THE INFLUENCE OF THE HIDDEN CURRICULUM ON PROFESSIONAL SOCIALISATION OF STUDENT NURSES IN A MILITARY NURSING CONTEXT

by

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"In his grace, God has given us different gifts for doing certain things well. So if God has given you the ability to prophesy, speak out with as much faith as God has given you. If your gift is serving others, serve them well. If you are a teacher, teach well."

Romans 12:6-7

DECLARATION

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I declare that the above thesis is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

_____   _____

Karen Zägenhagen   Date

30 January 2017

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"Wat ek is, is net genade.
Wat ek het is net geleen."

Koos du Plessis

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ABSTRACT

The South African Military Health Service (SAMHS) Nursing College offers a four-year integrated nursing programme leading to registration as a professional nurse at the South African Nursing Council (SANC). Student nurses assume a dual role when entering the SAMHS to commence with nurse training – that of a soldier and a nurse. Because student nurses have to assume dual roles, hidden aspects of military culture may influence the professional socialisation of student nurses in one way or another.

With a view to determining whether the military environment does indeed impose any influence on student nurses' professional socialisation, this study set out to explore the multifaceted context in which these students find themselves.

Given the organisational and locational complexity of the SAMHS Nursing College, its campuses and the three military hospitals in South Africa, the population was narrowed down to an accessible target population comprising nurse educators and student nurses of the SAMHS Nursing College (Main Campus).

Included in the two samples were nurse educators at the SAMHS Nursing College who had at least three years' experience as nurse educators and who were registered with the SANC as nurse educators, and student nurses registered at the SANC for the four-year Integrated Nursing Programme and who were in their fourth year of training.

A qualitative constructivist grounded theory study was conducted based on the researcher's philosophical assumptions. The researcher made use of focus groups and

critical-incident narratives to collect data. In keeping with the constructivist paradigm adopted for this study, Charmaz's (2014) data-analysis approach was followed.

Concepts derived from the qualitative data were used to develop a substantive model to create an awareness of the existence of a hidden curriculum, to guide role players through the impact of the hidden curriculum on students' professional socialisation and to help them to understand how their contribution could improve the outcome of the professional socialisation process.

KEY CONCEPTS

Curriculum; grounded theory; hidden curriculum; military culture; military nursing; model development nursing; nursing education; professional socialisation; substantive model.

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List of abbreviations

ANC	African National Congress
APLA	Azanian People's Liberation Army
BDF	Bophuthatswana Defence Force
C SANDF	Chief of the National Defence Force
CDF	Ciskei Defence Force
CIN	Critical Incident Narrative
CO	Candidate Officer
CSS	Core Service System
DOD	Department of Defence
DODI	Department of Defence Instruction
DOH	Department of Health
FGL	Focus Group Lecturers (nurse educators)
FGS	Focus Group Students
HPCSA	Health Professions Council of South Africa
ICRC	International Committee of the Red Cross
IFP	Inkatha Freedom Party's
MK	Umkhonto we Sizwe
MOD	Minister of Defence
MOOTW	Military-operations-other-than-war
MPI	Military Psychological Institute
MSDS	Military Skills Development System
PDCA	Plan-Do-Check-Act
RSM	Regimental Sergeant-Major
SADF	South African Defence Force
SAMC	South African Medical Corps
SAMHS	South African Military Health Service
SAMNS	South African Military Nursing Service
SAMS	South African Medical Service
SANC	South African Nursing Council
SWP	Standard Working Procedure
TDF	Transkei Defence Force
UDF	Union Defence Force
UNISA	University of South Africa
VDF	Venda Defence Force

CHAPTER 1

ORIENTATION TO THE STUDY

1.1   INTRODUCTION

One of the most consequential and enduring aspects of training to become a professional nurse is that the process shapes one's professional identity. The word *profession*, as derived from the Latin word *profiteri,* means to publicly speak out, to make a statement or to give an undertaking to others (Sadler 2001:61). Baingana, Nakasujja, Galukande, Omona, Mafigiri and Sewankambo (2010:76) refer to professionalism as a collection of attitudes, values, behaviours and relationships – all of which shape the foundation of the health professional's contract with society.

The professional values associated with nursing serve to guide the nurse's behaviour so that it complies with the profession's preferred standards. It forms the foundation for the provision of committed, caring, safe and ethical healthcare. The development of professional values and value-based behaviours is crucial towards ensuring improved quality of care.

1.2   BACKGROUND TO THE RESEARCH PROBLEM

As is evident from various calls to improve the teaching of professionalism to healthcare professionals, the acquisition of the professional attributes mentioned above can clearly not be left to chance (Frenk, Chen, Bhutta, Cohen, Crisp, Evans & Zurayk 2010:1923-1958; Seggie 2011:508-509; Tomson, Tomson & Savage 2012:1388-1389). During a National Nursing Summit held in April 2011, issues of central concern to the future of the nursing profession in South Africa were highlighted. Among the concerns pertaining to professional ethos raised and discussed by attendees were a decline in the standards of nursing, the decline in both the image and the status of the profession and a lack of professionalism. An increase in instances of unethical conduct and complaints against nurses, poor nurse-patient relationships as a result of poor communication, bad attitudes, incidents of violence and abuse, and moral distress among nurses were also mentioned (DOH 2013:22-23).

Similarly, during 2013, the Military Psychological Institute (MPI) conducted a client satisfaction survey that aimed to determine whether the clients of the South African Military Health Services (SAMHS) were satisfied with the health services they were receiving. A 21-item questionnaire was compiled so as to measure the key components of client satisfaction in healthcare. It was found that SAMHS clients generally had positive experiences at the SAMHS service points countrywide. Despite this largely positive feedback, it emerged that respondents had however also encountered some very serious challenges at the various facilities. These issues included inter alia lengthy waiting times, SAMHS personnel's negative attitudes to patients and a perceived lack of professionalism among staff (MPI 2013).

The process by means of which a person acquires the required norms, attitudes, behaviours, skills, roles and values to shape her/his professional identity, one that qualifies an individual to become a member of a specific group or society is described as *professional socialisation* (Chitty & Black 2011:131). Zarshenas, Sharif, Molazem, Khayyer, Zare and Ebadi (2014:432-438) identify two aspects of socialisation that are especially important to health professionals. Firstly, the process of organisational socialisation entails fitting into the structure of the organisation, learning the organisational culture, learning the formal and informal rules of the organisation and maintaining relationships with colleagues. Secondly, professional socialisation refers to the internalisation of the values and the culture of the profession. By integrating the definitions of the various authors cited above, one can thus describe professional socialisation as the process whereby a lay person is influenced to assimilate, internalise and reflect the norms, values, beliefs, attitudes, behaviours, skills, knowledge and roles of a profession into her/his own behaviour and self-concept in order to acquire the professional identity characteristic of that profession.

De Swardt, Van Rensburg and Oosthuizen (2014:4) reported that the professional socialisation process is influenced by diverse factors related to the learning environment, student behaviour, role models, teaching practices, mentors, educators and preceptors. This implies that the professional nurse, and by implication also the nurse educator, forms an integral part of the professional socialisation process and underscores the importance of student support in the development of a professional identity that will reflect those qualities needed to provide quality patient care.

With regard to the teaching of professionalism, Cruess and Cruess (2009:112-113) identify two distinct approaches. The first contemporary formal didactic approach emphasises the need for professionalism to be explicitly taught by following a cognitive learning style to ensure that the student understands the nature, the characteristics, the reasons and the obligations of professionalism. The second approach regards professionalism as fundamental to the process of socialisation during which the values, attitudes, interests, skills and knowledge associated with the profession are acquired through experiential learning in an authentic context. In line with the second approach, Stern and Papadakis (2006:1794) posit that professionalism is "caught rather than taught", and as an outcome is implicit rather than explicit. Numerous studies (Chuang, Nuthalapaty, Casey, Kaczmarczyk, Cullimore, Dalrymple, Dugoff, Espey, Hammoud, Hueppchen, Katz & Peskin 2010:316; Gaufberg, Batalden, Sands & Bell 2010:1709-1716; Karimi, Ashktorab, Mohammadi & Abedi 2014:53-57) have established that most of what is learned takes place not within the formal course curriculum, but by means of interactions and influences that are intrinsic to the teaching and learning environment. These perspectives on the teaching of professionalism and the process of professional socialisation within a multidimensional teaching and learning environment suggest the existence of different types of curricula.

Van Veen, Van Fenema and Jongejan (2012:65) define a curriculum as "an interrelated set of plans and experiences that a student undertakes under the guidance of the school". This definition makes allowance for different views on curricula and learning. These authors also distinguish between three types of curricula, namely the planned curriculum, the enacted curriculum and the experienced curriculum.

The planned curriculum reflects the documented intentions of educational institutions in the form of reports, web pages, policies and other documents. These written plans typically represent explicit information, the reach of ideas and intentions and serve as a means for communication, management and alignment of the course content. The planned curriculum emphasises the notion of curriculum development.

The enacted curriculum is about what happens in the classroom. Educators interpret the planned curriculum and translate it into their courses, instructions, assignments and activities. The enacted curriculum stresses the importance of curriculum implementation and change management.

The experienced curriculum is about what the student actually perceives while being trained. It reflects how students construct ideas about the intentions, the aims and the content of the course, the subjects and the profession by means of communicating, using course material, observing the behaviour of educators, completing assignments and following the programme. Depending on a student's individual learning style, personal condition and response to the learning environment, the experienced curriculum will be different for each student. The experienced curriculum falls beyond the scope of the planned and the enacted curriculum.

Educational theorists such as Jackson (1968), Tyler (1969), Snyder (1970), Apple (1980) and Eisner (2002) have come up with a different classification, which distinguishes between three layers of curricula, namely the formal, the informal and the hidden.

The formal curriculum is seen as the explicit transmission of official knowledge to students. It represents the structure and content of intentional education, designed in accordance with specific objectives. Educators have however long determined that the formal curriculum does not serve as the only means of education within social institutions (Hafferty & Franks 1994:869).

According to Stern and Papadakis (2006:1794), the informal curriculum is "an unscripted, predominantly ad hoc and highly interpersonal form of teaching and learning that takes place among and between faculty and students". Learning thus takes place outside a dedicated learning environment and arises from conversations between and activities and interests of students and educators.

The hidden curriculum is about "those parts of the environment that influence the experience of students but that are either not accounted for or cannot be accounted for in curriculum planning" (Van Veen et al 2012:66). Jackson (1968) introduced the term and it became especially useful in terms of discovering mechanisms that underlie students' experiences.

Melrose, Park and Perry (2015:37) use the terms *incidental learning* or *unintentional learning* to refer to unplanned learning where students are only aware that learning has occurred after the experience. Learning of this kind is situated, contextual and social

and can happen when one is watching or interacting with others, makes mistakes or is forced to accept or adapt to situations.

