewer must come to the transcript prepared to let the interview breathe and speak for itself. (p. 100)

The process of bracketing was Husserl's way of reducing the natural world to a transcendental consciousness (Moyle & Clinton, 1997; Natanson, 1973). Bracketing is "transcendental because it constitutes every transcendence in pure subjectivity" (Ricoeur, 1996, p. 94). To accomplish bracketing, the researcher must suspend the "natural attitude" and shift to the "phenomenological attitude" in order to understand the true meaning of experienced phenomenon. Bracketing is a philosophical device that negates the natural attitude prior to phenomenological inquiry (Paley, 1997). Natanson described this transition as follows:

The turn from the natural to the phenomenological attitude is a shift in the direction of one's interests, not in the abandonment of one world for another. There is but one world, though there are different ways of attending to it. In the natural attitude ... the individual lives spontaneously in his perception of what there is; in the phenomenological attitude, he makes of his perceptual life an object of inquiry. In Husserl's language, the phenomenologist thematizes perceptual experience. (p. 54)

Paley emphasized that with Husserlian phenomenology, only descriptions are allowed because bracketing prohibits researchers from making decisions that belong to the natural attitude.

Eidetic reduction reflects Husserl's concern to describe essences. It is a "philosophical device whose purpose is to render concepts clear, explicit, and complete" (Paley, 1999, p. 191). The procedure involves free variation of an experience in the imagination in order to examine all of the possible forms it can take from all possible angles. By adding and deleting certain features, and recognizing when the experience no longer exemplifies the concept, the researcher can identify what is essential to the concept. Thus, during eidetic reduction, uncommon experiences are laid aside and common areas are focused upon. Once an essence is identified, the researcher can then proceed with describing it (Moran, 2000; Paley, 1999; Stiver, 1999; Streubert & Carpenter, 1999).

Eidetic reduction is integrated with Husserl's concept of intuiting. Accurately interpreting what is meant in the description of the phenomenon being studied describes the process of intuiting (Streubert & Carpenter, 1999). Phenomenology is "a purely descriptive discipline which studies the whole field of transcendental consciousness in the light of pure intuition" (Husserl, 1913/1952, p. 176). For Husserl, intuition had nothing to do with feeling or psychic power but rather is "unmediated seeing" (Natanson, 1973, p. 23). Husserl's belief that one could "intuit" essences is another controversial aspect of his philosophy (Stiver, 1999). When writing a description of the essence(s) that have been identified through intuition, the researcher needs to keep in mind Husserl's (1913/1952)

belief that “the decisive factor lies before all in the absolutely faithful description of that which really lies before one in phenomenological purity, and in keeping at a distance all interpretations that transcend the given” (p. 262). Phenomenology must begin and end with what is given. The first transgression in phenomenology is to transcend the given (Bell, 1990).

So how does one accomplish eidetic reduction by way of bracketing? Natanson (1973) illustrated the process beautifully:

As I write these lines I am looking out over a view of the city. In sight are the rooftops of the neighboring houses, their chimney stacks jutting upward; some of the fences surrounding yards are visible, part of a school building can be seen, there are many trees about, and, in the far distance, a part of the bay can be glimpsed. I know who lives in some of the houses in the line of my vision, the kinds of trees around me, the style of the enviroing architecture.... Each time I look out the window, I see once again the same sight, the same buildings and foliage. I know that they are reliable features of my prospect, part of my world. Now, in eidetic reduction, I choose to attend to the scene in a different way. I set aside the actuality of the houses and the details of their ownership and history. The house across the way has a mortgage, a roof in need of repair, and a freshly painted door. I concern myself only with its being there for me as a something seen and a something noticed. The mortgage drops away; the roof presents itself as a patchwork.... That Haskell lives next to Immerbind is no longer part of my viewing – that knowledge has been set aside. I see rectangular and oblong stretches of multicolored shapes.... Depending now on what I wish to do as a descriptivist and analyst of the scene, I may attend to those patches as houses, as water, or as Mrs. Mayhew standing in the driveway, calling her cat.... What is set aside in eidetic reduction is becoming clear, but it is no less important to note what has not been altered: there is still the ‘I’ who looks over the view; there is still the past of that ‘I’, its history; there is still the scene set within the world which surrounds and includes it; and there is still the history of that world.... Bringing all of these subtle elements into clarity is the first requisite of phenomenological reduction, and refraining from positing and building upon those primordial grounds is the goal of that ultimate reduction. (pp. 65-66)

The German Movement and Martin Heidegger.

Martin Heidegger spent ten years under Husserl's tutelage. Gradually, he developed his own philosophy of phenomenology. For Heidegger, phenomenology lent itself to a new way of seeing rather than to a set of philosophical propositions. Heidegger disagreed with Husserl's concept of epochè (bracketing). He believed in the "hermeneutic circle" whereby all questioning carries certain presumptions that guide the inquiry (and, thus, cannot be bracketed). Therefore, one seeks an answer in the context of what is already known (Moran, 2000). Heidegger placed enormous stress on thoughtful questioning – looking for the thoughts behind the thoughts.

The German Movement and Hans-George Gadamer.

Hans-George Gadamer was influenced by Greek philosophy and was a follower of Heidegger. Gadamer's hermeneutic philosophy focused on understanding understanding. He felt that all understanding was determined by pre-judgments and that pre-judgments were formed by history:

Our consciousness of being affected by history belongs to the manner in which we understand everything, including the history itself. When we understand an object, we do not grasp the object as it is in itself, but rather we grasp it through the accumulations of its historical effectiveness. (Moran, 2000, p. 252)

Gadamer felt that understanding was actually facilitated by pre-judgments; therefore, his philosophy also differed from that of Husserl's because Gadamer did not support the concept of epochè (bracketing). While Heidegger placed enormous stress on thoughtful questioning, Gadamer focused on linguistics. Gadamer was deeply interested in the structures that were involved in the art of conversation. According to Gadamer, full

understanding was only achieved “because of language and in language,” (Moran, 2000, p. 270).

The French Movement and Merleau-Ponty.

Gabriel Marcel, Jean Paul Sartre, and Maurice Merleau-Ponty led the third phase of the phenomenological movement (French). They developed two concepts: embodiment and being-in-the-world (Streubert & Carpenter, 1999). Embodiment means that through the body, one gains access to the world (being-in-the-world). In other words, lived experiences are affected by perceptions and it is these perceptions that must be described. Moran (2000) wrote that Sartre’s contribution to phenomenology was mostly literary and that it was Merleau-Ponty who made the greatest contribution to post-Husserlian phenomenology in France.

In a discussion with a professor in the Philosophy Department at George Mason University (J. Fletcher, personal communication, July 10, 2000), it was ascertained that Husserl’s concept of bracketing included bracketing of the existential (because Husserl was grounded in the metaphysical aspects of discovery). If one is a purist ingrained in Husserlian tradition, then bracketing of the existential negates investigating the phenomenon in the first place because if existence is bracketed, then there is nothing left to study (because existence of the phenomenon is bracketed). Dr. Fletcher explained that one does not need to be a traditionalist with Husserlian phenomenology and that most of Husserl’s followers were indebted to his basic tenets despite choosing a different path for analysis. Dr. Fletcher’s discussion was shared with this study’s consultant, Dr. Streubert. Dr. Streubert (personal communication, July 10, 2000) confirmed Dr. Fletcher’s point and

clarified that her work is a compilation based on the works of both Husserl and Merleau-Ponty (the latter being an existentialist) in order to overcome this philosophical dilemma.

Merleau-Ponty was an existential phenomenologist in that he denied the possibility of bracketing existence. He believed in the concept of reduction (although not exactly as Husserl practiced) and combined his philosophical interests with Gestalt psychology (in that Merleau-Ponty believed that things are always discovered within a context). Merleau-Ponty felt that reduction was provisional and that it always led back to the source of the experience rather than transcending that experience. Since Husserl's concept of bracketing included bracketing of the existential, the philosophical underpinnings of this study included Merleau-Ponty's beliefs in existentialism: truth is found "in-the-world" and it always begins with existence (Moran, 2000).

Rationale for Choosing Husserl for the Conceptual Framework of this Study

Descriptive phenomenology (such as Husserl's) and interpretive phenomenology (such as Heidegger's) are two distinctive schools of thought. The distinctiveness lies not so much in the methodological steps associated with these philosophers but rather in the goals of the research endeavor. The goal of descriptive phenomenology (also known as "eidetic" phenomenology) is to describe the meaning of an experience from the perspective of those who have "lived" the experience. The goal of interpretive phenomenology (also known as "hermeneutic" phenomenology) is based on the premise that lived experience is in itself an interpretive process. Hermeneutics focuses on the ontological questions of "how" individuals come to understand, not "what" they understand. With Husserl's descriptive phenomenology, epistemological questions of

knowing are accentuated and the focus is on experience (Cohen & Omery, 1994; Koch, 1995).

Because Husserl emphasized pure description, rather than finding hidden meaning, and the goal of this endeavor was to describe the lived experience of shipboard nursing on aircraft carriers, his phenomenological philosophy was selected to provide the theoretical framework guiding this inquiry.

Phenomenological Nursing Studies

In a recent review of phenomenological nursing studies, I found that some articles clearly revealed Husserlian concepts yet Husserl was never mentioned in the articles (i.e., Alteneider, Rowland, Kenner, Greene, & Pohorecki, 1998; Little, 1999; and Sadala, 1999). This finding is consistent with other authors who have criticized nurse researchers for referencing but never quoting Husserl or misunderstanding Husserlian philosophy (e.g., Koch, 1995; Paley, 1997; Porter, 1998; and Yegdich, 1999). Other authors did discuss the philosophical underpinnings of Husserl in their research studies (e.g., Baillie, 1996; Beck, 1998; Kralik, Koch, & Wotton, 1997; Moyle & Clinton, 1997; Murphy, 1998; and Thibodeau & MacRae, 1997). Streubert and Carpenter (1999) caution that in an attempt to avoid "sloppy" science, a researcher must have a thorough understanding of the philosophical assumptions that are the foundation of one's research methodology. Without this solid understanding, research findings may be misunderstood.

Alteneider et al. (1998) interviewed 16 pregnant women in order to gain an understanding of the experiences of women who had been informed that there might be a problem with their unborn infant. The participants were interviewed on two occasions:

immediately after contact with their maternal-fetal medicine specialist, and again during their immediate post-partum period. The interviews were conducted until data saturation had occurred. The authors employed Paul Colaizzi's nine-step method for data analysis and developed an exhaustive description of the experience. Alteneider et al. identified four essences: an initial reaction, a support reaction, a delayed reaction, and, in false positive result situations, a perfect child reaction. The article discussed appropriate clinical implications for nurses working with this patient population. Husserl was not mentioned in any part of the article.

Little (1999) studied students' views that relate to the post-basic curriculum for preliminary studies in intensive care and coronary care units. The author interviewed 10 nurses in the United Kingdom. The first six nurses were individually interviewed approximately three months after they completed their course of study. The remaining four were interviewed as a group on their last day of study. Little used Heidegger's hermeneutic analysis and discovered that the common concerns were learning as: focusing, questioning, and technological mastery. However, learning as technological mastery was the only theme considered essential because it was revealed in all of the interviews. Little briefly described some Heideggerian concepts; however, Husserl was never credited with some of his and Heidegger's shared concepts.

Sadala (1999) interviewed 18 nursing students in Brazil in order to ascertain their experience in caring for patients on an isolation ward. The author analyzed the participants' descriptions using the techniques of reduction and phenomenological interpretation. Throughout the entire article, Husserl was never mentioned despite the

fact that Sadala described several concepts that were purely Husserlian. Sadala determined that the students had difficulties and anxieties when working with patients in isolation; however, the students overcame these obstacles to become more involved with their patients.

Baillie (1996) wanted to gain an understanding of the nature of empathy as perceived by nurses working in a surgical setting. The author interviewed nine participants and utilized Colaizzi's methodology to interpret the data. Baillie extracted significant statements from the interviews and clustered them into seven themes:

1. The concept of empathy
2. Closeness and involvement in empathy
3. Empathy can be active and therapeutic
4. Empathy as an individual and personal experience
5. Developing the ability to empathize
6. Developing empathy with the individual patients
7. When empathy is difficult

The seven themes were utilized to form an essential structure (similar to an exhaustive description) of empathy. Baillie concluded that to develop empathy, nurses needed a natural ability to empathize, but they also needed experience in both nursing and in their own personal life. The author identified and integrated Husserlian concepts throughout the study.

Beck (1998) described the experience of panic disorder in mothers during the postpartum period. The author interviewed six participants and utilized Colaizzi's phenomenological method to analyze the data. Two-hundred-and-fourteen statements regarding mothers' experience of panic were obtained and clustered into six themes:

1. Panic attacks paralyzed the women, leaving them feeling out of control
2. Cognitive abilities decreased during panic attacks
3. The women became exhausted when they struggled to maintain composure during panic attacks
4. Preventing panic attacks was paramount to the participants
5. Negative changes in the women's lifestyles ensued as a result of panic attacks
6. Mothers were fearful that their panic attacks would have residual effects on themselves and their families

Beck gave a brief, but thorough, account of Husserl's phenomenology; however,

Colaizzi's procedural step to compose an exhaustive description of the fundamental structure of the phenomenon being studied was inexplicably missing from the article.

Murphy (1998) described the experience of early miscarriage from a male perspective using Husserl's phenomenology as a conceptual framework and Colaizzi's phenomenological method to analyze the data. Murphy had to extend the timeline for data collection when no participants would enroll in the study. The technique of snowballing was utilized until five male participants eventually agreed to participate. Seven categories relating to the men's experience of early miscarriage were identified:

1. Feelings
2. Loss
3. Characteristics and differences between men and women
4. Staff action and attitudes
5. What to do?
6. Coping
7. Time

Murphy concluded that based upon the needs of both partners, nurses have a key role in delivering effective interventions after miscarriage. Again, an exhaustive description of the fundamental structure of the phenomenon being studied was inexplicably missing from the article.

Thibodeau and MacRae (1997) described the experience of female breast cancer survivors using Alfred Schutz's interpretation of phenomenology as their theoretical framework. They did not reach data saturation until their forty-fifth interview.

Hermeneutic analysis was utilized to arrive at an interpretive understanding of surviving breast cancer. Twenty-five codes were consolidated into ten major categories:

1. Advice
2. Coping and support
3. Diagnosis
4. Life changes
5. Health care providers
6. Health habits
7. Relationships
8. Religion and spirituality
9. Treatment options
10. Worry about health and recurrence

Each of the categories was analyzed for recurring themes. The themes were then synthesized into three paradigm cases: busy and engaged, helping others with cancer, and deniers. The authors mentioned that Schutz relied heavily on Husserl when developing his concept of phenomenology; however, the remaining discussion was void of Husserl's name despite the prevalence of Husserlian concepts.

Draucker (1999) reviewed over 25 nursing research reports published from 1987 to 1997 that used the phenomenological method of hermeneutics for data analysis. Draucker criticized the lack of hardy descriptions of the research process in a majority of these interpretive studies. Also lacking was a frank discussion of faults that may occur during the research process. In my review of phenomenological nursing articles, I found only one article that addressed any problems: Kralik's et al. (1997) study regarding patients'

experiences with nursing. The authors recognized that they were unsuccessful with phenomenological reduction because they found it impossible not to be influenced by their preconceptions (also, the authors noted that it was impractical to give a longer explanation about their methodological decisions given the confines of the publisher's guidelines). Thus, Kralik et al. turned to Heidegger's phenomenology (which allows for preconceptions). Heidegger believed that presuppositions could not be suspended and that they might actually contribute to the meaning of the phenomenon being studied; hence, his philosophy focused more on meaning than description.

Moyle and Clinton (1997) wrote that bracketing posed a conceptual challenge for them when they were studying a psychiatric patient's experience with memory loss. They turned to the phenomenology of Sartre and Merleau-Ponty and reasoned that after a full exploration of this issue, they were able to lay aside their assumptions and move from a naïve to intuitive understanding of the phenomenon being explored because they felt that they were now well-versed in the art of phenomenology.

Chapter Summary

The purpose of this study was to describe the lived experience of shipboard nursing on aircraft carriers. This exploratory literature review included scholarly writings related to nursing practice in service unique environments, aircraft carriers, and phenomenological inquiry. The review of phenomenological inquiry validated my choice of using Husserlian phenomenology as the conceptual framework that guided this study.

As confirmed by this literature review, this study could not build on what was already done because there had never been any research conducted on this aspect of Navy nursing.

The phenomenon of interest – nurses' experiences while stationed aboard aircraft carriers – had never before been explored, analyzed, or described from a research perspective.

Given this lack of research-based information available on nursing aboard aircraft carriers, this study contributes to the dearth of knowledge available regarding this unique form of operational nursing.

In Chapter III, the research methodology for this study is described.

CHAPTER III

Methodology

This chapter consists of the research design of my study, including what transpired during data collection and data analysis. The following are presented: (a) research design, (b) sample, (c) protection of human rights, (d) data collection, (e) data analysis, (f) criteria for judging the quality of an inquiry, (g) dissemination of findings, and (h) funding.

Research Design

Qualitative research is an inductive process. Because pure induction is impossible, “qualitative researchers operate within theoretical frameworks” (Taylor & Bogdan, 1998, p. 8). Edmund Husserl’s phenomenology provided the theoretical framework guiding this study and Streubert’s (Streubert, 1991; Streubert & Carpenter, 1999) methodological approach was chosen to analyze the phenomena. Streubert synthesized the work of several phenomenological researchers (e.g., Spiegelberg, 1975; Colaizzi, 1978; Paterson & Zderad, 1976; Oiler, 1982; and van Manen, 1984) in order to develop a clear and consistent method to investigate experiences and perhaps formulate theory. Streubert’s method involved the following steps:

1. Explicating a personal description of the phenomenon of interest
2. Bracketing the researcher’s presuppositions
3. Interviewing participants in settings comfortable to the participant
4. Carefully reading the transcripts of the interview to obtain a general sense of the experience

5. Reviewing the transcripts to uncover essences
6. Apprehending essential relationships
7. Developing formalized descriptions of phenomena
8. Returning to participants to validate descriptions
9. Reviewing the relevant literature
10. Distributing the findings to the nursing community (Streubert & Carpenter, 1999, p. 51)

There are a number of methodological approaches available for analyzing phenomena (Holstein & Gubrium, 1994). I chose Streubert's approach because it was grounded in Husserlian phenomenology. Also, it was clear and concise – and it just made sense. Additionally, I became comfortable with Streubert's method when our class used it for a research exercise in NURS 920: Qualitative Research in Nursing and Health Care. An added benefit was that Dr. Streubert was available to consult with me on this research endeavor.

Sample

The most common type of sampling utilized in phenomenology is purposive sampling (Streubert, 1991). Thus, one purposively searches for those participants who actually "lived" the experience being studied. Once the appropriate group is identified, the researcher seeks access, provides informed consent, and then collects data until saturation. Saturation is described as the "sense of closure [one] experiences when data collection ceases to yield any new information" (Polit & Hungler, 1995).

Navy Nurses

Nurses have been serving aboard Navy ships since the 1800s; however, the United States Navy Nurse Corps was not founded until May 13, 1908 when Public Law Number 115 came into effect (Sterner, 1997). At that time, it was specified that all Navy nurses

would be female (male nurses were not commissioned into the Navy Nurse Corps until 1965). As of April 2001, there were 3,094 active duty nurses in the Navy Nurse Corps (Dorr, 2001).

Currently, the Navy has 12 aircraft carriers in operation and each carrier's medical department includes one Navy nurse. Poyner (1992) and Sterner (1997) reported that nurse anesthetists were the first Navy nurses assigned to aircraft carriers during the 1980s. With the shrinking of the nurse anesthetists' pool in 1988, and the addition of collateral duties that required more of their time than those duties related to their specialty, the decision was made to replace them with general duty Nurse Corps officers. By the mid-1990s, general duty nurses were aboard all of the carriers. The Navy Nurse Corps has no official record of the number of nurses who have served as the ship's nurse on an aircraft carrier; however, according to the Navy Specialty Leader for Operational Nursing, it is estimated that greater than 140 Navy nurses (including the nurse anesthetists that served as ships' nurses in the 1980s) worked in this capacity (C. McLarnon, personal communication, August 13, 2001).

Inclusion Criteria

After a long discussion with the Navy Specialty Leader for Operational Nursing, it was decided that to be included in this purposive sample, all of the participants had to have been previously stationed on an aircraft carrier (for at least two years) and the carrier could not have been in drydock (the shipyard) throughout their entire tour (assumption being that nurses working in drydock would not have had the same experience as those who had sea duty). In an attempt to ascertain whether a gender difference existed in the

participants' lived experience, and based upon the recommendations of my Dissertation Committee, the sample included an equal representation of females and males.

Finding Participants

The nurses for two pilot interviews were directly solicited because they had been recommended by mutual acquaintances and were readily available. The Navy Specialty Leader for Operational Nursing acted as the liaison with the remaining 10 nurses. This advisor notified the participants that I would be contacting them by telephone or electronic mail (e-mail). Out of the entire 12 participants, four were initially contacted via the telephone, one was approached in-person, and the remaining seven were secured through e-mail correspondence.

Aside from the two pilot interviews, those nurses who had left the aircraft carriers within the past two years of when data collection began (September 2000) were the first participants sought for this study. I utilized a backwards year-by-year progression to solicit former aircraft carrier nurses until study participants were no longer needed (once data saturation was obtained).

Incidentally, Taylor and Bogdan (1998) reported that it is not difficult to schedule participants for interviews because most people are willing to talk about themselves and that individuals are usually honored at the prospect of being interviewed for a research project. Such was true with this study in that every nurse contacted enthusiastically agreed to participate in this study without any degree of hesitation.

In an attempt to limit the fears of coercion, subject identification, and possible retaliation, the sample population was those nurses who had already left aircraft carrier

duty instead of those nurses currently stationed aboard the aircraft carriers. This also addressed the concern made by one reviewer of my initial proposal (for the Tri-Service Nursing Research Program – TSNRP) that a nurse in an aircraft carrier billet (assignment) for six months (who would be considered a novice) could not be compared to one who had been in the billet for two years (who would be considered an expert).

Protection of Human Rights

IRB Approval

In accordance with George Mason University's (GMU) Office of Sponsored Programs (OSP), any research activity involving human subjects conducted by GMU personnel, including doctoral students, needed approval. OSP found this proposal exempt from review by the Human Subjects Review Board at GMU because it fell under the Department of Health and Human Services' (DHHS) Exempt Category 2 (See Appendix A for the approval letter).

Letters of endorsement were also obtained from the Commander, Naval Air Forces, U.S. Pacific Fleet (COMNAVAIRPAC) – the command that governs aircraft carriers on the West Coast – and the Commander, Naval Air Forces, U.S. Atlantic Fleet (COMNAVAIRLANT) – the command that governs aircraft carriers on the East Coast (see Appendix B and Appendix C for copies of the letters). Both COMNAVAIRPAC and COMNAVAIRLANT indicated that individual letters from the commanding officers of the aircraft carriers were not necessary because the Force Medical Officers at COMNAVAIRPAC and COMNAVAIRLANT were the approval authority for research issues.

Also, a letter of endorsement was obtained from the head of the division of Navy Medicine that governs health care on aircraft carriers (Director, Aerospace Medicine Programs [MED-23] at the Bureau of Medicine and Surgery [BUMED] in Washington, D.C. – see Appendix D for the endorsement).

Based upon the recommendation of the Navy Nurse Corps' Career Plans Officer in the Staff of the Nurse Corps Division (MED-00NC) at BUMED, the endorsement of the Navy's Specialty Leader for Operational Nursing was acquired (see Appendix E for the letter). Thus, all levels involved in shipboard nursing aboard aircraft carriers were "in the loop."

Finally, it was learned that there was no need to obtain permission from PERS-OOH (the division of the Bureau of Navy Personnel that was responsible for the coordination and control of all surveys, including interviews) for this project because PERS-OOH was only interested in approving quantitative surveys involving Navy personnel (Commander Rossi, personal communication, July 20, 1999). PERS-OOH communicated that asking one research question, which fell in the qualitative research domain, was of no concern to PERS-OOH. PERS-OOH recommended obtaining approval for the study through the Institutional Review Board (IRB) at one of the major medical centers in the Navy.

Because these nurses were stationed all over the United States, and because it would be logistically difficult to try to obtain IRB approval from the nurses' current commands, the IRB at the National Naval Medical Center (NNMC), Bethesda, MD agreed to conduct the IRB approval process that would cover all the nurses involved in this study (see Appendix F for approval letter). Additionally, because this study was funded by the Tri-

Service Nursing Research Program (TSNRP), and TSNRP is associated with the Uniformed Services University of Health Sciences (USUHS) in Bethesda, MD. USUHS also gave its IRB approval (see Appendix G for approval letter).

Ethical Considerations

Qualitative research has some unique ethical considerations. Because the interviews were taped, anonymity was not possible. Therefore, all measures to ensure confidentiality were taken. For this study, all of the participants were asked to sign written informed consent in order to participate in the study. Audiotapes were returned to the participants upon completion of this research endeavor. It is important to note that the original consent form stated that the audiotapes would be destroyed; however, permission was granted by all three IRBs to return the audiotapes to the participants so that the nurses could decide what they wanted to do with the audiotapes (e.g., keep them, destroy them, or donate them to a Navy historical organization since the audiotapes represented a part of their oral Naval history).

All data were stored in locked filing cabinets. A codebook containing code numbers and names and addresses of informants was stored in a locked file cabinet separate from all other data. Participants were assured that their identities would not be revealed. In fact, all of the nurses received a copy of this dissertation's Chapter IV and were asked to convey to me whether they wanted me to change anything that they felt compromised their confidentiality – no changes were necessary. Finally, any publications resulting from these data will be devoid of identifying information.

It is interesting to note that most of the participants were not as concerned with maintaining their confidentiality as I was. Several asked if I had talked to "so-and-so;" whereby, I told them that only "so-and-so" could tell them that. This community of nurses is very small so by the time I got to the twelfth interview, most of the participants had already deciphered whom I had probably interviewed even though I personally did not discuss this information with them.

In an attempt to avoid a fear of coercion, military rank was not used when coordinating and conducting the interviews. Civilian attire was worn when meeting with the participants. Because the day-to-day activities of life on an aircraft carrier could involve classified information, the participants were directed not to reveal any information they thought might be considered classified.

Finally, in congruence with the roles and responsibilities of being an officer in the Navy Reserves, I was concerned that I would have to report sensitive information (e.g., reports of fraternization, homosexual activity, drug use, etc.) if revealed in an interview. However, after a conversation with the Department Head of the JAG Corps at the Navy Yard in Washington, D.C. (Lieutenant Commander Gordon, personal communication, October 21, 1999), I learned that I had no obligation to report any revealed sensitive information because I was not acting in an official capacity for the Navy when the interviews were conducted.

Potential Benefit

Participants did not receive any compensation for participation. The potential benefit for the participants to partake in this study came from the opportunity to share their

experience and to know that their unique perceptions would contribute to advancing nursing practice on board aircraft carriers.

Hutchinson, Wilson, and Wilson (1994) identified several benefits (including catharsis) when participating in qualitative interviews. Several of the participants in this study sent e-mail messages following the interviews whereby they remarked how “cathartic” (one mentioned “therapeutic”) the interview experience had been.

Potential Risks/Inconveniences

The known risks associated with participating in this study were the prospect of awkward or embarrassing events during the interview and the possible loss of composure when dealing with emotional issues (Streubert & Carpenter, 1995). If any of the participants displayed any signs of stress or anxiety associated with the interview, I was prepared to inform him or her of my desire that the participant access the military health system and/or contact appropriate support organizations. In a conversation with the Department Head of the Judge Advocate General (JAG) Corps at the Navy Yard in Washington, D.C. (Lieutenant Commander Gordon, personal communication, November 1, 1999), it was clarified that if the participant expressed an unwillingness to use available services, I was released from any liability. Fortunately, this situation never arose during any of the 12 interviews.

Subject Rights

Participants were mailed a copy of the consent form (see Appendix H for document) to review prior to the interview. The consent form was then signed in person prior to the start of the interview and the participants were then given a copy of the signed consent at

the same time. The consent form included my e-mail address, telephone number, and all other required information as well as the statement that they could withdraw from the study at any time. Because there was no way to know exactly what might transpire during each interview, consent was viewed as an ongoing transactional process.

Data Collection

Bracketing

I utilized two processes that supported the concept of bracketing. First, I fully illuminated my own pre-conceived ideas about the phenomenon of interest through documentation in a journal (Streubert & Carpenter, 1999). Further, journaling occurred prior to and following each interview. Through this procedure, I attempted to maintain my ideas and conceptions about the phenomenon foremost in my consciousness prior to and during data collection and data analysis. Murphy (1998) acknowledged that it was almost impossible to be entirely free of preconceptions; however, it was possible to control them. In actuality, I felt that this journaling exercise was not helpful because I had no difficulty with bracketing my preconceptions (or, at least, "controlling" them). Second, Locke, Spirduso, and Silverman (1993) recommended crosschecking the researcher's perceptions and decisions with a colleague whenever it appears that individual biases may influence the project. I was able to utilize this crosschecking method with my Dissertation Chair, Dr. Jeanne M. Sorrell, and my consultant, Dr. Helen J. Streubert, because both made themselves readily available to me and promptly responded when I needed guidance.

Context of Interviews

According to Creswell (1998), phenomenological study requires in-depth interviews. The primary data collection strategy for this study was the use of tape-recorded personal interviews. In keeping with Streubert and Carpenter's (1999) recommendations, the interviews took place in settings familiar (and comfortable) to the participants so that each respondent could share his or her perceptions freely. Taylor and Bogdan (1998) professed that most people feel comfortable and relaxed in their own homes and offices; thus, each participant was allowed to choose the place he or she felt most comfortable (and where privacy was assured). Five participants were interviewed in their offices, five were interviewed in their homes, one was interviewed in a hotel lounge, and another was interviewed in my hotel suite. The interviews were conducted from September to mid-December of 2000. I traveled within the United States to the East Coast, the West Coast, and to the South to conduct the interviews (the exact locations are not disclosed in order to maintain the participants' confidentiality).

The participants were initially contacted either by telephone, in-person, or via e-mail prior to the formal interview session in order to solicit their interest in the study and to give them time to reflect on the phenomenon of study. It was anticipated that a period of reflection would enable richer descriptions during the interview (Streubert, 1991). Once the nurses agreed to participate in this study, they each received a package that contained a cover letter that addressed the nature of the study and a copy of the informed consent form.

Prior to the start of the formal interview, informed consent was documented and demographic data (see Appendix I for the demographic sheet) were obtained (in order to fully place the data into context). The demographic data included:

1. Gender
2. Race
3. Age
4. Marital Status
5. Educational preparation
6. Length of time in the Navy
7. Current rank and rank while on the ship
8. Current duty status – active duty, reservist, retired, or civilian
9. Number of years on the ship
10. Length of time since leaving the ship
11. Number of tours of duty on a ship

Each interview began with the question: “What was your experience as a nurse on an aircraft carrier?” (see Appendix J for the interview sheet). The participants were encouraged to fully describe their perceptions without being interrupted or led by me. I maintained a balanced rapport whereby I was both casual and friendly but also directive (Fontana & Frey, 1998). During the course of each interview, any unclear descriptions were clarified. Taylor and Bogdan (1998) cautioned researchers to always clarify a participant’s remarks and never assume that one knows what the participant means. They recommended using the following phrases when clarifying remarks:

1. What do you mean by that?
2. I don’t follow you exactly.
3. Explain that again. (p. 63)

In addition to clarifying remarks, I also became comfortable with probing participants. According to Taylor & Bogdan (1998), a successful interviewer knows when and how to probe. Two styles of probes that proved useful for these 12 interviews were the

recapitulation probe and the silent probe. As per Sorrell and Redmond (1995), recapitulation is used when the participant stops talking and the researcher directs the individual to return to previous comments in order to clarify or elaborate on his or her description. When participants are asked to retell parts of their stories by returning to the beginning, they often add new details. The researcher should also recognize periods of silence as being important because "powerful silence ... may speak more than words" (Sorrell & Redmond, p. 1121). Thoughtful probes can also bring out important contextual details that are embedded in each participant's narrative. The following questions may help the respondent to reflect on the experience of interest:

1. How were you feeling at that time?
2. What else was going on then?
3. Tell me more about that (Sorrell & Redmond, p. 1122)

Seidman (1998) offered some specific suggestions that assisted me with my interviewing techniques:

1. Listen more, talk less
2. Follow-up on what the participant says but don't interrupt
3. Ask questions when you do not understand
4. Ask to hear more about a subject
5. Avoid leading questions with tones that imply an expectation
6. Ask open-ended questions
7. Keep participants focused and ask for concrete details
8. Avoid reinforcing your participants' responses
9. Explore a participant's laughter (Seidman writes that laughter can be a cry of pain and silence may be a shout)
10. Follow your hunches, trust your instincts
11. Tolerate silence (pp. 63-78)

When the participant felt he or she had expended his or her description, I offered the concluding question: "Is there anything that you have not offered, either positive or

negative, about the experience that you would like to add?" According to Streubert and Carpenter (1999), requesting negative descriptions of the phenomenon assists the researcher with determining authenticity and trustworthiness of the data (by allowing data to be compared and contrasted). If there were no additions, the interview ended. The interviews lasted anywhere from 38 to 110 minutes (an average of 81 minutes per interview).

The interview sheet contained additional questions in the event that any of the participants were not very talkative. In actuality, only two of the participants required the use of any of these questions. These two participants required some thoughtful probing after silent probes produced nothing but silence. With the remaining 10 participants, all I had to do was ask the initial question and it was literally a half-hour to an hour before I ever got to make a comment, clarify a remark, or ask for the participant to recapitulate a story.