Hafferty (1998:403) points out that although some of the learning processes occur in the formal, explicit part of the training, others operate latently in the sphere of the hidden curriculum. He introduced the concept of the hidden curriculum to the medical education community by highlighting both the importance and the impact of structural factors on the learning process and challenged medical educators to acknowledge those factors present during training that would define "good" and "bad" medicine. Hafferty (1998:404) therefore defines the hidden curriculum as a set of influences that function at the level of organisational structure and culture, inclusive of commonly held understandings, implicit rules, customs, rituals, and taken for granted aspects. According to Cribb and Bignold (1999:197), the hidden curriculum refers to the "processes, pressures and constraints which fall outside the formal curriculum, and which are often unarticulated or unexplored". The hidden curriculum entails the potential transmission of knowledge and also of attitudes, behaviours, values, norms, perceptions and skills that were not originally intended by the formal curriculum.

From the above discussion, it is evident that there is a clear correlation between the process of professional socialisation, and factors in the teaching and learning environment that could potentially influence the process.

1.3   CONTEXTUAL BACKGROUND

This section sketches the environmental framework or context within which the professional socialisation of military students takes place.

1.3.1 Historical background

"As nursing had been born under the triple influence of religion, military needs and science, it had inherited three great qualities from these sources namely charity, discipline and learning."
(Searle 1975:13)

1.3.1.1 *Military nursing*

Prior to the establishment of the Union of South Africa on 31 May 1910, the two British colonies, i.e. the Cape and Natal, each had its own military health establishment, namely the Cape Medical Staff Corps and the Natal Volunteer Medical Corps. Of the two Boer republics, the Transvaal and the Orange Free State, only the Transvaal had the Transvaal Medical Staff Corps. Soon after Union, all of these medical corps changed their respective names to the Cape Medical Corps, the Natal Medical Corps and the Transvaal Medical Corps (SAMHS 2012). After the Defence Act, no. 13 of 1912 (South Africa 1912) had been promulgated on 13 June 1912 with a view to establishing the Union Defence Forces, the Cape, Natal and Transvaal Medical Corps were integrated to form the South African Medical Corps (DOD 2012). At the outbreak of the First World War in August 1914, the South African Military Nursing Service (SAMNS) was established, thereby becoming the first women's service in the Union Defence Forces. The South African Medical Corps (SAMC) and SAMNS personnel took part in the campaigns in German South West Africa, German East and Central Africa, Egypt, France and Flanders throughout the war (Stratford & Collins 1994:24-69). After the signing of the Armistice in November 1918, nurses who had served in the SAMNS were promptly demobilised and returned to their pre-war jobs. This left only a small military nursing reserve that was available to be called up in case of a national crisis (Stratford & Collins 1994:70). At the outbreak of the Second World War in 1939, a severely depleted military nursing reserve was promptly reinforced with civilian nurses when the Union Defence Force (UDF) entered the conflict on the side of Britain. For the next five years, these nurses served side by side with the allied soldiers in both East and North Africa, in Italy and on various hospital ships, ambulance trains and aircraft. Following the Allied victory in Europe and the subsequent return of military personnel to the Union, the SAMC and the SAMNS were again reduced to a minimal number to provide only essential peacetime support to the UDF (Stratford & Collins 1994:75-107).

In 1950, the SAMNS was integrated into the SAMC, which allowed nurses to become permanent force members, thereby, like any other soldier, subjecting them to military law, rules and regulations. The newly elected Nationalist Government passed a new Defence Act, no. 44 of 1957 (South Africa 1957) in terms of which the Union Defence Force became the South African Defence Force (SADF). In 1979, the name South African Medical Corps was changed to the South African Medical Service (SAMS) and

the latter formed the fourth arm of service of the SADF, alongside the South African Air Force, the South African Navy and the South African Army (DOD 2012, Stratford & Collins 1994:24-69).

Following South Africa's first democratic elections in 1994, the South African National Defence Force was born out of the integration of the SADF with the armies of the various resistance movements: Umkhonto we Sizwe (MK) of the African National Congress (ANC), the Azanian People's Liberation Army (APLA) of the Pan Africanist Congress (PAC) and the self-protection units of the Inkatha Freedom Party (IFP). Also integrated into the SADF were the Transkei Defence Force (TDF), the Ciskei Defence Force (CDF), the Venda Defence Force (VDF) and the Bophuthatswana Defence Force (BDF) (Williams 2002:17). This integration eventually led to the formation of SAMHS in June 1998 (DOD 2012).

1.3.1.2 *Military nursing education*

In terms of the Nursing Act, no. 45 of 1944 (South Africa 1944), the military hospital in Pretoria (1 Military Hospital) was approved as a training school by the SANC in as far back as July 1945. The Act authorised the SANC to offer a three-and-a-half-year course in medical and surgical nursing. Shortly after, between 1952 and 1956, a pre-nursing course of six months was also offered so as to attract more candidates to the profession and to provide scholars with a matriculation certificate. Initially, training progressed so favourably that the school was registered as the South African Military Nursing Service Training School. However, by 1955, the numbers of female surgical and paediatric patients had declined to such an extent that the hospital no longer met the minimum prescribed requirements of the SANC and it was finally closed down in April 1956 (Stratford & Collins 1994:119-120).

Only in the late 1960s, when the threat of communist insurgency had forced government to enlarge the Defence Force rapidly and conscription laws had dramatically increased the number of national servicemen (Stratford & Collins 1994:124-125), did it become evident that the Military Nursing Service would once more have to start training its own nurses. In 1970, once the initial problems of a shortage of tutors and a lack of suitable classrooms had been surmounted, 1 Military Hospital was authorised to train nursing assistants. The hospital subsequently also received approval to offer a three-year diploma course in General Nursing in 1972, a one-year course in

Midwifery in 1974, a two-year course leading to enrolment as a nurse in 1978, a diploma course in Operating Theatre Nursing in 1983 and a bridging course in 1990 (Stratford & Collins 1994:142-146). With a view to meeting the training needs of the military hospitals in Cape Town and Bloemfontein, campuses of the College were established in each of these hospitals respectively.

Whereas, before 1984, all nursing training was delivered in a training hospital, the SANC subsequently gave recognition to a nursing college affiliated to a university as an autonomous and official training school. In January 1985, this historic change led to the establishment of the South African Medical Service Nursing College (SAMS Nursing College) in collaboration with the University of South Africa at 1 Military Hospital. The SAMS Nursing College was the first college in the then Transvaal to present the four-year Diploma in Nursing Science leading to registration as a general, psychiatric and community nurse and midwife. In 1988, the SAMS Nursing College became an independent military unit (Stratford & Collins 1994:145-146). On 1 July 1995, the various training institutions of SAMS merged to form the SAMS Academy and the College moved from 1 Military Hospital to its current location in Thaba Tshwane, Pretoria (SAMHS 2009:94). Following the integration of the statutory forces and the restructuring of the South African National Defence Force (SANDF) after 1994, SAMS was renamed the South African Military Health Service (SAMHS) on 1 June 1998. The SAMS Academy was subsequently renamed the Military Health Training Formation and the SAMS Nursing College was renamed the South African Military Health Service Nursing College.

1.3.2 The organisational context of SAMHS and the SAMHS Nursing College

Officially, the new, post-apartheid South African Department of Defence (DOD), comprising the Defence Secretariat and the South African National Defence Force, came into being on 27 April 1994 with the establishment of the new democratic South Africa. The Department of Military Veterans was added in 2011 after the promulgation of the Military Veterans Act, no. 18 of 2011 (South Africa 2011).

The Minister of Defence (MOD) is the member of Cabinet responsible for defence. The Defence Secretariat is headed by the Secretary for Defence, acting as the accounting officer for the department and the principal advisor to the MOD in matters regarding defence policy. The SANDF is headed by the Chief of the National Defence Force (C

SANDF) who is responsible for executing defence policy, directing the work of Defence Headquarters and managing the overall functioning and the operations of the SANDF. The C SANDF is also the principal advisor to the MOD on military, operational and administrative matters. The structure of the DOD is shown in Figure 1.1.
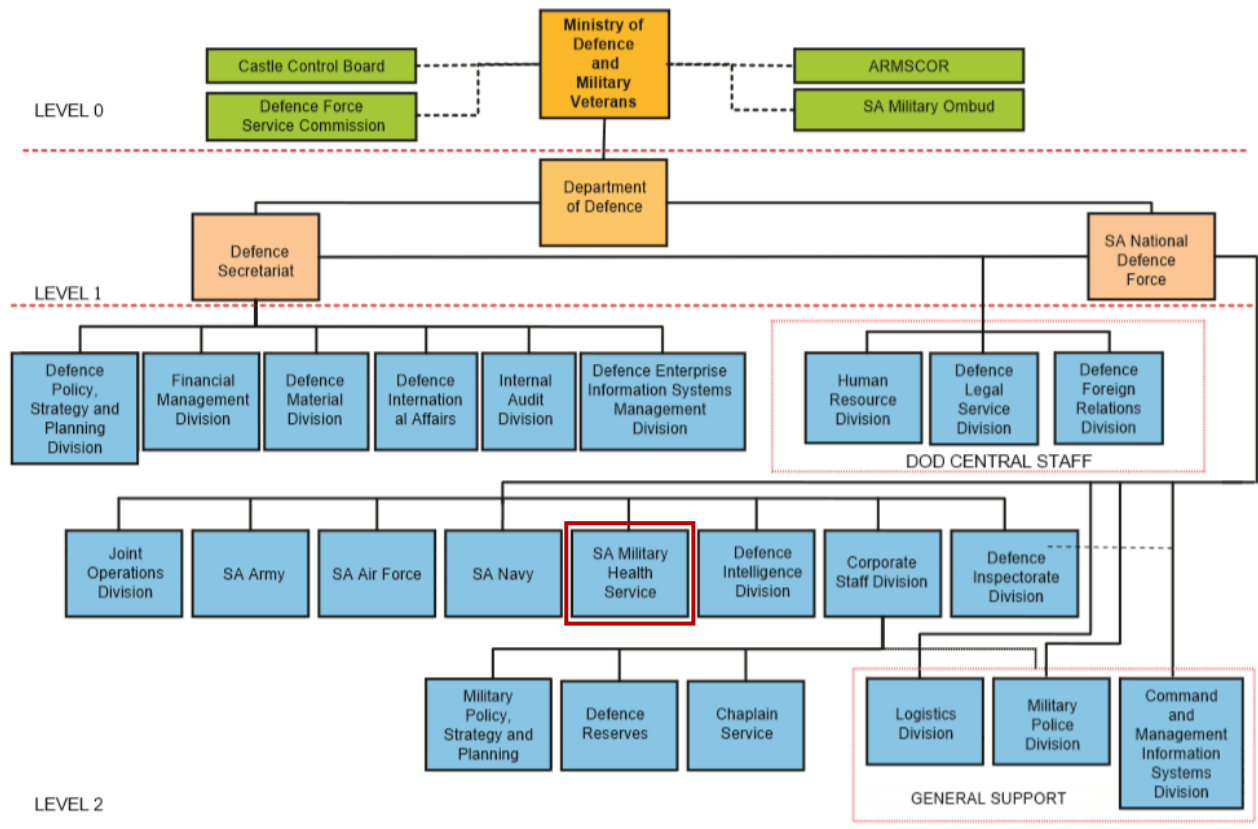
Figure 1.1: The structure of the South African Department of Defence
(DOD 2013:2)

SAMHS is one of the services reporting directly to the C SANDF. In order to support the defence mandate, mission, goals, tasks and strategic defence concept, the South African Defence Review (DOD 2014:207) dictates a military health capability comprising deployable health capabilities to provide healthcare for all operationally deployed forces and a static healthcare capability providing a comprehensive continuum of healthcare with an inherent rehabilitation capability for all serving members, military veterans, their dependants and other approved patients. The SAMHS force design comprises deployable medical units, military and specialist health services and facilities, logistical support, and operational and medical product-support capabilities.

1.3.3 The military teaching and learning environment

The SAMHS Nursing College has three campuses, one at each of the military hospitals located in Pretoria, Bloemfontein and Cape Town.

1.3.3.1 Military training

Students are recruited and selected by the Military Skills Development System (MSDS). This voluntary service system was incorporated into the Defence Strategy in 2003 (DOD 2003:2) with the aim of

- providing the SANDF Regular Force and Reserve Force with the human resources required to execute its mandate;
- empowering the youth who serve in the Defence Force with specific functional skills as required by the different utilisation capacities in the SANDF;
- developing leadership qualities and instilling sound values and the ethics of civic responsibility including loyalty, discipline and patriotism; and
- providing young South Africans with transferable skills that will improve their marketability in the formal employment sector.

The MSDS is guided by the following four basic principles (DOD 2014):

- It provides for an initial two-year employment contract with the option of further employment in the Core Service System (CSS) in terms of a two- to five-year service contract.
- It provides for a further five-year Reserve Force contract on completion of the initial two-year contract.
- It aims to provide for accreditation of the military and enablement skills obtained during the initial two years of full-time employment.
- It must provide for the rejuvenation of the SANDF with young and fit operationally deployable personnel.

The generic MSDS model requires an initial six months of basic military training and a further six months of specialist training during the first employment year. The second year is devoted to operational deployment.

Students recruited and selected to follow the four-year programme leading to registration as nurse (general, community, psychiatry) and midwife, follow the generic MSDS model by doing the initial basic military training, followed by the officers formative course aimed at equipping students with the necessary skills, knowledge and values to function as junior military officers in a specific, designated military environment. In the second year of the MSDS programme, students commence with the first year of nurse training. During this period, to allow them to complete their studies, their service contracts are converted to CSS contracts.

1.3.3.2 Professional nursing training

The SAMHS Nursing College is responsible for the training of various categories of nurses to meet the healthcare needs of the SANDF and approved clients. In accordance with the SAMHS Nursing College Business Plan Financial Year 2015/2016 (SAMHS 2015), the following basic and post-basic programmes accredited by the SANC under the Nursing Act, no. 50 of 1978 (South Africa 1978) are currently offered:

- Two-year programme leading to enrolment as a nurse
- Two-year programme leading to registration as a general nurse
- Four-year programme leading to registration as a nurse (general, community, psychiatry) and midwife
- One-year course in clinical nursing science, health assessment treatment and care
- One-year course in midwifery

The structure of the SAMHS Nursing College makes provision for the training of 20 students for the two-year programme leading to enrolment as a nurse, 20 for the two-year programme leading to registration as a general nurse, 260 for the four-year programme leading to registration as a nurse (general, community, psychiatry) and midwife, 30 for the one-year course in clinical nursing science, health assessment treatment and care, and ten for the one-year course in midwifery. Fifty-three academic staff and 18 support staff are responsible for the education, training and management of these students (SAMHS 2015).

Clinical practice is gained through the placement of students at the various military health facilities. Memoranda of Agreement with the Gauteng Department of Health and

the Tshwane Municipality assist in augmenting students' clinical exposure by placing the latter at their facilities (SAMHS 2015).

1.4   STATEMENT OF THE RESEARCH PROBLEM

The professional socialisation of students at the SAMHS Nursing College is compounded by simultaneous military socialisation within a teaching and learning environment inundated with military culture. Given the unique teaching and learning environment in which these students find themselves, it is difficult to determine whether the military nursing education environment nourishes the desirable professional attributes or whether it inhibits the development of these attributes. It is thus likely that factors implicit in the military organisational structure, culture and learning environment, implying the existence of a hidden curriculum, may influence the professional socialisation of these students.

1.5   THE RESEARCH QUESTION

What is the influence of the hidden curriculum on the professional socialisation of students in a military nursing context?

1.6   PURPOSE OF THE STUDY

The purpose of this study was to explore the nature of the hidden curriculum in a military teaching and learning environment, and to determine its influence on students' professional socialisation. Concepts derived from the qualitative data were used to develop a substantive model to create an awareness of the existence of a hidden curriculum, to guide role players through the impact of the hidden curriculum on students' professional socialisation and to help them to understand how their contribution could improve the outcome of the professional socialisation process.

1.7   OBJECTIVES

In order to achieve the purpose of the study, the following research objectives were formulated:

- To establish the existing knowledge, attitudes and perceptions of nurse educators and students with regard to military and nursing professionalism
- To explore and describe the nature of the hidden curriculum in a military teaching and learning environment and its influence on the professional socialisation of students
- To develop a substantive model to provide nurse educators and professional nurses with a frame of reference that would create an awareness of the existence of a hidden curriculum, to guide them through the impact of the hidden curriculum on students' professional socialisation and to help them to understand how their contribution could improve the outcome of the professional socialisation process of students

1.8   SIGNIFICANCE OF THE STUDY

Exploring the hidden curriculum in a military teaching and learning environment could allow nurse educators to acknowledge the subtle or not-so subtle messages that are not part of the intended curriculum and to help them understand the role played by the transmission of "tacit messages to students about values, attitudes and principles" (Kentli 2009:6).

As part of the theory-generating process of the grounded theory method, the development of a substantive model on the influences of the hidden curriculum in the military teaching and learning environment, and recommendations for its implementation could assist nurse educators and professional nurses to recognise its presence, and enhance their understanding both of the phenomenon and of its influence on the professional socialisation of students.

1.9   DEFINITIONS OF KEY CONCEPTS

The key terms and concepts are clarified below for the purpose of this study:

1.9.1 The hidden curriculum

The term *hidden curriculum* refers to a set of influences that functions at the level of organisational structure and culture. It refers to those unwritten, unofficial, and often

unintended lessons, values, perspectives, attitudes and principles that may be implicitly conveyed to students (Hafferty 1998:404). In this study the hidden curriculum referred to the elements unique to the military nursing context.

1.9.2 Professional socialisation

According to Chitty and Black (2011:131), *professional socialisation* refers to the process by which a person acquires the norms, attitudes, behaviours, skills, roles and values that enable her/him to form a professional identity. In this study, professional socialisation referred to the theoretical and clinical teaching processes involved in facilitating the development of professional military nurses.

1.9.3 Nurse educator

A *nurse educator* is a professional nurse who has undergone a programme of education at an approved education institution and is registered for an additional qualification in nursing education (SANC 1987). The nurse educators referred to in this study were employed at the SAMHS Nursing College and were involved in the four-year Diploma in Nursing Science (General, Community and Psychiatry) and Midwifery in accordance with the stipulations of Regulation 425 of 1985 (SANC 1985). In this study, students referred to nurse educators as lecturers during the focus-group interviews.

1.9.4 Student nurse

Student nurse denotes a person who has successfully completed 12 years of schooling and meets the entrance requirements of an approved nursing school (Kotzé 2008:187). For the purpose of this study, a student nurse referred to a person who is studying at the SAMHS Nursing College and who was, at the time of this study, registered as a student at the SANC for the four-year Diploma in Nursing Science (General, Community and Psychiatry) and Midwifery in accordance with the stipulations of Regulation 425 of 1985 (SANC 1985). In this study, the term *student* was used.

1.9.5 Healthcare professional

A healthcare professional is "any person registered in terms of the applicable Act which governs the functioning of any of the Councils that form part of the Forum of Statutory Health Councils" (HPCSA 2008:2). For the purpose of this study, the term was used in referring to doctors and ancillary healthcare professionals registered with the Health Professions Council of South Africa

1.9.6 Theoretical learning environment

The *theoretical learning environment* is the accredited physical location at which teaching and learning facilities and resources are available for the delivery of teaching and learning to students (SANC 2013:3). For the purpose of this study, the theoretical learning environment included both the classroom setting and the broader training environment of the SAMHS Nursing College at which teaching and learning took place. In some instances, the SAMHS Nursing College was simply referred to as *the College*.

1.9.7 Clinical learning environment

Billings and Halstead (2009:286) define the clinical learning environment as a place where students learn to apply (in practice) their synthesised theoretical knowledge. The SANC (2013:2) uses the term *clinical facility* when referring to a place that offers a continuum of services to promote health and provide care to individuals and groups and which is also used to teach learners. In this study, the term *clinical learning environment* was used when referring both to the selected Military Hospital in South Africa and also to governmental facilities that provide students clinical learning opportunities.

1.9.8 Teaching and learning environment

Students of the SAMHS Nursing College receive nursing training in a variety of settings. *The teaching and learning environment* as applied to this study encompassed the overarching milieu in which healthcare professionals, nurse educators and students interacted, inclusive, that is, of the clinical and theoretical learning environments in military clinical facilities and also in civilian clinical facilities.

1.9.9 Professional nurse

A *professional nurse* is a person registered under section 31(1) of the Nursing Act, no. 33 of 2005 (South Africa 2005:s 31) so as to practise nursing or midwifery. In this study, nurse educators and students often referred to professional nurses as registered nurses.

1.9.10 Professional soldier

A *professional soldier* is a person who chose the military as a career and refers to a member of the Defence Force who is subjected to the military law of the country (South Africa 2002:s 1). In this study, the nurse educators and students are regarded as professional soldiers.

1.9.11 Nursing professionalism

Nursing professionalism is an inevitable, complex, varied, and dynamic process, characterised by the attribution of cognitive, attitudinal, and psychomotor skills (Ghadirian, Salsali & Cheraghi 2014:1). In this study, nursing professionalism refers to the attitudes, values, behaviours and relationships desirable of a professional nurse.

1.9.12 Military professionalism

Military professionalism in South Africa comprises the maintenance of technical, managerial and organisational skills to enable the military to perform its functions efficiently and effectively (Vrey, Esterhuyse & Mandrup 2013:224). In this study, military professionalisation focuses on the development of competencies that define a professional soldier.