Finally, more than one type of data were collected. This involved:

1. Asking participants to bring any journals, diaries, letters, records, calendars, memorabilia, and/or photographs they wished to share regarding their experiences on the aircraft carriers (Taylor and Bogdan [1998] felt that personal documents can be used to guide interviews and that later in the interviews, they may even "spark memories and help people recall old feelings" [p. 105])
2. Taking notes during the interviews (Seidman [1998] encouraged documenting all non-verbal signals such as coughs, laughs, sighs, pauses, outside noises, and interruptions [p. 98])
3. Making arrangements for the participants to contact me after the interviews for "ah-ha" types of questions (my e-mail address and phone number were made available to the participants in order to accomplish this goal)

Only a minority of the participants brought personal artifacts to the interview. Two had actually composed an outline of what they wanted to cover in the interview (which

made my job easier). Some note taking occurred; however, I found myself distracted when I was constantly writing so I minimized my note taking despite Seidman's (1998) recommendations. Following the interviews, all of the participants corresponded with me via e-mail to clarify remarks or to offer further information.

Interviews were conducted until saturation occurred (when no new themes emerged). In retrospect, saturation was probably reached by interview number six or seven; however, this fact was not fully appreciated until the last two interviews. This impression is validated by Sandelowski's (1995) comment that novice qualitative researchers, such as myself, often require more sampling units than experienced researchers and that saturation may not be recognized until more data are collected.

Pilot Testing

The interview approach for this study was pilot tested twice prior to starting the interviews. Based upon the recommendations of this Dissertation Committee, and those of the qualitative researchers who reviewed the TSNRP grant proposal regarding this study, these pilot data were eventually included in the overall findings of this inquiry because the interviews were conducted in the same manner and the data were consistent with that obtained in the subsequent interviews. According to Sorrell and Redmond (1995):

Trying out a variety of openings and probes before undertaking the actual research interview will help the interviewer to avoid situations where a respondent reacts with long silences, confusion, or irrelevant chatter. Use of a pre-interview may also help to prepare both the interviewer and the respondent for the experience of the future interview. (p. 1118)

Seidman (1998) wrote that pilot interviews might alert researchers to elements of their own research techniques that either contribute or distract from the objectives of the study. This warning reflected the experience of my first interview whereby I noticed that I said, "Uh, hum" a lot (especially towards the end of the interview). I made sure that I did not repeat this habit for the remaining interviews because I did not want to give the participants the impression that I was in a hurry for the interview to end or that I was getting bored (which was not the case at all). I found that my interviewing technique got much better with subsequent interviews.

Incidentally, Perry (2001) and Morse (1997) questioned the use of pilot studies (not pilot interviews) in qualitative research because the goal of the research is to gain an understanding of the phenomenon; however, patterns may be difficult to identify when the data are not complete enough for a thorough analysis. Those seeking funding for qualitative research may be turned down, based on their pilot studies, because reviewers may not be impressed with the limited findings of the pilot studies.

Obstacles

A back-up tape recorder, extra batteries, and extra tape cassettes were brought to each interview. Despite these precautions, some difficulties did emerge. Toward the end of the fourth interview, the batteries started to die; unfortunately, this was not noticed until I was already conducting the fifth interview (when I observed that the tape recorder was not recording). These two interviews were conducted on the same day, back-to-back; therefore, I did not have a chance to listen to the fourth interview (to ascertain if the interview was comprehensible) until the end of the day (when the fifth interview had

already occurred). My transcriptionist was able to recapture some of the data from the fourth interview (which sounded very fast when the audiotape was listened to at normal speed) and the participant chose to e-mail the response to me regarding the final question. As for the fifth interview, when I noticed what had happened, I replaced the batteries, reassured the participant that all was not lost, quickly jotted down what the participant had been talking about prior to the interruption, and resumed the interview. The next day, I listened to the interview and, in conjunction with my notes, determined that three narrative stories had been lost. I offered the participant the opportunity to recapture the stories via a telephone interview; however, this participant elected to e-mail a response to me instead.

Given my experience with lost data, I would offer future researchers the following tips when tape recording interviews:

1. Bring a back-up tape recorder, extra batteries, and extra tape cassettes to each interview.
2. If possible, use a tape recorder that is powered by an electrical source (and only use the battery-powered feature when an electrical source is not available).
3. If one has to use a battery-powered device, then always place new batteries in it prior to each interview. This may seem like a waste of money but replacing batteries frequently is much cheaper (both monetarily and psychologically) than losing precious data.
4. Never schedule interviews back-to-back (in my case, I had just flown cross-country, to an unfamiliar area, with a three-hour time difference, the night prior to both interviews. The fourth interview lasted longer than expected, which made me late for the fifth interview. In retrospect, I should have scheduled the interviews on subsequent days; however, I was on a predetermined budget so I had to make the best use of my time. Being exhausted, in an unfamiliar setting, and feeling rushed may have contributed to this episode of lost data).

Incidentally, telephone interviews were considered for this study. However,

according to Polit and Hungler (1995), "when the interviewer is unknown, respondents

may be uncooperative and unresponsive in a telephone situation, especially if the interview is long" (p. 188).

Data Analysis

Transcription

The first interview was personally transcribed for a class exercise. In December 2000, after all of the interviews had been conducted, the remaining 11 interviews were sent to DataSense, LLC (<http://www.datasense.org>) in Bakersfield, CA for transcription. As a precaution to losing data, the tapes were duplicated prior to mailing (in case they got misplaced or destroyed in the mail). See Figure 1 for specifics of the interviews.

Participant Number	Date of Interview	Location of Interview	Length of Interview (in Minutes)	Interview Transcripts (Number of Pages in 12-point Font)
1 (Pilot)	04/11/00	Office	110	35
2 (Pilot)	07/17/00	Home	98	28
3	09/09/00	Home	106	30
4	09/21/00	Office	90	23
5	09/21/00	Office	101	26
6	09/22/00	Home	63	19
7	09/22/00	Office	38	10
8	10/04/00	Hotel Lounge	90	22
9	10/06/00	Home	62	17
10	11/02/00	Hotel Suite	87	19
11	11/16/00	Home	52	12
12	11/17/00	Office	80	18

Figure 1: Specifics of Interviews

Steps in Data Analysis

Data analysis took four months and included four steps:

1. Carefully reading the interview transcripts to obtain a general sense of the experience
2. Reviewing the transcripts to uncover essences
3. Apprehending essential relationships
4. Developing a formalized, exhaustive description of the phenomenon

Steps in data analysis: Step one.

In-depth analysis commenced after all the interviews were completed. Seidman (1998) reported that some researchers think that interviewing and analysis should be integrated so that each informs the other. However, Seidman advocated avoiding any in-depth analysis of interview data until all have been completed in order to avoid imposing meaning from one participant's interview onto the next. Dr. Streubert (personal communication, July 10, 2000) also recommended not analyzing the data until after all of the interviews had been completed so as to not impose the researcher's thinking about the previous interview onto the new interview. Additionally, Dr. Streubert thought this might become a means of directing the participants into the researcher's line of thinking (thus, introducing bias into the interview). Dr. Streubert preferred to keep each interview as "clean" as possible.

The first step involved reading the transcripts while listening to the audiotapes so that the accuracy of the transcriptions could be verified. During this phase, I was amazed at how much I remembered about the circumstances surrounding each interview. Once I started listening to the audiotapes, I could remember where I sat for each interview, what

each participant was wearing, etc. Listening to each interview triggered my memory of the interview and it felt like each interview had just taken place.

Verifying the accuracy of the transcriptions also provided me with my first opportunity to begin “dwelling in the data.” Streubert (1991) described dwelling in the data as the time and reflection committed to reading the interviews over and over and becoming immersed in their content. This process is also called immersion (Streubert & Carpenter, 1999). Once I verified the transcriptions (which took several weeks), I sent copies back to the participants in order to give them a piece of their Navy history. I also asked them to verify the transcriptions for accuracy and to notify me of any thoughts that occurred since each interview. All of the participants appreciated receiving the transcriptions, and only one provided additional information.

Steps in data analysis: Step two.

The second step involved reviewing the transcripts to uncover the essences. Essences compose the basic units of common understanding of any phenomenon (Moyle & Clinton, 1997; Streubert, 1991; Streubert & Carpenter, 1999). This step entailed a sentence-by-sentence review to identify any themes that might eventually create an essence.

Data organization was aided through the use of the computer program entitled NVivo. NVivo is a descendant of NUD*IST. It uses an index-based approach composed of a document system (that holds the textual-level data about documents) and an index system (that allows one to create and manipulate concepts and store and explore emerging ideas) (Richards & Richards, 1998). St. John and Johnson (2000, p. 394) listed the following advantages of using qualitative data analysis software:

1. Allows one to deal with large amounts of qualitative data
2. Reduces the amount of time needed for manual handling tasks
3. Increases the flexibility and thoroughness in handling the data
4. Provides a visible audit trail in data analysis

During this second phase of data analysis, the transcripts were reviewed repeatedly to gain an overall impression of the data. Over 2,500 passages pertaining to the lived experience of shipboard nursing aboard aircraft carriers were eventually isolated and assigned to 98 codes (otherwise known as “nodes” in NVivo). St. John and Johnson (2000) cautioned that with so many codes, researchers may not remember all of the established codes and that they “may not be able to see the conceptual ‘forest’ for the coding ‘trees.’” (p. 395). I did find myself drowning in the number of codes I created so at this point (during the coding of the fourth transcript), I organized the 98 codes by creating five “umbrella” categories (i.e., coping, relationships, life at sea, shipboard nursing, and recommendations) and placing each code into one of these five categories (see Appendix K for coding documentation). These umbrella categories did not readily translate into essences – they only assisted me with ordering my coded descriptions. Data management occurred when some of the codes obviously went with others – “By moving the uncoordinated nodes [codes] into connected groups, you start to get a sense of a system of categories, rather than just a mess” (Richards, 1999, pp. 67-68).

Steps in data analysis: Step three.

Once the transcripts were coded, I proceeded with the third step of apprehending essential relationships. Using NVivo, I ran an “assay scope” of all of the codes in relation to each participant. The assay scope of 98 codes revealed which codes were common to

the participants (meaning that seven to 12 of the participants had significant statements attributed to that code) and which codes were not (meaning that less than six of the participants had significant statements related to that code). I then printed the NVivo assay scope of the significant common codes, along with their extracted passages, and used these reports to apprehend essential relationships.

During this step of data analysis, and in support of bracketing, I shifted from Husserl's "natural attitude" to the "phenomenological attitude" in order to understand the true meaning of the phenomenon of interest – nurses' experiences while stationed on aircraft carriers. By reading and re-reading the extracted passages of the common codes, I practiced eidetic reduction through "free variation" whereby I allowed my imagination to examine all of the possible forms the experience could take from all possible angles. By adding and deleting certain features, and recognizing when the experience no longer exemplified the concept, I identified what was essential to the experience. During this phase, uncommon experiences were laid aside and common areas were focused upon. Once an essence emerged in my imagination, I wrote it down and then proceeded to the fourth step of data analysis in order to describe it. Six essences were eventually identified and are described in the overall exhaustive description that is discussed in the next step of the data analysis process.

Steps in data analysis: Step four.

The fourth step was developing a formalized, exhaustive description of the phenomenon. At this point, I used the word processing capabilities of my computer and entered and deleted portions of the description until I felt I had captured an accurate

depiction of the essence. When in doubt, I returned to the extracted passages of the common codes and read and re-read them until I felt I had accurately represented the essence I was attempting to describe.

This exhaustive description was a compilation of the commonalities (as determined by the essences) across all 12 interviews and its success was determined by whether the participants agreed that the exhaustive description did indeed reflect their experience as the ship's nurse on an aircraft carrier. The initial exhaustive description I wrote was shared with the study participants, the Committee Members of my dissertation process, and Dr. Streubert. The participants offered minor suggestions, and after some fine-tuning of the essences with both Dr. Streubert and Dr. Sorrell, a final exhaustive description was formed. This final version of the exhaustive description was again shared with the participants of this study and it was determined that no further modifications were needed. During the writing of this description of the essences that I identified through intuition, I was dedicated to Husserl's belief to begin and end with what was given.

According to Huberman and Miles (1998), there is a danger that multiple cases that focus on abstract common characteristics may end up with a set of generalizations that may not apply to any single case. When asked if the exhaustive description may become too condensed or watered-down, Dr. Streubert (personal communication, July 10, 2000) replied that it is important to describe the common experience (not each individual's experience) – the object of this methodology is to identify the common elements across all descriptions. One should not lose the richness of the data if one has clearly captured the experience of those interviewed. As with quantitative research, one can never report on

everything. I am confident that I have captured the common elements, across all of the descriptions, regarding the lived experience of shipboard nursing aboard aircraft carriers.

Criteria for Judging the Quality of an Inquiry

Despite over 20 years of experience with defining qualitative research terms, Denzin and Lincoln (1998a, 1998b) concluded that the issue of quality criteria for qualitative research is not resolved and thus invite further critique of the process. Cutcliffe and McKenna (1999) and Emden and Sandelowski (1998, 1999) visited this issue and reported that some qualitative researchers believe that others are doing themselves a disservice when they try to equate qualitative methods with those used by quantitative researchers.

Lincoln and Guba (Lincoln & Guba 1985; Denzin & Lincoln, 1998a, 1998b) are pioneers in the field of qualitative inquiry. They are committed to the paradigm of "constructivism" (which they previously called "naturalistic inquiry") in informing and guiding inquiry. The aim of constructivist inquiry, like phenomenology, is to produce understandings. The term constructivism denotes an alternative paradigm whose main objective is to move away from the positivist and post positivist belief that reality cannot be apprehended. Constructivists believe that reality can be apprehended from the individuals who experience that construction. With constructivism, the positivist and post positivist criteria of internal and external validity are replaced with the terms "trustworthiness" and "authenticity." Trustworthiness incorporates the terms of "transferability" (which parallels external validity); "dependability" (which parallels reliability); and "confirmability" (which parallels objectivity).

Transferability (fittingness) refers to the likelihood that the findings will have meaning outside of the study situation. Some researchers believe it is up to the reading audience as to whether the findings are transferable (e.g., Greene, 1990; Lincoln & Guba, 1985; Sandelowski, 1986; and Streubert & Carpenter, 1999).

Dependability is a criterion of neutrality. By minimizing subjectivity, through neutrality, credibility of the findings may be maximized. There can be no dependability unless credibility has been established (Lincoln & Guba, 1985). "The question to ask is, 'How dependable are these results?'" (Streubert & Carpenter, 1999, p. 29). Lincoln and Guba recommend having an "auditor" inspect the process by which the accounts were acquired and examine the product for accuracy.

My auditor for this study was my phenomenology consultant, Dr. Helen J. Streubert (Streubert, 1991; Streubert & Carpenter, 1995, 1999) (see Appendix L for Dr. Streubert's letter of agreement). I sent Dr. Streubert a binder containing copies of each interview transcript; copies of my NVivo data analysis documents; and a copy of my initial exhaustive description (which contained 11 initial essences). Without looking at my data analysis or exhaustive description, she read and hand-coded all 12 interviews. Dr. Streubert then compared her data analysis with mine, read my exhaustive description, and discovered that our findings had more similarities than differences. We then conversed on the phone (personal communication, April 29, 2001) about our findings and Dr. Streubert suggested three essences: constantly operating in an environment of uncertainty, having two families, and leaving a legacy (see Chapter IV for further discussion about the essences). After further consultation with the Chair of my Dissertation Committee, Dr.

Sorrell, I reworked, renamed, and consolidated my 11 initial essences into six essences: experiencing the best but toughest job the Navy has to offer its nurses; ensuring operational readiness; being one-of-one; operating constantly in an environment of uncertainty; having two families; and making the job better for the next generation. The last essence (making the job better for the next generation) was changed from Dr. Streubert's initial suggestion that the nurses wanted to leave a legacy because Dr. Sorrell and I felt that the passages that related to this essence pertained more to recommendations rather than leaving something behind.

"Confirmability [audibility] is a process criterion" (Streubert & Carpenter, 1999, p. 29). The way the researcher confirms the findings is by leaving an audit trail. The audit trail consists of raw data, memoranda, communications, thought processes, etc. (Lincoln & Guba, 1985). The purpose of the audit trail is to document decisions made.

Lincoln & Guba (1985) also believed in the concept of "credibility." Credibility includes activities that increase "the probability that credible findings will be produced" (p. 301). To confirm the credibility of the findings, the researcher shares the outcome with the participants. If the participants recognize the findings to be true to their experience, then credibility has been established (Yonge & Stewin, 1988). When each participant read the one exhaustive description, he or she should have thought, "Yes, this is true. This reflects my experience as a nurse on an aircraft carrier." Lincoln and Guba called this activity "member checking." Taylor and Bogdan (1998) wrote that even if a participant rejects one's interpretation, the rejection might enhance the researcher's understanding of the participant's perspective. Seidman (1998) reported that sharing the descriptions is

crucial for credibility of the study; however, Seidman “would not give the person automatic censure on matters of interpretation” (p. 54).

After some minor changes, all 12 of the participants verified that the exhaustive description accurately described their experience as the ship’s nurse on each carrier, thus, credibility was established. One participant felt that it did not incorporate all this particular nurse did on the ship once the participant became an Assistant Department Head. However, this nurse was the only participant who became the Assistant Department Head during the tour on the ship. Once I explained how the exhaustive description involved the commonalities of the job, and that this participant’s reflections would be portrayed in the write-up of this dissertation, the nurse was pleased.

Dissemination of Findings

Streubert’s last methodological step entailed distributing the findings to the nursing community (Streubert & Carpenter, 1999). I plan to disseminate the findings through this dissertation process, by addressing Navy administrators, via publications in peer-reviewed journals, and by presenting at three national conferences.

Funding

In 1998, I submitted a research proposal to the Tri-Service Nursing Research Program (TSNRP). Because my research was judged to have high potential, I was awarded a \$4483 training grant to assist me in refining the grant application. In 1999, I submitted the revised proposal and subsequently was awarded \$21,341 to study the phenomenon of nursing aboard aircraft carriers (see Appendix M for approval letter).

This grant paid for my:

- **Consultant**
- **Computer**
- **Printer/copier/scanner/fax machine**
- **Computer software to organize data**
- **Tape recorders**
- **Office supplies**
- **Travel to the East Coast, West Coast, and to the South to conduct the interviews**
- **Transcription costs**
- **Postage, phone, and printing costs**
- **Attendance at one national meeting to present findings**

Chapter Summary

This chapter described the methodology used in this study and included the research design, sample, protection of human rights, data collection, data analysis, criteria for judging the quality of an inquiry, dissemination of findings, and funding of this inquiry.

Chapter IV will present the findings that emerged from this study.

CHAPTER IV

Findings

This study was designed to describe the lived experience of shipboard nursing on aircraft carriers. The methodology addressed in the preceding chapter was used to analyze the lived experience of 12 participants. In this chapter, “just the given” will be offered. The participants’ profile from the demographic sheet will be presented first, followed by the exhaustive description, its corresponding essences, and miscellaneous discoveries.

Participants’ Profile

In order to protect the participants’ confidentiality, a summary of the background information obtained from the demographic sheet (see Appendix I), rather than more specific information (e.g., the participant’s interview number linked with gender, age, and rank) is presented. The demographic information was gathered from the participants prior to the start of each interview. The sample included six females and six males between the ages of 32 and 45 years of age (mean = 40) at the time of the interviews. When first assigned to the ships, their ages ranged from 29 to 40 years old (mean = 36). All 12 nurses were Caucasian.

All of the participants were on active duty at the time of the interviews and their length of time in the Navy ranged from eight to 22 years (mean = 14). The participants’ assignment on the ship ranged from a two to three-year period (six spent two years, three

spent almost two-and-a-half years, and the remaining three spent three years on the carriers). The participants' length of time since leaving the ships at the time of each interview ranged from several months to four years (eight left less than a year before the interview, two left within two years of the interview, and two had left four years prior to each interview). Six of the participants had previous experience on Navy ships prior to the carrier tour.

The Navy rank structure for officers is as follows:

1. Ensign (ENS – level O-1; equates with Second Lieutenant in other services)
2. Lieutenant Junior Grade (LTjg – level O-2; equates with First Lieutenant in other services)
3. Lieutenant (LT – level O-3; equates with Captain in other services)
4. Lieutenant Commander (LCDR – level O-4; equates with Major in other services)
5. Commander (CDR – level O-5; equates with Lieutenant Colonel in other services)
6. Captain (CAPT – level O-6; equates with Colonel in other services)

At the time of the interviews, three of the participants were lieutenants, three were lieutenant commander-selects (promotions pending), one was a commander-select (promotion pending), and the remaining were commanders. When assigned to the ships, the nurses were more junior in rank. One was a lieutenant junior grade, six were lieutenants, four were lieutenant commanders, and one was a commander-select (promotion pending). Five of the participants' highest level of education was a bachelor of science in nursing (BSN) and the other seven held masters degrees at the time of the interviews.

Exhaustive Description and Its Corresponding Essences

Exhaustive Description

The exhaustive description is presented and is followed by its corresponding essences and their interpretations (note that the underlined portions of the following text correspond with an identified essence):

The nurses felt that shipboard nursing on aircraft carriers was one of the best but toughest jobs the Navy has to offer its nurses. They experienced a great sense of pride in being called the "Ship's Nurse" and enjoyed being a member of each ship's company. Carrier nursing was a worthwhile experience that included both rewards and challenges. The rewards included practicing in an autonomous environment; going to sea and experiencing what the Navy was all about; feeling a sense of mission and contributing to that mission; and traveling to unique locations. Among the job's challenges were working in a dangerous work environment that incapacitated or even killed shipmates; being away from home when deployed; participating in work-ups; navigating equipment and supply issues; and adjusting to the constant turnover of both the medical department personnel and the ships' crew.

The nurses' primary and most time-consuming job was ensuring operational readiness by coordinating the medical training team (MTT). In this capacity, they developed scenarios, simulated medical casualties throughout the ship, and conducted various briefings regarding each drill. Orchestrating these exercises, and being a member of the larger Integrated Training Team (ITT), involved substantial assimilation with all of the departments on the ship; consequently, the nurses got a lot of face time with each ship's Commanding Officer (CO), Executive Officer (XO), and Department Heads.

The nurses were considered one-of-one because they were the only nurse assigned to their carrier as the "Ship's Nurse." Not only did they represent nursing services for their ship, they were nursing services. The nurses felt an incredible sense of responsibility to their job. They were on call 24-hours a day, seven days a week. The nurses knew their ships inside and out and made it a point to visit all of the ships' spaces, especially in their capacity as coordinators of the medical training teams. It was not uncommon for the nurses to be stopped in the passageways and consulted on matters ranging from the crew's own health care needs to questions about a family member's health status. Everyone on the ship recognized the nurse.

The nurses constantly operated in an environment of uncertainty. They could never be sure of what was going to happen next and always wondered about the "ifs": if

their qualifications were sufficient to get the job done; if they could trust their corpsmen with the inpatient ward; if the ships' crew could manage a trauma victim given the training the nurses had coordinated for them; if they could handle a critically injured patient in their Intensive Care Unit; and if they could manipulate the sometimes archaic equipment they had inherited. The leadership capabilities of each commanding officer (CO), executive officer (XO), and senior medical officer (SMO) set the tone for the nurses' work environment. Feeling a strong sense of support from these individuals was paramount in allowing the nurses to excel in their role as the ship's nurse while practicing in an environment of uncertainty.

The nurses had two families: their significant others and their shipmates. Working with the Line community was a great experience for the nurses. Never before had they seen such amazing teamwork, and felt such a sense of camaraderie, and they realized that once they left their ships, they would most likely never experience this again. Because they worked, lived, ate, and socialized with the crew, they learned about their lives. Enduring tough times, such as work-ups, brought the nurses and their shipmates together as a family. When all was said and done, they had a true appreciation for the Line and felt that the Line had developed an understanding and respect for them not only as Navy nurses, but also as Naval officers.

The nurses wanted to make the job better for the next generation. Because their own shipboard orientation had been varied and ill defined, they felt it imperative that their replacements be better prepared than they were when each assumed the duty of an aircraft carrier nurse. This philosophy spilled over into their subsequent tours whereby they took advantage of opportunities to prepare their Navy colleagues for operational assignments.

Corresponding Essences and Their Interpretations

The lived experience of shipboard nursing on aircraft carriers was best described by the following six essences:

- A. Experiencing the best but toughest job the Navy has to offer its nurses
 1. Pride
 2. Rewards
 - a. Practicing in an autonomous environment
 - b. Going to sea and experiencing what it was all about
 - c. Feeling a sense of mission and contributing to that mission
 - d. Traveling to unique locations
 3. Challenges
 - a. Working in a dangerous work environment
 - b. Being away from home when deployed

- c. Participating in work-ups
 - d. Navigating equipment and supply issues
 - e. Adjusting to the constant turnover of both the medical department personnel and the ships' crew
- B. Ensuring operational readiness
- 1. Coordinating the medical training team (MTT)
 - 2. Integration
 - 3. Other job responsibilities
- C. Being one-of-one
- 1. 24/7
 - 2. Sense of responsibility
 - 3. Lack of sleep
 - 4. Respect
 - 5. Replacements
 - 6. Time-consuming job
 - 7. Isolation
 - 8. Peers
 - 9. Liberty
 - 10. Visiting the ships' spaces
 - 11. Everyone recognized the nurse
- D. Constantly operating in an environment of uncertainty
- 1. Stressful
 - 2. Training of the corpsmen
 - 3. Equipment
 - 4. Leadership
- E. Having two families: significant others and shipmates
- 1. Teamwork
 - 2. Camaraderie
 - 3. Surface Warfare Medical Department Officer (SWMDO) pin
 - 4. Showing off the Nurse Corps
 - 5. Appreciation and respect
- F. Making the job better for the next generation
- 1. Orientation
 - 2. Preparation of successors
 - 3. Preparation of colleagues
 - 4. Recommendations

Additionally, three essences emerged as miscellaneous discoveries (meaning they were important enough to be discussed by the participants but were not felt to contribute to the exhaustive description). They were: (a) women on ships, (b) anesthesia, and (c) shipyard (drydock).

The preceding headings are used to organize the following text. Exemplars follow each essence and there are some occasions whereby the exemplars overlap with other essences. Descriptions that best illustrate the essences are offered. Some of the exemplars have been edited (without changing the meanings' intent) in order to make the text clearer to the reader. The first essence – Experiencing the Best but Toughest Job the Navy Has to Offer Its Nurses – was clearly the essence that dominated all of the participants' descriptions. The remaining essences are presented in no particular order.

Experiencing the Best But Toughest Job the Navy Has to Offer

Corresponding Essence in the Exhaustive Description

The nurses felt that shipboard nursing on aircraft carriers was one of the best but toughest jobs the Navy has to offer its nurses. They experienced a great sense of pride in being called the "Ship's Nurse" and enjoyed being a member of each ship's company. Carrier nursing was a worthwhile experience that included both rewards and challenges. The rewards included practicing in an autonomous environment; going to sea and experiencing what the Navy was all about; feeling a sense of mission and contributing to that mission; and traveling to unique locations. Among the job's challenges were working in a dangerous work environment that incapacitated or even killed shipmates; being away from home when deployed; participating in work-ups; navigating equipment and supply

issues; and adjusting to the constant turnover of both the medical department personnel and the ships' crew.

Pride

Upon reflection, the nurses proudly recalled what a unique opportunity they had experienced when serving as the ship's nurse on an aircraft carrier. A prevailing thought among the interviews was exemplified by the comment:

Gosh, it's a good feeling to be called 'ship's nurse.' There's only one of you.
(Interview 3, Section 2, Paragraph 7)

There were times that the nurses could not believe that they were actually in the Navy doing something that only a small percentage of Navy nurses ever get a chance to do: serve on a Navy vessel! In their role as the ship's nurse, they constantly remembered that they represented the United States in their role as Naval officers:

I think being part of a big command that has such an enormous mission, you get this great sense of pride that just comes out of you. It's like, 'Wow!' You see yourself steaming in with the whole battle group and you are part of something that is striving to represent this country. You're working up so that you can deploy and essentially be the ambassador. That's how we were made to feel. It was impressed upon us that you're the ambassador. So to be part of that as a nurse, you're thinking, 'I was in nursing school. Never did I think I'd be considered an ambassador of my country representing this ship ashore.' (Interview 4, section 0, Paragraph 7)

Rewards: Practicing in an Autonomous Environment

All of the nurses came to this sea duty tour after having completed at least one rotation at a military treatment facility (MTF). At the MTF, the nurses performed clinical duties similar to their civilian counterparts. Although they knew that once they reported to the fleet, their roles would change, they never imagined that they would experience as

much autonomy as they did. They were amazed, and sometimes intimidated, at the latitude given to them when defining their role as the ship's nurse:

I enjoyed the work. It was the first time in my professional career that I had the autonomy that I did. Usually the SMOs [senior medical officers] allowed me to make the decisions. I followed orders just like you normally do, but I was the one that decided when to change the beds, I was the one that decided that the patient needed to get up and go walking. And there was nobody to answer to. I was the one that decided when my corpsmen were ready to work nights and I liked that. I had always been kind of scared of that, because, I didn't know whether or not I could. [I was worried that] the first time I tried to do something, things would go wrong. So I enjoyed that. I enjoyed being my own boss. (Interview 11, Section 0, Paragraph 35)

Rewards: Going to Sea and Experiencing What It Was All About

One of the rewards of the job included going to sea and experiencing what sea duty was all about. However, days could go by where the nurses were so busy, they never got around to climbing the steps to go look outside. When this participant did, an amazing experience occurred:

It dawned on me that I hadn't gone outside in a couple of days. So I said, 'Man, you got to walk up to the sponson' [a projection from the ship's side, as a bracket for something], which is just one deck literally twenty feet from where I work everyday. And I walked up there, and the ship is moving through the water at about five knots and we were somewhere around the equator and it was one of these days that is absolutely indescribable. I got up to the sponson and I looked out, and the ocean was completely flat. It was completely calm. Not so much as a ripple.... Flying fish would leap away from the ship. And you could see them rippling out of the water. And they would fly for sometimes as much as a hundred, two hundred feet. And you could see all this happening. Just crystal clear, absolutely no motion whatsoever. No swells, no waves, no wind action. Nothing – just perfectly calm. I'd never seen that. It was just so remarkable. And I was just standing there going, 'Oh, my God. This is totally unreal.' And I stood and I watched it for several minutes thinking that it was going to go away any second. And then I ran back downstairs and I got my corpsmen. And I said, 'You guys have got to see this. You've got to go up to the sponson to see this.' They went up and we all just stood there together on the sponson, not saying anything as we just looked out over the ocean. It was a color of blue none of us had ever seen before. Off in the distance, there was some little tropical island as we were moving slowly past. It was a completely magical moment.

No way to recapture it. No way to describe it. The feeling that passed between the three of us as we just stood there quietly watching all that. I know I could mention this to my corpsmen twenty years from now, that day! And what a day! And you know what? That was one of my best days. (Interview 5, Section 1.1.1, Paragraph 59)

Rewards: Feeling a Sense of Mission and Contributing to that Mission

In prior assignments, the nurses occasionally worked for organizations whose goals and objectives were in a constant change of flux. It was a relief for them to join the fleet and to be a part of something bigger than themselves. Being a nurse in an operational assignment, and not working for a military treatment facility, was a refreshing change.

This nurse remarked:

My biggest first impression, within the first month that I was there, was: 'Oh my God, I finally rejoined the Navy.' (Interview 5, Section 0, Paragraph 7)

All of the nurses felt that shipboard nursing was not without its challenges; however, they were pleased that they had a chance to experience what the Navy was all about:

It's hard, hard work. But, all in all, probably one of the most ...rewarding [experiences]. [It] helped me to understand the gray Navy better.... I've always wanted to do it. (Interview 9, Section 0, Paragraph 37)

It was probably the most challenging, demanding, rewarding, and exciting job I'll ever have in the Navy. I think you really got a sense of what the Navy was all about ... when you're out to sea.... You can see the Navy working, launching jets and doing underway replenishments and seeing every aspect of the Navy at once from every sailor doing their job. And so it was really kind of neat to be a part of something bigger and you felt a sense of mission and you felt your contribution to that mission. (Interview 4, Section 0, Paragraph 7)

The participants felt good about their tours as shipboard nurses and commented on how they sometimes missed the experience:

It was a very good three-year tour. And when I left the ship ... it was emotional, because I'd spent three years of my life being, probably, the busiest I've ever been.