1.10   RESEARCH DESIGN AND METHODS

As is evident from the background to this study, little has been documented on the role of the hidden curriculum in nursing education and even less on its role in the context of the military environment. Qualitative studies often apply an emergent design that evolves as the study progresses and which is a reflection of the researcher's desire to

base the research on the realities and viewpoints of the participants who are being studied (Polit & Beck 2014:266). Based on the general premises of the constructivist paradigm, the grounded theory research method was chosen not only to determine the nature of the phenomenon under scrutiny, namely the elements of the hidden curriculum in a military teaching and learning environment, but also to analyse, explore and describe their meanings, in this case, the effect of the hidden curriculum on the professional socialisation of students (Polit & Beck 2014:275). By applying the grounded theory research method, this study not only described and explored the unknown aspects of the hidden curriculum in a military teaching and learning environment but it also sought to explain and understand the various concepts related to the research problem, the research question and the research objectives (Birks & Mills 2011:16). The application of the theory-generation process of the grounded theory method further led to the development of a substantive model to assist nurse educators and professional nurses to recognise the presence of the hidden curriculum, to enhance their own understanding of both the phenomenon and its influence on the professional socialisation of students and to help them to understand how their contribution could improve the outcome of the professional socialisation process.

Table 1.1 provides a summary of the research methods that are to be discussed in detail in Chapter 2.

TABLE 1.1: SUMMARY OF THE RESEARCH METHODS

Phase	Objective	Population/data source	Sampling method	Data collection	Data analysis	Rigour
Phase 1	Establish the existing knowledge, attitudes and perceptions with regard to military and nursing professionalism	Sample A: registered nurse educators involved in the four-year integrated nursing programme at the SAMHS Nursing College (Main Campus)	Purposive sampling	Focus groups	Charmaz's data-analysis approach Theoretical sampling	Credibility Dependability Confirmability Transferability Authenticity
		Sample B: Students involved in the four-year integrated nursing programme at the SAMHS Nursing College (Main Campus)	Volunteer sampling			
	Explore and describe the nature and significance of the hidden curriculum in a military teaching and learning environment	Sample A: registered nurse educators involved in the four-year integrated nursing programme at the SAMHS	Purposive sampling	Focus groups	Charmaz's data-analysis approach Theoretical sampling	Credibility Dependability Confirmability Transferability Authenticity

Phase	Objective	Population/data source	Sampling method	Data collection	Data analysis	Rigour
	and its influence on the professional socialisation of students	Nursing College (Main Campus)				
		Sample B: Students registered at the SAMHS Nursing College (Main Campus) for the four-year integrated nursing programme	Volunteer sampling	Focus-group narratives		
Phase 2	Integrate the findings in respect of samples A and B	Findings of Phase 1		Integration of data from phases 1 and 2	Charmaz's data-analysis approach Theoretical sampling	Credibility Dependability Confirmability Transferability Authenticity
Phase 3	Develop a substantive model	Data from Phase 2 Experts	Purposive sampling	Theoretical sampling	Theoretical sampling Deductive reasoning	Credibility Originality Resonance Usefulness

1.11   RESEARCH SETTING

Stemming from the research question and the subsequent rationale for conducting qualitative research with a view to understanding human experience from the participants' perspective and to explore and describe the underlying meaning of their experiences (Streubert & Carpenter 2011:22), the setting of this study was the natural setting in which the phenomenon in question occurred. In an effort to achieve the objectives set out for this study, the research setting thus comprised the SAMHS Nursing College (Main Campus), the selected Military Hospital and various governmental health facilities at which students are placed for clinical experience. Section 1.3 described the contextual background of the study in order to explain the research setting. The research setting of this study was contextually unique in that it is not only situated in a military environment but both the students and the nurse educators are employed by the Defence Force. Although the research setting is contextually specific, the findings and also the ultimate substantive model will be transferable to comparable settings.

1.12   ETHICAL CONSIDERATIONS

To ensure that the research was based on mutual trust, acceptance, cooperation, promises, well-accepted conventions and expectations (De Vos et al 2011:113), the researcher adhered to the three primary ethical principles – as articulated in the

Belmont report (Polit & Beck 2016:139) – on which research must be based: beneficence, respect for human dignity and justice. A detailed discussion of the ethical considerations follows in Chapter 2. The study was approved by the Department of Health Studies Higher Degrees Committee at University of South Africa (UNISA) (see Annexure A) and the 1 Military Hospital Research Ethics Committee (see Annexure F).

1.13   TRUSTWORTHINESS

Rigour was ensured by the consistent application of the principles of trustworthiness – namely credibility, transferability, confirmability, dependability and authenticity – as described by Lincoln and Guba (1985,1999 in De Vos et al 2011:419-422), and also by Creswell (2014:201). The strategies employed to enhance trustworthiness are discussed in Chapter 2.

1.14   SCOPE OF THE STUDY

The study evolves as follows:

Chapter 1:   Orientation to the study

This chapter introduces the background to the research problem and the problem statement is explicated. The contextual background is described to familiarise the reader with the research setting. It further describes the research purpose, the research objectives, the research question and the significance of the study. This is followed by a clarification of the key concepts and a brief description of the research design and methods, and of the research setting. After touching on the aspects of ethical considerations and trustworthiness, the chapter concludes with the scope of the study.

Chapter 2:   Research design and methodology

This chapter comprises a detailed exposition of the research design and the methods employed. Included are the theoretical foundation of the study and aspects related to the research design, specifically the population, sampling, data collection, data analysis, measures to ensure trustworthiness and ethical considerations.

Chapter 3: Findings of Phase 1: Sample A

Chapter 3 presents the research findings of the data collected from Sample A in Phase 1.

Chapter 4: Findings of Phase 1: Sample B

This chapter presents the research findings of the data collected from Sample B in Phase 1.

Chapter 5: Findings of Phase 2 and literature control

This chapter elaborates on and interprets the integrated research findings from samples A and B collected in Phase 1. The significance of the findings is then discussed in the context of the relevant existing literature. The chapter continues by describing the hidden elements in the military teaching and learning environment – extracted from the data collected in the course of Phase 1 – and how these elements influence the professional socialisation of students.

Chapter 6: Phase 3 – model development, validation and refinement

Chapter 6 describes Phase 3 of the study, namely the process of developing the substantive model, the measures taken to validate the model and the alterations made to the substantive model. The final model is then presented.

Chapter 7: Conclusions, recommendations and limitations

This final chapter provides an overview of the study before turning to some concluding remarks, the recommendations and a discussion of the limitations encountered in the course of the study.

1.15   SUMMARY

This chapter provided an overview of the study by firstly situating professional socialisation within the domain of nursing training and, secondly, drawing attention to

the challenges of teaching professionalism. The researcher then alerted the reader to the existence of a hidden curriculum and explained how it relates to professional socialisation. Next, the unique military teaching and learning environment that serves as the contextual background to this study was outlined. The aforementioned discussion led to the identification of the research problem, and the formulation of the research question, the purpose and the objectives. It was emphasised that in achieving the stated purpose and objectives, this study could contribute by assisting nurse educators and professional nurses to recognise and acknowledge the presence of the hidden curriculum, to enhance their understanding both of the phenomenon and of its influence on the professional socialisation of students and to help them to understand how their contribution could improve the outcome of the professional socialisation process. The researcher next presented a brief explanation of the rationale for choosing the grounded theory method so as to achieve the purpose and objectives of this study and gave a summary of the research methods. The chapter concluded with an overview of ethical considerations, measures to ensure trustworthiness, the scope of the study and the structure of the thesis.

The next chapter will be devoted to the research design and the methods utilised in the study.

CHAPTER 2

RESEARCH METHODOLOGY

2.1   INTRODUCTION

Chapter 1 served as orientation to the study. The attributes of professionalism, the process of professional socialisation and the challenges of teaching professionalism were discussed. The researcher then dealt with the hidden curriculum and indicated how it relates to professional socialisation. The research setting was explicated by providing a historical overview of military nursing and education, and by describing the current organisational context of both SAMHS and the SAMHS Nursing College. This was followed by a discussion of the uniquely military teaching and learning environment with specific reference to military and nursing training.

The focus of this chapter, namely research methodology, comprises aspects such as the philosophical foundation of the study, the research paradigm, approach, design and methods (De Vos et al 2011:73-74; Polit & Beck 2014:51-52). Research methodology refers to the underlying sets of beliefs and principles that guide the researcher to choose one research approach over another (Birks & Mills 2011:4). A particular methodological framework is chosen because it is considered the best possible way to solve the research problem, answer the research question and generate the most accurate evidence (Brink et al 2012:199).

This chapter provides an exposition of the philosophical foundation of the study before turning to a discussion of the research design and the methods. The discussion includes references to the population, sampling, data collection, data analysis, ethical considerations and the measures aimed at ensuring trustworthiness.

2.2   PHILOSOPHICAL FOUNDATION OF THE STUDY

There is an inextricable link between the researcher's intentions, goals and philosophical assumptions, and the research in which she/he is engaged (Mack 2010:2). Grix (2004:57) cautions that people who want to conduct clear, precise research and evaluate the research of others need to understand the philosophical

underpinnings that inform their choice of research questions, methodology, methods and intentions. According to Brink et al (2012:26), philosophy is a worldview that represents the assumptions, values and beliefs about the nature of reality, knowledge and methods of obtaining knowledge. Creswell (2014:6) defines worldview as "a basic set of beliefs that guide action" and "a general philosophical orientation about the world and the nature of research that the researcher brings to the study". How a researcher answers basic philosophical questions will inform the research paradigm. The research paradigm will in turn dictate the research approach, design and methods. The main philosophical dimensions that distinguish research paradigms are ontology, epistemology, methodology, axiology and rhetoric. In the following section, each of these dimensions is discussed and applied to the study in order to justify the way in which the research was conducted.

2.2.1 Ontology

The term *ontology* is derived from the Greek word meaning *to be*. The philosophical question of ontology, according to Polit and Beck (2014:6-7), asks: "What is the nature of reality?" Ontology is defined as the study of "assumptions that are made about the nature of social reality, claims about what exists, what it looks like, what units make it up and how these units interact with each other" (Mack 2010:1). Scotland (2012:9) summarises the concept as the researcher's perception of how things really are and how things really work.

The ontological debate asks whether reality exists independent of human consciousness and experience or whether it exists within consciousness and only through experience (Levers 2013:2).

The former argument represents the realist ontology, a contemporary perception that reality exists independent of the human mind and behaviour. According to Killam (2013), realism is bound by natural laws, can be measured objectively and can be generalised so as to form the foundation for traditional science in which truth or fact is determined by scientific laws. She further states that realists believe that knowledge or truth is static – once it has been discovered, it does not change. Realists attempt to discover a single truth through reasoning rather than through mere observation because they believe that knowledge about reality is acquired in the form of a cause-effect

relationship in which only the results of causal forces can be observed rather than the causal forces themselves (Chen, Shek & Bu 2011:133). Critics of realism propose that it does not allow for human behaviour to be studied in depth and that it disregards feeling and mental constructions of reality (Killam 2013).

Relativist ontologists, on the other hand, according to Killam (2013), believe that reality is a subjective experience and that knowledge is contextual. She argues that the context cannot be separated from reality because it is the meaning attached to the experience that shapes what is true. The relativist stance postulates that instead of two people experiencing an external world differently, their worlds are indeed perceived as different. This multiple interpretation of experience creates multiple realities – as many different realities as there are people. The purpose of research from a relativist ontological perspective is therefore to attempt to understand the subjective experience of reality and multiple truths (Levers 2013:2). It can thus be concluded that relativists believe that there are numerous mental constructions of reality that evolve from culture and experience, that what is real or true is influenced by individual perceptions and that knowledge is contextual, dynamic and evolving (Killam 2013).

This study sought to determine whether implicit elements in the military teaching and learning environment tend to influence the professional socialisation of students. From a critical realist perspective, professional socialisation may be seen to be the result of causal forces, namely implicit elements in the military teaching and learning environment. The study did not however endeavour to observe the result of causal forces per se, but rather attempted to identify the causal forces by means of, inter alia, focus-group interviews. The study further attempted to gain an understanding not only of nurse educators' and students' perceptions regarding military and nursing professionalism, but also students' experiences of acquiring military and nursing professionalism. It was assumed that participants would attach their own meaning to and have their own individual interpretations of events, which would result in multiple perspectives – thus denoting a relativist ontology.

2.2.2 Epistemology

The term *epistemology* is derived from two Greek words meaning *knowledge* and *to understand* or *know* (Killam 2013). Epistemology sets out to determine the nature of

knowledge and also of the relationship between the inquirer and the phenomenon under scrutiny (Polit & Beck 2014:7). It is concerned with how knowledge can be created, acquired and communicated (Scotland 2012:9-10).

According to Levers (2013:3), there are two opposing epistemological stances, namely objectivism and subjectivism. Objectivism is the belief that truth and meaning reside within an object and that these are independent of human subjectivity (Levers 2013:3). Objectivists claim to remove all contextual factors, including human bias, to observe the phenomenon as it exists – thus independent of the human mind – in the quest to discover knowledge. This knowledge is universally applicable since the essence of the object does not change, regardless of who happens to be studying the object. From the objectivist epistemological standpoint, the purpose of knowledge is to explain, predict and control.

Subjectivism is the belief that knowledge is "always filtered through the lenses of language, gender, social class, race, and ethnicity" (Denzin & Lincoln 2005:21). Subjectivists acknowledge that observations are influenced by the observer and that the observer is influenced by the observed. Subjective research aims to develop understanding and increase sensitisation to ethical and moral issues.

The researcher's epistemological stance during this study was one of subjectivism because she engaged with the participants on a personal level during the focus-group interviews and because the participants provided views and experiences from their own personal frames of reference.

2.2.3 Methodology

Research methodology refers to the underlying sets of beliefs and principles that guide researchers to choose one research approach over another (Birks & Mills 2011:4). The choice of a particular methodological framework depends on whether it is considered the best possible way to solve the research problem, answer the research question and generate the most accurate evidence (Brink et al 2012:199). Research methodology comprises aspects such as the study population, sample, sampling and methods of data collection, analysis and dissemination (Brink et al 2012:200). The researcher considered a qualitative research approach and a grounded theory method to be the

most suitable means of determining the nature and significance of the hidden curriculum in a military teaching and learning environment, and also the influence of the hidden curriculum on the professional socialisation of students. The theory-generation process inherent in the grounded theory method was thought to be ideal to guide the development of a substantive model.

2.2.4 Axiology

The term *axiology* is derived from the Greek word meaning *to be strong* or *to be worthy* (Hiles 2008:53) and sets out to determine what is of value and what is worthwhile (Heron & Reason 1997:287). In research, axiology refers to what the researcher believes is valuable and ethical. Incorporating an axiological philosophy enables the researcher to identify the internal value systems that may influence perceptions, decisions and actions related to the study (Killam 2013). The qualitative researcher accepts the established codes of ethically sound practice but also strives to achieve a transparency of values. Heron and Reason (1997:287) advocate the idea of cooperative inquiry that offers a transparency of values. Cooperative inquiry promotes inquiry as being *with* people as opposed to being *about* people. Axiology also demands the application of process ethics that emphasises that codes of practice must be supported by open-minded vigilance in respect of ethical matters that might arise at any point during the research process (Hiles 2008:55).

With a view to reaching the objectives of this study, the researcher closely interacted with the participants. It was assumed that values and biases related to both the researcher and the participants would influence the research approach. Although subjectivity might have aided in terms of enhancing the depth of data generation, the researcher applied measures of bracketing to protect data integrity and applied the ethical principles as suggested by Creswell (2014:92-101), De Vos et al (2011:114-129), Grove, Burns and Gray (2014:100-126), and Polit and Beck (2014:80-95).

2.2.5 Rhetoric

Pigrum (2008:793) defines *rhetoric* as the "art of persuasion, of convincing the hearer or reader of a particular line of argumentation". He further explains that in order to make the study meaningful and to convey the results in a meaningful way, the researcher

needs to think about the kind of questions that will obtain rich data, how the data will be organised and augmented, and also the possibilities of representation in terms of style and articulation. To optimise the rhetoric in this study, the researcher gathered data qualitatively by means of focus-group interviews and narratives. The results were reported by means of detailed description and visually supplemented by a substantive model.

2.3   RESEARCH PARADIGM

The research approach is dictated by the research paradigm. According to Guba and Lincoln (2005:107), paradigms are basic belief systems based on ontological, epistemological, methodological and axiological assumptions. Brink et al (2012:26) draw on the definitions of Kuhn (1970) and Lauden (1995) to describe a paradigm as "a discipline's specific method of constructing reality" and "assumptions about the basic kinds of entities in the world, how these entities interact and the proper methods to use for constructing and testing theories of these entities". There are various research paradigms, each based on its own philosophical assumptions. Researchers' differing philosophical positions therefore often lead to different research approaches in respect of the same phenomenon (Grix 2004:64).

Numerous research paradigms have emerged from the literature. Authors such as Chen et al (2011:129-139), Creswell (2014:6-10), De Vos et al (2011:5-10), Gray (2013:16-28), Levers (2013:3-4), Mack (2010:6-10), Oktay (2012:22), Scotland (2012:10-14) and Wahyuni (2012:70) distinguish between the positivist, post-positivist, constructivist, pragmatic, interpretive and critical paradigms.

In alignment with the researcher's philosophical stance as outlined in Section 2.2, this study was approached from a constructivist point of view because constructivist studies are heavily focused on understanding the human experience as it is lived (Polit & Beck 2014:9). This study focused on the lived experiences of nurse educators and students in a military teaching and learning environment. Data collection and data analysis occurred simultaneously within the research setting and were influenced by the participants and the researcher, thereby generating data that were narrow and subjective. This approach however yielded findings grounded in the real-life experiences of the participants. The researcher acknowledged the uniqueness of each individual participant and also the

presence of an ever changing environment, placing emphasis on the dynamic, holistic and individual aspects of human life and attempting to capture these in their entirety within the context of those experiencing them. Data were collected by means of various methods including focus-group interviews and critical-incident narratives and analysed concurrently. These flexible, evolving procedures characteristic of Charmaz's constructivist grounded theory method, helped to capitalise on findings as they emerged and generated rich, in-depth information that assisted in clarifying the complicated phenomenon being studied. The inductive nature of data analysis of the grounded theory method further aided the researcher in developing a substantive model.

2.4 RESEARCH APPROACH

Earlier discussions on the philosophical foundations of this study alluded to the fact that a researcher's philosophical stance informs the choice of a particular research paradigm, which in turn dictates the research approach. The term *research approach* refers to the plans and procedures that are to be followed to solve the research problem and includes the research design and the specific methods of data collection, analysis and interpretation (Creswell 2014:11). A qualitative research approach was followed to determine the nature and the significance of the hidden curriculum in a military teaching and learning environment, and its influence on the professional socialisation of students. The decision to follow a qualitative research approach in this study was based on the researcher's personal philosophical views and also on the relevant characteristics of the approach as explained in the works of Patton (2002:40-41), Grove et al (2014:57) and Roller (2013:14-16).

Grove et al (2014:67) define qualitative research as a systematic, subjective approach used to describe life experiences and give them meaning. Qualitative research is characterised both by its regard for the uniqueness of the individual and its holistic approach to understanding human experience from the perspective of the persons involved (Grove et al 2014:67-77) and by exploring and describing the underlying meaning of the participants' experiences a natural setting (Streubert & Carpenter 2011:22).

In general, according to Grove et al (2014:67-77) and Streubert & Carpenter (2011:22) the qualitative research approach

- is flexible and adjustable, depending on what emerges during the data-collection process;
- often involves triangulation of data-collection strategies;
- strives to understand the whole;
- requires the researcher to become intensely involved with the participants; and
- makes use of ongoing data collection and analysis until data saturation is reached.

2.5   RESEARCH DESIGN

Being rooted in symbolic interactionism that focuses on social processes (Oktay 2012:10-11), grounded theory research is suited to the nature of this study, which investigated the influence of social interaction between nursing educators and students, and the interaction of students with both the military and the professional environment. The study moreover sought to gauge the influence of symbols emanating from the military structure and culture on the professional socialisation of students. By applying the grounded theory research method, this study explored and described the unknown phenomenon of the hidden curriculum in a military teaching and learning environment. It also sought to explain and understand the various concepts related to the research problem, question and objectives.

The researcher's ontological and epistemological assumptions led to the selection of Charmaz's (2006) version of grounded theory research because, philosophically, it is explicitly located within the constructivist paradigm. As discussed in Sections 2.2.1 and 2.2.2, it implies a relativist ontology and a subjective epistemology. The characteristics and principles of the constructivist grounded theory method and its application in this study are incorporated in the discussion on research methods.

2.5.1 Constructivist grounded theory method

Constructivist grounded theory method comprises systematic though flexible guidelines for collecting and analysing qualitative data so as to construct theories from the data (Charmaz 2014:1). The constructivist grounded theory method is an inductive approach

– a form of reasoning that begins with a large number of concepts that are then reduced, through assimilation and integration, into an explanatory theory (Birks & Mills 2011:11).

The constructivist grounded theory method offers a set of general principles, guidelines, strategies and exploratory procedures for data collection and analysis rather than rigid prescriptions. Several authors (Charmaz 2014:5-13; Oktay 2012:12-13) relate the modifications that grounded theory research has undergone since the original work of Glaser and Strauss (traditional grounded theory) was published in 1967, the most debated and significant having been Strauss and Corbin's 1990 version (evolved grounded theory) and Charmaz's 2006 version (constructivist grounded theory).

Despite there being various versions of grounded theory methods – which basically differ only in terms of philosophical assumptions – the principles and basic strategies employed by grounded theorists remain constant. According to Charmaz (2014:15), the following generic strategies of grounded theory research distinguish this method from other qualitative research methods:

- Data collection and analysis are conducted simultaneously.
- Actions and processes rather than themes and structures are analysed.
- Constant comparative analysis is used.
- New conceptual categories are developed by drawing from the data.
- Abstract analytic categories are developed through inductive, systematic data analysis.
- The emphasis is on theory construction rather than on the description or application of existing theories.
- The researcher engages in theoretical sampling.
- The researcher searches for variation in the emerging categories.
- Rather than cover a specific empirical topic, the researcher attempts to develop a category.