Forging friendships that I'll never see probably again [with] the Line community and it was a good feeling.... I still miss it. (Interview 2, Section 1, Paragraph 7)

I have nothing negative to say at all about my tour as a carrier nurse. On a positive note, it will always be one of the most profound experiences of my career and my life. It was more than a job; the ship was my home and the crew was my Navy family for three years. The call sign of our ship is 'Courage' and I saw examples of it at every level everyday. Our ship's motto is 'Look Ahead.' To me that is what visionary leaders do and on the ship I served with many individuals who personified our motto through their exemplary leadership. I wish there was a way to turn back the clock and start those three years all over again! (Interview 4, Section 0, Paragraph 99)

Experiencing what the Navy was all about, and contributing to the mission of the organization, also meant enduring periods of role conflict. In this example, the nurse described what happened when the physician wanted to release a psychiatric patient back to the patient's work environment. When the patient's division officer balked, the nurse went to the patient's workspace to determine the problem. The participant then ascertained that one's primary nursing role was not always going to be that of patient advocate. The nurse sometimes had to make decisions that benefited the organization more than the patient. In this situation, the nurse realized that if an explosion occurred in the patient's work environment, and that patient suffered a paralyzing panic attack while exiting the work space through the one and only available exit (a ladder), then those behind the patient might suffer severe injuries, or even death, because they would be trapped behind a shipmate who blocked their only exit out of a dangerous work environment. Therefore, even though it was in the best interest of the patient to return him back to work, it was not in the best interest of the organization to do so because the prospect of a pending hazardous circumstance was too great:

So just walking into the space, I get the impression that this is a really, really dangerous place, I mean, there's only one way out. And the catapult machinery room has an enormous steam load. Anything that could happen that's bad would certainly be catastrophic. People would need to leave in an awful hurry. So, I spied this guy's division officer over in the corner. But even before I did, I was already coming to an epiphany. I understood that I would no longer be in the role of patient advocate. It would be a whole new focus for me. So I meet up with this division officer. The timid guy [the patient], by the way, is standing outside the hatch. He refused to go in the space. That's where he was. So the division officer says to me, 'Okay. So you see what the space looks like? Now, imagine this. I got thirty guys working for me. And you see that big old steam vessel over there? Say that thing gets a hole in it. The amount of pressure that steam is under will cut metal for fifteen feet. It will slice through it just like butter. Any human being who gets in that path will be cut in half without a second's hesitation. They're gone. They're toast. And oh, by the way, it is hot. So it's dangerous down there. Now, say these thirty guys that work for me, that I'm responsible for, have to get out of this space in a hurry. That ladder you came down is the only way out and that kid that works for me who says he's afraid of the ship ... [now he] stops in the middle of that ladder with the other twenty-nine guys behind him. Do you see a problem here?' And I said, 'I see a problem here.' That's when I realized I wasn't a nurse for [the] people anymore. I was a nurse for an organization – that my first responsibility had to be to the organization, not to the person. Sometimes that was going to be to the detriment of the person. (Interview 5, Section 1.1.1, Paragraph 43)

Another nurse experienced role conflict when conducting training exercises. This emergency nurse was used to caring for the sickest patients first; however, in battle situations, the sickest patients are sometimes the last to be attended to because the priority of the ship is to get the wounded back to their work stations so that the ship can defend itself. This nurse supposed that:

One of the hardest things to accept is the order of caring for battle damage. When they push the sick and wounded off into the corner and take care of the ship first. That was one of the biggest things for me to get over, because for me it was always the patient first, the patient first. But it took realizing that what are we saving these people for if the ship goes down? So yeah, I guess, maybe we do have to save the ship first and then take care of the dead and the dying. And that was one of the hard things to learn and to accept, but it comes with time. (Interview 11, Section 0, Paragraph 9)

Rewards: Traveling to Unique Locations

Traveling to unique locations was a perk of the job. One nurse spent a majority of a six-month deployment in the Persian Gulf during a period of crisis. When the aircraft carrier pulled into port for some liberty, the participant dusted off the golf clubs and hit the desert:

If you haven't played golf in the desert, it's the experience of a lifetime. The largest sand trap I've ever seen.... So when you finally get that break from work and you pull into port, it's time to just have time off ... enjoy the countries and see the world and study other cultures and just take that time away. Because you're going to get back out to sea, and it's all over again, back to the grindstone. So [take] that opportunity there. (Interview 10, Section 0, Paragraph 93)

Challenges: Working in a Dangerous Work Environment

Every job comes with its rewards and challenges. However, the job of shipboard nursing aboard aircraft carriers provided extraordinary challenges that a nurse working in a military treatment facility was not exposed to. The nurses worked in an industrial environment that proved dangerous for all of the crew. One nurse remarked:

I certainly enjoyed the autonomy and the independence that the ship offered but then I was quickly reminded that this was a dangerous place. (Interview 1, Section 0, Paragraph 55)

Another participant reiterated the constant threat of working in a dangerous environment while explaining the philosophy of the senior medical officer on this nurse's ship:

We have two jobs in military medicine. Job number one, keep the players on the playing field. Everyone should know that. People lose sight of that. It's very important. Job number two, we're here to give America's fighting men and women the perception that if something bad should happen to them, they will get the best care that ... health care can deliver.... Bad things ... certainly didn't happen to my

shipmates with any regularity, but they did happen. (Interview 5, Section 1.1.1, Paragraph 49)

Bad things did indeed happen. One of the challenges of the job was working in a dangerous and industrial environment that incapacitated or even killed shipmates:

People ... constantly falling down ladders. Got some good head injuries.... A guy was carrying a .50 caliber [gun] down a ladder fell [and] put a hole in his knee. Another guy walked behind a huffer, which is a machine that blows hot air into the jet engine intakes just to start them up. And if it's running, we've got this air going out the back and you just walk behind it, it will blow you off your feet. Well, his feet stuck to the non-skid and his legs went out and his ankles went.... So some big injuries like that. We had some burns. We had crushing fingers ... sunburns, lots and lots of drunken sailors. (Interview 2, Section 1, Paragraph 93)

There were two sailors that went overboard.... They both ended up in the ICU [intensive care unit] because one of them blew a lung, the other one blew a kidney. And it happened right as we were between Japan and Hawaii. There was a two-day span there where we can't medevac anyone because the helo's [helicopters] can't go that far. And usually if you are medevacing [performing a medical evacuation], they're not healthy enough to get the cat-shot [take off from the carrier with the catapult]. So we had them in there for about three days before we were in range of Japan to get them off.... How did they go overboard? She was backing up a plane, got a little too close to the edge ... hit one of the bomb seals and went over.... He jumped overboard to save her.... So picked both of them up.... It was during the day and it was off the coast of Hawaii. So it wasn't like it was real rough seas. [The crew] pretty much saw [it happen]. It wasn't like it was at night.... She had hit the hanger bay, the deck, on the way down. So she had some head injuries. Popped both of her lungs. And some minor abdominal type stuff. He bruised a kidney and fractured his spleen. And she actually came out a lot better off than he did because she had hit her head and went unconscious so she was relaxed when she hit the water. Whereas, he wasn't, so he had a lot of the impact injuries. (Interview 11, Section 0, Paragraphs 17-21)

The bad stuff was like the guy that lost his arm. That was really tough. When we had the people that died. That was a tough one. (Interview 7, Section 0, Paragraph 37)

With sadness, one participant confessed that the demise of a shipmate was this nurse's first exposure to death. The exemplar also illustrates the fact that the nurses practiced in an environment of uncertainty. At one point, this nurse experienced a moment of

trepidation. After regaining composure, the participant used the occasion as a learning opportunity for the corpsmen, all the while maintaining a role as the patient's advocate, even in death, to make sure that the deceased pilot's dignity was not compromised:

We had an F-14 pilot get killed.... Two F-14s ... were flying towards each other and they got too close. And one clipped the other. The one that did the clipping actually did make it back to the ship okay. Those two guys were okay. But the other one ... was flying fine, and they felt that they could make their alternate landing area, which was on the shore.... They wound up not. They had to eject out of the plane and we're not sure whether the ejection killed him or his parachute didn't open up and he wound up in the water. But at any rate, the back seater, he wound up with a right lower extremity fracture, and we wound up having to medevac [medical evacuation] him back to the states.... But they did recover the body of the pilot. And at the time, whenever we had had a mishap up until then, people had survived. It was like no big deal. They got the pilot out of the water. The routine was they bring them down to [the] medical [department], they collected all their clothes.... Our senior medical officer ... was up there [in flight operations]. He had radioed down to us, saying that the survivor, how did he put it? 'The survivor is on his way.' And we knew it was an F-14 [which seats two]. So we were like, 'What does that mean?' Nobody had briefed us. Like what does that mean, 'the survivor?' We were like, 'Does that mean the other one is not a survivor?' You know, we just didn't know. We were completely ignorant, and we're doing this over the radio where everybody can hear.... And it turns out that, yes, that was right. One of them died. They pretty much knew right away that he was dead. And so they brought him on board and before they brought him on board, [the senior medical officer] came over to me and he's like, 'We need to put him somewhere while we prep him, prep his body.' And I didn't have any protocol for that. Nobody ever explained to me what do I do with somebody who dies. So we actually had two isolation rooms in addition to the ICU [intensive care unit], because he originally said the ICU. And I didn't feel that was appropriate because we had a big glass window to it. And I thought the isolation room would actually be more private and that's what we did use. We used an isolation room and brought him in there.... Going through that procedure, we had to cut off his flight suit, right along the seam.... they had to do a number of x-rays on him. I actually didn't get involved in that, because the guys did. They had to flip him and whatnot, and I just felt like, 'Okay. You guys can handle that.' But immediately when I realized that there was somebody dead, I started shaking. I was shocked. Because like I said, up until then, everybody lived. Then it occurred to me how dangerous their job was. I gained my composure and went back to work.... My corpsmen [and I] ... figured out what we were going to do together ... any patients that were kind of near the area where we were working, we kind of told them a little bit of what was going on, that there was going to be a lot of commotion here in a few

minutes.... We had the Chaplain's support. And I think that it drew all of us together. This event, because everyone just kind of came out of the woodwork ... they came up and they were helping out. And I guess that's just always the way whenever there's a big tragedy, even though ... I mean this is nothing like the U.S.S. Cole, but it still was for us, because he was our first. I think that we all handled it well. We did kind of use it as a teaching experience. Some of the corpsmen were so new they had never actually seen a deceased person before. And to tell you the truth, I had never actually seen somebody die from trauma. I've never done emergency room nursing. Pretty much when they get to the ICU or the wards, they're already cleaned up ... so that actually was my first experience seeing [a deceased trauma patient].... We did treat him with dignity. I think that we still needed to bring in some of the corpsmen to just kind of show them some things and everybody was very respectful in that department I think. (Interview 12, Section 0, Paragraph 23)

Not only did the nurses work in a dangerous environment, they also lived in one. All aircraft carriers are powered by steam; consequently, steam pipes run throughout the ship. In this exemplar, the nurse described the constant threat of steam leaks:

My rack [bed], fortunately, was the most top rack so I had the overhead pipes ... within inches of my face. The one thing that was kind of discomforting was the knowledge that some of those pipes carried high-pressured steam and steam leaks were a problem on the ship and folks can get significant injuries with high-pressured steam. So, you always wondered ... 'will that pipe above your head [be] ... the next pipe that ruptured?' Fortunately, that was not the case with me; however, when [one of] the ... boiler[s] exploded, I was in [the] medical [department] at the time but I do remember coming back to my room ... [which] had gotten a pretty good beating and I couldn't help but [think] if I had been in the room at the time, what that might have felt like. (Interview 1, Section 0, Paragraph 99)

Challenges: Being Away from Home when Deployed

Another challenge was being away from home for numerous deployments. Not all of the nurses left behind significant others; however, being deployed meant being away from all that was familiar. The nurses essentially ended up with two homes: their private residence and the ship. Those with families regretted a loss of intimacy with their spouses

as well as missing out on being a part of their children's day-to-day lives when they were out to sea:

You literally have two homes. Because when you're gone for fifty percent of the time, you have to have things set up so that your bills are paid. I changed everything. I changed all my addresses to get mail on the ship because we get mail everyday. One time I came home and my electricity had been turned off because my bills were sitting in my mailbox at home. So you really have to have some foresight and understanding. (Interview 3, Section 2, Paragraph 7)

In the three years I was on board, I was gone an entire year away from home. (Interview 2, Section 1, Paragraph 41)

Out of my two-year tour, granted I was only away from my family at sea only about eight months, but that was eight months that I was not with my family. (Interview 8, Section 0, Paragraph 65)

I think what [I] missed the most is you can send e-mail and you can show pictures, but you can't hug and you can't touch. And I think I missed that the absolute most. (Interview 2, Section 1, Paragraph 53)

[The tour was] professionally rewarding. Why rewarding? Because of the independence and autonomy, the camaraderie. Ah, challenging in it's extended family separations which was my greatest challenge. Losing intimacy with my wife for extended periods of time was not something that I would want to do again. I would say at least 40%, if not 50%, of our department had been divorced by the time my 3 years ended.... My greatest disappointment, from the whole experience, was the toll it took on my son and the separation anxiety he had for a long time. (Interview 1, Section 0, Paragraphs 258 and 637)

Those that were single were cautious about starting relationships because they knew that they would be away a lot of the time:

What was an issue for me personally was it was hard to try and start a relationship because you knew you were [going to] be gone so much.... So I didn't have an awful lot of, outside of the ship, friendships really and truly because it was hard to get one started and then you'd be gone. (Interview 3, Section 2, Paragraph 7)

Challenges: Participating in Work-ups

Part of the deployment cycle of an aircraft carrier is participating in “work-ups.” During work-ups, the carrier undergoes multiple testing phases to prepare the ship for potential combat. Various battle scenarios are played out so that in the event of an actual fighting situation, the ships’ crew already knows what to do and can anticipate their actions once adverse events start to occur, (e.g., a fellow shipmate being hit by gunfire may have to have his or her battle station manned by another crew member). A carrier that fails work-ups cannot deploy on schedule. Not deploying on schedule can be a career-ending event for those in charge.

Work-ups were a stressful period for the participants because they had to organize many drills in a short period of time in order to prepare each ship for war. In addition, the nurses realized that if the medical response of their ship was judged inadequate during work-ups, then it would be a direct reflection of their role as the leader of each medical training team (MTT). Also, it was not uncommon to have a full surgery schedule and inpatients while the ship was underway. So not only were the nurses busy with the duties on the MTT, they also had to worry about the status of the inpatient ward:

Work-ups were also hard in that we’d be gone ten days, come back for ten days, be gone again ten days, and then it’s the 24/7 really, especially since there was always a patient on the ward. (Interview 11, Section 0, Paragraph 9)

In coordinating the medical training team, the nurses were responsible for conducting numerous drills during the work-up cycle:

The busiest time for the nurse on board a carrier is during the pre-deployment work-up cycle. There is no doubt about it in my mind.... The medical department is required to do a minimum of a hundred and twenty some odd drills.... We did almost

a hundred and ninety medical drills in ten days to fourteen days. And that does not include the two mass casualty drills that are required. Now, a mass casualty drill [occurs when] there's five or more injured in any given area at a given time.... But what they really want to see is [a] fifty or more mass casualty drill. And generally you're taking up the whole flight deck and you've got to move all these people in an expeditious manner to get them off the flight deck and then down into main medical eventually.... So here we're now talking about major amounts of people that need to be moved and in a mass casualty manner. So not only you as a nurse are evaluating patient movement, you're also evaluating how are the flight surgeons and other medical people triaging these patients. (Interview 8, Section 0, Paragraph 39)

It's really an interesting evolution to see the inexperience level of, not just the corpsmen, but the whole ship's crew. They start out and it's kind of like kindergarten. And you get through each stage of the work-ups, and then you're finally down to your final evaluation problem. And we actually did very, very well. We saved the ship. The ship didn't sink. And it's just so interesting to watch these young sailors grow and grow through the phases. And I think that's what's rewarding about being on a ship, being a nurse on a ship, being with the fleet, understanding what they go through, and seeing them develop and get stronger and grow and be really top notch professionals, if you will. Firefighters, engineers, and the enlisted guys and gals up on the flight deck, and working incredibly long hours in the engineering departments, getting very little sleep and working unbelievable hours. And what they do to keep us safe and, you know, the world safe for democracy. And no one could ever, I think, understand it unless they've been there. (Interview 9, Section 0, Paragraph 7)

It was not uncommon to have a full surgery schedule and inpatients while the ship was underway. Some nurses discovered that their inpatient census was highest during work-ups but inexplicably declined once the ships were at sea for a long period of time. Also, the nurses tended to work with inexperienced corpsmen during work-ups (because the corpsmen did not get their bedside training until the ships were fully deployed). Thus, not being able to count on an experienced crew added to the nurses' stress:

The ward and the ICU [intensive care unit] are just empty spaces when the ship is pier side. But when you get underway, patients come in, you admit them, and all of a sudden it becomes alive. (Interview 5, Section 1.1.1, Paragraph 47)

Our first six-week underway [was] where we did all the work-ups. We trained to become a fighting ship. I had 40 or 50 patients during that six-week period. During the entire six-month West Pac [deployment to the Western Pacific Ocean], I only had a little over 60 patients in six months. So my patient-to-time ratio was much greater when we were doing work-ups. I don't know if we had people that were not strong enough to be there. There were certainly more accidents, people learning their job ... cuts and cellulites. Trying hard. 'Yeah, my foot hurts but I'll continue to work until I get this red streak on my leg. Maybe I better go to [the] Medical [department] [now].' I mean there's some hard chargers up there just wouldn't come down unless they just were driven down to Medical.... It was ... the one time that I was stressing myself to the max. I had more patients and I didn't have anybody trained to take care of them because you can't train your hospital corpsmen if you don't have a hospital. And it would be great to [have the corpsmen] go to the naval hospital ... and get trained, but there's no time to do it because they're chipping paint or they're painting or they're doing sick call or umpteen things that happened on a ship. (Interview 2, Section 1, Paragraph 13)

During work-ups, the nurses could count on 16-hour workdays and sometimes getting little sleep at night:

As we went through the workup cycle, not only are you having to do the drills for the Afloat Training Group and [COMNAV]AIRLANT and all those people, [but] you [also] have to go do the drills down in the reactor plant for the reactor trainers and for ORSE [Operational Reactor Safeguard Exam] and get ready all of those people and then take care of patients. There [were] times I would have pretty much a whole ward of patients and a full surgery schedule and put in some really long hours. So [there] was more than one day that it was twenty-four hours in length or even thirty-six, close to thirty-six hours sometimes. (Interview 7, Section 0, Paragraph 11)

One nurse offered the following advice for enduring the tough times:

The environment is just that tough. So, it's nice to have a sense of humor. It's helpful and that's probably what got me through it was a sense of humor. (Interview 1, Section 0, Paragraph 131)

Several of the participants recommended tapping into local resources prior to deployment. This proved to be a blessing during work-ups:

Being the only nurse is tough. When we were doing the workups, I did get nurses to come out from [the local Navy hospital].... Other people told me, 'If you can get somebody, get them to come along.' So that did help, because there was times that I

could go sleep and they could take care of the ward. (Interview 7, Section 0, Paragraph 13)

I used a couple reservists during work-ups to help, especially during the final evaluation period [FEP].... One drill required four meetings ... and during FEP, you had ... eight drills [which meant] thirty-something meetings just for that two-week period. So time on the ward [was limited].... Fortunately ... everybody's focused on FEP, so people don't have time to think about their ailments. I think we may have had three people that were admitted to the ward during that time period [but] nobody critical. One was chickenpox, which could have been disastrous, but I augmented a reservist nurse who came out. And she took care of the ward, so I could turn around and manage all these meetings and complete FEP with no problems. (Interview 10, Section 0, Paragraph 81)

Once the ships were underway, the nurses felt that the job actually got a little easier because they did not have to be home by a certain time. They worked because there was nothing else to do. Their next challenge was overcoming the boredom that could ensue:

At sea, it was a lot better 'cause I didn't have to try and get out of there by 16:00 [4 pm]. I had all day. I mean half the night if I wanted to do things. (Interview 2, Section 1, Paragraph 25)

Everybody stays up all the time. You work seven days a week. There's nothing to do. If you're not working, you're ... a-hurting. Because when boredom sets in, there's nothing more painful than being bored on deployment. It's the worst. People work for their sanity. (Interview 5, Section 1.1.1, Paragraph 57)

Once work-ups were successfully completed, then the ships deployed, usually for a six-month period. Nurses that experienced long deployments alluded to the movie Groundhog Day because the experience of being at sea got to be so routine that none of the days differed, just as in the movie:

I don't know if anybody's referred to Groundhog Day. But it's a really pretty predictable routine. So keeping busy was really important. (Interview 9, Section 0, Paragraph 9)

Several of the nurses were deployed during periods of armed conflict. This meant that they were at sea for long periods of time and had few diversions. In this exemplar, the nurse recounted how hot the environment was and hinted that morale could be low when the crew had infrequent port calls and could not e-mail home during bombing raids:

You have 6,000 sailors on a large vessel that's pretty much confined. We did 62 days straight at sea before we saw land. And then when we got to land, we couldn't leave the pier. And then you turned around and went back to sea for another 45 days before you saw land again. The Internet helped increase some of the morale, but when you're bombing, everything's shut down. Tensions were getting high and stuff like that. Long hours out there in the heat. (Interview 10, Section 0, Paragraph 19)

Challenges: Navigating Equipment and Supply Issues

Navigating equipment and supply issues proved to be trying at times. The ordering lists remained stagnant. Some of the supplies that had been ordered were not always utilized; but instead of being recycled or returned, the supplies just never left the ship:

People just kind of order things. I mean, I had my storerooms filled with stuff and when you first ask around, and ... you asked, 'Do we have all these things?' 'Oh, yeah, we have plenty.' Well, nobody bothers to look at the expiration date. And, yeah, we have plenty, and it was all going to be expired within six weeks.... And this is just before a major deployment so [now] you're having to look at these things.... Then you find out that you really don't have the supplies there that you need.... When I got there, [we had] right around twenty cases of triple lumens. And I'm thinking, 'If I have to put in a triple lumen, if I have to put in a Swan [Ganz catheter] here, we need the Chaplain here more than anybody.' It was just one of those ordering snafus. I think somebody wanted ten single triple lumens and now we have twenty... cases that are all about to expire. (Interview 6, Section 0, Paragraph 7)

Even the medical department had trouble deciphering exactly what their resources were:

When you look at a line item that says, 'rubber hose, one each, stock number,' ... and you have a price of ten dollars, you don't really know what that is. It's a rubber hose. 'Well, is it an NG [nasogastric] tube?' 'Is it an old red robin catheter?' 'What the heck is it?' ... The supply people don't know either. You have to physically go to that

bin in the supply system and pull it out and go, 'Oh, it's an oxygen tube that hooks to a tank! Oh, good.' But you don't know, and it's 'cause it's a three-word descriptive item that non-medical people put together. So it just boggles your mind. So you make sure. So a lot of the stuff you buy out of your operational target budget, because they don't keep that AMAL [Authorized Medical Allowance List] as current as you would like. (Interview 2, Section 1, Paragraph 11)

Challenges: Adjusting to the Constant Turnover

The last challenge revealed was the constant turnover of personnel on the ship. The nurses found it frustrating to train with people that inevitably left for new duty assignments. Additionally, some of the medical department staff accompanied the ships for deployments only (e.g., anesthesia and surgery support). Thus, the nurses had to constantly adapt their work environment to the desires of varying personnel:

Then you have ship turnover and it was just non-stop. There's always somebody there to train, always somebody to take care of because you had such turnover in that place. It was huge. It was huge turnover. (Interview 4, Section 0, Paragraph 17)

It just so happened that the medical administrative officer, the general medical officer, and I all reported on board within a couple months of each other. And so we all learned how to do everything together. Although it would have been nice to have one person who knew what the heck they were doing, but that's okay. We all kind of learned and then got used to each other's ways of doing things. (Interview 12, Section 0, Paragraph 13)

Every time we went underway, we had a different surgeon ... every time and as I explained, we were out fifty percent of the time. So we would be out two weeks, back for a couple of weeks, out for four days, back for a couple of weeks, and this continued for two and a half years.... It was very difficult because there was always a topsy-turviness to whoever the surgeon was or who the surgeon didn't get along with and I mean it was very, very difficult. (Interview 3, Section 2, Paragraph 7)

Ensuring Operational Readiness

Corresponding Essence in the Exhaustive Description

The nurses' primary and most time-consuming job was ensuring operational readiness by coordinating the medical training team (MTT). In this capacity, they developed scenarios, simulated medical casualties throughout the ship, and conducted various briefings regarding each drill. Orchestrating these exercises, and being a member of the larger Integrated Training Team (ITT), involved substantial assimilation with all of the departments on the ship; consequently, the nurses got a lot of face time with each ship's Commanding Officer (CO), Executive Officer (XO), and Department Heads.

Coordinating the Medical Training Team

Ensuring operational readiness included training the ship's crew on basic first aid and the GTMO war wounds. The GTMO war wounds are considered to be the most likely injuries to occur in an industrial environment such as that of an aircraft carrier. The classification of the GTMO war wounds was created when the Navy's fleet training group was located at Guantanamo Bay, Cuba (and the Navy's nickname for Guantanamo Bay is "GTMO"). The GTMO war wounds are:

1. Amputated hand
2. Burns
3. Electrical shock
4. Compound fracture of the lower extremity
5. Fracture of the jaw with facial injury
6. Open abdominal wound with extruded viscera
7. Smoke inhalation
8. Sucking chest wound/pneumothorax (Virtual Naval Hospital, 2001)

The primary and most time-consuming job that all of the nurses unequivocally recounted was being the medical department's training officer:

A large part of the job turned out to be training. Probably three-quarters of my time was spent on training issues. (Interview 12, Section 0, Paragraph 7)

The nurses trained the ship in "buddy aid." The concept of buddy aid is that a trauma patient's first responder is the one working next to him or her when the accident occurs.

Thus, while medical personnel are enroute, the patient's "buddy" is stabilizing him or her:

My focus was still training, not only our medical people, but training the ship, because all the stretcher bearers and a lot of the other people in the different sections ... have to be trained up to a certain level of medical competence. (Interview 6, Section 0, Paragraph 7)

We also [trained] the general crew. The general crew on board an aircraft carrier is approximately 3,600 people.... Once you get underway [then] the aircrew brings their 3,000 people. So you're really looking at about sixty-five to sixty-seven hundred personnel that are on board a carrier at any given time when they are fully loaded up and ready to go to sea ... [to] perform a mission. One of the primary things that is needed, in preparation for deployment, is to ensure that the crew is trained from a medical aspect for buddy aid.... In case there is an actual personnel casualty, the first person at the scene will most likely be another member of the ship. So that individual needs to at least know how to provide initial life saving actions, to stop bleeding, [to] ensure there's an adequate airway ... the basic ABC's.... There is also the need of having people carry injured individuals. We have stretcher-bearers. They're certain criteria to ensure the safe transport of people, especially among the multifaceted decks of a aircraft carrier. So, therefore, stretcher-bearer training is also very important. (Interview 8, Section 0, Paragraph 7)

This nurse conducted drills in the crew's workspaces and modified training scenarios to make the crew realize that they were learning life-saving measures that would assist them both on the job and at home. In this exemplar, the participant describes how every opportunity was used to "show off the Nurse Corps" to the Line community:

As head of the medical training team, you needed to be able to train every area's response to a medical emergency.... we had a medical response team ... [that was]

made up of a couple corpsmen with the drill packs on their back, and they call them the rabbit. It's like they hustle to wherever in the ship they announce over the 1-MC [loudspeaker] a medical emergency. So these guys have to hustle to that area with a radio [and] call back ... until the corpsmen get there. Then it's really the ship's company who's tasked ... to take care of the stuff. So if you impress upon these folks that you're there to take care of your shipmate and you do this in your first-aid training. The way you really impress upon them ... is you go and you do a drill in their space.... seeing their work space, seeing what potential hazards they face in their work space and challenging them to respond correctly.... I [would] try to expand it to, 'All right, so, you know, it doesn't happen here. Or there's somebody else that's going to be around, but you know what? You could go home and your little kid could be choking on something or your neighbor could be having a heart attack or you could drive home and come upon a car accident' 'cause we were teaching cardiac stuff and trauma stuff.... So they really saw that they could benefit from that. And being the nurse ... that was one of the fun parts of the job. So I thought that that was kind of ... showing off nursing, showing off Nurse Corps – what our contribution to them can be. Both ... shipboard and on a personal level. (Interview 4, Section 0, Paragraph 7)

The nurses felt frustrated when they ascertained that training scenarios were not standardized across the fleet. When they queried Commander, Naval Air Forces, U.S. Atlantic Fleet (COMNAVAIRLANT) or Commander, Naval Air Forces, U.S. Pacific Fleet (COMNAVAIRPAC), they learned that there was no nurse assigned to either command to give them guidance:

What I learned when I was going through this process of learning how to run drills, do drills was that there was nothing in place that I could go by in order to do this. Like every time I ran a drill, I felt like I was reinventing the wheel. There was nothing for me to go by. And then, when I would call over to COMNAVAIRLANT, which was supposedly our resource command, there was no Nurse Corps Officer stationed there. So there wasn't really any resource person in particular that I could look to, and so I found that I had to rely on other ships' nurses to find out what they were doing. So that was a little disheartening, because I would call over there and say, 'Hey, I'd like to know how I'm supposed to do so and so.' And they'd be like, 'Well, what's everybody else doing?' And I said, 'Well, what am I supposed to be doing?' I wanted to do it the right way, not what everybody else was doing. So I kind of just had to find my own way of doing things. (Interview 12, Section 0, Paragraph 7)

Integration

Being a member of each ship's larger Integrated Training Team (ITT), involved substantial assimilation with all of the departments on the ship; consequently, the nurses had numerous encounters with each ship's Commanding Officer (CO), Executive Officer (XO), and Department Heads:

In order for it to be integrative training, you had to integrate with at least two other parts of the ship.... Well, now, all of a sudden, everybody wanted medical. That's the simplest one. We'll have some injuries down there, you can impose them anywhere and that would cover integration. And so we really had to learn, or at least I really had to learn, all the other different functions of the ship.... A lot of this training met some very dangerous evolutions. The training in the engine spaces is hiking these people up four, five, six levels ... that in itself imposes a lot of hazards.... Medical really came into focus as far as the ship's training. And this was a big part of our inspection, was this integrated training. So you get a lot of face time with the XO and the CO and the Department Heads on all of the departments, which is a very good thing.... Because you really need to show that you have the interest in what they do. (Interview 6, Section 0, Paragraph 7)

Integrated training encompassed as many as 17 different departments on the ship. In this exemplar, the nurse differentiated the training philosophy of the aviators, the "nukes" (those who worked with the nuclear reactors), and the engineers. In addition, the nurse described the briefing process associated with each drill:

As far as getting along with the people in other departments, that was interesting.... [There were] closer to seventeen different departments on an aircraft carrier [with the] air department being one of the larger ones. Engineering being another one. Reactor department. And these are the departments that I worked directly with in coordinating drills and so there [were] some major people that I had to learn to work with, aviators [and] ship drivers. And these are people that I had never really worked with before, of course, coming from the medical community. So that was interesting, just learning their ways of doing things. Of course, the people in the reactor department are very rigid. They have everything done by the book. You know, when they want to run a drill, they'll open up a folder and say, 'Okay. We're running drill number 33A today,' and they have everything planned out. Where everybody is going to be standing, what it is they're looking for, and all that. And that's the kind

of thing that I guess I was looking for when I was planning my drills: something very straightforward and laid out. And then you have your engineers who are just like on the fly kind of people. And they'll just throw down an instrument that is supposed to represent a fire, and say, 'Okay. Fight that.' They were just very spontaneous, which is, I guess, very similar to medical where ... you run people through a code and then you say, 'Okay. His blood pressure's dropping, you know, what do you do?' And then you have the air department, the aviators. They brief everything. They want to have a brief before the drill. They want to have a brief after the drill.... All the commanding officers of carriers are aviators, so ... every time we ran a drill with casualties, I would have to pre-plan where each one of the casualties was going to be in the ship. I couldn't just do anything spontaneously.... You couldn't do anything that wasn't briefed. It's very, very different, very different. But, you know, I played with their rules, so I think I earned the respect that I wanted to while I was there. (Interview 12, Section 0, Paragraph 17)

The nurses quickly learned that briefs were succinct and to-the-point:

Briefs are brief.... It's hard. You want to be detailed and you want to give a good analysis. And when you're with a big group of people, and they want to get through a meeting, they ... want you to be quick, short, and to the point.... It was just a big change from being in nursing meetings where you maybe have a little more discussion and you hash it over a little more, where here you're just like short, sweet, get to the point, lessons learned, boom, next person. And if there's anything more you want to address, you just talk about it afterwards. So it was a big transition from being that touchy-feely nurse. (Interview 9, Section 0, Paragraph 33)

Once the nurses were comfortable with orchestrating drills, they found that they could organize an operational exercise within minutes. This attests to the effective working relationships the nurses developed while on each ship:

[I] got to be real good friends with other departments. I could pick up the phone and put together a mass casualty with sixty casualties – make three phone calls – one e-mail [and] three phone calls ... that was it. (Interview 3, Section 2, Paragraph 9)

A lot of forethought had to go into planning the drills. The nurses had to have accurate knowledge of the crew's drill spaces, and their work routines, prior to implementing an operational exercise. They were cognizant of the fact that medical training was not the only game in town:

With the integrated training team, you need to decide, 'Is my drill going to not make somebody's day, somewhere?' 'How do we best coordinate this effort so that we all can get some good quality training in the least amount of time and not make some mistake?' Or the big issue is safety.... You have safety pre-walkthroughs of an area just before you actually run the drill, besides going there maybe a day or so before and ensuring that 'Yeah, I think this will be a good spot to run a drill,' and coordinating it with the division and departmental people to ensure that they don't have any work project planned for that day and you're not going to come running in there with all your medical crew and tell them to clear the space because you need to run your own potential drill. (Interview 8, Section 0, Paragraph 7)

Not all of the nurses taught basic life support (BLS); however, as the training officers, they were responsible for ensuring that it was done. This participant taught BLS and took pride in the fact that so many people were certified under the participant's tutelage; however, after leaving the ship, the nurse had not pursued BLS instruction for another organization. This was attributed to burn out:

I thought eventually my time spent on BLS would decrease, but it actually just remained constant throughout because maintaining a database of thousands of people who are constantly coming and going, it's difficult.... I guess I personally certified over two thousand people the whole time I was there. So I haven't taught since. I kind of got a little burned out on teaching CPR [cardiopulmonary resuscitation]. (Interview 12, Section 0, Paragraph 7)

Other Job Responsibilities

Numerous job responsibilities, including various collateral duties, were described. However, the top three activities mentioned consistently during each interview were: acting as the medical training officer (as discussed in the previous section entitled "Ensuring Operational Readiness"); caring for the inpatient ward (which involved working with the corpsmen and is described in greater detail under the "Constantly Operating in an Environment of Uncertainty" section below); and monitoring quality assurance.

Other job responsibilities: Monitoring quality assurance.

The nurses were responsible for monitoring the quality assurance (QA) program in the medical department. This also entailed filing a lengthy monthly report with either COMNAVAIRLANT or COMNAVAIRPAC. Unfortunately, the program standards were not uniform; thus, the nurses proposed standardizing the requirements across all of the carriers. Incidentally, the term "QA" does not always spark a sense of excitement. Therefore, some of the nurses were pleasantly surprised with their experience in supervising this program:

One of my medical department collateral duties was as a QA Officer. And that was interesting, because I was QA-ing myself a lot of times. It should have been a separate person really, but I did it the best I could and I had to submit a monthly report that was usually about this thick, which was probably about ... thirty pages. So that was time-consuming to do that. (Interview 12, Section 0, Paragraph 9)

I think it would be helpful if there were specific things that had to be QA'd instead of just leaving it up to the department because I know of one ship that hadn't done QA for months. (Interview 3, Section 2, Paragraph 18)

Quality Assurance.... The nurse is always tasked because they say, 'Oh, the nurse can wrap it up. The nurse can look at it from a clinical standpoint of patient care'.... Although I didn't have a great expertise in how to run a lab or what the issues were with x-ray, I knew from a patient care standpoint what we need to be watching out for. 'Are the lab chits tracked ... once the tests are sent out of the ship, do they come back?' 'Are they tracked back to the buyer who ordered them and does it make it to their records?' 'Who they should contact with the results?' I mean those are things that we know from a patient care standpoint need to be done.... Some nurses go, 'Ooh! QA.' They find that once they get in and really see that it can impact the quality of care, they don't mind it. Don't mind getting involved and actually concerting the whole thing. So I actually enjoyed it. (Interview 4, Section 0, Paragraph 7)

Other job responsibilities: Collateral duties.

In addition to the three primary responsibilities, each nurse held at least ten collateral duties. The method of assignment of collateral duties was sometimes inexplicable; however, letting a legitimate duty go unfulfilled was inconceivable to these nurses. These collateral duties included, but were not limited to:

1. Accompanying medevacs
2. Acting as Assistant Department Head
3. Functioning as a liaison between the ship and medical treatment facilities (MTFs)
4. Acting as a tour guide to distinguished visitors
5. Assisting in sick call, the emergency room, or the operating room
6. Assisting with court martials
7. Assisting with research protocols
8. Attending numerous daily meetings
9. Being a member of the Command Assessment Readiness team
10. Being a member of the sexual assault victim intervention (SAVI) team
11. Performing interventions as a sexual assault nurse examiner (SANE)
12. Being a member of various process action teams (PATs)
13. Being the Family Advocacy Representative for the command
14. Coordinating mass blood draws
15. Coordinating the Exceptional Family Member Program
16. Coordinating health promotion activities
17. Coordinating professional affairs
18. Coordinating the Surface Warfare Medical Division Officer (SWMDO) study classes
19. Coordinating telemedicine activities
20. Giving allergy shots
21. Informing the crew of issues regarding TRICARE (the military's managed care program)
22. Managing funds for temporary active duty (TAD) for professional development
23. Performing preventive medicine activities
24. Performing psychiatric evaluations
25. Performing respiratory therapy functions (especially when ventilators were involved)
26. Procuring medical equipment and supplies
27. Standing numerous watches/duties
28. Writing numerous reports

Following are a handful of exemplars related to some of the collateral duties listed above.

Other job responsibilities: Give it to the nurse.

In addition to the three key job responsibilities, the nurses also had numerous collateral duties. The majority of duties were understandable; however, some of the duties were given to the nurses for no apparent reason:

Found out that pretty much I was going to be what we termed the SLJO – the shitty little job officer. Anything nobody else wanted to do got stuck on my desk. Anything even remotely touchy-feely ... bring it up to the nurse. (Interview 11, Section 0, Paragraph 7)

Sometimes the nurses felt like they were a “jack-of-all trades but a master of none” because their duties were numerous and so varied. The participants were seen as the ultimate resource for their department. Their workdays could be so busy yet at the end of the day, the nurses could not articulate exactly what had transpired that day:

I was the ‘go-to’ guy. Okay? ‘Hey, I need this.’ ‘Okay.’ ‘Go there.’ ‘Lieutenant, can you get this person in CHCS [composite health care system] so I could order meds?’ ‘Yeah. No problem. Sit down.’ And so I was constantly doing that. When you do that all day long, at the end of the day you sit down and you go, ‘What the hell did I do today?’ (Interview 2, Section 1, Paragraph 25)

Other job responsibilities: Accompanying medevacs.

Some of the nurses accompanied patients on medevacs; however, this duty meant leaving the ship without a nurse for a period of hours, days, or weeks at a time. This participant raised a valid point in that it was not uncommon for the nurse to anticipate adverse side effects associated with patient transport; thus, it was only natural that the nurse escorted a patient on a medevac:

I did most of the medevacs on the ship, which is probably a lot different than the other nurses. They have very strict criteria on who can go up.... And our very first patient was a serious one. It was myself and a flight doctor that went on that. And then after

that, they wanted me on all of them. They just miss out on a lot of things. I mean, these are doctors that have only completed an internship and gone to flight surgery school. And so they miss out on a lot of things. Our first one was that guy that I told you that got hit with a large bearing, had a fractured hip. Well, now you've got this guy on a backboard, flying over water, that has to have all his gear on, which sometimes we don't take into consideration. And now you're giving him pain medication, which most patients are going to puke from anyway. And now you're going to put him flat on a helo [helicopter] with all that spatial disorientation and all the vibration, which is just going to increase the pain of the fracture site. And then, what are you going to do if he does puke, since you've got him strapped down on this board? And what are you going to do if he gets in the water, if the helo goes in the water and this type thing? And so it started off as I was explaining all these things to the Flight Doc that all of the sudden, it was, 'Well, you need to come.' And then, after that, it was pretty much that I either did them alone or did it with one of the flight surgeons. I did ... close to thirty some medevacs off the ship, when we were out floating around. (Interview 6, Section 0, Paragraph 15)

Other job responsibilities: Acting as Assistant Department Head.

Being the Assistant Department Head was an unusual, but not unimaginable, duty for the ship's nurse. This participant's primary responsibilities changed when assuming this role:

Then the SMO [senior medical officer] offered to go ahead and make me the Assistant Department Head. So at that point, my job changed considerably. My job changed to where I owned everything in the medical department. And now I'm having to make decisions on the lab and on x-ray and on pharmacy, on sick call, as well as all the traditional nursing areas and education training.... The job of the ... Assistant Department Head ... is [coordinating] the day-to-day function of the department. See that everything is there from the Band-Aids to the drugs, that things are getting done, and things are getting cleaned and all these things are happening.... All of the sudden you have to become very familiar with the RAD[iation] health program, and what [that means], because that's a showstopper. Where are we getting our drugs from? Do we have the drugs we need? Simple little things. (Interview 6, Section 0, Paragraph 7)

Other job responsibilities: Acting as a liaison.

When the ship is underway, the inpatient ward is open for business. When the ship is pier side (docked), the inpatient ward is closed. Therefore, any crew member that requires

hospitalization when the ship is docked becomes an inpatient at the local medical treatment facility (MTF) or civilian hospital. Some of the nurses felt it their duty to act as a liaison between the ship and the MTFs so that they could keep track of a patient's plan of care:

Whenever we had an inpatient that was in ICU [intensive care unit] or another hospital, I usually would go and see them. And I think it's important to do that 'cause then you can come back and tell the ship, the division, [and/or] the department. I know some nurses don't do that but I did that. (Interview 3, Section 2, Paragraph 12)

Other job responsibilities: Being a member of various process action teams.

Several of the participants were members of various process action teams (PATs). Sometimes the nurses volunteered for PATs, and sometimes they did not. This participant was assigned to a PAT that studied the issue of smoking on the ship. The nurse realized that the team's conclusions contrasted with what nurses usually advocate. However, the team appreciated the fact that the goal of zero tolerance was not realistic and that smoking on the ship was going to occur no matter what; thus, it was up to the PAT to define the limits of smoking on the ship. This nurse was amazed at how empowered the PAT was because at previous military treatment facilities, the participant had never experienced immediate implementation of a PAT's recommendations:

In less than four meetings, we accomplished all of our objectives. We found out that we had to allow smoking on the ship and we had to figure out where that could happen. And we walked around the ship and we looked all over and we found the best places to do that. And we solved the problem of the engineers who are basically moles and can't leave their spaces. They're down there in that dark, hot, uninviting space. And we opened up several of the engineering spaces to smokers so they could smoke in certain areas. We opened up a couple sponsons [projections from the ship's side], and that was that. We defined very clearly the limits of smoking.... Overnight the way that people smoked on the ship changed. And so all of a sudden now, I

would walk to sponson six and there were all the smokers. As if by magic, they just knew. And communications on the ship is an amazing thing.... Very, very refreshing. And I really got an addiction for results. (Interview 5, Section 1.1.1, Paragraph 43)

Other job responsibilities: Miscellaneous comments.

The method of assignment of collateral duties was sometimes baffling; however, letting a legitimate duty go unfulfilled was inconceivable to these nurses:

I was the EMP person, the Exceptional Family Member Program. I was a TRICARE [the military's health maintenance organization] person, basically all of those things that nobody else wanted to do. Somebody had to do them, and so usually being a nurse and being (laughter) educated in that style, we're taught to pick up all the pieces and make sure everything follows the patient. And so it would usually end up in my lap. Either I'd do it or nobody does it, and that's not an option. (Interview 11, Section 0, Paragraph 41)

One nurse was not intimidated with being assigned an unfamiliar duty because the participant felt that one did not have to be an expert in everything – one just needed to know the questions to ask to ensure safety:

The biggest thing you need to have going into something like this is knowing the questions to ask.... I think this is very important, especially when you're looking at all the preventive medicine type of things you need.... Do you have time to dig down into every nitty-gritty thing there? No. But you have to have some idea what's going on. So by going into an area and asking certain questions, if you get the right answers, then you know you have a higher percentage chance that everything in there is going okay. (Interview 6, Section 0, Paragraphs 7 and 25)

Maintaining job satisfaction with so many responsibilities was tough for the nurses.

It was not unusual for them to have misgivings:

Once you go out and you're underway and you're doing these drills, you're trying to brief everything, and then you get your first wave of patients. And you have your ward patients and your psych patients.... We had several ruptured appendixes. And you're trying to give good nursing care to the patients on the ward and trying to make good drills and quality drills when you're doing your training for the crew on the ship. And then, you're trying to hold meetings and QA meetings and credential's meetings.

And as new flight surgeons or doctors come out or ship's riders, nurses come out, and getting their credentials and getting them settled in, and just achieving a real balance. It was tough.... At one point, I kind of reached a breaking point and tried to be departmental training coordinator, ward nurse, ICU nurse, training team leader, credentials nurse, QA nurse, and try[ing] to do health promotions, and wear all the hats, and try to have balance. It was really difficult. (Interview 9, Section 0, Paragraph 7)

Being One-of-One

Corresponding Essence in the Exhaustive Description

The nurses were considered one-of-one because they were the only nurse assigned to their carrier as the "Ship's Nurse." Not only did they represent nursing services for their ship, they were nursing services. The nurses felt an incredible sense of responsibility to their job. They were on call 24-hours a day, seven days a week. The nurses knew their ships inside and out and made it a point to visit all of the ships' spaces, especially in their capacity as coordinators of the medical training teams. It was not uncommon for the nurses to be stopped in the passageways and consulted on matters ranging from the crew's own health care needs to questions about a family member's health status. Everyone on the ship recognized the nurse.

24/7

Most of the participants had come from military treatment facilities where they were one of many nurses who worked for nursing services. Once they got to their ships, they came to the realization that there was no department of nursing to report to – they were the department of nursing. Even though the nurses did not practice in isolation (because they were surrounded by physicians, physician assistants, and corpsmen), they were

considered one-of-one because each was the only nurse assigned to his or her carrier to perform the arduous duties of the ship's nurse:

... In the Nurse Corps, it's not that often where you're ... the director of nursing service.... even though it's just one-of-one ... it's kind of neat. 'I'm the ship's nurse.' With a ship of 5,000 people ... that was a fairly significant experience. (Interview 1, Section 0, Paragraphs 469-471)

I definitely think ... positively about the experience.... [being] the only nurse assigned to the ship. You are very independent. You ...are nursing services. (Interview 10, Section 0, Paragraph 93)

When you're a nurse on carrier, you're it. You're the only game in town. It's a 24/7 job.... But to do the overall nursing care, you're it to lead the job. (Interview 4, Section 0, Paragraph 7)

Sense of Responsibility

Being one-of-one could be great but it could also be daunting. Once the nurses realized their level of accountability, they fell vulnerable to periods of self-doubt:

We had 4,800 people on board our ship so you're the one and only nurse for that 4,800 people, plus whatever's in the rest of the battle group. So you could have six or seven thousand people that you could ultimately be responsible for as the only nurse out there, which is kind of interesting. (Interview 7, Section 0, Paragraph 13)

I was the only nurse and that kind of made me feel important, I guess ... but also very stressed because I just felt like I had the weight of the world on my shoulders sometimes ... because everyone looked to me for anything that had to do with nursing or taking care of patients or anything like that. (Interview 12, Section 0, Paragraph 7)

In this exemplar, the nurse hypothesized that a patient could have a primary nurse throughout his or her entire period of hospitalization given that the nurse rotated through various areas of the medical department:

I really did have kind of the full realm. I was first assist on just about all our surgical cases. I had to do the conscious sedation on all our conscious sedation patients.... Then you were in there on the ER [emergency room] on all the patients, because

you're really the main person that can get a lot of the technical procedures done, you know, make sure things are going along. Then, you've got them in the ICU [intensive care unit] and you've got them on the wards. So, talk about continuity in care, you had the same nurse throughout your entire hospitalization, literally. (Interview 6, Section 0, Paragraph 7)

Lack of Sleep

Being on-call 24-hours a day, seven days a week (24/7) meant experiencing a lack of sleep at times:

Sometimes I would get woken up in the middle of the night to come down, because we would have ... an emergency ... or we were getting a medevac in from one of the other ships. And so I would get woken up and I would just have to stay up. That was the bad part of being the only one there. If there was something that was needed during the night, there wasn't someone else that could be called. It was me. (Interview 12, Section 0, Paragraph 21)

This nurse anticipated being awakened during the night to push intravenous (IV) medications so the participant negotiated with the surgeon for an alternative delivery system (that the corpsmen could give) for pain control for the post-operative (post-op) patients so that he or she could have some uninterrupted sleep:

'Look, Doc, I'm here from 6:00 to midnight. Are you sure I need to get up at 4:00 in the morning to give that med?' Because, you know, I never would let my corpsmen do IV push. I drew the line there. We had one surgeon ... [who] wanted IV push [pain medication for the patients] every four hours.... [I would say], 'How about an IM [intramuscular] so i can get some sleep?' And usually they would be okay with that. Either that or 'how about you come up and do that?' That generally stopped them. (Interview 11, Section 0, Paragraph 39)

If the nurses had patients in the Intensive Care Unit (ICU), they could count on getting very little sleep because they had to deliver direct patient care round-the-clock. They could not count on their corpsmen to be their substitute because the corpsmen were generally not trained to take care of ICU patients. Whereas the physicians could tradeoff

on their coverage, the nurses could not because they were one-of-one. Even anesthesia personnel did not make themselves available to the nurses for support when caring for critically ill patients (e.g., those requiring ventilator support) once those patients left the operating room. As the only nurse, experiencing the autonomy of critical care nursing could be both an exciting and frightening prospect:

I had no corpsmen that had any inpatient experience whatsoever. You are the only ICU nurse, which means when I [had] my two ICU beds full, I was literally catching a catnap on the floor between the two patients type of thing. (Interview 6, Section 0, Paragraph 7)

But you're on your own – all on your own. The one person I expected to come by, to be something of a critical care expert, would be the anesthesiologist.... But once these people have faith in your skills, you're alone, really alone. And that was the case for me. It really opened my eyes to the fact that if anything bad happens to these people while they're in the ICU, someone will realize I'm taking care of them lock, stock, and barrel. (Interview 5, Section 1.1.1, Paragraph 51)

Respect

The nurses were surprised at the level of confidence instilled in them by their medical counterparts. In the military treatment facilities, the nurses had experienced working relationships with the physicians that were not always conducive to nursing opinions. Once they had proven themselves on the ships, the nurses felt a sense of respect for their nursing knowledge that they had never quite experienced before:

There was a lot more respect than in the hospital. Because you're the only one and they can see the difference and usually if the docs realize that they need you, and you're not their, you know, 'go-to' girl. And there's a lot more camaraderie even within the department. Usually the docs, if they were writing orders, would let me know what the orders were ... and whether or not I thought that we could do it. And I was like, 'Cool. Wow.' I've never come across that before. (Interview 11, Section 0, Paragraph 39)

Replacements

Since they were one-of-one, the participants expressed concern as to who would do their job if they got sick or had to leave the ship for any reason:

I worried a lot of the times, too, about me getting sick.... But you feel an incredible responsibility, you know. And I'm glad that I didn't have any family emergencies and that's always kind of in the back of your mind 'cause you don't know who's [going to] step in and do your job. (Interview 3, Section 2, Paragraph 12)

You have to look at from the standpoint if there's not anybody there that's trained out to take your place, what are you going to do if something happens to you? You know, who's going to step up to the bat. And that's how I looked at things. (Interview 6, Section 0, Paragraph 25)

Time-consuming Job

The participants recounted how time-consuming their job was. The nurse quoted in this exemplar was thankful to be single and without children because being the ship's nurse on an aircraft carrier was such a tough job:

I put a lot of my focus into the job. And so, I felt that I had put my life on hold from the outside. (Interview 12, Section 0, Paragraph 27)

Isolation

Sometimes the participants felt isolated from their nursing peers (yet they did not practice in isolation because they worked in a department of over 50 personnel). During periods of stress, they could not physically go to another nurse's office or stateroom to ventilate their feelings because there was no other nurse around (unless the carrier had a nurse anesthetist assigned to the ship for anesthesia support). The availability of electronic mail (e-mail) alleviated some of this void:

So it was kind of growing pains, and I was feeling extremely overwhelmed, even before that as to juggling all the balls, as the only nurse on a ship and maybe not

having the support, because you don't have your peers. (Interview 9, Section 0, Paragraph 7)

He forwarded my e-mail address to ... the Executive Director of the Nurse Corps.... So here in less than 24 hours, I'm talking to people I'm not sure I want to talk to 'cause ... that's way too high up in the food chain. But she did a great job of keeping me informed in the Nurse Corps and keeping me out there. And as the Nurse Corps kind of started going digital with the Nurse Corps Christmas cards and stuff, I'd get those quite often.... So we weren't abandoned. I mean I could [write], 'Hey, you got an isolation policy? Can you send it on e-mail?' I mean technology has made it much easier than it was with the people out before. (Interview 2, Section 1, Paragraph 27)

Peers

Some of the nurses organized luncheons or dinners with their nursing counterparts on the other carriers. Coordinating a meeting with full attendance was tricky because of the deployment schedules of all of the carriers. The nurses who attended felt a great sense of camaraderie among their peers. Competition for the medical department's award for excellence in operational readiness (known as the Blue "M" for "Medical") was not an issue among peers because more than one aircraft carrier's medical department could earn it. However, the overall "Battle E" award for excellence in combat readiness is given to only one Atlantic Fleet and one Pacific Fleet carrier each year. This participant alluded to a spirit of competition for the "Battle E"; however, it must be stressed that there is no advantage for any of the nurses to hold "trade secrets" because the Blue "M" component of the "Battle E" award can be won by as many medical departments that meet the established criteria:

You just try to make contact with other ships' nurses to learn from them and to share. When I was in Norfolk, we had a quarterly meeting. All the ships' nurses met at the O'Club [Officers' Club] because there's five carriers in Norfolk [Virginia] and on down to Jacksonville [Florida].... Once we had all five carriers in, which is pretty rare. But anyway, we would get together and just have lunch and just kind of have

shop talk and decompress and share lessons learned and swap stuff. Very, very worthwhile, very therapeutic. So it was a good group and you wanted to help them out. And at the same time, you were competitive, because you're all competing for the Battle E, which the carrier group has only one Battle E. (Interview 4, Section 0, Paragraph 47)

Liberty

Being the one and only nurse assigned to the carrier influenced how the nurses experienced port calls. When the nurses did go sightseeing, the ship – and the status of the inpatient ward – was always on their minds. Whether the senior medical officer required it, or it was just the nurses' sense of responsibility, the medical department always knew how to reach the nurse during periods of liberty:

Being a ship's nurse is hard when you're one-of-one because ... how do you go on liberty when you're one-of-one? Judgment calls had to be made when it was okay for the nurse to leave the ship. Basically, that judgment call pivoted on one thing: how good [were] the medical treatment facilities in the port of call that we entered. So, you as a ship's nurse [were] always a little bit concerned [about] the medical intelligence of the port of call you were going [to] ... because it would impact your liberty.... Fortunately, for a carrier, nine times out of ten, the port of call is ... in a city that ... has good, definitive care capabilities.... You could go [on liberty in the port of call] on a short leash. On a very, very short leash. (Interview 1, Section 0, Paragraphs 285-303)

[It was hard] whenever we were in a foreign port, [because] we ran the hospital. And I don't know if it was just my sense of responsibility ... if I had patients in the hospital, I wouldn't be gone a lot. So I usually took part in the 'admins' [where the officers would pool their resources to get a hotel room, usually a suite, to use as a retreat during the port period].... I would participate in that but would never stay overnight.... And [I] usually always made sure that, if I was going on tours and whatnot, that they didn't last all day, didn't last all night, and that at least the beach det [detachment], if not the SMO, knew exactly where to find me. (Interview 1, Section 0, Paragraph 37)

It's tough being on duty in port when everybody else is out having fun and there was a couple times that that was a little tough. (Interview 7, Section 0, Paragraph 37)

Visiting the Ships' Spaces

The nurses purposefully sought out opportunities to become intimate with their ships' surroundings. In this exemplar, the nurse recounted being given very unusual advice that turned out to help the participant the most in learning about the ship:

One of the tips that he gave me was very bizarre. He said, 'Sign up for Zone Inspection every week. Go down and ask for it.' Zone Inspection ... consists of getting in your formal zone inspection uniform with your inspection gear, and your flashlight and all the goodies, [and] going to a list of spaces.... went to places where people weren't necessarily appreciative of the fact that [we] were there to inspect them. And, by the way, nothing good can come of an inspection. There [are] always negative remarks that are made. So nobody liked it.... He said, 'You know, first of all everyone knows that Zone Inspections are a hated responsibility. So, by doing it every week, they'll understand your level of commitment. Number two, in a very short period of time, you'll go to almost every space in the ship, places that almost no one else goes. And I can guarantee you that the Senior Medical Officer has never gone to these spaces. And by going to the spaces, you'll meet the crew.' Best advice I ever got. I'd say probably within two months, people already knew everywhere who I was and within four months I was completely comfortable with the ship. (Interview 5, Section 0, Paragraph 7)

Everyone Recognized the Nurse

Being one-of-one and conducting drills throughout the ship provided the nurses with ample opportunity to be recognized on the ship:

Very high visibility. And that was fun. Everybody pretty much knew me and I pretty much knew everybody. It's a great community. (Interview 11, Section 0, Paragraph 27)

Sometimes being well known proved to be a disadvantage; however, this nurse did not let it interfere with implementing training:

As soon as they saw the nurse come onto the smoking sponson [a projection from the ship's side, as a bracket for something], they're like, 'Oh my God! The nurse is here again.' Right away, they knew what I was thinking of. I said, 'Yes, this is medical training and it's health promotion at the same time. You're getting your money's

worth out of this.' I really tormented the ship. They hated seeing the nurse come around. (Interview 4, Section 0, Paragraph 11)

Being easily recognized appeared to make the nurses more accessible to the crew at large. The participants remarked that it was not unusual for them to be stopped in hallways, or to have a shipmate peek into their offices in search of the nurse, when seeking out advice:

I would walk along the p-way [passageway] and folks would approach me. Every rank, every level, both genders and I can't tell you how many hallway consultations I did. For information, for counseling, for a variety of things like everything from the Chief wanting to know what does he say to his wife who [has] a lump in her breast [and] who might end up having a mastectomy.... How does he cope with this and how does he, [in] his term, 'handle' her?... He felt so lost and he didn't know who to go to speak with. This is a rough and tough sea-going chief. But you saw folks just kind of open up. (Interview 4, Section 0, Paragraph 7)

Constantly Operating in an Environment of Uncertainty

Corresponding Essence in the Exhaustive Description

The nurses constantly operated in an environment of uncertainty. They could never be sure of what was going to happen next and always wondered about the "ifs": if their qualifications were sufficient to get the job done; if they could trust their corpsmen with the inpatient ward; if the ships' crew could manage a trauma victim given the training the nurses had coordinated for them; if they could handle a critically injured patient in their Intensive Care Unit; and if they could manipulate the sometimes archaic equipment they had inherited. The leadership capabilities of each commanding officer (CO), executive officer (XO), and senior medical officer (SMO) set the tone for the nurses' work environment. Feeling a strong sense of support from these individuals was paramount in

allowing the nurses to excel in their role as the ship's nurse while practicing in a constant environment of uncertainty.

Stressful

Practicing in an environment of uncertainty was certainly stressful. Not all of the nurses specifically articulated this thought; however, when listening to the audiotapes, and re-reading the transcripts, it was apparent that all of the nurses experienced it. They constantly worried if they were qualified, and clinically competent, to spontaneously handle any event (whether it be an administrative dilemma or a critically ill patient):

As a nurse, you're always in the back of your brain wondering, 'Oh, am I going to have a ventilated patient? Am I going to have an aircraft mishap, a major trauma, a major mass casualty type situation?' – which is just your worst nightmare and how would you handle it? (Interview 9, Section 0, Paragraph 9)

Several nurses voiced that the worst part of working in an environment of uncertainty was always wondering if they were going to make an irreversible mistake:

As the only nurse on the ship I sometimes felt vulnerable to opportunistic scapegoating..... I was responsible for so much and was always afraid of the proverbial career-ending incident that may present itself when you least expect it. I often felt overextended. (Interview 1, Section 1, Paragraph 732)

Training of the Corpsmen

Caring for the inpatient ward (which was one of the nurses' key job responsibilities) included training the two or three corpsmen assigned to the ward. Because the nurses were involved with various activities around the ship, they had to be able to trust the corpsmen to be their eyes and ears on the ward. This proved to be a challenge since most of the corpsmen initially assigned to the ward had no experience with direct patient care. The nurses did not have much of a say in who worked for them. They strived to develop

their corpsmen's clinical competency levels and were amazed at the progress a lot of the corpsmen made under their mentorship.

The corpsmen assigned to the nurse were responsible for direct patient care of those hospitalized on the ward (including those in the intensive care unit – ICU). In this exemplar, the nurse explained a hard lesson learned:

After I got my butt chewed a few times, I realized I better train these guys to be my eyes, because I'm the eyes and ears for the doctors, and I can't be here 24-hours a day. (Interview 5, Section 1.1.1, Paragraph 53)

The nurses recognized that the more they devoted to the training of their corpsmen, the more they could trust the corpsmen to report pertinent patient information when they were busy performing other duties or even when they were catching up on their sleep. Since the nurses were on call 24-hours a day, seven days a week, they had to relinquish some control in order to survive the experience:

Invest, invest, invest and get your corpsmen as trained as you can because ... [the job] is 24/7 [and] you've got to be able to count on those guys. (Interview 4, Section 0, Paragraph 17)

I think the biggest challenge of a ship's nurse is developing your corpsmen. It's pretty obvious. No matter who you are, no matter how good you are, 24 hours a day, seven days a week, at some point, you're going to have to get sleep and some point, you're going to have to shower, at some point, you're going to have to eat. So, in other words, at some point, you're going to have to leave the ward, and trust the ward, and the patients to the corpsmen. If you can't do that, you're not going to adjust, you're not going to make it because physically, Mother Nature says you have to eat, you have to sleep, you have to have socialization or you just won't do well. (Interview 1, Section 0, Paragraph 103)

Investing in the corpsmen meant providing them with training opportunities that would allow them to excel in their job. Sometimes this concept was supported by the medical department, and sometimes it was not:

While in port, I would make sure they got to critical care courses. Whatever was offered at [the local Naval Hospital], I would make sure my corpsmen participated in it. Dysrhythmia recognition, critical care, getting them experience in respiratory therapy, getting them experience in whatever you could conceptually think that could happen while you were at sea. I made sure that the corpsmen who worked on the ward with me [got training]. Not all 44 corpsmen in the department could be sent to a critical care course but you identify who your corpsmen are going to be for cruise and workups on the ward, and those are the folks I tried to get to ACLS [Advanced Cardiac Life Support], or dysrhythmia recognition, or critical care, etc. (Interview 1, Section 0, Paragraph 105)

I made a point of really standing my ground that a corpsman can learn how to do something. And that's really what you're looking for is opportunities for them to do stuff just like taking them to the hospital. I wanted to take them to the hospital during the workday when we were in port and that was never supported. And that was very frustrating to me 'cause I really felt that they were missing out and I felt like if I could work with them one on one, they'd be inspired to do a better job. And that's one of my disappointments: that I didn't push harder to get that to happen. (Interview 3, Section 2, Paragraph 7)

Aircraft carriers are a dangerous place. Each ship was an industrial environment that made it an ideal surrounding for accidents to occur. Sometimes the corpsmen were exposed to traumatic events that they were not prepared for. The nurses recognized this fact and tried to the best of their ability to use untoward experiences to the corpsmen's benefit:

Because it is an industrial environment, you do wind up having significant events. I mean accident prevention is ... big. I mean you're talking an airport, you're talking a power plant. The hangar deck is ... [an] industrial environment. And things that can happen, happen so quickly. And you see one life changed and snuffed out very quickly.... As much as corpsmen think they're ready or as much as you can train a corpsman in all that kind of stuff, they've never really seen blood and guts trauma. And when they see it for the first time, you see how young your corpsmen really are. We had a significant trauma on the ship when I was there.... One young corpsman was so paralyzed with ... the sight of this thing – it was pretty gruesome. And [I directed] him just to, 'Talk to this guy. What music does he like? What sports does he like? Just talk to him.' And so as soon as he got ... [a] task, he could do that. And in talking to him later ... that's pretty much what he said. He said, 'I had no idea what was out there.' (Interview 4, Section 0, Paragraphs 15-17)

We had a flight deck death. It was pretty bizarre because some of the corpsmen fell apart. And that to me signaled that these corpsmen needed to have better training than they had. And it justified to me being pushier about trying to get them over to the hospital where they'd get better training.... [When asked, 'How did they fall apart?,' the participant said:] Well, crying in the hallway, seeing a dead guy – couldn't handle it. The first class that I had such a difficult time with, he thought it was disrespectful to have people look at the guy that was already dead. And it was my opinion that they needed to see a dead person because if the first time they're seeing a dead person is when they're trying to save their life, that's not the time. (Interview 3, Section 2, Paragraphs 9-11)

Some of the corpsmen demonstrated overconfidence in their ability when responding to a distress call. In this exemplar, in the role of both patient advocate and corpsmen advocate, the participant explained what steps were taken to remedy a potential problem:

We have these medical response bags that the corpsmen carry as they respond to these things. And I opened it up, and there [are] test tubes in there and there [are] these drugs in there – epi [epinephrine] and lidocaine, and all the rest of this. And I'm going, 'Why is a corpsmen carrying a bag that has all this stuff in it?'.... so I'm asking one of the corpsmen, and he said, 'Well, you know, the last surgeon told us how to put in these chest tubes if we ever needed to.' And I'm going, 'Not a chance.' And so we quickly rearranged things and we made those EMT [emergency medical technician] bags with EMT level appropriate supplies in them. (Interview 6, Section 0, Paragraph 25)

Usually two or three corpsmen were assigned to each nurse for an inpatient ward that consisted of 40 to 50 beds. The nurses found it difficult to trust the new corpsmen because they came directly from Corps School and were without any significant direct patient care experience. The schedule that worked best for the participants was putting the "weak" corpsmen on the day schedule (where the nurses would have some direct supervision) and placing the "strong" corpsmen on the night schedule (where the nurses could trust the corpsmen to call them for any important questions and to let them sleep for any events that could wait until morning to address):

The ward was mine, and it was about 50 [beds]. I had two corpsmen, both of them straight out of Corps School. One worked days and one worked nights. That was tough, because they didn't know anything about nursing. (Interview 11, Section 0, Paragraph 7)

So, out of 44 corpsmen, I got three. Which is fine. So we decided to go 12-hour shifts: two corpsmen on days, because that's when we did most of our post-ops and same day surgery kind of thing, and one corpsman on nights. We decided to put my senior corpsman, my stronger corpsman, on nights because that gave me the peace of mind that I needed to [sleep].... I put the stronger senior corpsman on nights because I needed the peace of mind and, because, I just [needed] to know that he could handle anything that's thrown at his way, on short notice before he [would] call for help. (Interview 1, Section 0, Paragraphs 115-119)

The nurses did not have a significant say in who worked for them. In fact, it was not uncommon to determine the inpatient ward assignments just before deployment. This could prove frustrating in that valuable training time, prior to going out to sea, had not been utilized for the ward corpsmen:

I bounced this off with the previous nurse, 'When are we going to find out who the corpsmen are going to be for the inpatient ward?' because it's supposed to be 24 [hour] coverage when you're at sea or in port other than home port. And she said, 'Well, we'll probably find out the day before we leave.' And sure enough, the day before we left is when we found out. And there was no rhyme or reason to the rank of assignments. And no preparation and no efforts supported to get them trained over at the hospital really and truly whatsoever.... What I tried to do is just to do the best that I could with whoever was thrown my way. And some of the corpsmen were very, very junior. (Interview 3, Section 2, Paragraph 7)

I liked the ability to pick my corpsmen but that was not always the case. Typically what happened was the leading chief petty officer gave you the corpsmen and unless you had a strong objection related to standards of care, or something, that this person could not do the job, you basically got who you got which were usually the more junior corpsmen. (Interview 1, Section 0, Paragraph 107)

Once the nurses trained their ward corpsmen, they were torn between wanting to keep them on the ward for long periods of time (especially since they could now trust the corpsmen) or letting the corpsmen experience other positions in the medical department:

I was pretty impressed with them. I thought they did an outstanding job. But ... I couldn't keep them for more than a year. I needed for them to do other things. Because there is a lot of excitement that [occurs] on the carrier and when they're stuck on the ward, especially during cruise, for seven days a week, twelve hours a day, they didn't get to take advantage of some of the other things going on, like getting their advancement stuff done, experiencing the flight deck, the other BDSs [battle dressing stations] ... they were stuck on the ward. And so, much as I hated to see them go after they knew what was going on, I figured I needed to take some of the other guys so that they had a chance to learn some of the other areas, get into the administration part of it, do sick call. (Interview 11, Section 0, Paragraph 25)

The nurses realized that they did not accomplish their duties on their own. Even though they were the only nurses on their carriers, the nurses had support staff that allowed them to excel in their job of managing the inpatient ward:

I think the corpsmen don't get enough credit.... The nurse doesn't do it all. You're there as an expert, but by no means do you do it all.... The credit by far was to the corpsmen because they did the lion's share of the work. (Interview 4, Section 0, Paragraph 7)