Streubert and Carpenter (2011:128) maintain that the grounded theory method entails the identification of theoretical connections among concepts with the aim of developing a theory that is grounded in the data and relevant to the substantive area. Thornberg and Charmaz (2012:41) define theory as "stating the relationships between abstract

concepts and [which] may aim for either explanation or understanding". Charmaz (2014:241-242) acknowledges that the term *theory* is ambiguous and that many grounded theorists appropriate unfounded theories to themselves. Streubert and Carpenter (2011:129) cite Corbin and Strauss (2008) who note that "not everyone wants to develop theory" and that "theory seems to have fallen out of fashion, being replaced by descriptions of lied experiences and narrative stories". What remains important is the discovery of concepts and themes from the data and the balanced conceptualisation and description of these.

The inductive approach used in grounded theory facilitated the researcher's decision to develop a substantive model as the outcome of this study. A model is an abstraction of reality, implying that it mirrors the patterns and relationships observed in the data. A model further aims to simplify the complexity related to the quantity of data describing the phenomenon under scrutiny and it allows the range of findings to be combined into a coherent whole (Baber, Harris & Stanton 2012:7-8). A model, according to Polit and Beck (2014:133), provides a conceptual perspective regarding interrelated phenomena, but is more loosely structured than theories.

Birks and Mills (2011:156) describe *substantive* as research being conducted for the purpose of understanding a tangible phenomenon in a clearly defined situation. A substantive model is thus suited for the purpose of this study that relates to a specific phenomenon (the hidden curriculum) in a specific context (the military teaching and learning environment) of a clearly identified group of individuals (military nurse educators and students). A substantive model, although pertaining to a specific context, is considered transferable, rather than generalisable, in the sense that elements of the context can be transferred to contexts with similar characteristics to the context under study (Gasson 2009:34-56).

2.5.2 Symbolic interactionism

Symbolic interactionism is a sociological perspective based on the premise that social symbols, such as language and communication, play a crucial role in how meaning and action are derived from interactions. According to Charmaz (2014:262), symbolic interactionists believe that people act and interact by means of symbols such as words and body language. A social situation only acquires meaning from the way in which

people define and interpret what is happening. This perspective implies that interaction – whether with other human beings, objects or environmental factors – the interpretation of such interaction, the meanings attached to it and people's reaction or response to it, are reciprocal processes (see Figure 2.1).

The potential for studying the influence of the hidden curriculum on the professional socialisation in a military teaching and learning environment is based on the premise, rooted in symbolic interactionism, that nurse educators and students react and respond to symbols present in their environment and then construct meaning from their experiences through the interpretation of symbolic communication (Munhall 2012:288). The application of symbolic interactionism to this study is described in Chapter 6.
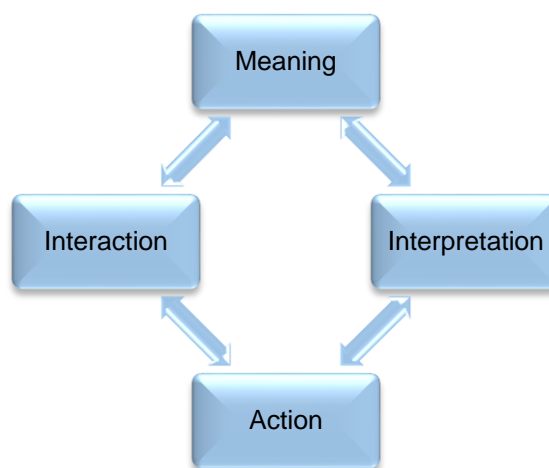
Figure 2.1: Symbolic interactionism
(Munhall 2012:288)

2.6   RESEARCH METHODS

This section on the research methods gives a detailed exposition of how the study was executed. Figure 2.2 provides an overview of the data-collection and -analysis processes.

2.6.1 Population

A population refers to the entire set of individuals or objects having some common characteristics who are the focus of any given research or who are of interest to the researcher (Burns & Grove 2011:290; Polit & Beck 2014:387). With a view to

determining the influence of the hidden curriculum on the professional socialisation of students in a military nursing teaching and learning environment, the population for this study included all military nurse educators and military nursing students. The population was narrowed down to a target population comprising all military nurse educators and military students in the SAMHS. Given the organisational complexity and geographical location of the SAMHS Nursing College, its campuses and the three military hospitals in South Africa, the accessible population was of necessity narrowed down to the nurse educators and students of the SAMHS Nursing College Main Campus in Pretoria.
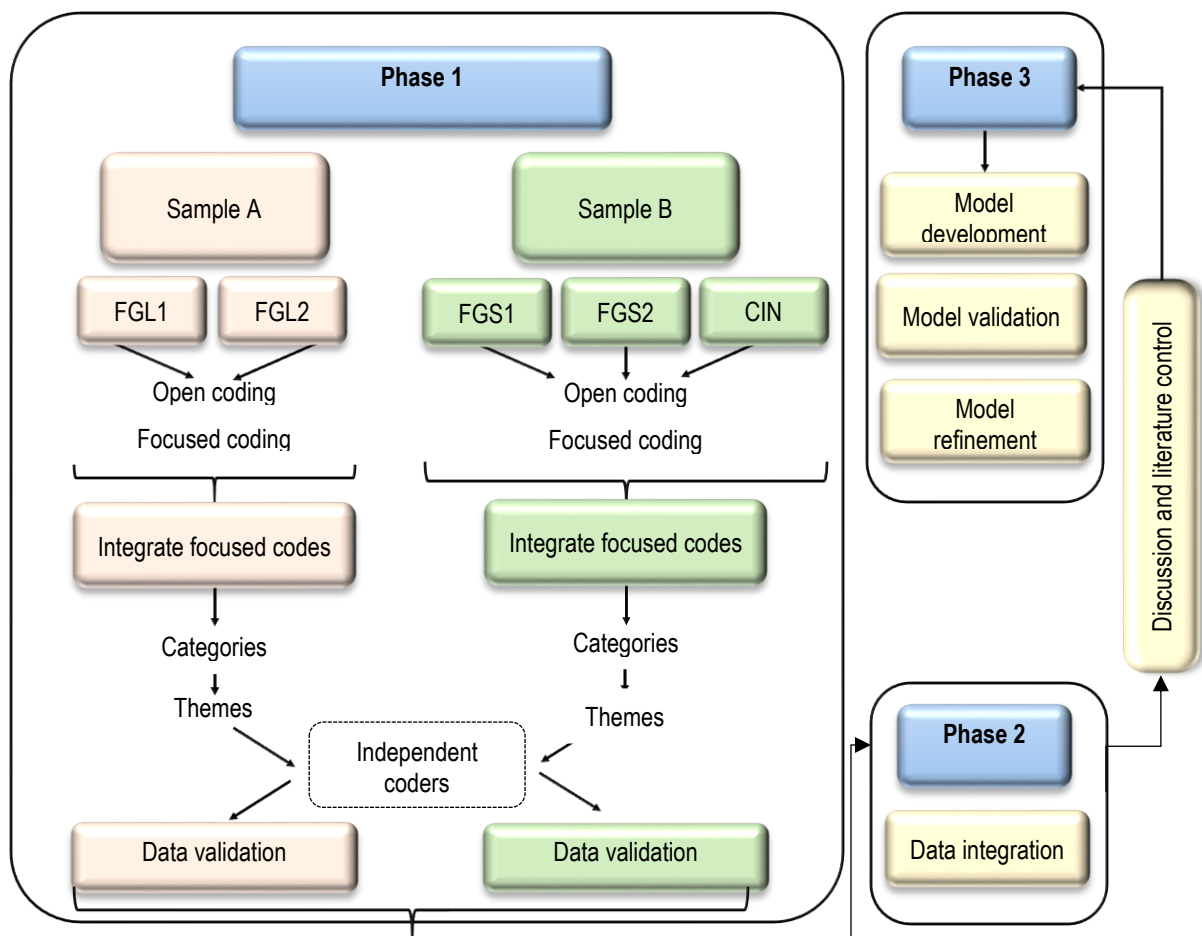
Figure 2.2: Overview of the data-collection and -analysis processes

The study population for Phase 1 was composed of two populations, namely Population A, comprising 46 nurse educators and Population B, comprising 223 students registered for the four-year Integrated Nursing Programme at the SAMHS Nursing College Main Campus (SAMHS 2016b).

2.6.2 Sample

A sample is a portion of the population, selected by means of a sampling process designed to represent the entire population to participate in the study (Polit & Beck 2014:391). The goal of sampling in grounded theory is to select participants who can best contribute to the evolving theory (Polit & Beck 2014:287) and, in the case of this study, to the development of a substantive model.

2.6.2.1 *Sampling frame*

The sampling frame, a comprehensive list of all the sampling elements used to determine the sample (Polit & Beck 2014:180, 391), was obtained from the SAMHS Nursing College (Main Campus) in the form of lists of the names of nurse educators and the class lists of students.

2.6.2.2 *Sampling approach*

Given the qualitative nature of the study and the need – rooted in grounded theory research – to obtain rich information that is relevant to the research question and the objectives, it was vital to heed Spradley's injunction (Bryant & Charmaz 2012:231) that it is necessary to locate "excellent participants to obtain excellent data". An excellent participant is one who has been through, observed or is experiencing the phenomenon under investigation, is willing to participate, has the time to share the necessary information, is reflective and able to communicate articulately. For these reasons, the researcher employed a non-probability sampling approach to select the study participants. Although often criticised for being biased, non-probability sampling allowed the researcher to judge and select those participants who were most likely to add the greatest value to the study (Polit & Beck 2014:178-180). Another criticism levelled against non-probability sampling, one highlighted by Brink et al (2012:139), is that this sampling method does not contribute to the generalisation of the findings. Because of the unique context of this study, the researcher was however more interested in the potential of the findings to be transferred to other contexts than in their generalisability.

2.6.2.3 Sampling technique

Non-probability sampling lends itself to a variety of sampling techniques, for example, purposive sampling, deviant case sampling, convenience sampling and sequential sampling (Brink et al 2012:140-142; Bryant & Charmaz 2012:235-241; De Vos et al 2011:392-394; Polit & Beck 2014:178-180). Sampling techniques must be targeted, efficient and purposeful. Participants were included in the study according to their knowledge, experience and the nature of the information that was required. The nature of the required knowledge depended on the categories that emerged, the level of data saturation and the need to verify categories. This implied that sampling varied according to the stage of the inquiry. Theoretical sampling, although regarded as an integrative process throughout data analysis, is also considered a sampling technique. Theoretical sampling involves the seeking of pertinent data to refine categories in themes (Charmaz 2014:193). This sampling process was explained in section 2.6.4.10.