The nurses took pride in mentoring their charges. Many had not experienced so much one-on-one time with the corpsmen and were amazed at how quickly the corpsmen picked up on the information they had imparted. A wonderful aim was achieved when some of the nurses' corpsmen advanced in rank while under their tutelage:

I had never actually trained and worked solely with the corpsmen for that length of time. And it was amazing how much they learned. I didn't know I was that capable. (Interview 11, Section 0, Paragraph 25)

The highlights of my career on the ship were seeing the people that I worked really, really close with advance. And almost every single ward corpsman advanced and that was very exciting. (Interview 3, Section 2, Paragraph 9)

The participants appreciated that with all of their other numerous duties, some of their corpsmen got short-changed in their training. In this exemplar, the nurse expressed regret with this occurrence:

I felt like I could have done certain parts of my job a lot better. One thing, to be a mentor to the corpsmen. I felt like I ignored the two that were assigned to me. I couldn't really spend a lot of time with them because I was off and doing other things. My focus was more on the whole ship's activities, rather than the medical department's troops. (Interview 12, Section 0, Paragraph 21)

The nurses developed a strong bond with their assigned corpsmen. They endured good times and bad times. They suffered periods of adversity and came through it together, stronger than they were before:

There were days when I would get on the corpsmen's nerves and there were days when the corpsmen would get on my nerves. But at the end of the tour, we all walked away respecting each other. We all walked away with something more than just friendship. You know, there was respect there. The respect probably was from having a shared experience [and] having overcome that shared experience of significant hardship. (Interview 1, Section 0, Paragraph 131)

Equipment

All of the nurses reflected on ventilator management because they were in doubt as to their capability to set-up and operate the ventilator (a task they never had to perform in a military treatment facility). The ships were not equipped with respiratory therapists (RTs); thus, the nurses (who had experience in critical care and/or emergency nursing and had worked with ventilator patients before) became the resident experts on ventilators. Some of the nurses relished this responsibility; however, the majority of the participants were fearful of one main event: having a ventilated patient in their intensive care unit (ICU). This can be attributed to the fact that in a military treatment facility, a respiratory therapist manages the ventilators and a physician orders the weaning parameters. On the ships, the physicians assumed the nurses knew how to wean ventilated patients without specific doctors' orders. The only other ventilator experts were anesthesia personnel; however,

once the anesthesia provider (either a nurse anesthetist or an anesthesiologist) released the patients from the operating room, they, too, left all of the ventilator management to the ships' nurses. To make matters worse, the nurses discovered that the ventilators were not the models they were accustomed to – they were the ancestors of the ones they had used at the military treatment facilities. Several nurses recommended becoming familiar with setting up ventilators prior to having to actually use one on the ships:

Never actually had to use the ventilator for a patient that was staying. We did bag some folks for an awful long time, but the ventilators were quite an interesting story. When I was in nursing school, we were introduced to ventilators and told that there was this one kind of ventilator that was still around, probably would never see it. Course I had never seen it until I got to the ship and [there it was].... Luckily, they're idiot-proof so ... it was pretty easy to figure out.... And of course, the oxygen tanks you have to manually take out.... But our PA [physician assistant] had been a CV tech, cardiovascular tech, so he was very familiar with the ventilators. So luckily he was able to teach me how to actually set them up because I had never done that. Every place that I had worked, respiratory had done that. So that was one of my biggest fears when I got to the ship was, 'What if I need this?' (Interview 11, Section 0, Paragraph 23)

Before we get this guy back in there, I had to slide back in the ICU [intensive care unit] to make sure that the blower [ventilator] is functional, because the surgeon and I pretty much decided that this guy is going to have to be ventilated for a day or two. He's an older guy, got a ton of fluids, big operation, he's going to need to be on the blower. No RT, no respiratory therapist out and about on the carrier. So, if you don't know how that ventilator works inside and out, you're sunk. And as luck would have it, I decided to use the Bear 3 [a type of ventilator, third generation]. And somebody had done something, and somehow the humidifier on this thing was broken. It worked just fine a week before. It's broken now. So I go to find another humidifier and what do I find? This brand spanking new humidifier in a box that had never been plugged into anything, and it's a humidifier I've never seen before. And it wasn't one of these that you can just hook up a bag of fluid to, run it into the thing and be done. Oh, no! It had a completely different mode of operation than I was completely unfamiliar with. So an hour later, water all over the deck and, you know, I'm practically swimming in water that I've tried to fill this humidifier up with – it's escaped everywhere – I finally see how this thing works and I realize, 'Oh, my God. I've been going about it all backwards.' I get the thing all filled up. I plug it into the electrical outlet – praise God I wasn't electrocuted when I turned the whole thing on

– and it works. I started from fresh with a new circuit, which most of us don't know anything about circuits and how the ventilator goes together, because ... RT does that. When there is no RT, you do it. So I got it all together. It all worked out. Whew! (Interview 5, Section 1.1.1, Paragraph 51)

When you have basic supplies, you do basic care. And so, having a critical care nurse that's up to speed in the most advanced vents [ventilators] and the most advanced lines with the most advanced vents [ventilators], when you put them on a ship that doesn't have any of these, can they still function? You have no respiratory therapist out there. These vents [ventilators] are yours. The monitors are yours. The [intravenous – IV] pumps are yours. You need to be able to use all of them. And they [successors] need to know and have the initiative, at least enough to get in there and set these things up and play with these things and make sure that they know how to use them. (Interview 6, Section 0, Paragraph 25)

The nurses did not share a common belief in the criteria for becoming the ship's nurse. Some were primarily critical care nurses and others came with a strong emergency nursing background. The critical care nurses thought that the ship's nurse should be a critical care nurse while the emergency nurses thought that the ship's nurse should be an emergency nurse because emergency nurses are experienced with the concept of triage. Regardless of their philosophical differences, both groups felt that the ship's nurse should be comfortable with managing ventilated patients:

From a critical care standpoint, you don't see a lot of critical care, but you better be able to hop to it in a heartbeat. That's not the place to say, 'I once took care of a vent[ilator] patient once.' You got to be comfortable and be able to come back from lunch and say, 'Oh, we're putting this guy in a vent. You're going to be taking care of him.' (Interview 4, Section 0, Paragraph 63)

Not only were the ventilators archaic, so was some of the other equipment available to the nurses. The participants cautioned their successors not to be disappointed when they came from a high-tech military treatment facility to the ship:

If anybody works in a modern ICU [intensive care unit] and you go out to fleet, the stuff you've got out there is ... kind of old. So you just have to do the best you can with it. (Interview 7, Section 0, Paragraph 33)

Another negative was ... some of the old equipment that you got to work with. I went and got a bunch of dial-a-flows. That way, I knew that patients weren't going to get bolused accidentally by fluid. That was a problem before getting on board, where they would just hook up an IV [intravenous fluid] bag and [say], 'Okay. It looks like it's running at 125 an hour.' And the next thing you know, 'Oh, the bag was gone.' So ... if you don't have equipment, you have to improvise or try to figure out ways of preventing things from happening. (Interview 10, Section 0, Paragraph 103)

Leadership

The nurses spoke with awe when reminiscing about their commanding officers (COs).

They really believed that they had finally experienced what quality leadership was all about – especially while working in an environment of uncertainty:

I think it starts at the top. A really good CO, who recognizes his wardroom, knows everybody by their first name and really tries to keep a tight wardroom. (Interview 9, Section 0, Paragraph 9)

The Skipper [CO] may not come down, the XO [executive officer] may not come down, the squadron COs may not come down to pat you on the back and tell you what a great job that you did with heat stress or tell you what a fine job you're doing monitoring lead levels on the ship. But you just let somebody get bad hurt and they are down there in minutes. Even underway, the Skipper will leave the bridge and come down to medical to see how things are going. (Interview 5, Section 1.1.1, Paragraph 49)

In this exemplar, the nurse described two excellent leadership examples the CO established. First, he flew two sailors, who had been injured earlier in a horrific accident during work-ups, out to the ship so that their shipmates could see that the ship's resuscitative efforts paid off. Second, the CO demonstrated his belief in the value of the

enlisted sailors by treating them with the utmost respect when they returned from a major deployment:

What the CO did, because of his concern for his crew is fly these folks out there, so these folks could say good-bye, see that they were doing okay, because the last time any of them had seen them, they were [injured].... This is the same CO that, when we came back from deployment ... would not let any officers on the ship leave, because he wouldn't open it up until the two sides of the enlisted brows had come down. And then ... he stood at the top of the enlisted brow and shook the hand of every sailor. That's leadership. You know, shook the hand of every sailor on that ship. (Interview 4, Section 0, Paragraph 31)

The participants were amazed that the COs and XOs knew their names and that they understood exactly how much the nurses contributed to the mission of their commands.

The nurses had not experienced this level of recognition at previous military treatment facilities:

It was very much appreciated, by myself, that the Skipper [CO] personally knew what I did on that ship, personally knew that I was the individual responsible for keeping the crew trained or getting their training at a heightened level where they were ready to deploy.... This individual knew me ... at a personal level.... I personally appreciated that the Skipper and XO knew what I did. Unlike [that] of Skippers and XOs in hospitals, who have much less for crew [and who] have not a single clue as to what their people are doing for their command. (Interview 8, Section 0, Paragraph 59)

Most of the nurses developed great working relationships with their senior medical officers (SMOs); however, it sometimes proved challenging to adapt to new SMOs. The best SMOs were those who fostered teamwork, trust, independent thinking, and autonomy within their medical departments:

We had a great SMO. He was very much into everybody gets the same treatment. We don't care if they're brand new ... [an] E-1 who just reported from boot camp, or if it's the Chief of Staff ... they all get the same quality of care. (Interview 4, Section 0, Paragraph 7)

Both [SMOs were] very good and supportive and very, very different. One was a hands off, you do your own thing, totally hands off. And the other one was just like a micro manager to the hilt, and you know he is just genuine. But he just wanted to know everybody's business and had all these great ideas and was like trying to change everything like really fast. And it was like, 'Oh, my gosh.' It was all really good stuff, but it was just so fast. So it was a huge adjustment from a hands off leader to a total hands on and then in everybody's business. So it was not necessarily a bad thing, but just that much change, he was causing a lot of discontent among the chiefs and whatnot. (Interview 9, Section 0, Paragraph 31)

Our senior medical officer in the beginning was very, very good, and we got a new senior medical officer. He didn't take suggestions well. His way was the only way, or the highway. And I think the whole deployment would have been a lot better if we had a little different kind of senior medical officer. (Interview 7, Section 0, Paragraph 13)

A less-than-ideal SMO was one who did not hold personnel accountable for their actions and whose leadership style contributed to a low morale among the staff in the medical department:

My boss [the SMO] [had] kind of laissez-faire leadership style, ... 'We should all be adults. We should all be able to get along.' But there was a lot of internal bickering, internal games, internal strife. I mean it was a mess.... The senior medical officer, in my opinion, didn't hold people accountable. (Interview 3, Section 2, Paragraph 7)

The nurses could tolerate just about anything as long as they felt supported by their leaders. In this exemplar, the participant described a scenario wherein another department was trying to impose an unannounced training drill on a busy medical department. The nurse went on to say that one's rank, when interacting with other officers, was not as important as was having the support of the SMO behind the ship's nurse:

He [the officer running the drill] didn't tell me one day and they tried to evacuate.... I said, 'Look, this is the deal, this is what you're doing. I've got sick people here, I've got people throwing up in here, I've got people on IV's [intravenous fluid therapy] in here. I can't evacuate. If we were on fire, we'd be out of here, okay? And when you're doing an assessment evaluation, hey, we're here for you, buddy. We'll make you look good but we know how to leave the space'.... But they get into their own

little world and they don't know what the rest of the world does.... And they don't really know what you do and they don't really want to know all of what you do. But they want you to work with them. But you have to tell them what your priorities are and sometimes you have to be really assertive about it. This is why they say you need an O-4 above Nurse Corps. No, you don't. You need a command that supports you. I had a Senior O-5 [who] supported me. I am just a JO [junior officer], okay, but I had support from my department. (Interview 2, Section 1, Paragraph 99)

Having Two Families: Significant Others and Shipmates

Corresponding Essence in the Exhaustive Description

The nurses had two families: their significant others and their shipmates. Working with the Line community was a great experience for the nurses. Never before had they seen such amazing teamwork, and felt such a sense of camaraderie, and they realized that once they left their ships, they would most likely never experience this again. Because they worked, lived, ate, and socialized with the crew, they learned about their lives. Enduring tough times, such as work-ups, brought the nurses and their shipmates together as a family. When all was said and done, they had a true appreciation for the Line and felt that the Line had developed an understanding and respect for them not only as Navy nurses, but also as Naval officers.

Teamwork

As discussed in Chapter I, the Line community consists of the war fighting community of the Navy such as the officers that man surface ships, fly aircraft, and operate submarines. The Line community is supported by the officers of the Staff Corps (which consists of nurses, physicians, dentists, allied health personnel, accountants, civil engineers, lawyers, and chaplains). The participants wholeheartedly expressed their appreciation for what their Line counterparts did on a day-to-day basis.

They were amazed at the sense of teamwork they experienced when working on the ships:

But boy, you felt like really you were part of the team. You were seen as a real player. (Interview 4, Section 0, Paragraph 7)

Sometimes nurses, or even those in the medical field, get so involved in their own little niche that they do not see the “big picture.” On the ships, the nurses realized that the medical department was not the only game in town and that the job of “medical” was to ensure the health and welfare of the crew so that the crew was physically fit to fight in periods of armed conflict. Also, the participants reiterated that the only way to get a job done was through teamwork:

The next best piece of advice that [my predecessor] gave me was [in] two pieces, really, that were linked. Piece number one was, ‘Remember you’re just a medical guy here. It’s not like the hospital where the medical people are important. And Medical is by no means the only show in town. As a matter of fact, it’s just a sideline, and really a relatively unimportant sideline at that. So find out what these other guys do for a living, so that you can get on board with the way they think and the way they do business.’ That was really, really good advice, because it linked with the second piece of advice which was, ‘You can’t get anything done here by yourself. Everything on the ship is a collaborative effort. And no matter what task you have in the course of a day, you’re going to have to go outside and enlist help doing it.’ And that just became more true as time went on, not less true. The examples are TNTC [too numerous to count]. (Interview 5, Section 0, Paragraph 7)

The teamwork concept never became more apparent than when a mishap occurred.

In this exemplar, the nurse illustrated what occurred when the crew was suddenly tasked with a common purpose:

The atmosphere when that Prowler went in the water was unlike anything that we experienced on a day-to-day basis. I was walking through the hanger bay. I can recall exactly walking through the hanger bay, when the Skipper [CO] came over the I-MC [loudspeaker], and he was very clear. Sometimes they’re garbled and they say things you don’t hear very well, but he was very clear. We could all hear him. And everyone stopped in place no matter what they were doing, no matter what the noise level, everyone just stopped everywhere as he said, ‘Shipmates, I need your help here.

We've had a crash. The EA-6B Prowler has gone down. We don't know the status of the aviators. We are steaming at emergency flank speed to go rescue our downed shipmates. I need everyone to return to [your workstations] and help out. Whatever your department is, everybody is playing in this evolution, and I'm merely asking your help here. That is all.' Wow! What a highly charged atmosphere the ship was at that point in time. No matter what people were doing, I looked around the hanger bay and people just scattered. They all went to their workspaces immediately. Probably 98% of the ship didn't know these guys ... couldn't have picked them out of a lineup. So we all go to work. (Interview 5, Section 1.1.1, Paragraph 49)

Working as a team, especially with trauma victims or mishaps, brought the crew together and made them stronger:

From a teamwork standpoint ... there's nothing better, especially after you've gone through something intense like work-ups or traumas or a sick patient and you medevac them and you get a sense of not only a team, but also kind of a sense of family.... It's neat to see that aspect [that] you don't [find at] a shore command and sometimes you get that overseas, but you know shipboard life brings out the best and the worst of folks. (Interview 4, Section 0, Paragraph 7)

Camaraderie

Because the nurses worked, lived, ate, and socialized with the crew, they learned about their lives:

One of the interesting aspects about being the nurse or any medical provider on an aircraft carrier is that you know your population in a way that other nurses don't know their population. You may know your patients as a nurse. You may know a lot of new patients who come and go, particularly in geriatric nursing, but it's not the same thing as hanging out with these people, eating meals with them, going on liberty, and partying with these people, and of course relating to them in a general sense as family. Completely different feeling. (Interview 5, Section 1.1.1, Paragraph 49)

The term "wardroom" had both physical and mental connotations. All of the participants believed that a resilient wardroom generated camaraderie. Daily stressors were alleviated with the help of a strong wardroom. Without the support of the fellow

officers in the wardroom, the nurses could not have endured the tough times the ships offered them:

We had a good wardroom, and that made it real bearable. (Interview 9, Section 0, Paragraph 33)

Most of those positive memories were a reflection on the wardroom and the teamwork that we had on the ship. The saying goes, 'misery loves company.' Well, there was lots of misery but at the same time we seemed to find ways to make it fun.... A wardroom can make or break a carrier. A wardroom is basically the leadership of the ship. It's kind of like a fraternity.... The wardroom is ...where all of the officers come together, both junior and senior. For most people the wardroom is the place where you go eat but it's a little more than that. The wardroom is yes, where you may go eat, but it's also a place where you can talk, solve problems, share experiences, that kind of thing. So, [my ship] had a strong wardroom. From day one I felt that I belonged. From day one I didn't feel like I was an outsider. I think I was welcomed. And that made a big difference. The camaraderie made a big difference. (Interview 1, Section 0, Paragraphs 71-75)

The ensuing three years taught me a lot about the people that belonged on that ship and that it wasn't a big steel Navy structure, that it was a ship full of shipmates. People ...you live, breath, eat, experience with. Fellow JOs (junior officers) learning to come together in a protective society to do what the XO [executive officer] and the CO [commanding officer] needed to be done. The camaraderie and the wardroom – something that I had never really ever experienced in the medical community at all. Certainly, that's defined by the structure itself – you can't go anywhere. (Interview 2, Section 1, Paragraph 7)

Even though Navy military treatment facilities have wardrooms, the concept is not the same as that on a ship:

There was a lot more camaraderie, a lot more autonomy, a lot more teamwork than you see on a shore command. (Interview 11, Section 0, Paragraph 27)

The participants had to be cognizant of the fact that they had to protect patient confidentiality when questioned by their fellow officers in the wardroom. This was sometimes a difficult role to maintain:

Confidentiality was another thing you really had to maintain. I think that was something when you're living in close quarters, you just notice that you have to protect that and ... you've got to watch out what gets discussed in the ward room.... And then you do have some of the division officers and all of these other folks that want to come and find out 'what's up with my troop,' and 'what's this?' And so you kind of have to walk a fine line. (Interview 4, Section 0, Paragraph 7)

Surface Warfare Medical Department Officer (SWMDO) Pin

The nurses had an opportunity to earn the Surface Warfare Medical Department Officer (SWMDO) pin while serving on the ships. Most of the participants obtained this treasured qualification during their tenure on the carrier. The participants felt that obtaining the SWMDO pin enhanced their credibility with the Line community:

I took it upon myself to make copies of the instruction and make an actual check off sheet of all the things that we needed to do. And I made little booklets up, and that's what I gave out to the Dental Officers, the other medical department officers.... There [were] a couple of other miscellaneous officers that were able to get this pin. And so we tried setting up classes to do all this, work on this, and we were good in the beginning. First few months started going out to sea, doing the classes and whatnot, but then there were some people that were starting to break out ahead of others who had more time to work on it. Like my roommate, she wound up getting her pin within six months. I didn't get mine until a year later. I just didn't have the time to work on it. It wasn't a huge priority in my life. I wanted to just be able to do my job. I knew that I was going to be on board enough time that I would be able to get it. But it just seems like a lot of people, when they report on board, that's immediately what they first asked for. It's, 'When can I start working on my pin?' [and I said,] 'How about learn your job first?' It was interesting, learning all about shipboard engineering, turbine systems, the steam cycle, fusion, how [do] the reactors work? I had to learn that. And then learning all the different aircraft. I had to learn the different ships in our battle group, the role of the amphib [amphibious] ships, there's a whole bunch of things. Radars, the capabilities of the different aircraft, like which weapons they carry, and then the weapons that were on board the carrier, like the Sea Whiz systems and the .50 Cal-Guns. I mean, it was just amazing. I thought, 'Why am I learning all this?' But you do. You learn it.... I felt prepared for the board but there's always questions they ask and you have no clue. There were questions there [and] it's like, 'I don't remember studying that at all.' But I knew that if I hadn't passed this oral board, that they would give me another shot at it. So I just felt confident. I didn't feel nervous or anything.... But we did all right. And that day, they told us right away that we passed our boards and they gave us our pins that

day. I mean, we went up to the bridge, and the CO [commanding officer] pinned them on us, and we had a nice little ceremony and everything. So it felt good because it's special. Not everybody can get this. (Interview 12, Section 0, Paragraph 25)

The opportunity to achieve the coveted pin is something that every nurse on a carrier should obtain.... because the ship's crew, the Line community, respect the individual who wants to be involved in and understand and know what their job is. 'How do they conduct their job?' 'What does their job entail?' 'What are the capabilities of the ship?' The officer community considers the obtaining of the SWMDO pin to be a relative passage into their community. That's about as close as the medical department individual is going to get to them ... being considered a Surface Warfare Officer. (Interview 8, Section 0, Paragraph 27)

Before I left the ship ... [I] got my pin. And that's probably one of my proudest achievements is wearing the Surface Warfare Medical Officer Department pin. So that's something that just makes you real proud to be carrier nurse, a nurse on a ship. (Interview 9, Section 0, Paragraph 19)

One of the participants cited damaged working relationships that prohibited the nurse from joining a SWMDO study group:

I had originally planned to try and get my warfare pin. And I didn't get my warfare pin which in some ways is one of my disappointments, but it was so much nursing stuff to do I couldn't see doing that. And I do regret that I didn't get it, but I would not have done it in the group that I would have had to work with because it was all these people that I just couldn't bear to be in the same room with. (Interview 3, Section 3, Paragraph 9)

Showing Off the Nurse Corps

Some of the nurses took the opportunity to qualify in specific Line community duties. They felt that this was their one and only opportunity to be a part of the "real Navy" and wanted to take advantage of all the Navy had to offer, even if it meant losing sleep:

I started standing bridge watch underway. I was OOD [officer of the deck] in port already; that's pretty much a paperwork name type thing. But standing at OOD watch, and bridge watch on the ship underway is a pretty special thing. So, I started the normal progression of any ensign, starting off as Conning Officer. And you have to learn how to drive the ship, which is particularly difficult during Flight Ops, because it's not like any other ship, in that, you have to be so many degrees into the

wind depending upon whether you're taking off or landing. And when you're doing these take-offs and landings so quickly, so close to each other. It's very difficult. And everybody's right there. You're on the bridge with the CO [commanding officer] and the gator [navigator] and the OOD and everybody's right there. And your voice is the only voice that they hear. You know, as the Conning Officer, you're the one that's calling out all the commands on to the Helmsman and the Lead Helmsman on how fast the ship needs to go and the direction it needs to go. And everything is very precise. The verbiage you use is very precise. There are certain ways that you say things, and that's the only way that you are supposed to say it. So when you make a mistake, everybody on the bridge knows exactly who made that mistake, because you're the only one that's talking on the bridge. And then ... after you learn Conning Officer, then you progress up to JOD and you work on your Junior Officer of the Deck quals [qualifications] and then on to the Officer of the Deck quals. On our ship, there had to be redundancy there just because of my position as ship's nurse. I mean, anybody that was hurt, I needed to be involved in. Any of the medical emergencies that were called out, day or night, I needed to be in the emergency room for in case they progressed on to the OR [operating room] or to the ICU [intensive care unit] or whatever. And so the Assistant Navigator is the one that does the watch bill for the bridge. So he's the one I had to talk to and told him that this was something I was interested in which just kind of blew him away that somebody would take on these extra hours. But they did build in a redundancy. So if I needed to leave the bridge, there was somebody there that could step up to take my place. So because of that, the highest quals that we could really get, though, was Junior Office of the Deck, because you really couldn't have the redundancy as the Officer of the Deck. You're either the Officer of the Deck or you're not. So, that was fine. So, during that whole cruise period now, for me, I mostly worked the midnight to 0400 shift, mid-shift.... About 1100 you have to start getting all your information to go up to the bridge. So you have to go to CIC [Combat Information Center], you have to go down in the engine spaces, you have to go up to the Air [department], and you have to find out what's going on in all these things, because you've got to know what's going on in all these different areas. So you start about 1100 and you go to these departments and you get the information that you need. And then you go up to the bridge and you take over. So you do the Conning Officer or the JOD, whichever you're working on. And then you're on watch from midnight to 0400 and then, whenever you get properly relieved, then you're off. Usually I would go down, and that would be some time that I would get a little bit of paperwork done, maybe catch a nap.... It's a big time obligation. I mean, you're just running ragged all the time.... My primary focus had to be to the medical department.... I'm up there standing a bridge watch with all these other guys, midnight to 4:00 in the morning, and then I [had] my other job to do. Well, so did other people. We got off watch and we had jobs we had to do. And being on watch was not an excuse not to get your jobs done. And so that's the way it was. (Interview 6, Section 0, Paragraphs 11 and 29)

In this exemplar, the nurse alluded again to the difference of being on a ship versus at a military treatment facility:

It was really neat to be a Nurse Corps officer [and] get qualified as a CDO [command duty officer] on a ship 'cause they saw me ... as an officer ... they certainly saw me as an O-5. And I can't necessarily say ... I feel that coming back to me to an MTF [military treatment facility] ... because in an MTF ... you know what? You're seen [as] kind of, 'Who are you?' 'The nurse.' You're not an O-5, you're a nurse, a Nurse Corps officer.... So I don't get a sense that we get the same recognition within our own medical department community. So I think that's where this whole enjoyment is ... with nurses who serve with the fleet. Because you're ... treated as an officer and I don't think that same level is at all [present] in the medical department commands type of thing. (Interview 4, Section 0, Paragraph 17)

Appreciation and Respect

When all was said and done, the participants expressed a true appreciation for the Line and felt that the Line had developed an understanding and respect for them not only as Navy nurses, but also as Naval officers:

COs [commanding officers] and XO [executive officers] don't have a lot of contact with nurses. COs and XOs are aviators. Aviators are in touch with their Flight Surgeon and maybe their squadron corpsmen. And they don't have a lot of time for the nurses. And they do not really ... understand until you show them, I think, what the nurse can do for them.... Anytime that there was anything with regards to the drills ... they always turn to the nurse, because the general quarters drills is a big evolution in the ship. And so the nurse is the head of the medical training team. You know, if the medical response isn't locked on, isn't trained correctly, then they fail, you know. (Interview 4, Section 0, Paragraph 45)

The Line community demonstrated its respect by allowing the nurses to become equal players in the ships' operations:

It was good to [be the] head of the medical training team.... There's heads of all of the medical training teams that coordinate the whole ship's training cycle.... To sit there with my counterparts, which are folks who are head of their department training teams – the flight deck training team, the head of the engineering training team, the head of the reactor, propulsion plant training team, weapons training team, damage

control training team – [to] be sitting there with those folks who are so ship savvy. I didn't have a lot of ship savvy when I got there. But these folks saw ... somebody who cared about the ship and all this stuff. So here's somebody who they didn't just see as a nurse. I mean there's that other aspect of it: You're Nurse Corps to them but you're also ... a Naval citizen. You're going there to be part of that ship. And you're a shipmate. And so they never just blew me off because I was a nurse. (Interview 4, Section 0, Paragraph 7)

The participant in this exemplar addressed the unspoken trust the nurse earned from the Line community. In a horrendous accident, when the crew wanted to immediately free the injured from their surroundings, the nurse locked eyes with the person in charge and gestured that the patients should not be moved until the medical response team had stabilized them:

But you could see their level of wanting to help out and free their shipmates and do whatever. So the air boatswain ... he saw me, and I just went like this to him [gestured a 'no' sign], and we connected. And right away, it's kind of like I had such credibility, because I knew what he was wanting to do, but he took direction from me. This was his flight deck, and yet he took direction from me, because, I think, of the professional demeanor you have and the rapport you develop with these folks. They see that you're not going to tell them the wrong thing. (Interview 4, Section 0, Paragraph 31)

Working with the Line community was an unforgettable experience for the participants. Never before had they seen such amazing teamwork, and felt such a sense of camaraderie, and they realized that once they left their ships, they would most likely never experience this again:

The toughest thing I had to do was leave that ship and leave that crew.... To walk down the brow knowing that as much as I can go back there, I'm not part of the ship anymore. You're not part of the crew at this point. And there's something really special about being wearing the ball cap and being part of it. But the bond that you develop is just pretty tight.... You've done things together.... I have walked through the courtyard here and they'd go, 'Hi, Nurse! How are you?' I mean they may not know your name, but they always say, 'Hi, Nurse!' You know, it's so neat. I don't

care if you don't know my name, but I really, really wanted them to know I was their Ship's Nurse. (Interview 4, Section 0, Paragraph 17)

Making the Job Better for the Next Generation

Corresponding Essence in the Exhaustive Description

The nurses wanted to make the job better for the next generation. Because their own shipboard orientation had been varied and ill defined, they felt it imperative that their replacements be better prepared than they were when each assumed the duty of an aircraft carrier nurse. This philosophy spilled over into their subsequent tours whereby they took advantage of opportunities to prepare their Navy colleagues for operational assignments.

Orientation

The participants were adamant that their successors begin their assignments to the carriers with some structure to their orientation. The first hurdle was trying to get orders to overlap so that both nurses had time to turn over prior to the predecessor's transfer.

The turnovers lasted anywhere from several hours to several months at a time:

I had gotten kind of dumped on and I felt like one of my goals is going to be to make the next nurse's job easier. (Interview 3, Section 2, Paragraph 7)

When I showed up on the carrier, [the ship's nurse] ... was able to give me a quick turnover before he had to literally go up the stairs and catch the COD [carrier onboard delivery] that flew me in [because it was] the COD that flew him off. (Interview 1, Section 0, Paragraph 31)

The longest a turnover should be is four to six weeks absolute max, minimum of two weeks. And ideally, at least a week should be at sea. (Interview 3, Section 2, Paragraph 7)

Some of the nurses advocated that their successors actually have some time at sea with them prior to coming to the ship for good. They felt that an ideal time to orient a

new nurse was during work-ups because that was the time to see the many roles of the ship's nurse:

I think one of the biggest things that should be done for them ... before they go to the ship, is to have the opportunity to go TAD [temporary active duty], and fly on board a ship, and spend maybe a week or two underway, while that ship is doing their work-up cycle. So they can actually see the big picture. This is one thing that a lot of them do not have. They don't have the big picture, before they get out to the ship. And they get involved in the miniscule stuff. And then they're not really sure what direction to go in. (Interview 8, Section 0, Paragraph 23)

This nurse actually extended a planned rotation date (PRD) in order to give the successor a thorough orientation:

I would have done work-ups ... but not any yard [drydock] periods. So I extended.... It is a tough time to do a turnover to the next nurse because so much of the job is doing the drills. And you really can't do them to the max unless you're at sea. And knowing the ship wasn't going to be at sea and nobody really wants to take the ship in the yards kind of thing ... so, I just took my PRD out two additional months.... Did I want to leave the ship? No, but I was being very genuine about it from a mission standpoint of the ship. Not that you want to say, 'Oh, I'm indispensable.' You want to get through but my replacement would [have been left] out in the dark. I know how I felt when I got on this ship. I mean, it's a lot to take on. So, I extended through August [which] got us through our whole work-ups or evaluation. (Interview 4, Section 0, Paragraph 19)

Examining previous cruise reports might be helpful to the new nurses:

If they're coming to a ship that's going to be getting ready to leave or they're going to be going out to a ship that's currently deployed, [then] getting advance copies of cruise reports ... gives them an understanding of what to expect and what to anticipate during that long haul. Because that cruise report covers everything. (Interview 10, Section 0, Paragraph 81)

Preparation of Successors

One participant recounted not having an office when this nurse arrived on the ship.

During the nurse's tenure, the participant acquired an office, at great personal expense, so

this nurse wanted the successor not to take the office for granted nor ever let the office be taken away at a future date:

We had a lot of other space wars and this was something that I had written up in my lessons learned.... I actually wrote in my lessons learned ... because you're sort of writing it to an ex-nurse: 'The nurse's office used to be' and I wrote the tack number ... 'Don't let that happen [to you].' The nurse needs an office. You need to be able to talk to people. You need to be able to counsel people. You need to be able to have a place to go. (Interview 2, Section 2, Paragraph 9)

In their final days, the nurses concentrated on activities that would make their job easier for the next person:

Probably the most cathartic thing was I stayed until 8:00 the night before my last day, and I went through every single file. I threw stuff out. And it was something that I needed to do. Could I have dumped it on her? Yeah. Did I want to? No. So I met my goal. I mean I made her job easier. (Interview 2, Section 2, Paragraph 12)

Being realistic, one nurse offered that the job was going to be so overwhelming that the only way to survive was to shape the job to become manageable; otherwise, the successor could be doomed to failure:

I shaped [the job] to what I wanted to do, which is what I gave my successor: 'This is what you have to do, shape it to what you want to do because kind of that's what the reality. There are so many things that you will end up doing, you need to mold it to where you're happy.' (Interview 2, Section 1, Paragraph 7)

Upon leaving the ships, the nurses never forgot how important it was to communicate with other Nurse Corps officers while underway. In this exemplar, the ex-ship's nurse remembered to send Christmas cards to all those nurses in operational billets:

I know that I still correspond to the fleet nurses today and I made sure that every operational command with a NC Officer received a Christmas card from [my current command]. (Interview 10, Section 0, Paragraph 12)

One piece of wisdom offered was to never operate with just the present day in mind.

Nurses on ships always need to be looking to the future when charting their territory:

Don't just look at the two years that they are going to be there. Look at where's that ship going to be five years down the road and what can they do now to prepare that ship to be five years down the road, instead of [thinking], 'I'm just doing my two years and I'm leaving.' If they're proactive and they look towards the future, if they have a vision as to where they want to see the department go, where they want to see the ship go, [then] they can make a difference. (Interview 10, Section 0, Paragraph 109)

Preparation of Colleagues

In their subsequent tours, the participants took advantage of opportunities to prepare their Navy colleagues for operational assignments:

Now, my experience on the ship, I tried to share that as much with my nurses to really get them to understand. But they don't have any idea of what goes on in ships. So I like to think that the experience on the ship is helping me. It is continuous.... I'm not directly contributing to the ship, being part of the ship's company, but I know any corpsmen that comes off of my ward, [who] is going to go to the fleet or the FMF [Fleet Marine Force – the Marines], hopefully is going to be all the better for it, because he has invested in us here. (Interview 4, Section 0, Paragraph 31)

I guess when they get back from being out at sea on a ship, I guess the big thing is they look at things a lot different. They look at training the corpsmen a lot different. They look at, or at least I did, looked at, 'Okay. If this sailor was to go to a ship tomorrow, what could I do to prepare that individual to go?' Or if a catastrophe happened or a humanitarian effort was needed and they were going to pull staff, 'Did I prepare that individual, that Corps Staff, to go?' So you look at them a lot different, as well as looking at the nurses, because ... we're all being assigned to platforms [and] you never know when that platform is going to get called. (Interview 10, Section 0, Paragraph 109)

Recommendations

Making the job better for the next generation included offering suggestions for improvement. The participants offered numerous recommendations. A primary suggestion was related to being "one-of-one" for too long. Being one-of-one is associated

with the fact that Naval officers are evaluated by being compared to their peers. In a military treatment facility setting, where there are many nurses, an individual nurse is ranked among a group of other nurses with similar seniority and experience (e.g., ranked number four of 15). On a ship, however, where there is only one nurse, the single nurse is typically ranked one-of-one. In the Navy Nurse Corps, being one-of-one, rather than being rated against one's nursing peers, can actually hurt one's chances at being promoted. The participants expressed fear of being one-of-one for too long:

If you are a 'one-of-one' officer for a long period of time, it makes it challenging for a board member to determine how competitive you are in relation to your peers, the officers with whom you are being evaluated for promotion.... This is a sore point for me as I was told that I wasn't competitive for promotion due to the solo tour on the carrier with [a subsequent assignment to attend graduate school where this participant was again not rated against peers]. I was 'one of one' for too long. (Interview 1, Section 1, Paragraphs 707-710)

I'd go back tomorrow. But I would be afraid of being one-of-one too many times. (Interview 2, Section 1, Paragraph 101)

They [the detailers] told me that I could not do another tour on a ship, otherwise that would be the end of my career.... Another tour on the aircraft carrier where I'm one to one ... would be ... detrimental to my career.... Which is sad.... I do miss the sea life. (Interview 10, Section 0, Paragraph 67)

In this exemplar, the nurse discussed the failed-to-promote status of one of the participant's peers and the belief that the Navy Nurse Corps did not value what these operational nurses did on the carriers:

Okay, so here's a guy who must be a pretty sharp performer because he was asked to extend. The command extended him there and then to go to duty under instruction and then failed to select because you're not rated against your peers. That kind of worries me and I think that's because there's such a small percentage of us out there in the real world or in our hospital world and they [the Nurse Corps] don't know what to do with us. They don't understand what we have done to further nursing in

the eyes of the Line community. And maybe all of us haven't done that. I don't know. (Interview 2, Section 1, Paragraph 13)

The participants expressed concern in their dealings with the Navy Nurse Corps detailers (assignment officers). They felt that the detailers did not appreciate how hard they had worked as ships' nurses when it came time to negotiate new orders:

Not everybody in the Navy ever gets to be stationed on a ship ... they just don't understand. That also brings me to the higher-ranking Nurse Corps officers when they are making career decisions for us, like when they are detailing us, and they don't necessarily understand everything about the ship's nurse role, what we've been through, and all that. Not that I expected anything special, but maybe just a little understanding in certain areas.... I have heard other ships' nurses had problems getting the duty stations that they wanted or, for whatever reason, being told, 'Well, you need to go overseas because you haven't done that.' And they were like, 'Well, I was out to sea. Doesn't that count?' (Interview 12, Section 0, Paragraph 7)

For some reason or another, my perception and maybe some others, [is] that the detailers don't really look upon the tour of a ship's nurse as being equivalent to ... overseas shore duty.... To have a detailer just laugh on the phone [and say] that 'It's too bad' that I'm getting picked up for [school] ... because all the overseas billets are filled and that I really need to go overseas after my ship [tour] doesn't really sit well with me. And then, when asked, 'Well, perhaps are there any other billets around, or even a clinic?' to have the detailer laugh [and say] that, 'Well, the clinics are really reserved for those people coming from overseas'.... I don't appreciate hearing that ...the detailers ... feel that being on a ship is not equivalent to being overseas on shore duty. Because that's what it is. Overseas but shore duty. You go home almost every night [while on shore duty]. (Interview 8, Section 0, Paragraph 65)

The participants recommended assigning a second nurse to each carrier. If a second nurse could not be allocated, then the nurses recommended having peers from a Navy military treatment facility transferred to the ships for underway periods:

I was literally running almost from one drill set, zipping through the medical department, getting into the ICU [intensive care unit]. I had a box of ten syrettes of demerol in one pocket and a box of ten syrettes of morphine in the other pocket as I'm running around the ship. And I'd come down into Medical. I had the different names ... labeled on the tubex and then I would give them a little bit of IV [intravenous] push med [medication] for pain. And then, boom! I was out the door

again after documenting it that I gave something. And then, boom! I was out running more drills or attending more meetings. That was absolutely ludicrous. I couldn't have been getting but maybe three hours of sleep every night. That's another reason why you kind of need another nurse. (Interview 8, Section 0, Paragraph 39)

There should be two critical care nurses on board. If bad things were to happen, there will be burning dead people and there will be people that are salvageable and you would not run a three-bed ventilated ICU [intensive care unit] with one nurse. You would never do that. You aren't alone, 'My God, where is my back up?' and you may have an anesthesiologist who would help you out, but they're not nurses. You might have a nurse anesthetist [but] not all of them think they're still nurses; [however], the ones I went to sea with were. (Interview 2, Section 1, Paragraph 49)

I think there needs to be two nurses, at least for cruise. (Interview 3, Section 2, Paragraph 12)

It would be really nice to have like a junior nurse on the ship that could do health promotions, and like physical fitness, and health enhancement programs, and just the overall health of the ship sailors would be great. And then if you got in a bind and you really needed another body to help out on the ward, they'd be there if you needed somebody like to just hang out on nights or whatever and do that. But it would have to be a job description. I think you might get into, 'Well, I do this and they do that' or whatever. So but I think it would be very useful. (Interview 9, Section 0, Paragraph 19)

Another recommended sending a junior nurse, as the second nurse, to the carrier as a retention strategy:

Let them go ahead and do ... [two years] on a ward and then ... two years on a ship, and there's their four-year commitment. And now they've been on a ship. They've been [in] a hospital. They've done actual patient bedside care. They've now been on a ship. They've [been] exposed to the real Navy. They were able to meet the Line community.... This person may say, 'Hey, I think I want to stay Navy. This is pretty cool. I like this'.... This person is not just joining the Navy to become a great nurse. They're also joining the Navy because they'd like to try something a little bit different.... If they wanted to be a basic nurse, they could stay in Idaho, doing the med-surg [medical-surgical] ward and generating some quality patient care plans. (Interview 8, Section 0, Paragraph 39)

Another recommendation was that the nurses being assigned to aircraft carriers be senior in rank. The participants felt that it was a real disservice to put a Lieutenant Junior Grade (LTjg) or junior Lieutenant (LT) in the role because a junior nurse's opinion would not be valued at important meetings on the carriers:

The ship's nurse is a member of the integrated training team (ITT). The majority of the people on ITT are lieutenant commanders or above. So, you know, to put a JG [lieutenant junior grade] or a junior person on board an aircraft carrier is somewhat of a major disadvantage for that individual. Not only do they not have the experience and knowledge of shipboard life, but they're looked upon as 'Oh, pffiff – there's Medical'.... So ... here you've got the nurse now who's at departmental level meetings and interacting with ... the department heads and the XO [executive officer]. So it's extremely important that the nurse be a little bit more senior and savvy with ships. (Interview 8, Section 0, Paragraph 7)

We put some junior nurses on there that haven't done well at all. You're in a system that's very rank oriented, that's one thing. And then you're in a system where weakness is sniffed out pretty quickly. And whereas the nurse has a very important function there, if they're real junior, they're just going to kind of get brushed to the side, even within their own medical department. And then, all of a sudden, you're going to be in a situation where you've got to perform and the things that you've been saying all along and has fallen on deaf ears because you [do not have] the seniority ... it's going to be your problem and your fault. So I don't think that a carrier is a place for a junior nurse. (Interview 6, Section 0, Paragraph 25)

You have to be fairly senior rank to go on board the carriers because you're sitting in a room, fighting with a couple of captains, usually. So try and get drills done because not only do you do the medical side, you [also] do the medical training side and have to fight for those drills sometimes on a daily basis. I think the rank is important on that. (Interview 7, Section 0, Paragraph 11)

I would recommend a Senior Lieutenant or a brand new Lieutenant Commander. I think the background needs to be split between ambulatory, whether it's ER [emergency room] or clinics with health promotion and some background in critical care ... and [you need] someone with good communication skills. Someone that isn't easily pushed around because I don't know if it's just unique to my department, but boy, I guess if they had just pushed me and I fell over, I wouldn't be pushing anymore. (Interview 3, Section 2, Paragraphs 9 and 12)

I think they need to be more senior. You know, lieutenant commanders or a good strong lieutenant. I know they're pushing that critical care background. And, yeah, you do need some critical care background but I think you need some ER [emergency room] background because you do deal with a lot of the traumas. And of course, the basic ward stuff, 'cause you need to know the forms. You need to know how to do a post-op, how to do a pre-op. (Interview 7, Section 0, Paragraph 29)

The participants were split on what the nursing qualifications [e.g., intensive care versus emergency nursing experience] should be for their replacements; however, they all agreed that the successors should be familiar with ventilator management. An ideal situation included being trained in critical care or emergency nursing, with cross training in either field for those lacking experience, and some operating room and psychiatric experience:

One of the other epiphanies that I think we all have is that when really, really bad stuff happens, when people come to [the] medical [department], which is always one of the stops on the route of where people go when bad things happen, that critical care nursing expertise is absolutely indispensable. (Interview 5, Section 1.1.1, Paragraph 49)

My recommendations are a strong critical care, not necessarily ICU [intensive care unit]. I found that my ER [emergency room] background was a lot more helpful because the patients didn't stay that long and you don't have all the gadgets and gizmos that you have in an ICU.... I found that my ER background was a lot more valuable when it came to drills and stretcher-bearer training, because [I had taken] the TNCC or Trauma Nurse Core Course. And one thing that I really wished that I had had was some paramedic type training, some pre-hospital type stuff. Because, you are considered the [subject] matter expert.... I was good with once they get to the ER, I can do that. But the pre-hospital stuff was my responsibility to teach to the corpsmen and to the stretcher-bearers. (Interview 11, Section 0, Paragraph 41)

As for scope of practice, a ship's nurse needs to be comfortable with the OR [operating room] environment. If you do have a major case, you're going to have to be in there helping. Ah, comfortable in the ER [emergency room]. Comfortable, certainly, with sick call, ambulatory care [and] being able to triage and screen in addition to the traditional inpatient role. And your ward is multidisciplinary. On one side of your ward, is going to be ortho[pedics], musculoskeletal [and] on another side of the ward it's going to be post-ops. On another side of the ward is going to be your

behavioral patients on a one-to-one watch. So, it's not like you can be good at one thing, you have to be good enough at all things. (Interview 1, Section 0, Paragraph 43)

A two-week cross-training program [in the operating room] for nurses on board the carriers [would be good].... Because, to be quite honest, there could be something going on in there that, right in front of my eyes, and I'd have no idea what I was looking at, because my eye has never been trained to look for something specific. (Interview 8, Section 0, Paragraph 11)

I wanted to ... [identify] concrete learning needs ... because there is no training pipeline for the nurse other than go to a hospital, get critical care, get to the ship.... The critical care piece was nice [but it is] only a small piece.... And it's very important [to have] OR [operating room] [and] ER [emergency room] [experience], but the psych [psychiatric] piece should not be neglected because it's a fairly large population of the ship. (Interview 1, Section 0, Paragraph 539)

Another participant recommended attending a shipboard training course that is currently only offered to the general medical officers (GMOs) once they complete their internship and prior to reporting to the fleet.

Most GMOs come out of their internship and they get to go to ... a one-month course that's offered in June or July, once a year for the GMO to go to so that they can get shipboard orientation training. Well, this is not done for any of the nurses. This should be a part of the training for the nurse so that they also have the 'big picture.' So that when they get onto the ship, they know where the pointy end is, the front, and things of that nature. (Interview 8, Section 0, Paragraph 23)

One nurse who had accompanied numerous medevacs recommended that the carrier nurses receive formal flight nurse training:

I would put these nurses through flight nurse training because I think they do play an important part in the medevac with these patients. (Interview 6, Section 0, Paragraph 25)

Because sexual assaults involving both genders occurred on the ships, another participant recommended that successors be trained as sexual assault nurse examiners (SANEs):

I think it's important that the nurse go into a ship as a SANE.... [Sexual assault] is something that [is] coming more to light. (Interview 8, Section 0, Paragraph 27)

The nurses questioned whether they lost some of their critical nursing competencies while aboard ship because they did not utilize these skills with such a healthy patient population. They struggled to find the time to perform some clinical nursing shifts at the military treatment facilities in their homeports; however, with so many duties and not enough hours in the day on the ships, the nurses tended not to work shifts at the local military treatment facilities:

The con is that you don't really have that many patients, so you're not doing day-to-day critical care.... And you start to lose that stuff. The old saying, 'You don't use it, you lose it' is absolutely true.... I will say though that if somebody wanted a yes or no answer out of me, 'While you're in port, should you be at the hospital or should you be on the ship?' I'll have to say that I'd probably lean more towards being at the hospital to keep up your skills because that's your real, primary function of being on the ship is to take care of the critically ill and injured patient. That is the real reason you're there. (Interview 8, Section 0, Paragraph 27)

The chain of command was an issue for some of the nurses. They discovered that technically they did not report directly to the senior medical officer (SMO). For the most part, they reported first to the medical administrative officer (MAO) – and that created tension for some:

My personality is such that I had to sit down with the MAO and tell him that I did not work for him, although he, per instruction, has the title of Division Officer. That individual has not a clue as to what my function is, has not a clue as to how to take care of people, and should not be an individual who would be making decisions in regards to patient care. That is something that myself and the surgeon and the SMO should be doing. Period. And I'll just have to say that that is one of the things that was probably one of the biggest headaches for me, was the organization of the medical department. (Interview 8, Section 0, Paragraph 13)

The rest of us were just hanging out on the limbs of the chain of command and never really felt like we were part of it. So if we had any concerns or issues with the

enlisted, especially since I had two assigned to me on the ward, it was always difficult to get something addressed. (Interview 12, Section 0, Paragraph 15)

The participants wished there was a resource nurse at COMNAVAIRLANT and COMNAVAIRPAC so that when they needed input on nursing issues, a nurse was the one that responded to their questions. Incidentally, TYCOM stands for "TYPE COMMANDER." In the Navy, there are four TYCOMs on the East Coast and four TYCOMs on the West Coast. The four TYCOMs (with representation on each coast) are: Air Forces (the Navy's Air Forces), Submarine Forces, Fleet Marine Forces, and Surface Forces. Commander, Naval Air Forces, U.S. Atlantic Fleet (COMNAVAIRLANT) is the Navy's Air Forces' (or aviation) TYCOM on the East Coast and Commander, Naval Air Forces, U.S. Pacific Fleet (COMNAVAIRPAC) is the Navy's aviation TYCOM on the West Coast:

You need a nurse at the TYCOM level to be there as a representative. to be there as a liaison for the other nurses.... If there was a nurse at the TYCOM level, [this] would be the person who could ensure that there is some sort of uniformity of the way in which the programs are run on board the ships. They would be the individual[s] who would be inspecting the medical training. (Interview 8, Section 0, Paragraph 23)

I wish there was a nurse at [COMNAV]AIRLANT or a nurse at [COMNAV]AIRPAC and I had put that in my lessons learned. That even if it was only for the inspections prior to going underway but having a nurse come out that had aircraft carrier experience who would know the same kind of things that the MSCs [Medical Service Corps] and the docs know what to look for. Because I did not think it was appropriate to have my stuff evaluated by an MSC or a doc because they don't see things the same way. (Interview 3, Section 2, Paragraph 9)

Regarding COMNAVAIRLANT and COMNAVAIRPAC, the first exemplar revealed the neglect that one nurse felt when dealing with them. In the second exemplar, the nurse had a recommendation for the type of backboards the carriers should possess:

Speaking of [COMNAV]AIRLANT/AIRPAC, the people seem to forget to contact the nurses and other ancillary people when changes occur. Frequently the nurses were left off of the e-mail listings published to all of the carriers.... They also frequently forgot our names or even how to spell them. (Interview 7, Section 0, Paragraph 50)

I think that right now the best thing that's needed on board a ship, even though [COMNAV]AIRLANT may not think so, is a full size back spine board is what's needed to transport people, not the Miller board. The Miller board is inadequate for moving people around the ship. (Interview 8, Section 0, Paragraph 7)

Navy health care utilizes an integrated computer system known as the Composite Health Care System (CHCS). The availability of CHCS on ships proved to be both inconsistent and a problem on the carriers:

At the time we had CHCS. We've lost that now due to funding. The ships need CHCS. They need computer programs so that they can communicate and run and maintain their databases. (Interview 8, Section 0, Paragraph 39)

What I found out was we would be sending pap smears to the hospital and the patient wasn't registered in CHCS, so there would be a pap smear, a lab chit, but they couldn't enter it. And our female healthcare was horrible. So is it the nurse's job to be involved with CHCS? Well, not really but you can look at it that it's a training issue. It's a quality assurance issue. You're also in charge of quality assurance.... So we had meeting after meeting after meeting and all I got was excuses, and it's like it's our responsibility to enter patients into CHCS. And then there was just this cavalcade of nobody has anybody to do it.... And then putting up with the complaints from patients who didn't know what their pap smears results were. I was concerned medically, legally and just humanistically. You get your pap smear. If you don't hear about it, you think something is wrong. So it was a female healthcare issue. (Interview 3, Section 2, Paragraph 7)

The carriers do not have respiratory therapists allocated to them. Assigning respiratory therapists to carriers could alleviate the nurses' fear of ventilator management:

The carriers do not have a respiratory therapy [RT] technician assigned to them. The Fleet Surgical Teams do. I'm not saying that the Navy should waste a billet of having an RT tech on board a carrier, but 'Gee. It would be nice.' (Interview 8, Section 0, Paragraph 11)

One of the nurses felt that the usefulness of the independent duty corpsman (IDC) had diminished and that IDCs should be replaced by nurse practitioners (NPs) or physician assistants (PAs). If and when that day comes, this participant would be one of the first to go back to a ship:

I will tell you that there was nothing negative about the experience. It was a very enjoyable experience. And if I could go back out to sea, I would do it in a heartbeat. Hopefully ... Navy medicine will realize that the day of the IDC corpsmen is gone. You know, we do not subject anybody else in the medical department to that level of care ... it's just not right. And at some point somebody needs to realize that all the IDC corpsmen do have a place. It's not as the solo practitioner. They need to be putting PAs and NPs out on the small boys [smaller Navy vessels] and I think that's a perfect place for them. And so, hopefully, if that day ever comes, you know, I'd get the opportunity to go back out. (Interview 6, Section 0, Paragraph 31)

The participants wanted to caution their successors to choose shipboard life for the right reasons. They want future carrier nurses to go into the job with their "eyes wide open":

I think you got to go to these billets for the right reasons, because you just want to be part of the fleet, you want to contribute, you want to help advance the mission and stuff. If you go there because you're trying to get out of an MTF [military treatment facility], escape an MTF, and get out of nursing service, and if you go there because you want an independent job to make yourself stand out to get your promotion, then those are all the wrong reasons. (Interview 4, Section 0, Paragraph 45)

The main thing is, I don't want anybody to be fooled. You know ... all they hear is the good stuff, the sea stories. Then I think they show up and it's a big disappointment. "Why am I not having the fun that I heard about?" What people need to understand it's fun now but then you quickly get into some significant hardships. (Interview 1, Section 0, Paragraph 633)

In conclusion, the nurses offered 15 recommendations related to the role of the ship's nurse on an aircraft carrier:

1. Not being one-of-one for too long
2. Having the appreciation of the detailers

3. Sending a second nurse to each carrier
4. Having seniority when reporting to the carriers
5. Possessing certain nursing qualifications before being assigned to the carriers
6. Obtaining flight nurse training to accompany medevacs
7. Training as a SANE
8. Maintaining clinical competencies while in port
9. Clarifying the chain of command
10. Placing a nurse at AIRLANT and AIRPAC
11. Offering miscellaneous recommendations to AIRLANT and AIRPAC
12. Placing CHCS on all of the ships
13. Assigning respiratory therapists to carriers
14. Replacing IDCs with NPs and/or PAs
15. Taking the job with "eyes wide open"

Miscellaneous Discoveries

Three essences emerged as miscellaneous discoveries. They were: (a) women on ships, (b) anesthesia, and (c) shipyard (drydock). These essences were important enough to be discussed by the participants but were not felt to contribute to the exhaustive description.

Women on Ships and Exemplars

All of the participants talked about gender-specific issues; however, there were no significant differences in those reported by the male versus female nurses. In the next two exemplars, both genders reported that integrating the ships with women made the men better:

I'm kind of glad it's a mixed gender crew, because I think it makes us better men. (Interview 2, Section 1, Paragraph 65)

Somebody asked, "As a woman, do the guys act different or do you feel like they're disrespectful?" I said, "If anything, by having women on a ship, the guys act better." It's like having mom around. They don't cuss as much.... I think they try to be a little more gentlemanly when there are women around. (Interview 9, Section 0, Paragraph 9)

The women participants never saw themselves as women first. They envisioned themselves primarily as Naval officers and could not understand why people asked them if they felt out of place when reporting to the male-dominated ships. They just considered themselves to be doing their jobs. They did not view their male shipmates as one big “dating pool”:

They never blew me off because I was just the only woman in this whole room. We had 300 women on the ship ... [and] 30 female officers out of a wardroom of about 180. So we did better than other ships 'cause our ship started out as dual gender from the ground up because it was a new carrier. So it really never had that whole difficulty with women being infused into an all male environment. So I think I benefited by that. But I think that may have been some of it, but I think it's how you carry yourself or how you conduct yourself from a professional standpoint. (Interview 4, Section 0, Paragraph 7)

But people did their jobs. I mean it was unbelievable how some people did their jobs. I mean they just did their jobs. And honest to God, there were times where I won't say you forget that you're a woman, but you're just doing your job so you don't think of it. And then when someone asks you something like, 'Oh, wow, there's all those guys,' [but] ... I never thought of it as a dating pool.... I never felt any element of sexual harassment whatsoever. But I think a lot of that is how you carry yourself. (Interview 3, Section 2, Paragraph 12)

The male nurses may have felt a twinge of envy when female nurses first started reporting to the carriers because of all the attention the women were receiving:

My hat's off to the first female Nurse Corps officers who went out there because I know that ... a lot of eyes [were watching them].... And it's still kind of sad to me that we have to distinguish between a male nurse and a female nurse because you don't hear 'female doctor' or 'male doctor', or 'female lawyer' and 'male lawyer,' but in the nursing profession, we seem to be stuck still making that distinction. 'Well, he's a male nurse' and, so, 'a female nurse,' that kind of thing. But I do know that when the female nurses got to the ship, there was a lot of attention thrown their way. They need[ed] to not just set the example but kind of set the standard kind of thing. Which was a little awkward for me because we had been out there doing the thing and we never really got that special attention, or the fanfare kind of thing. (Interview 1, Section 0, Paragraph 251)

Just doing their job sometimes meant teaching others how to do their job, too. In this exemplar, the female nurse responded to the situation by offering helpful advice that the shipmate could use with future problems:

Sometimes people would bring someone to medical, a female or a male, because they stunk. And one time, they brought a female and said, 'Someone has to talk to her.' It's ... a chain of command issue. You try to pull back and say, 'That's not a female issue. She stinks.' I said, 'You never had to deal with a stinky sailor?' 'Well, I never had to deal with a stinky female sailor.' I said, 'Well then just talk to her like she's a guy and if you need to clean it up, then clean it up, but she needs to hear the same message.' And he actually came back and thanked me.... A lot of the middle management, the first classes and the chiefs, are avoiding some of the female issues because they don't know what to do. So I think if you come across as being professional and serious and approachable, that's probably more important than anything. (Interview 3, Section 2, Paragraph 12)

The nurses recited how pregnancy impacted their ships' ability to be ready for deployment:

As a female ... on a ship ... getting pregnant is discouraged. And again, not that I was planning to do that, the option was not there for me. Obviously, there were females that would get pregnant and then leave the ship, and that was always a source of tension. (Interview 12, Section 0, Paragraph 27)

If you took eighty-three people off the ship, that's a lot of horsepower.... We were in [the] Persian Gulf [and] we hadn't had any authorized liberty ports, which meant when this girl got pregnant, she didn't get pregnant in a liberty port.... We took them both to Captain's Mast because standing orders is, 'You will not have sex on my ship. And you both are guilty.' And I went to that Captain's Mast ... to see the leadership example.... His lines were, 'You know you' and he points at the male, 'have taken away a shipmate from this ship' ... and I can't replace her.' (Interview 2, Section 1, Paragraph 49)

Anesthesia and Exemplars

The anesthesia support supplied to the carriers consisted of either a certified registered nurse anesthetist (CRNA) or a physician anesthesiologist for each ship. The anesthesia provider was not a member of the ship's company. In other words, the nurse

anesthetists or anesthesiologists worked at a military treatment facility and were assigned to the ships only during underway (at sea) periods. They did not train with the medical department on a routine basis. Thus, it was not unusual for the anesthesia support to continuously rotate so that the ships had a new person for every deployment. The nurses preferred having a nurse anesthetist aboard because they welcomed the companionship of another Nurse Corps officer; however, the nurses could not count on the support of the nurse anesthetists with general nursing duties:

The routine is we don't have a permanently assigned anesthesia. There's an anesthesiologist or a nurse anesthetist who comes with us whenever you go underway and it's an adjustment. If it's a nurse, it's great because you [have] the camaraderie of a Nurse Corps officer. But sometimes if it's an anesthesiologist, you just kind of have to figure out how are they going to do things differently.... I loved it when a nurse anesthetist came because you just automatically had some camaraderie. (Interview 3, Section 2, Paragraph 7)

You've got to understand that the CRNA did not always make him or herself available. Sometimes when the CRNA came out to the ship ... nursing duties were a thing of the past and they did not participate in the nursing care. We pretty much got a different anesthesia provider for every at-sea period so some anesthesia providers would pitch in and help, some wouldn't. So I couldn't count on the anesthesia provider being an extra nursing body. (Interview 1, Section 0, Paragraphs 121-123)

Additionally, the nurses felt that the nurse anesthetists were more accessible than their medical counterparts:

My impression is the nurse anesthetists are more team players, work very hard, would do anything to help me, and help the department, teaching. They were wonderful, did a lot of great classes to the corpsmen and whatnot. But the anesthesiologists, when they came out, some were better than others, would ... hide in their stateroom and didn't want to be a team player. (Interview 9, Section 0, Paragraph 19)

Shipyard and Exemplars

All of the participants experienced sea duty when assigned to the ships. Sometimes the carriers had to enter a period in drydock, in the shipyard, so that they could be repaired, receive a tune-up, or even undergo a major overhaul. It was possible for nurses to be assigned to a carrier and never go to sea during their entire tour because the carrier was in the shipyard for a long period of time. When asked by their detailers, the participants requested that they be assigned to a sea-going carrier so that they could experience what Navy life was all about:

Two weeks later I got a phone call from the detailer. And he said, 'Do you want a ship?' And I said, 'Absolutely.' But he said, 'Don't you want to know which one it is?' I said, 'As long as it's not in drydock.' So my big thing was I wanted to go on an operational. I did not want an assignment in the yards. (Interview 3, Section 2, Paragraph 7)

No carrier [tour] is complete without a deployment.... Only because you don't really get a sense of what you're all about until you really do deploy because that's when you're tested to your max. (Interview 4, Section 0, Paragraph 15)

The shipyard environment was also a dangerous surrounding. The medical department was a busy place and always functioned in the shipyard whether it was located on the ship or on a floating accommodation facility (FAF):

You're in an industrial environment in the shipyards. We had to wear the hardhats and you were supposed to wear steel tipped shoes. I did. Some people didn't. And then you had to wear the goggles when you were walking around the outside, but once you came inside it, you could take them off. And we actually didn't work on the ship right away. We were, what they call the floating facility, right next door, and it was quite busy, sick call was due every day. There were mainly complaints of back injuries and upper respiratory injuries, because most of these E-1s, E-2s, E-3s [enlisted personnel] who have just joined the Navy thinking that they're going to learn a skill are here chipping paint and working in a dirty, filthy environment. And it was just a very, like low morale kind of environment. (Interview 12, Section 0, Paragraph 19)

Spirits brightened when the shipyard period came to an end. In the first exemplar, the nurse recalled how the carrier looked when the participant reported to the ship and how it was transformed during the overhaul period. The reference to Medical being the last focus referred to the mentality of the Line community whereby “beans and bullets” (food and weapons) came first because the medical department did not get as large a budget on the ship. In the second exemplar, the nurse recounted how excited the crew became when they realized they would finally get to do what they were trained to do:

When I came on the ship, the ship had just gotten back from its six-month cruise. It was about three months into a complete overhaul. So all the medical spaces were completely gutted. There wasn't anything. In fact, the one ward that I owned was just packed from the deck to the ceiling with remnants from all the other rooms, as we were completely redoing the floors, etc. So you couldn't even really get a good idea of what your medical spaces were supposed to be. I had no idea what equipment I had, because it was all packed away. And so at that point, you're just kind of doing chaos control. You're there trying to knock out sick call in the morning time and, other than that, just trying to get a feel for the ship and a feel for your spaces and trying to figure out what's going on. And that lasted the first five months that I was on board the ship. And then all of the sudden, things very rapidly started coming together, and we started having to get our areas cleaned up and, of course, Medical is always the last focus, because everything else is more important. And had to get everything done, because we had to sail in December to go up to [another shipyard] ... to finish up the rest of our overhaul period. So for the first four or five months, it was just very confusing. You just try and get a feel of what's going on. Then, you started putting your area back together, you started getting ready to go out to sea. And [when] we did our first sea trials, [it was] very motivating. And you really got a feel of a little bit more what it was like to be out to sea. (Interview 5, Section 0, Paragraph 7)

The attitudes of the junior enlisted people ... coming out of the yards ... were brightening, because they were then thinking, ‘Oh, finally, I'm going to be doing what I came in to do.’ I saw that happening. As far as the medical department ... we were still busy even in the yard, so [we] were doing what [we] were trained to do [anyway]. (Interview 12, Section 0, Paragraph 19)

One participant recounted how the pregnancy rate for the nurse's ship actually went up while in the shipyards:

It [the pregnancy issue] got worse when we were in drydock and then it became an issue ... [because] there was no mission. We weren't going anywhere. There's a lot of free time. Some people didn't have anything to do. Their spaces were all torn up, there was nothing to do. Some people, like [the] Reactor [Department], were constantly working. We'd take a four-day weekend, they'd take none. They were working.... Flight deck was all tore up.... Can't land planes, can't work on gear, can't train. So what do you do? I think that's a lot of it. Air Department's a big department. You're looking at about five hundred people and a large portion female.... I think part of it is ignorance. I really do. They don't think they can get pregnant. (Interview 2, Section 1, Paragraph 47)

If the medical department was not moved to a floating accommodation facility (FAF) during drydock, then the nurses had to endure the sights, smells, and sounds of the overhaul:

The medical department is right below the hanger bay. And what they do is they resurface the whole hanger bay. And then we resurface the flight deck. So to resurface it, you have to get a needle gun and you [constantly hear] 'ddddd' and pull up this old nasty, rotten [material]. You're talking days and days and weeks of this stuff. (Interview 4, Section 0, Paragraph 21)

Accidents frequently occur in the shipyard. The participant in this exemplar remembered that during the nurse's entire tour, including sea duty, the only major accident occurred while the carrier was in drydock:

It's not the most glamorous time and their attention span is not always there. But, we came through it pretty well, except for [an] unfortunate ... accident [which] happened right at the end of it. (Interview 4, Section 0, Paragraph 29)

Chapter Summary

This chapter presented the participants' profile and was followed by the exhaustive description, its corresponding essences, and miscellaneous discoveries that emerged from

the participants' descriptions. After each essence, exemplars from the participants' descriptions that best reflected the essences were presented.

This study's summary, second literature review, summary points, recommendations, and limitations are presented in Chapter V.

CHAPTER V

Summary, Summary Points, Recommendations, and Limitations

In this chapter, the summary, second literature review, summary points, recommendations, and limitations of the study are presented.

Summary of Study

The purpose of this study was to describe the lived experience of shipboard nursing on aircraft carriers. Using the principles of phenomenology, 12 Navy nurses previously stationed aboard aircraft carriers were interviewed in person to explore their experience as ships' nurses.

This study could not build on previous research because the phenomenon of interest – nurses' experiences while stationed on aircraft carriers – had never before been explored, analyzed, or described in the literature. Because there is no current research that describes nursing on aircraft carriers, this study contributes to the dearth of knowledge available regarding this unique form of operational nursing. The significance of studying shipboard nursing on these floating cities is that each ship's nurse has enormous potential to impact the health care of the carrier's crew and the operational readiness of both the ship and its battle group. The findings from this study provide valuable insight into nursing practice in a service unique environment and describe issues related to operational readiness.