2.6.2.3.1 Phase 1: Sample A

For Phase 1, a sample from Population A (42 females and two males) was selected by means of purposive sampling. Purposive sampling ensures a sample that contains the characteristics, experiences, knowledge and insight that best serve the purpose of the study (De Vos et al 2011:392). The eligibility criteria for Sample A were being a nurse educator registered with the South African Nursing Council as a nurse educator and having at least three years' experience as educator at the SAMHS Nursing College. There were 23 nurse educators who met the criteria. They were provided with a written invitation to participate in the study. The invitation contained information regarding the study and also a consent form (see Annexure G). The nurse educators were each requested to complete the consent form and then to return it to the researcher if they were willing to participate in the study. Of the 23 nurse educators who were invited, 15 (13 females and 2 males) consented to participate.

2.6.2.3.2 Phase 1: Sample B

For Phase 1, the sample from Population B (116 females and 107 males) was obtained through convenience sampling, also called volunteer sampling (Polit & Beck 2014:284). According to Silverman (De Vos et al 2012:394), volunteer sampling works well when

the participants know one another and can thus encourage one another to become part of the study. De Vos et al (2011:394) also indicate that people who volunteer to participate in a study are generally more motivated. The eligibility criteria for Sample B were a student registered with the SANC for the four-year Integrated Nursing Programme and in the fourth year of training. The researcher specifically decided to include student nurses in the fourth year of training because of the military and nursing experience they would have gained in the course of their training and the considerable exposure they would have had to the military teaching and learning environments. The researcher invited the entire group of 56 (30 females and 26 males) students to participate. The students were invited to attend a briefing on the nature of the study and on what their involvement would entail. The 12 (7 females and 5 males) students who subsequently volunteered to participate were each requested to sign a consent form (see Annexure H). Six of the participants were chosen based on their availability to attend the first scheduled focus group and were labelled FGS-1.

2.6.2.3.3   Phase 3

During Phase 3, the researcher used purposive sampling to engage experts in each of the fields of nursing education, military nursing, model development, student development, and military culture and strategy to participate in the evaluation of the model. The participants were each purposefully selected based on their fields of expertise. Each potential participant received an invitation to participate in the evaluation of the model, an overview of the study and the model, and also the tool to be utilised for the evaluation. Of the 15 experts who were approached, 11 provided feedback.

2.6.2.4   Sample size

The sample size in grounded theory research depends on the initial and emergent research questions, how the study was conducted and how data analysis was constructed (Charmaz 2014:108). Because of the process of constant comparative analysis, Birks and Mills (2011:70) argue that it is not possible to know from the outset how many participants or data sources the researcher will use in the study. Since the aim of data collection in grounded theory research is to reach theoretical saturation – that is, when no new concepts or codes emerge from the data – theoretical sampling

could be applied (Charmaz 2014:193). Theoretical sampling is a form of sampling that is unique to grounded theory research and it serves to assist in the process of refining the categories and filling the voids in the data. This form of sampling does not necessarily imply an increase in the original sample size. The researcher could use other sources of data, for example, documents, or return to the same sample or situation for more information (Birks and Mills 2011:70).

The researcher initially planned to conduct two focus-group interviews, one with each sample, but selected more participants, should the need for more focus-group interviews arise.

2.6.3 Data collection

Birks and Mills (2011:17) propose that, depending on the role of the researcher in grounded theory research, one should distinguish between data generation and data collection. They suggest that during data generation, researchers are more involved in or they directly engage with the data source. During data collection however the researcher has very little influence over the source of the data. Glaser and Strauss (1967:9) argue that in grounded theory research, data collection and data analysis are not treated as two separate processes but rather as one simultaneous, ongoing and cyclical process. This is the case because of the emerging nature of the research, the need to verify findings and the need to saturate the data to the point beyond which no more new concepts or insights materialise.

The important point regarding data collection and analysis in grounded theory research is that the process must make allowance for continuous incorporation of the techniques of constant comparison, theoretical sampling and theoretical saturation (Oktay 2012:49).

In this study, data were collected by means of four focus-group interviews, two with educators and two with students. The focus groups consisted of 15 educators and 12 students respectively. Further data were collected through critical incident narratives by the students. Of the 12 participating students, nine returned their narratives.

2.6.3.1   Data triangulation

According to Polit and Beck (2014:326), *data triangulation* is the use of multiple referents to help capture a more complete, contextualised picture of the phenomenon being investigated. Data triangulation involves the use of multiple data sources to aid in the validation of conclusions. In this study, the researcher applied three forms of triangulation, namely (1) space triangulation, by collecting data on the same phenomenon from different sites (the theoretical learning environment, the clinical learning environment and the military environment); (2) data-source triangulation, by collecting data from different groups of people (nurse educators and students); and (3) method triangulation, by collecting data by means of focus-group interviews and critical-incident narratives. The researcher also used literature integration by conducting a literature control. The purpose of the literature control was to integrate existing literature, to validate or refute the findings, to gain a better understanding of the findings and to determine how other researchers have conceptualised and explained similar findings.

2.6.3.2   Focus-group interviews

During Phase 1, the researcher employed focus-group interviews to address the research objectives. The focus-group interviews entailed the collection of data through an unstructured group-interview process. This data-collection method is useful in terms of obtaining perceptions on a defined area of interest in a conducive, non-threatening environment and represents a means of better understanding how people think or feel about an issue (De Vos et al 2011:360). Focus-group interviews have the potential to generate concentrated quantities of data specifically pertaining to the phenomenon being studied. This is ascribable to the spontaneous exchange of ideas, thoughts and attitudes stimulated by the secure setting, group dynamics and interactions (De Vos et al 2011:373-374). This study had a two-fold aim. On the one hand, the researcher endeavoured to elicit the existing knowledge, attitudes and perceptions of nurse educators and students with regard to military and nursing professionalism. On the other, she aimed to explore the nature of the hidden curriculum in a military teaching and learning environment with a view to identifying the elements of the hidden curriculum present in the military teaching and learning environment. This was done by posing a central question, which was followed by probing questions. The rationale for

this approach was to allow the participants to talk, act and write freely without due influence from the researcher (Polit & Beck 2014:290).

2.6.3.2.1   Pre-test

The term *pre-test* refers to either a so-called feasibility study or a trial run that is done in preparation of the major study (Polit & Beck 2014:388) or to the pre-testing of a research instrument (De Vos et al 2011:394-396).

The researcher conducted a trial focus-group interview so as to identify potential practical problems, to determine whether additional resources – for example, additional tables and chairs, light or air-conditioning – might be needed, to determine whether the focus-group guide would be adequate in terms of stimulating appropriate responses from the participants and to test her interviewing skills. Four nurse educators who met the inclusion criteria and were available at the time were requested to participate in the trial focus-group interview. Each participant was provided with the participant information letter and, once they had agreed to participate, requested to sign the informed consent form.

The trial focus-group interview was conducted in the same venue identified for the actual focus-group interviews to determine its suitability and conduciveness. The researcher welcomed the participants, explained the purpose of the focus-group interview and the procedure that was to be followed, and stipulated some group norms as indicted in Box 2.1.

BOX 2.1: FOCUS-GROUP INTERVIEW GROUP NORMS

- YOU must do the talking. Full participation is requested.
- One person at a time
- There are no right or wrong answers. Divergent views are welcome.
- Your own personal views are important.
- Respect one another's opinions.
- What is said in here stays in here – confidentiality is key.
- Stick to the topic.
- Keep it informal and interactive.

After the topic had been introduced, the researcher elicited a discussion about the nurse educators' perceptions regarding military and vocational professionalism and the current strategies they use to instil military and vocational professionalism in students.

The trial focus-group interview was audio-recorded to ensure that the digital recorder would be used correctly in the actual focus-group interview and also to assess the researcher's interview skills. After listening to and reflecting on the audio recording, the researcher realised that, in an effort to elicit responses from the participants, instead of probing questions, structured questions had been asked. Pre-testing the focus-group interview therefore reinforced the importance of posing an initial, carefully designed central question and following this with probing questions, if necessary, with a view to maintaining the unstructured format of the focus-group interview. The questions posed during the pre-test focus-group interview served to elicit very formal, patterned responses from the participants instead of a more free-flowing discussion. Pre-testing once again emphasised the value of making use of a co-facilitator to assist with field notes. The researcher also realised that the venue was not altogether suitable because it was located within the participants' working/learning environment, which could supress their spontaneity. The venue was also rather noisy and uncomfortable in terms of seating and temperature control. As a result, the researcher sought an alternative venue that was first inspected. The new venue was further removed from the participants' working environment but not so far away as to make it difficult to reach. As the venue of choice was situated in a library, it was very quiet and the room had luxurious chairs and temperature control.

To avoid the risk of data contamination, none of the participants in the pilot focus-group interview were included in the actual study nor were any of this data included in the main findings. The outcomes of the pre-test with the nurse educators were also applicable to the students.

2.6.3.2.2 Conducting the focus-group interviews

Sample A was recruited by means of purposive sampling. The nurse educators who consented to participate in the study were provided with a few possible dates and they had to indicate which of the dates would suit them best. The researcher then selected the date that suited most of the participants and reserved the venue for that date.

Volunteer sampling was used for the recruitment of Sample B. For the focus-group interviews, two dates were agreed upon that would not interfere with the students' academic programme. It was left to the participants themselves to decide which date would suit them best.

A day or two before each of the scheduled focus-group interviews, the researcher confirmed the availability of each participant and also confirmed whether they knew the exact location of the venue and whether they would need transport. To ensure her availability, these dates were also communicated to the co-facilitator.

At the beginning of each focus-group interview, participants were welcomed by the researcher and introduced to the co-facilitator. Each participant was then provided with a copy of the signed consent form and the importance of confidentiality and anonymity was re-emphasised. The researcher together with the participants, established the group norms to ensure that there would be optimal participation, mutual respect, the least possible disturbance and that the group would remain focused on the topic (Box 2.1). Participants were each given a name card and a pen with which to indicate how they would prefer to be addressed during the focus-group interview. This exercise also served as an ice-breaker because most of the chosen names elicited some form of comment and humour. The researcher then proceeded to introduce the main topic, namely the hidden curriculum, which was followed by the opening statement. For Sample A, the opening statement was: "*Let us hear your views, thoughts, feelings, and experiences regarding this unique military teaching and learning environment and the influence it may have on the professional socialisation of our students.*" For Sample B, the opening statement was: "*Let us talk about how you experience your military and nursing training in this unique military environment and the effect thereof on your socialisation as a professional nurse.*" The co-facilitator, a civilian, also skilfully provided focus to the discussion by asking some probing and clarifying questions regarding military-unique terminology and processes. The focus-group interviews were recorded by means of a digital voice recorder and the co-facilitator assisted with the taking of field notes. The average duration of the focus-group interviews was about two hours. On each of the four occasions, the discussions seemed only to gain momentum towards the end and the researcher found it difficult to terminate the focus-group interviews in the fear that some valuable inputs would be missed.