Husserlian phenomenology provided the theoretical framework guiding this study and Streubert's (Streubert, 1991; Streubert & Carpenter, 1995, 1999) methodological approach was chosen to analyze the phenomena. Streubert's method involved the following steps:

1. Explicating a personal description of the phenomenon of interest
2. Bracketing the researcher's presuppositions
3. Interviewing participants in settings comfortable to the participant
4. Carefully reading the transcripts of the interview to obtain a general sense of the experience
5. Reviewing the transcripts to uncover essences
6. Apprehending essential relationships
7. Developing formalized descriptions of phenomena
8. Returning to participants to validate descriptions
9. Reviewing the relevant literature
10. Distributing the findings to the nursing community (Streubert & Carpenter, 1999, p. 51)

An exploratory review of the literature included scholarly writings regarding nursing practice in service unique environments, aircraft carriers and phenomenological inquiry. The review of phenomenological inquiry validated my choice of using Husserlian phenomenology as the conceptual framework that guided this study.

Twelve nurses who had been stationed on an aircraft carrier for at least two years and had not been in drydock throughout their entire tour were purposively selected to participate in this study. Six of the participants were female and six were male. I initially contacted those nurses who had left the aircraft carriers within two years of the start of data collection (September 2000). A backwards year-by-year progression was utilized to solicit former aircraft carrier nurses until study participants were no longer needed (once data saturation was obtained).

The primary data collection strategy for this study was the use of tape-recorded personal interviews. The interviews took place in settings familiar to the participants so that each respondent could share his or her perceptions freely. Prior to the start of the formal interview, informed consent was documented and demographic data were obtained (in order to fully place the data into context).

Each interview began with the question: "What was your experience as a nurse on an aircraft carrier?" The participants were encouraged to fully describe their perceptions without being interrupted or led by me. When the participant felt he or she had expended his or her description, this concluding question was asked: "Is there anything that you have not offered, either positive or negative, about the experience that you would like to add?" If there were no additions, the interview ended. The interview approach for this study was pilot-tested twice prior to starting the interviews. These pilot data were eventually included in the overall findings of this inquiry because the interviews were conducted in the same manner and the data were consistent with that obtained in the subsequent interviews. Interviews were conducted until saturation occurred (when no new themes emerged).

The interviews were transcribed prior to data analysis. In-depth analysis commenced once all interviews were completed. Data organization was aided through the use of the computer program entitled NVivo. Data analysis included four steps:

1. Carefully reading the interviews to obtain a general sense of the experience
2. Reviewing the transcripts to uncover essences
3. Apprehending essential relationships
4. Developing a formalized, exhaustive description of the phenomenon

All 12 of the participants verified the exhaustive description and after some minor changes, all agreed that it accurately reflected their experience as the ship's nurse on each aircraft carrier. Lincoln and Guba's (Lincoln & Guba, 1985; Denzin & Lincoln, 1998a, 1998b) criteria for evaluating the quality of an inquiry (transferability, dependability, confirmability, and credibility) were applied to this study.

The 12 participants in this study described their lived experience of shipboard nursing on aircraft carriers as follows (note that the underlined portions of the following text correspond with an identified essence):

The nurses felt that shipboard nursing on aircraft carriers was one of the best but toughest jobs the Navy has to offer its nurses. They experienced a great sense of pride in being called the "Ship's Nurse" and enjoyed being a member of each ship's company. Carrier nursing was a worthwhile experience that included both rewards and challenges. The rewards included practicing in an autonomous environment; going to sea and experiencing what the Navy was all about; feeling a sense of mission and contributing to that mission; and traveling to unique locations. Among the job's challenges were working in a dangerous work environment that incapacitated or even killed shipmates; being away from home when deployed; participating in work-ups; navigating equipment and supply issues; and adjusting to the constant turnover of both the medical department personnel and the ships' crew.

The nurses' primary and most time-consuming job was ensuring operational readiness by coordinating the medical training team (MTT). In this capacity, they developed scenarios, simulated medical casualties throughout the ship, and conducted various briefings regarding each drill. Orchestrating these exercises, and being a member of the larger Integrated Training Team (ITT), involved substantial assimilation with all of the departments on the ship; consequently, the nurses got a lot of face time with each ship's Commanding Officer (CO), Executive Officer (XO), and Department Heads.

The nurses were considered one-of-one because they were the only nurse assigned to their carrier as the "Ship's Nurse." Not only did they represent nursing services for their ship, they were nursing services. The nurses felt an incredible sense of responsibility to their job. They were on call 24-hours a day, seven days a week. The nurses knew their ships inside and out and made it a point to visit all of the ships' spaces, especially in their capacity as coordinators of the medical training teams. It was not uncommon for the nurses to be stopped in the passageways and

consulted on matters ranging from the crew's own health care needs to questions about a family member's health status. Everyone on the ship recognized the nurse.

The nurses constantly operated in an environment of uncertainty. They could never be sure of what was going to happen next and always wondered about the "ifs": if their qualifications were sufficient to get the job done; if they could trust their corpsmen with the inpatient ward; if the ships' crew could manage a trauma victim given the training the nurses had coordinated for them; if they could handle a critically injured patient in their Intensive Care Unit; and if they could manipulate the sometimes archaic equipment they had inherited. The leadership capabilities of each commanding officer (CO), executive officer (XO), and senior medical officer (SMO) set the tone for the nurses' work environment. Feeling a strong sense of support from these individuals was paramount in allowing the nurses to excel in their role as the ship's nurse while practicing in an environment of uncertainty.

The nurses had two families: their significant others and their shipmates. Working with the Line community was a great experience for the nurses. Never before had they seen such amazing teamwork, and felt such a sense of camaraderie, and they realized that once they left their ships, they would most likely never experience this again. Because they worked, lived, ate, and socialized with the crew, they learned about their lives. Enduring tough times, such as work-ups, brought the nurses and their shipmates together as a family. When all was said and done, they had a true appreciation for the Line and felt that the Line had developed an understanding and respect for them not only as Navy nurses, but also as Naval officers.

The nurses wanted to make the job better for the next generation. Because their own shipboard orientation had been varied and ill defined, they felt it imperative that their replacements be better prepared than they were when each assumed the duty of an aircraft carrier nurse. This philosophy spilled over into their subsequent tours whereby they took advantage of opportunities to prepare their Navy colleagues for operational assignments.

Additionally, three essences emerged as miscellaneous discoveries (meaning they were important enough to be discussed by the participants but were not felt to contribute to the exhaustive description). They were: (a) women on ships, (b) anesthesia, and (c) shipyard (drydock).

Second Literature Review

Some researchers advocate conducting the major review literature review after data analysis so as to avoid any preconceptions (e.g., Taylor & Bogdan, 1998; and Streubert & Carpenter, 1999). However, an exploratory literature review may be conducted in order to verify the need for studying the phenomenon under investigation (refer to Chapter II for the exploratory literature review). In conjunction with Streubert's (Streubert & Carpenter, 1999) ninth methodological step, a second literature review was conducted in order to place the lived experience of shipboard nursing on aircraft carriers into context.

Job Satisfaction

The essence of experiencing the best but toughest job the Navy has to offer reflected job satisfaction, a theme noted in the exploratory literature review (e.g., LaRocco, Tetrick, & Meder, 1989; Maloney, Anderson, Gladd, Brown, & Hardy, 1996; McNulty, 1994; Puksta, 1995; Robinson, Rodriguez, Sammons, & Keim, 1993; Savage, Simms, Williams, & Erbin-Roesemann, 1993; and Yoder 1995).

The second literature review, after data analysis, focused on overall nursing job satisfaction, not just military nursing job satisfaction. Cumbey & Alexander (1998) defined job satisfaction as "an affective feeling that depends on the interaction of employees, their personal characteristics, values, and expectations with the work environment, and the organization," (pp. 40-41).

Grindel, Peterson, Kinneman, and Turner (1996) concluded that three variables which contributed most to nursing job satisfaction were autonomy, communication with supervisors and peers, and feedback for a job well done. Factors associated with job

dissatisfaction included poor communication, powerlessness, alienation, and stress.

McNeese-Smith and van Servellen (2000) also found age to be a factor that contributed to job satisfaction: older nurses, and those in more mature developmental stages, experienced greater job satisfaction, productivity, and organizational commitment than the other study participants. Allgood, O'Rourke, VanDerslice, and Hardy (2000) and Finn (2001) also found autonomy to be an important job component of nursing job satisfaction; however, Wade (1999) cautioned that accountability is the primary consequence of professional nurse autonomy. Hutchison, All, Loving, and Nishikawa (2001) identified autonomy as being a personal fundamental value that would promote job satisfaction and retention in Air Force nurses.

Leveck and Jones (1996) examined the effects of management style, group cohesion, job stress, organizational job satisfaction, and professional job satisfaction in relation to staff nurse retention and quality of care. They found that nurses experienced lower job stress in units where they perceived a participative management style and group cohesion. In turn, higher group cohesion and lower job stress were associated with higher levels of organizational and professional job satisfaction. Lucas, Atwood, and Hagaman's (1993) replication study showed that group cohesion promoted, and job stress inhibited, both organizational and professional job satisfaction. Finally, Adams and Bond (2000), McNeese-Smith (1999), and Shader, Broome, Broome, West, and Nash (2001) also found that higher group cohesion was associated with greater work satisfaction.

Several studies incorporated organizational factors, including leadership style, when evaluating job satisfaction (Bolon, 1997; Cumbey & Alexander, 1998; Grindel et al.,

1996; Keuter, Byrne, Voell, & Larson, 2000; Knoop, 1995; McNeese-Smith, 1996, 2001; Morrison, Jones, & Fuller, 1997; Moss & Rowles, 1997; Mullen, 1996). Bolon (1997) hypothesized that job satisfaction was positively related to the performance of organizational citizenship behaviors (OCB). OCBs relate to both behaviors that benefit the general organization and those that benefit specific individuals. Bolon felt it important to select and retain employees who identified with the organization's mission, goals, and objectives. Another implication of Bolon's study was that employees needed to be satisfied with their coworkers if they wanted to achieve high job satisfaction. Finally, Bolon recommended that administrators who wanted an environment that supported OCBs needed to demonstrate the behaviors themselves in order to communicate to their employees that such behaviors were valued by their organization.

McNeese-Smith (1996) theorized that hospital managers could increase employee productivity, job satisfaction, and employee involvement in the goals of their organization by demonstrating certain leadership behaviors. The author found that employees who felt empowered by management had high job satisfaction; that high organizational commitment occurred when employees thought their managers were focused on change and new technology; and that staff who considered their managers to set high standards, and behaved according to the same values they set for their employees, experienced high productivity. Another study by the same author in 2001 revealed that organizational commitment was related to numerous aspects including personal factors, opportunities for learning, job satisfaction, coworkers, and cultural

factors. Lack of organizational commitment was related to such factors as conflict with personal needs, lack of appreciation and fairness, and poor relations with coworkers.

Morrison et al. (1997) discovered that leadership style and empowerment were positively related to job satisfaction. Moss and Rowles (1997) also found that managers could positively affect nursing job satisfaction by using appropriate management styles.

Cumbey and Alexander (1998) revealed that the critical variable for predicting job satisfaction in public health nurses was organizational structure (vertical participation, horizontal participation, and formalization). Vertical participation was the degree to which staff and management collaborated with regard to job tasks and decisions. Horizontal participation was the degree to which staff collaborated with their peers in decision-making and task definition. Formalization was the extent to which rules, procedures, and instructions were used (or even existed). Knoop (1995) found that involvement in work and job, commitment to an employing organization, and job satisfaction were positively correlated.

Erbin-Rosemann and Simms (1997) researched the relationship between work locus of control and job satisfaction. They discovered that internally oriented, proactive individuals perceived their jobs to be more enriched and intrinsically motivating than externally oriented, reactive individuals who reported low levels of job satisfaction and higher levels of powerlessness.

Schwab (1996) wondered why some nurses held on to their enthusiasm for their job while others in the same environment became stressed, discouraged, and disillusioned. The author concluded that the difference could exist because some nurses were just

“tougher” than others. This toughness, also known as hardiness, has three dimensions: a sense of commitment, the perception of control, and the ability to view change as a challenge. Schwab believed that the stressors that led to a low level of hardiness could be averted through a self-care wellness program.

Collins, Jones, McDonnell, Read, Jones, and Cameron (2000) concluded that the majority of their study participants who held innovative roles in their organizations experienced high job satisfaction. The authors cautioned that these individuals still needed to be trained properly, and that the boundaries of their practice be well-defined, in order to maintain such job satisfaction.

Literature Review: Conclusion

The essences of experiencing the best but toughest job the Navy has to offer and ensuring operational readiness matched with information discovered in either literature review. However, four of the discovered essences had no corresponding literature identified in both literature reviews; however, many of the themes regarding nursing practice in service unique environments – that were revealed in the exploratory review of the literature – were reflected in the participants’ comments. In a conversation with my consultant (personal communication, April 29, 2001), Dr. Streubert replied that this was not uncommon – that the goal of this type of research is to identify essences that may be revealed for the first time ever. Such is the case with being one-of-one (not to be confused with practicing in isolation because the nurses were not alone); operating constantly in an environment of uncertainty (although this could be implied from some of the operational readiness literature that discussed the need for flexibility); having two

families (however, the spirit of camaraderie was well-documented in the service unique environment literature review and the effect of group cohesion on job satisfaction was discussed above); and making the job better for the next generation.

Summary Points

The following summary points pertain to the lived experience of 12 Navy nurses who practiced shipboard nursing aboard aircraft carriers:

Summary Point 1: The participants were proud to serve in the “real Navy” and were committed to the organizational values of their ships’ commands

The nurses valued the opportunity to perform a tour of duty outside of a medical treatment facility (MTF). When joining the fleet, they immediately felt a sense of mission and believed they finally understood what the Navy was all about. No matter how much MTF commanding officers feel they run their commands like a Navy ship, it is just not the same atmosphere as that found on a combatant vessel. The leadership style and empowerment opportunities available to the ships’ nurses positively related to their sense of job satisfaction. Group cohesion definitely promoted both organizational and professional job satisfaction for the participants.

Summary Point 2: The participants felt that senior Navy Nurse Corps officers neither comprehended nor fully appreciated the job each did as the ship’s nurse on an aircraft carrier

The nurses’ encounters with senior Nurse Corps officers were not always positive. Several cited conversations with detailers that reflected an unsympathetic tone for the jobs they were leaving behind. Others were worried about their promotion opportunities

in the Navy Nurse Corps when they experienced or heard stories of nurses who remained in MTF billets, where they were rated against their peers, having a more favorable chance of promotion than those nurses who took on the challenge of an operational tour. These nurses should not be penalized for “going operational.” A lack of appreciation and fairness from the Navy Nurse Corps splits the nurses’ loyalty between the needs of the Navy and those of the Navy Nurse Corps when in fact the loyalty should be to the mission of the Navy as a whole.

Summary Point 3: The participants felt obligated to ensure their replacements were truly qualified to assume the role of the ship’s nurse on an aircraft carrier

The participants wanted their successors to come to the job for the right reasons. Shipboard nursing on aircraft carriers can be daunting at times. However, it can be very gratifying for those who are ready and willing to work hard. The nurses wanted the best-qualified people to be placed in these billets. Operating in an environment of uncertainty leaves no room for weak individuals – those going aboard ship need to be clinically competent and flexible enough to handle any situation. Assigning senior lieutenants or lieutenant commander nurses to these positions gives successors an added advantage at the bargaining table. The participants offered numerous recommendations regarding their successors’ qualifications in an attempt to avoid an unfavorable tour both for their replacements and for the ships’ company they were leaving behind.

Summary Point 4: Gender made no difference in the lived experience of shipboard nursing on aircraft carriers

The interviews of the male versus the female participants were much more alike than different. The women participants never saw themselves as women first. They envisioned themselves primarily as Naval officers who were just doing their jobs.

Summary Point 5: The participants' experience as the ship's nurse on an aircraft carrier was a momentous, career life event for each nurse

All of the participants remarked on how lucky they were to have had such an assignment because many Navy nurses never set foot on a ship throughout their entire careers. The participants filled innovative roles that allowed for more autonomy than the nurses had previously experienced. Shipboard nursing on aircraft carriers provided a diversified opportunity that most nurses viewed as having a positive effect on their career. They will remember their shipboard experience for the rest of their lives.

Recommendations for Practice, Education, and Administration

The following recommendations for practice, education, and administration are derived from the lived experience of the 12 nurses who participated in this endeavor.

Practice

The concept of maintaining clinical competence should be formally supported at both the department and command level. The participants questioned whether they lost some of their critical care and/or emergency nursing competencies while assigned aboard ship because the general health of the patient population did not require them to use these skills. They struggled to find time to perform some clinical nursing shifts at MTFs

located in their homeports. Because they had so many duties and not enough hours in the day as ships' nurses, the participants tended not to work additional hours at local MTFs. Certainly a nurse's clinical competence enhances the operational readiness of the medical department.

Education

Prior to being assigned as the ship's nurse on an aircraft carrier, each nurse should have critical care, emergency, psychiatric, and operating room nursing experience. Being the only nurse assigned to the carrier, and constantly working in an environment of uncertainty, means that each nurse needs to have a foundation that allows him or her to be able to anticipate and handle any situation. The participants remarked that their critical care nursing experience helped them manage ventilator patients and that their emergency nursing experience contributed to their ability to triage patients in sick call. The nurses also found themselves circulating in the operating room of the ship – an experience they felt unprepared for. Additionally, the participants were astounded by the number of psychiatric patients they encountered; thus, they recommended attaining some post-baccalaureate psychiatric nursing training.

In 1997, Parodi recommended that the Navy provide a formal training curriculum for nurses reporting to aircraft carriers. To my knowledge, this has not been acted upon. These nurses must attend a shipboard training course with a curriculum similar to what general medical officers (GMOs) are offered, yet tailored to nursing specifics. Again, ships' nurses need to have some educational foundation in order to acclimate them to

shipboard life. Not only are they reporting to a new role, they are also reporting to a whole new way of life!

Because sexual assaults occur aboard ship, and involve both genders, the ship's nurse should become certified as a sexual assault nurse examiner (SANE) prior to reporting to the ship. Training as a SANE ensures continuity in the handling of sexual assault investigations.

If the ship's nurse is expected to accompany medevacs from the ship, then the nurse should also obtain formal flight nurse training. Nurses cannot anticipate the peculiarities of patient safety in an airplane or helicopter when they have never been exposed to flight nursing in their nursing education. At this writing, flight nurse training is neither required nor authorized for nurses reporting to aircraft carriers.

Finally, a three- or four-week turnover period must be provided in order to transition successors to the fleet. The participants frequently commented on how the role of the ship's nurse differed from anything they had ever done before – they asked that the turnover period be standardized so that they had enough time to adequately prepare their replacements for their new role in Navy nursing.

Administration

Only senior lieutenants or lieutenant commanders should be assigned to these positions. The participants were unanimous in their belief that assigning a junior nurse to the carrier sets that nurse up for failure because a junior nurse's opinion would not be valued at important meetings on the carriers.

The nursing capabilities of the medical department would be enhanced if a second nurse was assigned to each carrier, either temporarily during underway periods or on a permanent basis. The senior nurse could continue with the training obligations of the job while the junior/second nurse could tend to the inpatient ward and assist the ward corpsmen with obtaining their clinical competencies. This opportunity could also serve as a retention strategy for junior nurses because they, too, would have a chance to experience the "real Navy."

Nurse Corps officers must be placed at the TYCOM (TYPE COMMANDER) level to ensure consistency across all carriers and to provide a nursing resource and nursing leadership to the ships' nurses. Not having a seasoned, ex-ship's nurse at the TYCOM proved frustrating to the participants.

Nurses who have completed aircraft carrier tours must receive appropriate recognition by promotion boards and assignment officers (detailers). The warning "not to be one-of-one for too long" should not be an absolute. These nurses perform an invaluable task for the Navy when assigned to the carrier and this fact should not be overlooked.

The chain of command for the ships' nurse should be standardized and made consistent across all carriers. Carrier nurses that did not report directly to the Senior Medical Officer (SMO) experienced more tension than their counterparts on other ships.

All carriers must be equipped with CHCS (Composite Health Care System), the same clinical information system utilized by shore-based medical treatment facilities (MTF). Without CHCS, the quality of patient care becomes disparate between the ship

and the MTF when actually it should be the same. The nurses recounted stories of lost lab results specifically related to the fact that the information was not entered electronically into CHCS.

Respiratory therapists need to be assigned to each carrier. If not cost effective, then anesthesia support personnel must be directed to assist with the management of ventilated patients in the intensive care unit (ICU). The participants overwhelmingly voiced concern about being the only resource person expected to handle ventilated patients when, in reality, the nurse anesthetist or the anesthesiologist was also available – but not always willing – to assist with ventilator management in the ICU.

Summary of Recommendations

In summary, the recommendations for practice, education, and administration are as follows:

- The concept of maintaining clinical competence should be formally supported at both the department and command level.
- Prior to being assigned as the ship's nurse on an aircraft carrier, each nurse should have critical care or emergency nursing experience, with cross-training in either field for those lacking experience, and receive some operating room and psychiatric experience before reporting to the ship. Additionally, they should attend a shipboard training course; train as a sexual assault nurse examiner (SANE); and obtain formal flight nurse training (if expected to accompany medevacs from the ship).
- Mandate a standard three- or four-week orientation to transition successors to the fleet.
- Designate only senior lieutenants or lieutenant commanders for these billets.
- Assign a second nurse to each carrier (either temporarily during underway periods or on a permanent basis) to enhance the nursing capabilities of the medical department.
- Place nurses at the TYCOM level to ensure consistency across all carriers and provide a nursing resource and nursing leadership to the ships' nurses.
- Ensure nurses who have completed aircraft carrier tours receive appropriate recognition by promotion boards and assignment officers (detailers).

- Standardize the chain of command across all of the carriers.
- Equip the carriers with CHCS (Composite Health Care System).
- Allocate a respiratory therapist to each carrier to alleviate some of the nurses' fear of managing ventilators. If not cost effective, then direct anesthesia support personnel to assist with the management of ventilated patients in the intensive care unit (ICU).

Recommendations for Further Research

Recommendations for further research include the following:

- Explore the patient outcomes of the medical training teams (MTTs) on the ships.
- Develop a questionnaire and survey other Navy nurses to discover if the findings in this study represent their experience as the ship's nurse on an aircraft carrier.
- Employ another type of qualitative methodology (e.g., narrative analysis) utilizing existing data from one or more of the interviews from this endeavor.
- Investigate the lived experience of shipboard nursing aboard other Navy vessels (e.g., hospital ships and amphibious assault ships).
- Examine the lived experience of Navy nursing in other operational arenas (e.g., fleet hospitals and with the Marines' medical battalions).
- Compare the lived experience of operational nursing in the Navy with operational nursing in the other armed forces.
- Study the lived experience of transitioning back to a military treatment facility (MTF) upon completion of an operational tour in the Navy.

Limitations

Possible limitations of this study included:

- The researcher was a novice.
- Some data was lost during an equipment failure.
- The sample size may be deemed too small.
- The personal agenda of the participants was unknown.
- Whether the participants responded in a truthful manner was assumed but could not be verified.
- The ship's nurse role may have changed since the data collection period of this study.

- The experience of shipboard nursing on the carrier may differ from the experience on other Navy vessels.
- This study was limited to just the Navy.
- Quantitative researchers may question the qualitative methodology utilized for this inquiry.

Dissertation Conclusion

This chapter presented the summary, second literature review, summary points, recommendations, and limitations of this study. The findings have provided valuable insight into nursing practice in a service unique environment and described pertinent issues related to operational readiness. The findings will also assist Navy Nurse Corps leaders in making appropriate assignments for nurses seeking these carrier billets. Finally, since there is a paucity of literature on this topic, the results have given a public voice to this extraordinary experience of military nursing.

Personally speaking (and placing all bracketing aside), I am in awe of the participants who contributed to this study! Their determination, dedication, and professionalism resounded throughout the entire study process. The Navy Nurse Corps is extremely fortunate to have had these nurses serve as their ambassadors to the Line community.

Finally, the American public was made keenly aware of the operational readiness of its military forces – including the rapid deployment of three aircraft carriers to the Persian Gulf and the Arabian Sea – in the United States' quest for justice when responding to the terrorist attacks on the World Trade Centers and the Pentagon on September 11th, 2001. As I conclude this dissertation, I cannot help but think about the ships' nurses on those deployed aircraft carriers. I now know that they play an integral part in their ships'

operational readiness and have a true appreciation for the role they play in maintaining our nation's freedom. I am immensely proud to be affiliated with such a magnificent group of people and only hope that the findings from this study will make their job better for generations to come.

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Appendix A

George Mason University Human Subjects Review Approval Letter

GEORGE MASON UNIVERSITY
4400 University Drive
Fairfax, VA 22030

Margaret E. Hanson
Institutional Review Board Coordinator
Office of Sponsored Programs MS 4C6
Futley Building, Room 205
Phone: [REDACTED]
FAX: [REDACTED]
email: [REDACTED]

MEMORANDUM

TO: Catherine Cox
College of Nursing [REDACTED]

FROM: Margaret Hanson [REDACTED]
Institutional Review Board Coordinator

SUBJECT: *The Lived Experience of Nurses Stationed Aboard Aircraft Carriers*
GMU Human Subjects Log #2603

DATE: November 15, 1999

Under George Mason University (GMU) procedures, the above cited research project is exempt from review by the GMU Human Subjects Review Board (HSRB) since it falls under DHHS Exempt Category 2. I understand that you will conduct interviews with non-vulnerable adults and that you will implement the required GMU HSRB procedures for protection of all audiotapes. Please forward a copy of the approval memo from the IRB at the National Naval Medical Center once it is available.

Please note that any adverse effects on participants or data confidentiality and/or any modification in your protocol must be reported to the GMU Office of Sponsored Programs. GMU is bound by the ethical principles and guidelines for the protection of human subjects in research contained in The Belmont Report. Even though your data collection procedures are exempt from review by the GMU HSRB, GMU expects you to conduct your research according to the professional standards in your discipline and the ethical guidelines mandated by federal regulations.

Thank you for cooperating with the University by submitting this protocol for review. Please call me at [REDACTED] if you have any questions.

cc: Jeanne M. Sorrell, Nursing

Appendix B

COMNAVAIRPAC Endorsement Letter



DEPARTMENT OF THE NAVY
 COMMANDER NAVAL AIR FORCE
 UNITED STATES PACIFIC FLEET
 BOX 357657
 SAN DIEGO, CALIFORNIA 92135-7657

6550
 NO1M 953
 9 APR 99

From: Commander, Naval Air Force, U.S. Pacific Fleet
 To: CDR Catherine Wilson Cox, College of Nursing and Health Sciences, George Mason University,
 4400 University Drive, Fairfax, VA 22030
 Subj: SUPPORT FOR CONDUCTING RESEARCH PROJECT THE LIVED EXPERIENCE OF NURSES
 STATIONED ABOARD AIRCRAFT CARRIERS

1. I support the research proposal "The Lived Experiences of Nurses Stationed Aboard Aircraft Carriers" to be conducted on the USS Nimitz, USS Carl Vinson, USS Abraham Lincoln, USS John Stennis, USS Kitty Hawk and the USS Constellation.
2. The goal of the study is to analyze and articulate the characteristics of nursing practice in the context of ship's nurses.
3. I will assist in the logistical processes by making contact and arrangements with each of the COMNAVAIRPAC Aircraft carrier medical departments.


 D.E. SPRAGUE
 By direction

Appendix C

COMNAVAIRLANT Endorsement Letter



DEPARTMENT OF THE NAVY

COMMANDER NAVAL AIR FORCE
 UNITED STATES ATLANTIC FLEET
 1279 FRANKLIN ST
 NORFOLK VA 23511-2494

6500
 N02/ 0 4 7 9
 APR 20 1999

FIRST ENDORSEMENT on CDR Catherine Wilson Cox, NC, USNR ltr
 of 01 Apr 99

From: Commander, Naval Air Force, U.S. Atlantic Fleet
 To: CDR Catherine Wilson Cox, NC, USNR

Subj: RESEARCH PROPOSAL

1. Your request to conduct a survey, entitled The Lived Experience of Nurses Stationed Aboard Aircraft Carriers, is approved.

2. It is understood that the goal of this study is to analyze and articulate the characteristics of nursing practice in the context of aircraft carrier nurses by interviewing the six active nurses currently assigned to carriers of AIRLANT. Each interview should not exceed two man-hours at an estimated cost to the Navy of \$77.11 for each nurse interviewed.

3. Although each AIRLANT carrier Senior Medical Officer has consented to these interviews, actual scheduling should be conducted through the AIRLANT Force Medical Office.

[Redacted Signature]
 R. D. O'Hanlon
 Chief of Staff

Appendix D

Chief, Bureau of Medicine and Surgery (MED-23) Endorsement Letter



DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
2300 E STREET NW
WASHINGTON DC 20372-5300

IN REPLY REFER TO

3900
Ser 23/ 0017
09 Jul 99

**ENDORSEMENT of The Lived Experience of Nurses Stationed Aboard Aircraft Carriers
Research Proposal submitted by CDR Catherine Wilson Cox, NC,
USNR, 577-74-9218**

From: Chief, Bureau of Medicine and Surgery (MED-23), 2300 E Street NW, Washington, DC,
23702-5300

To: CDR Catherine Wilson Cox, NC, USNR, 320 South Taylor Street, Arlington, VA 22204

Subj: RESEARCH PROPOSAL

1. Your request to interview nurses who have been stationed aboard aircraft carriers is approved.
2. It is understood that the goal of the study is to analyze and articulate the characteristics of nursing practice in the context of ship's nurses.
3. Scheduling of the interviews should be coordinated with COMNAVAIRLANT COMNAVAIRPAC Force Medical Offices, with carrier Senior Medical Officers and Ship's Nurses if interviews are to be conducted with current carrier nurses, and with the Specialty Advisor for Operational Nursing.
4. Upon completion of the study, a copy of results should be forwarded to Navy Bureau of Medicine and Surgery (MED-23), 2300 E Street NW, Washington, DC 23702-5300. I will be the BUMED sponsor and point of contact for this study. You can reach me at Fax [REDACTED] or email [REDACTED]

[REDACTED]
C. O. BARKER
By Direction

Appendix E**Specialty Leader for Operational Nursing Endorsement Letter**

14 Aug 99

FIRST ENDORSEMENT on CDR Catherine Wilson Cox, NC, USNR,
ltr of 17 July 99

From: Specialty Leader for Operational Nursing
To: CDR Catherine Cox, NC, USNR

Subj: RESEARCH PROPOSAL

1. Your request to interview nurses who have been stationed aboard aircraft carriers is supported.
2. It is understood that the goal of the study is to analyze and articulate the characteristics of nursing practice in the context of ship's nurses.
3. It is also understood that participation in the study is voluntary; the participants may withdraw from the study at any time; there is no compensation for participating in this study; the participants' identities will remain confidential; the participants will be directed by the principal investigator not to reveal any information that may be deemed classified; and that any publications resulting from this study will remove any identifying information.
4. Please contact me when you are ready to conduct the interviews and I will assist you with accessing the population you need to query.


J. D. McLEARNON
CDR NC USN

Appendix F

Approval Letter from the National Naval Medical Center's Institutional Review Board



DEPARTMENT OF THE NAVY

NATIONAL NAVAL MEDICAL CENTER
BETHESDA, MARYLAND 20885-5600

6500
Ser 10C/201
28 Feb 00

From: Commander, National Naval Medical Center
To: CDR R. Phillips, NC, USN, Nursing Services Directorate
CDR C. Cox, NC, USNR

Subj: APPROVAL OF CIP RESEARCH PROJECT #B00HLOO000-020,
"THE LIVED EXPERIENCE OF NURSES STATIONED ABOARD AIRCRAFT
CARRIERS"

Ref: (a) NSHSBETHINST 6000.41A
(b) NNMCINST 6500.2C

Encl: (1) Multiple Project Assurance (MPA)
(2) Consent Form
(3) Guidelines to Executing a Research Proposal

1. Congratulations! You have been granted approval to conduct your research project at the National Naval Medical Center.
2. Your official research project number is B00-020. Use this number on any correspondence about your research project. This will expedite the processing of your requests. Your research project has a completion target date of February 2001 and you are authorized a subject enrollment of 14.
3. Your research project was reviewed per references (a) and (b), and endorsed by our Chairperson Institutional Review Board (IRB) under NNMC's DOD Assurance 40001 and MPA M-1515. This proposal was reviewed during the 10 February 2000 IRB meeting. Enclosure (1) is the MPA that investigators agree to adhere to in conducting research at the National Naval Medical Center.
4. Enclosure (2) is the consent form that is to be duplicated and used for subject enrollment.
5. Please note that according to the guidelines provided by the Clinical Investigation Program (CIP) at the Naval School of Health Sciences, this project is not considered part of the CIP. Consequently, that office will not provide funding for travel associated with this project.
6. If collection and/or analysis of data for your project are to continue beyond one year, you must submit an annual report for continuation. Federal oversight agencies have found this to be a frequent source of problems during their audits, and have stated clearly that projects that have not received at least annual approval by the IRB of record must terminate activity immediately since they are no longer in compliance. In order for ongoing human subject research projects to be reviewed, approved and

Subj: APPROVAL OF CIP RESEARCH PROJECT #B06HL00000-020,
"THE LIVED EXPERIENCE OF NURSES STATIONED ABOARD AIRCRAFT
CARRIERS"

processed by the IRB within this time constraint, an IRB member will be assigned to conduct a continuing review audit within the IRB approval anniversary date. This audit requirement is your responsibility and you should contact the assigned IRB member when you receive the reminder.

2. Good luck on your research! Be sure to note your research project's requirements of reference (b) which are outlined in enclosure (3). This guidebook provides vital information on such items as your responsibilities as a principal investigator, the required research documentation, the procedure to use when making any changes to your research project, required reports and guidelines for publication. Please do not hesitate to contact the Clinical Investigation Department staff at [REDACTED] for any further questions or assistance.

[REDACTED]
A. H. HARRIS
By direction

Appendix G

Approval Letter from the Uniformed Services University of the Health Science's
Institutional Review Board



UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES
4301 JONES BRIDGE ROAD
BETHESDA, MARYLAND 20814-4700



August 8, 2000

MEMORANDUM FOR CDR CATHERINE COX, TRISERVICE NURSING RESEARCH
PROGRAM

SUBJECT: IRB Approval of Protocol TSNRP (N00-002) for Human Subject Use

In accordance with DoD Directive 3216.2 dated 7 January 1983, USUHS accepts the review and EXEMPT approval by the National Naval Medical Center (NNMC) Committee for the Protection of Human Subjects (CHPS) for the research protocol entitled "*The Lived Experience of Nurses Stationed Aboard Aircraft Carriers*" under your direction.

The purpose of this study is to describe the lived experiences of Navy nurses practicing aboard aircraft carriers. The IRB understands that this study involves taped interviews of 9 to 14 subjects regarding their nursing experiences aboard aircraft carriers. The IRB further understands that all subject identifying information will be coded during the study and all interview audiotapes will be erased once accurate transcription has been verified.

You are required to submit amendments to this protocol, changes to the consent form, adverse event reports, and other pertinent information relative to human subject use for this project to this office for review. It is your responsibility to maintain an accurate and accessible file of all consent forms of participating human subjects.

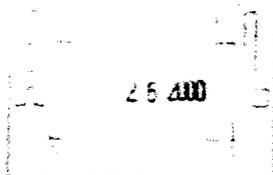
If you have any questions regarding human subject use, please call me at [REDACTED]

[REDACTED]
LTC, MS, USA
Director, Research Programs and
Executive Secretary, IRB

cc: Director, Research Administration

Appendix H

Consent Form



Pg 1 of 1
 Current Version: 7-00
 OIP #800-020
 Date: _____

**NATIONAL NAVAL MEDICAL CENTER
 BETHESDA, MARYLAND**

Consent for Voluntary Participation in a Research Project

1. I, _____, have been asked to voluntarily participate in a research project entitled, "The Lived Experience of Nurses Stationed Aboard Aircraft Carriers."

2. The purpose of this research project is to describe the lived experience of Navy nurses practicing aboard aircraft carriers.

3. If I agree to participate, I will be personally interviewed in order to explore the research question: "What is your experience as a nurse on an aircraft carrier?" The interview will last approximately 1-2 hours.

The interview will be tape recorded, transcribed, and then analyzed. Once the data analysis has been completed, I will receive the exhaustive description and be given the chance to respond to whether the description accurately reflects my experience. Reviewing my description, as well as conducting correspondence with the principal investigator, may take an additional 1-2 hours of my time.

4. 8 to 14 participants (2 for the pilot interview and 7-12 for the research study) are expected to participate in this project.

5. The only foreseeable risk to me may be the unlikely prospect of awkward or embarrassing events during the interview and the possible loss of composure with emotional issues. Should the principal investigator recognize signs of stress or anxiety associated with the interview, I will be informed of the principal investigator's desire for me to access the military health system and/or contact appropriate support organizations. I accept these risks.

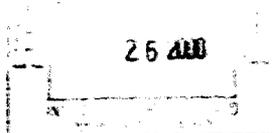
Participant's Initials _____

6. The research may or may not help me personally. Personal benefits for participating in this research endeavor may come from the opportunity to share my experience and to know that my unique perceptions may contribute to advancing nursing practice on board aircraft carriers as well as offer recommendations to consider prior to assigning future Navy nurses to these billets. I will not receive any compensation for participating in this study.

7. Because the day-to-day activities of life on an aircraft carrier may involve classified information, I will not reveal any information during the interview that may be deemed classified.

8. All data collected in this study will be confidential. I realize that the Institutional Review Board of the National Naval Medical Center, Bethesda, MD, the Uniformed Services University of the Health Sciences, Bethesda, MD, and other Federal agencies who provide oversight for human subject protection may see my records in order to verify that my rights have been safeguarded. All person-identifiable data will be coded so that I cannot be identified. All

Participant's Initials & Date _____



Current Version: 7/00
 #B00-020
 Pg 2 of 3

audiotapes will be erased once accurate transcription has been verified. All data will then be stored in locked filing cabinets. Under no circumstances will my identity be revealed to those seeking such information. Any publications and presentations resulting from this research project will be devoid of any identifying information.

9. If I suffer physical injury or if I should require hospitalization as a result of my participation in this project, immediate medical treatment will be available at the National Naval Medical Center. However, if I require inpatient hospitalization, I will be required to pay the customary fees for subsistence (hospital meals) to the National Naval Medical Center in accordance with standard regulations. It has been explained to me that my participation in this research project will be evaluated and treated in accordance with the benefits to care to which I am entitled under these regulations. I will not be entitled to compensation for injuries or to future medical care as a result of my participation in this project except as may be provided for through these regulations or other remedies available under federal law.

10. My participation in this project is voluntary and my refusal to participate will involve no penalty or loss of benefits to which I am entitled under applicable regulations. If I choose to participate, I am free to ask questions or to withdraw from the project at any time. If I should decide to withdraw from the research project, I will notify CDR Catherine Wilson Cox, MC, USNR at [REDACTED] to ensure an orderly termination process.

11. This study is being conducted by CDR Catherine Wilson Cox, MC, USNR who is a student in the Ph.D. in Nursing program at George Mason University in Fairfax, VA. If I have any questions regarding this research project, I may contact CDR Cox by calling her collect at [REDACTED] or by sending her e-mail via cathcox@aol.com. If I have any questions regarding my rights as an individual while participating in a research project at the National Naval Medical Center, Bethesda, I can contact one of the Research Administrators, Clinical Investigation Department, at [REDACTED]. They will answer my questions or refer me to a member of the Institutional Review Board for further information.

I certify that I have received a copy of this consent form.

Participant's Initials

I have read this form, understand it, and agree to participate in this research project.

Date Signed

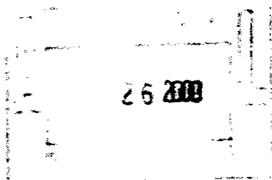
Participant's Signature

Participant's Printed Name-Rank-SSN

Date Signed

Principal Investigator's (PI) Signature

PI's Printed Name-Rank-SSN



Current Version: 1-00
CIP #B00-020
Pg 3 of 3

PRIVACY ACT STATEMENT

1. Authority. 5 USC 301

2. Purpose. Medical research information will be collected to enhance basic medical knowledge, or to develop tests, procedures, and equipment to improve the diagnosis, treatment, or prevention of illness, injury or performance impairment.

3. Use. Medical research information will be used for statistical analysis and reports by the Departments of the Navy and Defense, and other U.S. Government agencies, provided this use is compatible with the purpose for which the information was collected. Use of the information may be granted to non-Government agencies or individuals by the Chief, Bureau of Medicine and Surgery in accordance with the provisions of the Freedom of Information Act.

4. Disclosure. I understand that all information contained in this Consent Statement or derived from the experiment described herein will be retained permanently at National Naval Medical Center, Bethesda, Maryland and salient portions thereof may be entered into my health record. I voluntarily agree to its disclosure to agencies or individuals identified in the preceding paragraph and I have been informed that failure to agree to such disclosure may negate the purposes for which the experiment was conducted.

Date Signed

Participant's Signature

Participant's Printed Name-Rank-SSN

Participant's Date of Birth

Date Signed

Principal Investigator's (PI) Signature

PI's Printed Name-Rank-SSN

Appendix I

The Lived Experience of Nurses Stationed Aboard Aircraft Carriers

Demographic Sheet

Demographic Information	Answers
Interview #	
Date	
Gender	Female <input type="checkbox"/> Male <input type="checkbox"/>
Race	
Age (Current)	
Marital Status	Currently: During tour on ship:
Educational Preparation	
Length of Time in Navy	
Current Rank	
Rank While on <i>this</i> Ship	
Current Duty Status	Active Duty <input type="checkbox"/> Reservist <input type="checkbox"/> Retired <input type="checkbox"/> Civilian <input type="checkbox"/>
# of Years on <i>this</i> Ship	
Length of Time since Leaving <i>this</i> Ship	
Number of Tours of Duty on <i>any</i> Ship	
Miscellaneous Information	

Appendix J

The Lived Experience of Nurses Stationed Aboard Aircraft Carriers

Interview Sheet

1. What was your experience as a nurse on an aircraft carrier?

HINTS:

How were you feeling @ that time?
 What else was going on then?
 Tell me more about that.

Ask for concrete details.
 Ask to hear more about a subject.
 Explore laughter and/or silence.
 F/U but don't interrupt.

POSSIBLE QUESTIONS/PROBES:

Describe a typical day.
 How was the medical department organized?
 How was a code handled?
 What did you do when off duty?
 Experience w/ integration of women?
 Experience w/ telemedicine.
 Experience w/ medevacs.

2. Is there anything you have not offered, either positive or negative, about the experience you would like to add?

Appendix K

Coding Documentation

Node Listing

This section reveals the node number, its address, and the node name it was given.

Node Addresses

In the 24-page NVivo report (following the 3-page Node Listing report), the first **Scope Items** has a node address of: (2 9). Looking at the Node Listing report, (2 9) is the address of node number 28 – **Life at Sea** (the umbrella term) and **SWMDO Pia** (the theme).

This same scope item (2 9) shows that it was mentioned by at least 9 of the participants. In contrast, scope item (4 10) is the address of node number 51 – **Relationships/SMO** – and it is mentioned by all 12 of the participants.

Scope Items (Assay Scope)

These are tables with documents as rows and nodes as columns with the body of the table showing the minimum number of passages coded at each node in each document.

M/ivo revision 1.2.142

Licensee: Catherine Cox

Project: Aircraft Carrier Nursing

User: Default

Date: 11/13/2001 - 11:06:16 PM

NODE LISTING

Nodes in Set: All Nodes

Created: 12/4/2000 - 8:05:59 PM

Modified: 12/4/2000 - 8:05:59 PM

Number of Nodes: 98

- 1 (1) /Coping
- 2 (1 1) /Coping/Diversional Activities
- 3 (1 2) /Coping/Fearful
- 4 (1 3) /Coping/It Was Tough
- 5 (1 4) /Coping/Humor
- 6 (1 5) /Coping/Intimacy
- 7 (1 6) /Coping/Stressful
- 8 (1 7) /Coping/Frustrating
- 9 (1 8) /Coping/Challenging
- 10 (1 9) /Coping/Anger
- 11 (1 10) /Coping/Self Esteem
- 12 (1 11) /Coping/Confidence
- 13 (1 12) /Coping/Overwhelming
- 14 (1 13) /Coping/Confusing
- 15 (1 14) /Coping/Disappointment
- 16 (1 15) /Coping/Embarrassing
- 17 (1 16) /Coping/Avoidance
- 18 (1 17) /Coping/Validation
- 19 (2) /Life at Sea
- 20 (2 1) /Life at Sea/Battle E
- 21 (2 2) /Life at Sea/Dangerous Work Environment
- 22 (2 3) /Life at Sea/Groundhog Day
- 23 (2 4) /Life at Sea/In Harm's Way
- 24 (2 5) /Life at Sea/Leadership
- 25 (2 6) /Life at Sea/Operational Readiness
- 26 (2 7) /Life at Sea/Carrier Specific
- 27 (2 8) /Life at Sea/Shipyard
- 28 (2 9) /Life at Sea/SWIMDO Pin
- 29 (2 10) /Life at Sea/Turnover
- 30 (2 11) /Life at Sea/Women
- 31 (2 12) /Life at Sea/Work-ups
- 32 (2 13) /Life at Sea/Medevac
- 33 (2 14) /Life at Sea/It Was Good to Come Home
- 34 (3) /Recommendations
- 35 (3 1) /Recommendations/NNC Detailers
- 36 (3 2) /Recommendations/NNC in General
- 37 (3 3) /Recommendations/Qualifications
- 38 (3 4) /Recommendations/Shipboard Orientation
- 39 (3 5) /Recommendations/Successors
- 40 (3 6) /Recommendations/TYCOM

- 41 (4) /Relationships
- 42 (4 1) /Relationships/Anesthesia
- 43 (4 2) /Relationships/Camaraderie
- 44 (4 3) /Relationships/Chain of Command
- 45 (4 4) /Relationships/CO
- 46 (4 5) /Relationships/Corpsmen
- 47 (4 6) /Relationships/Unique Community
- 48 (4 7) /Relationships/XD
- 49 (4 8) /Relationships/Line Community
- 50 (4 9) /Relationships/Other Medical Personnel
- 51 (4 10) /Relationships/SMO
- 52 (4 11) /Relationships/Significant Others
- 53 (4 12) /Relationships/Support, lack of
- 54 (4 13) /Relationships/Support, sense of
- 55 (4 14) /Relationships/Teamwork
- 56 (4 15) /Relationships/Trust
- 57 (4 16) /Relationships/Isolation
- 58 (5) /Shipboard Nursing
- 59 (5 1) /Shipboard Nursing/Appreciation
- 60 (5 2) /Shipboard Nursing/Autonomy
- 61 (5 3) /Shipboard Nursing/Equipment
- 62 (5 4) /Shipboard Nursing/Everyone Knows the Nurse
- 63 (5 5) /Shipboard Nursing/How I Got Here
- 64 (5 6) /Shipboard Nursing/Impact on Career
- 65 (5 7) /Shipboard Nursing/Integration
- 66 (5 8) /Shipboard Nursing/Job Dissatisfaction
- 67 (5 9) /Shipboard Nursing/Job Satisfaction
- 68 (5 10) /Shipboard Nursing/Lack of Sleep
- 69 (5 11) /Shipboard Nursing/Let's Give It to the Nurse
- 70 (5 12) /Shipboard Nursing/Medical Department
- 71 (5 13) /Shipboard Nursing/Mentorship
- 72 (5 14) /Shipboard Nursing/Orientation
- 73 (5 15) /Shipboard Nursing/Patient Advocate
- 74 (5 16) /Shipboard Nursing/Passageway Consults
- 75 (5 17) /Shipboard Nursing/Pride
- 76 (5 18) /Shipboard Nursing/Remembrance of Special Patients
- 77 (5 19) /Shipboard Nursing/Respect
- 78 (5 20) /Shipboard Nursing/Responsibilities
- 79 (5 21) /Shipboard Nursing/Role Conflict
- 80 (5 22) /Shipboard Nursing/Take Advantage of Opportunities
- 81 (5 23) /Shipboard Nursing/Understanding the Mission
- 82 (5 24) /Shipboard Nursing/Typical Day
- 83 (5 25) /Shipboard Nursing/Training
- 84 (5 26) /Shipboard Nursing/Ventilators
- 85 (5 27) /Shipboard Nursing/You're One of One
- 86 (5 28) /Shipboard Nursing/24-7
- 87 (5 29) /Shipboard Nursing/Regrets
- 88 (5 30) /Shipboard Nursing/Take Initiative
- 89 (5 31) /Shipboard Nursing/Don't Screw Up
- 90 (5 32) /Shipboard Nursing/Utilize Your Resources
- 91 (5 33) /Shipboard Nursing/Jack of All Trades

- 92 (5 34) /Shipboard Nursing/Austere Environment
- 93 (5 35) /Shipboard Nursing/Overcoming Predecessor's Reputation
- 94 (5 36) /Shipboard Nursing/Choose Your Battles
- 95 (5 37) /Shipboard Nursing/Show Off the Nurse Corps
- 96 (5 38) /Shipboard Nursing/Leaving a Legacy
- 97 (6) /Search Results
- 98 (6 1) /Search Results/Single Text Lookup

Group Name	(A)	(B)	(C)	(D)
Individual				
Individual 10				
Individual 11				
Individual 12				
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Individual 96				
Individual 97				
Individual 98				
Individual 99				
Individual 100				
Total	100.00	100.00	100.00	100.00
Percent				

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Group Name	(10)	(11)	(12)	(13)
Individual				
Individual 10				
Individual 11				
Individual 12				
Individual 13				
Individual 14				
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Individual 16				
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Individual 42				
Individual 43				
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Individual 64				
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Individual 66				
Individual 67				
Individual 68				
Individual 69				
Individual 70				
Individual 71				
Individual 72				
Individual 73				
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Individual 76				
Individual 77				
Individual 78				
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Individual 80				
Individual 81				
Individual 82				
Individual 83				
Individual 84				
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Individual 90				
Individual 91				
Individual 92				
Individual 93				
Individual 94				
Individual 95				
Individual 96				
Individual 97				
Individual 98				
Individual 99				
Individual 100				
Total	100.00	100.00	100.00	100.00
Percent				

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Group Items	(87)	(88)	(89)	(90)	(91)
Intersect1					(47)
Intersect10					
Intersect11					
Intersect12					
Intersect7					
Intersect8					
Intersect9					
Intersect6					
Intersect5					
Intersect4					
Intersect3					
Intersect2					
Intersect					
Total	11	13	13	13	13
Percent	0.07	(0.00)	(0.00)	(0.00)	0.09

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Group Items	(87)	(88)	(89)	(90)	(91)
Intersect1					(18)
Intersect10					
Intersect11					
Intersect12					
Intersect7					
Intersect8					
Intersect9					
Intersect6					
Intersect5					
Intersect4					
Intersect3					
Intersect2					
Intersect					
Total	10	10	10	10	10
Percent	(0.04)	(0.33)	(0.43)	(0.46)	(0.00)

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Group Name	(16)	(17)	(18)	(19)	(20)
INTERVAL					
INTERVAL 10					
INTERVAL 11					
INTERVAL 17					
INTERVAL 2					
INTERVAL 3					
INTERVAL 4					
INTERVAL 5					
INTERVAL 6					
INTERVAL 7					
INTERVAL 8					
INTERVAL 9					
TOTAL	10	10	100.00	10	10
PERCENT	01.07	01.07	100.00	10	0.33

Group Name	(16)	(17)	(18)	(19)	(20)
INTERVAL					
INTERVAL 10					
INTERVAL 11					
INTERVAL 17					
INTERVAL 2					
INTERVAL 3					
INTERVAL 4					
INTERVAL 5					
INTERVAL 6					
INTERVAL 7					
INTERVAL 8					
INTERVAL 9					
TOTAL	10	10	100.00	10	10
PERCENT	01.07	01.07	100.00	10	0.33

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Group Name	(08)	(09)	(10)	(11)	(12)
Intersect					
Intersect 10					
Intersect 11					
Intersect 12					
Intersect 13					
Intersect 14					
Intersect 15					
Intersect 16					
Intersect 17					
Intersect 18					
Intersect 19					
Intersect 20					
Intersect 21					
Intersect 22					
Intersect 23					
Intersect 24					
Intersect 25					
Intersect 26					
Intersect 27					
Intersect 28					
Intersect 29					
Intersect 30					
Intersect 31					
Intersect 32					
Intersect 33					
Intersect 34					
Intersect 35					
Intersect 36					
Intersect 37					
Intersect 38					
Intersect 39					
Intersect 40					
Intersect 41					
Intersect 42					
Intersect 43					
Intersect 44					
Intersect 45					
Intersect 46					
Intersect 47					
Intersect 48					
Intersect 49					
Intersect 50					
Intersect 51					
Intersect 52					
Intersect 53					
Intersect 54					
Intersect 55					
Intersect 56					
Intersect 57					
Intersect 58					
Intersect 59					
Intersect 60					
Intersect 61					
Intersect 62					
Intersect 63					
Intersect 64					
Intersect 65					
Intersect 66					
Intersect 67					
Intersect 68					
Intersect 69					
Intersect 70					
Intersect 71					
Intersect 72					
Intersect 73					
Intersect 74					
Intersect 75					
Intersect 76					
Intersect 77					
Intersect 78					
Intersect 79					
Intersect 80					
Intersect 81					
Intersect 82					
Intersect 83					
Intersect 84					
Intersect 85					
Intersect 86					
Intersect 87					
Intersect 88					
Intersect 89					
Intersect 90					
Intersect 91					
Intersect 92					
Intersect 93					
Intersect 94					
Intersect 95					
Intersect 96					
Intersect 97					
Intersect 98					
Intersect 99					
Intersect 100					
Total	18	18	18	18	18
Percent	(00.00)	(00.00)	(00.00)	(00.00)	(00.00)

Group Name	(08)	(09)	(10)	(11)	(12)
Intersect					
Intersect 10					
Intersect 11					
Intersect 12					
Intersect 13					
Intersect 14					
Intersect 15					
Intersect 16					
Intersect 17					
Intersect 18					
Intersect 19					
Intersect 20					
Intersect 21					
Intersect 22					
Intersect 23					
Intersect 24					
Intersect 25					
Intersect 26					
Intersect 27					
Intersect 28					
Intersect 29					
Intersect 30					
Intersect 31					
Intersect 32					
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Intersect 34					
Intersect 35					
Intersect 36					
Intersect 37					
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Intersect 44					
Intersect 45					
Intersect 46					
Intersect 47					
Intersect 48					
Intersect 49					
Intersect 50					
Intersect 51					
Intersect 52					
Intersect 53					
Intersect 54					
Intersect 55					
Intersect 56					
Intersect 57					
Intersect 58					
Intersect 59					
Intersect 60					
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Intersect 62					
Intersect 63					
Intersect 64					
Intersect 65					
Intersect 66					
Intersect 67					
Intersect 68					
Intersect 69					
Intersect 70					
Intersect 71					
Intersect 72					
Intersect 73					
Intersect 74					
Intersect 75					
Intersect 76					
Intersect 77					
Intersect 78					
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Intersect 81					
Intersect 82					
Intersect 83					
Intersect 84					
Intersect 85					
Intersect 86					
Intersect 87					
Intersect 88					
Intersect 89					
Intersect 90					
Intersect 91					
Intersect 92					
Intersect 93					
Intersect 94					
Intersect 95					
Intersect 96					
Intersect 97					
Intersect 98					
Intersect 99					
Intersect 100					
Total	18	18	18	18	18
Percent	(00.00)	(00.00)	(00.00)	(00.00)	(00.00)

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Sample Name	(118)	(119)	(120)
INTERVAL			
INTERVAL10			
INTERVAL11			
INTERVAL12			
INTERVAL13			
INTERVAL14			
INTERVAL15			
INTERVAL16			
INTERVAL17			
INTERVAL18			
INTERVAL19			
INTERVAL20			
Yield	11	2	6
Percent	81.87	31.33	76.60
			11.27

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Sample Name	(114)	(115)	(116)	(117)
INTERVAL				
INTERVAL10				
INTERVAL11				
INTERVAL12				
INTERVAL13				
INTERVAL14				
INTERVAL15				
INTERVAL16				
INTERVAL17				
INTERVAL18				
INTERVAL19				
INTERVAL20				
Yield	4	8	8	11
Percent	33.33	75.00	50.00	100.00

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Sample Items	(19)	(20)	(21)	(22)	(23)
Interval 1					
Interval 10					
Interval 11					
Interval 17					
Interval 2					
Interval 3					
Interval 4					
Interval 5					
Interval 6					
Interval 7					
Interval 8					
Interval 9					
Interval 12					
Interval 13					
Interval 14					
Interval 15					
Interval 16					
Interval 18					
Interval 19					
Interval 20					
Interval 21					
Interval 22					
Interval 23					
Interval 24					
Interval 25					
Interval 26					
Interval 27					
Interval 28					
Interval 29					
Interval 30					
Interval 31					
Interval 32					
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Interval 34					
Interval 35					
Interval 36					
Interval 37					
Interval 38					
Interval 39					
Interval 40					
Interval 41					
Interval 42					
Interval 43					
Interval 44					
Interval 45					
Interval 46					
Interval 47					
Interval 48					
Interval 49					
Interval 50					
Interval 51					
Interval 52					
Interval 53					
Interval 54					
Interval 55					
Interval 56					
Interval 57					
Interval 58					
Interval 59					
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Interval 62					
Interval 63					
Interval 64					
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Interval 66					
Interval 67					
Interval 68					
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Interval 72					
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Interval 77					
Interval 78					
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Interval 81					
Interval 82					
Interval 83					
Interval 84					
Interval 85					
Interval 86					
Interval 87					
Interval 88					
Interval 89					
Interval 90					
Interval 91					
Interval 92					
Interval 93					
Interval 94					
Interval 95					
Interval 96					
Interval 97					
Interval 98					
Interval 99					
Interval 100					
Total	31.33	4	13	18.00	88.07
Percent					

Sample Items	(19)	(20)	(21)	(22)	(23)
Interval 1					
Interval 10					
Interval 11					
Interval 17					
Interval 2					
Interval 3					
Interval 4					
Interval 5					
Interval 6					
Interval 7					
Interval 8					
Interval 9					
Interval 12					
Interval 13					
Interval 14					
Interval 15					
Interval 16					
Interval 18					
Interval 19					
Interval 20					
Interval 21					
Interval 22					
Interval 23					
Interval 24					
Interval 25					
Interval 26					
Interval 27					
Interval 28					
Interval 29					
Interval 30					
Interval 31					
Interval 32					
Interval 33					
Interval 34					
Interval 35					
Interval 36					
Interval 37					
Interval 38					
Interval 39					
Interval 40					
Interval 41					
Interval 42					
Interval 43					
Interval 44					
Interval 45					
Interval 46					
Interval 47					
Interval 48					
Interval 49					
Interval 50					
Interval 51					
Interval 52					
Interval 53					
Interval 54					
Interval 55					
Interval 56					
Interval 57					
Interval 58					
Interval 59					
Interval 60					
Interval 61					
Interval 62					
Interval 63					
Interval 64					
Interval 65					
Interval 66					
Interval 67					
Interval 68					
Interval 69					
Interval 70					
Interval 71					
Interval 72					
Interval 73					
Interval 74					
Interval 75					
Interval 76					
Interval 77					
Interval 78					
Interval 79					
Interval 80					
Interval 81					
Interval 82					
Interval 83					
Interval 84					
Interval 85					
Interval 86					
Interval 87					
Interval 88					
Interval 89					
Interval 90					
Interval 91					
Interval 92					
Interval 93					
Interval 94					
Interval 95					
Interval 96					
Interval 97					
Interval 98					
Interval 99					
Interval 100					
Total	19.00	8	11	91.07	100.00
Percent					

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16/24

Report Name	Period
Intercept1	09.23
Intercept10	72.73
Intercept11	68.83
Intercept17	68.83
Intercept2	74.73
Intercept3	78.83
Intercept4	73.83
Intercept8	61.34
Intercept9	67.83
Intercept7	68.84
Intercept6	68.34
Intercept5	67.83
Total	
Period	

Report Name	(8 13)	(8 10)	(8 04)	Yield
Intercept1				81
Intercept10				64
Intercept11				64
Intercept17				61
Intercept2				73
Intercept3				88
Intercept4				87
Intercept8				87
Intercept9				81
Intercept7				64
Intercept6				64
Intercept5				61
Total	11	12	7	769
Period	81.87	100.06	84.51	

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Passage Count Profiles

These are tables with documents as rows and nodes as columns with the body of the table showing how many passages each node codes in each document.

Page 25/25 of the NVivo report reveals 2,513 coded passages for this project.

	(B 10)	(B 11)	(B 12)	(B 13)
Increment 1 Interval 1	3	0	0	0
Interval 10	0	1	3	1
Interval 11	1	3	1	3
Interval 17	4	4	8	3
Interval 2	4	3	4	0
Interval 3	10	7	6	1
Interval 4	1	3	4	1
Interval 5	0	1	1	3
Interval 6	1	3	8	3
Interval 7	0	3	6	3
Interval 8	0	3	3	1
Interval 9	1	3	3	1
Total	34	34	44	19

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	(B 1)	(B 2)	(B 3)	(B 4)
Increment 1 Interval 1	3	1	1	1
Interval 10	6	3	1	3
Interval 11	4	1	1	0
Interval 12	3	6	6	1
Interval 13	6	6	3	3
Interval 14	1	6	1	3
Interval 15	6	3	3	0
Interval 16	2	8	1	0
Interval 17	4	1	4	3
Interval 18	3	8	1	1
Interval 19	3	8	2	2
Interval 20	4	3	2	3
Total	41	63	34	17

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Item	(4)	(5)	(6)	(7)
Item 1				
Item 2				
Item 3				
Item 4				
Item 5				
Item 6				
Item 7				
Item 8				
Item 9				
Item 10				
Item 11				
Item 12				
Item 13				
Item 14				
Item 15				
Item 16				
Item 17				
Item 18				
Item 19				
Item 20				
Item 21				
Item 22				
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Item 372				
Item 373				
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Item 375				
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Item 377				
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Item 380				
Item 381				
Item 382				
Item 383				
Item 384				
Item 385				
Item 386				
Item 387				
Item 388				
Item 389				
Item 390				
Item 391				
Item 392				
Item 393				
Item 394				
Item 395				
Item 396				
Item 397				
Item 398				
Item 399				

Documents	(6)	(61)	Yield
Intermittent	0	0	165
Intermittent	0	0	203
Intermittent	0	0	179
Intermittent	0	0	163
Intermittent	0	0	276
Intermittent	0	0	242
Intermittent	0	7	227
Intermittent	0	1	166
Intermittent	0	0	166
Intermittent	0	1	197
Intermittent	0	1	174
Intermittent	0	0	100
TOTAL	0	10	2013

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Appendix L

Dr. Helen Streubert's Agreement Letter

**HELEN J. STREUBERT, ED.D., RN
CONSULTANT**

**[REDACTED]
DALLAS, PA [REDACTED]**

Catherine Wilson Cox

[REDACTED]

Dear Ms. Cox:

I am most willing to work with you on your qualitative research study. The work you are planning is significant to nursing and the Navy. As I have shared with you, the best way to understand human experience is to do so using qualitative methodology. You must be able to clearly describe what a phenomenon is before you move onto trying to change it.

I wish you success in getting your project funded. Please keep me posted on your activities.

Sincerely,

[REDACTED]

Helen J. Streubert, Ed.D., RN

Appendix M

TriService Nursing Research Program (TSNRP) Funding Letter



UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES
4301 JONES BRIDGE ROAD
BETHESDA, MARYLAND 20814-4790



TriService Nursing Research Program

15 May 2000

MEMORANDUM FOR CDR CATHERINE COX, 320 South Taylor Street, Arlington, VA
22204

SUBJECT: FY 2000 TriService Nursing Research Program Grant Application

1. Congratulations! The TriService Nursing Research Program (TSNRP) is pleased to announce that your proposal entitled "The Lived Experience of Nurses Stationed Aboard Aircraft Carriers" was approved for funding. Congratulations on a job well done!
2. The reviewer critiques and the scientific review panel discussion summary are attached for your information and will provide valuable feedback regarding your research. The section on Human Subject Protection in the summary addresses ethical considerations of your work. An ethicist led the panel in the discussion of human subject protection. You are encouraged to review their comments and to use them to strengthen your proposal. The list of panel members for the FY2000 Scientific Review Panel has been enclosed for your information.
3. A copy of the Grantee Organization's Notice of the Award is enclosed. The Notice of Award goes to the applicant organization in advance of the Grant Agreement. The Notice of Award delineates the budget to be funded and stipulates changes that must be integrated into the project. The budget may have been adjusted from the original request in the application. Any specified changes must be integrated into the proposal and submitted to this office as soon as possible. Only those areas that need to be revised should be resubmitted.
4. Grant Agreements exist between the Granting Organization, in this case The Uniformed Services University of the Health Sciences (USUHS), and your applicant organization. The Grant Agreement is executed as soon as both parties sign the document. A signed Grant Agreement indicates acceptance of the funds as delineated in the Notice of Award and agreement to the terms and conditions. Funding is available to the applicant organization as soon as grant agreements are executed. However, no expenditures can be made until you receive an official start letter from this office.
5. A letter from this office will be sent to the organization stating that the project may be initiated. Prior to the initiation of the research, projects involving humans as research subjects must receive Institutional Review Board (IRB) approval. The submitted protocol, approved consent form and IRB approval letter must be forwarded to this office. USUHS conducts a secondary review for research conducted at military treatment facilities.

6. A post-award management workshop will be held 26-28 July 2000 for all TSNRP grant award recipients. The workshop is designed to facilitate your successful implementation of the research. Workshop attendance is mandatory so plan your schedule accordingly.

7. Again, congratulations on your successful submission. This was an extremely competitive process. If you have any questions, please do not hesitate to call at [REDACTED]

[REDACTED]
CATHERINE M. SCHEMP
Lieutenant Colonel (P), Army Nurse Corps
Director

Enclosure 1: Reviewer Critiques
Enclosure 2: SRP Panel Summary
Enclosure 3: SRP Member List
Enclosure 4: Notice of Award



UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES
4301 JONES BRIDGE ROAD
BETHESDA, MARYLAND 20814-4700



NOTICE OF GRANT AWARD

Grant Number: MDA-905-00-1-0005 (N00-002)
 PI Name: CDR Catherine Cox
 Grant Title: The Lived Experience of Nurses Stationed Aboard Aircraft Carriers
 Amount of Award : \$21,341
 Period of Award: June 1, 2000 - May 31, 2001
 Budget Category:

Category	Award Amount
Personnel	\$ 0
Consultant	\$ 2,352
Equipment	\$ 2,800
Supplies	\$ 900
Travel	\$ 3,175
Patient Care Costs	\$ 0
Other	\$ 6,539
Consortium/	Direct \$ 0
Contractual Costs	Indirect \$ 0
TOTAL DIRECT	\$ 15,766

Changes in Project Scope/ New Conditions: None

Signed:  Date: 17 May 2000

Printed on  Recycled Paper

Curriculum Vitae

Catherine Elizabeth Wilson Cox was born on November 20, 1959 in Washington, D.C. She received her BSN from Radford University in Radford, Virginia in 1981 and her MSN in Nursing Education and Critical Care from Marymount University in Arlington, Virginia in 1988. Ms. Cox has been a Navy nurse since 1981. She has had the privilege of serving on active duty for six years and has been in the Navy Reserves for the past 14 years. Ms. Cox holds the rank of Commander and currently drills twice a month in the Cardiac Intensive Care Unit (CICU) at the National Naval Medical Center in Bethesda, MD. She has held a variety of hospital-based clinical positions throughout her nursing career. Ms. Cox is a member of Sigma Theta Tau, the Navy Nurse Corps Association, the American Association of Critical Care Nurses, the Emergency Nurses Association, and the Association of Military Surgeons of the United States. She is married to Gerard and has two children, Alexander and Caroline.