2.6.3.3 Critical-incident narratives

The second data-collection method to be used by the researcher in Phase 1 (Sample B) was critical-incident narratives. Only the participating students were requested to write the critical incident narratives, since the researcher wished to explore their experiences of military and nursing training in a unique military environment in order to determine the significance of the hidden curriculum and its influence on their professional socialisation. Polit and Beck (2014:378) define the critical-incident technique as a method of obtaining data from participants by in-depth exploration of specific incidents and behaviours related to the topic under scrutiny.

When Sample B was selected, the participants were each provided with a notebook and broad guidelines to describe any incidents related either to their theoretical or to their clinical learning experiences, to reflect on the thoughts and the feelings provoked by the incident and to discuss how the incident may have influenced them professionally. The notebooks were unmarked and the participants were requested not to identify themselves in any way. They were however assured that any identifying reference would be omitted from both the transcripts and the report. The participants were given six months for this exercise and returned their notebooks to the researcher in person. Nine out of the 12 participating students returned their notebooks. The researcher scanned the content of each notebook and allocated only a code and a number to the file, for example CIN–1. The notebooks were then sealed in an envelope and the scanned copies sent to a transcriber to be typed up in MS Word format.

The data-collection process resulted in two separate data sets. The first data set comprised the focus-group interviews with nurse educators (Sample A). The second data set included both focus-group interviews with students and their critical-incident narratives (Sample B). For easy reference during the data-analysis process, the data sets were labelled as follows:

- Data set 1:
  - FGL1 – First focus-group interview with nurse educators
  - FGL2 – Second focus-group interview with nurse educators
- Data set 2:
  - FGS1 – First focus-group interview with students

- o FGS2 – Second focus-group interview with students
- o CIN – Critical-incident narratives by students

2.6.3.4 Data saturation

The term *data saturation* refers to the repetition of concepts by data sources, implying that no new information is forthcoming from additional samples (Brink et al 2012:144; Polit & Beck 2014:286). Wiener (2007 in Charmaz 2014:214) however states that saturation may also be based on judgement. The researcher thus used her own judgement and also theoretical sensitivity to determine when saturation was reached. After the initial focus-group interview with Sample A, the researcher decided to conduct a second focus-group interview since, even with probing, the researcher was not satisfied that the data were adequate. It was only during the second focus-group interview with Sample A that some new concepts emerged and others started re-occurring. Signs of data saturation were already evident during the initial focus-group interview with Sample B because the participants were starting to repeat themselves towards the end of the session. The researcher nonetheless decided to continue with a second focus-group interview with Sample B to confirm that data saturation had indeed been reached. Although the researcher initially planned for two focus-group interviews with each sample, the option to continue with a third focus-group interview was planned for, should the need arise. Analysis of the critical-incident narratives only confirmed what had already been found during the focus-group interviews.

2.6.4 Data analysis

Data analysis involves the transformation of data into meaningful findings by means of a process that involves reducing, sifting, sorting, synthesising and interpreting data (De Vos et al 2011:397). Qualitative research concentrates on the study of human behaviour in natural settings, thereby uncovering the richness and complexity of social reality. This requires the application of multiple perspectives and practices in the analysis of qualitative data that are often interconnected, complementary and overlapping (Miles, Huberman & Saldana 2013:36-37). A dynamic aspect of qualitative research is thus the variety of data-analysis approaches that may be applied (Kodish & Gittelsohn 2011:52). By looking at qualitative data from different perspectives and applying a variety of techniques, it is thus possible to highlight different aspects of the same set of data.

Although there is no one-size-fits-all approach to data analysis in qualitative research, the method used needs to be systematic, disciplined and transparent (Punch & Oancea 2014:219-220).

In keeping with the constructivist paradigm adopted for this study, Charmaz's (2014:109-136) approach to data analysis was applied. Her approach mirrors that of Glaser and Strauss's (1967) original methods of analysis with the key difference being the prominence of theoretical sensitivity, reflexivity and constant comparison throughout the study. Constructivist grounded theory offers flexibility in the methods employed to analyse data by allowing the researcher to adopt an open, flexible, and therefore emergent approach to the data, this facilitating fresh insights into the phenomenon being studied (Lawrence & Tar 2013:29). Theoretical sensitivity, intuiting, reflexivity, memoing, constant comparison and theoretical sampling form an integral part of data analysis, and were continuously applied throughout the process. Although the steps in Figure 2.3 are presented in a chronological order, they were applied in a non-linear, integrative manner throughout the data-collection and -analysis processes.
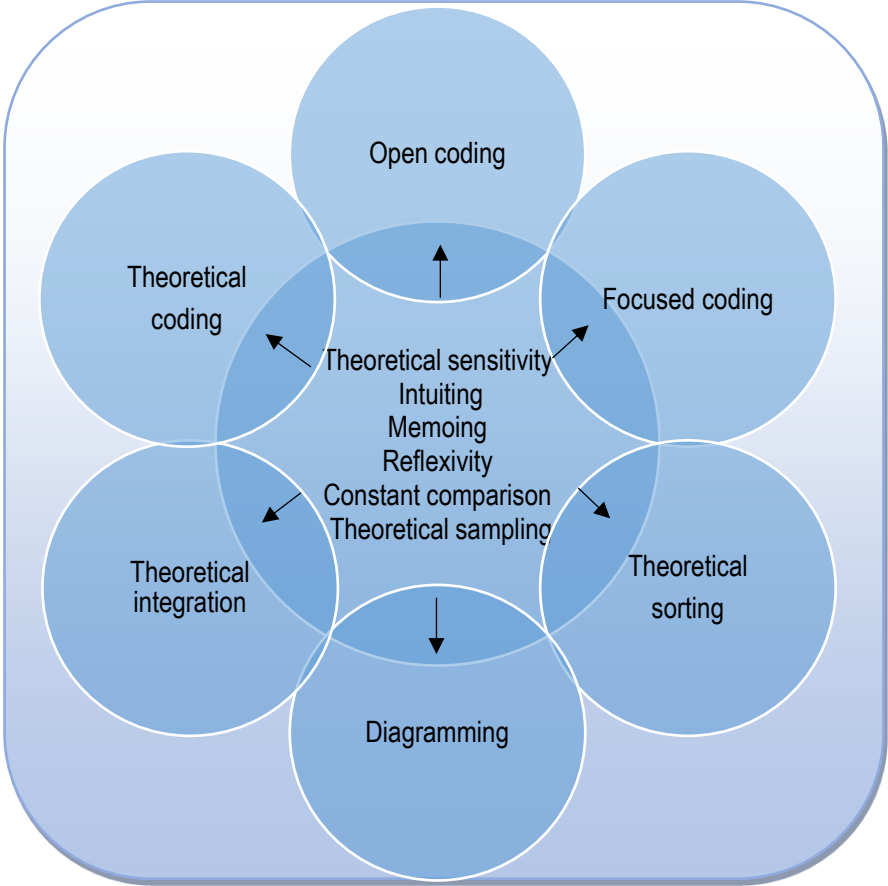
Figure 2.3: Charmaz's data-analysis approach
(Charmaz's 2014:109-136)

Initial data analysis commenced directly after each focus-group interview when the researcher and co-facilitator discussed the main concepts that had been elicited and some gaps had been identified. The approach for the next focus-group interview was then adapted accordingly. This process formed part of constant comparative analysis and theoretical sampling. Field notes taken during the focus-group interviews were also discussed and added to the raw data. This aided in finalising the themes.

The audio recording of each focus-group interview was labelled and submitted for transcription immediately after the focus-group interview. As soon as transcripts had been received, the researcher commenced with organising and preparing the data for coding. This involved formatting each of the transcripts in an MS Word document and the conversion of the text into a table in which a separate row was assigned to each response. Columns were then added for each subsequent step in the data-analysis process. The researcher proceeded to clean the data by listening to the audio recording while reading through the transcript. Whenever the transcriber had found the recording to be inaudible or had misheard what had been said, the researcher rectified these. She also replaced all references to the names of persons and institutions with pseudonyms or shaded these out. In the analysis of the critical-incident narratives, the same procedure was followed as in the focus-group interviews after the written documents had been typed up in MS Word format. The researcher preferred to do the data analysis manually instead of making use of software programmes such as ATLAS.ti or NVivo, as it allowed the researcher to become more emerged in the data.

2.6.4.1 Open coding

Open coding is the first step in data analysis in grounded theory research as recommended by Charmaz (2014:116-120). This commenced as soon as data were collected. Open coding enabled the researcher to remain open to what participants had perceived to be important. Transcripts, field notes and narratives were carefully scrutinised to highlight key terms and identify as many codes as possible to ensure that the data had been subjected to thorough scrutiny. This was followed by the identification, highlighting and, in some cases, the rephrasing of phrases and concepts that reflected the researcher's thoughts and interpretation in this connection and which the researcher considered to be relevant to and important for the purpose of the study. Each phrase or concept was given a number to assist the researcher in referring back

to a particular piece of data. This open coding process helped to familiarise the researcher with the content of the data. An example of the open coding process is reflected in Figure 2.4.

Ser No	Participant	Transcribed text	Open coding
20	FGS1-1	To add on that, on that experience I was talking about when we had those patients from CAR. This [203]authority does affects our nursing care. I remember I was the sister who were allocated per rooms. Then the Captain was working in Room 5, I think. So, I was going into every room even though I am not allocated. So, I was closing her drips. She was doing medication. They were running air and I was closing them. [204]When she came in, I can't remember what she said, but she said something very disrespectful, XXXX … what, what, what …! The way she talks, she, she doesn't have an approach, the specific Captain I am talking about. So [205]I felt offended. I was also doing her a favour because I closed the drips. It is her room where she is working and they were running air. So that approach, it affected me so badly such that I didn't want to go into that room anymore. Because imagine a CO has mentioned earlier that … [206]Imagine when you are told or you are being undermined in front of your client, the trust obviously what do these people think about you, you see. So it does affect a lot, because that specific [207]Captain wanted to be seen that she is in charge of the ward. Like everywhere, she was just shouting and everyone was just complaining about the same thing. So, it does affect nursing care a lot.	[S1-203] Military authority affects nursing care [S1-204] Being spoken to in a disrespectful manner in front of patient for closing IVs that were running empty in a room to which she had not been allocated [S1-205] Feeling offended, she did not want to go into that room again [S1-206] Concerned that trust of patient was jeopardised; concerned about what patient must think of her [S1-207] Captain wants to be seen as being in charge of the ward by shouting at everyone [S1-208] Student comparing hospital with heaven: there are no ranks, everyone is equal

Figure 2.4: Example of open coding

2.6.4.2   Focused coding

Focused coding aims to sift, sort, synthesise and analyse large quantities of data (Charmaz 2014:138). In this study, focused coding commenced with printing and then cutting the open codes of each data set into individual pieces of paper. These were sorted by comparing codes while simultaneously noting the frequency of occurrence, similarities between codes and their potential significance (Figure 2.5).

Although tentative categories started to emerge from this process, the researcher merely used these to create some sense of order from all the data. These tentative categories with their allocated codes were then transferred back to the MS Word document. Focused coding continued in this document by coding the open codes and providing these with the most descriptive or appropriate analytic words (Figure 2.6).
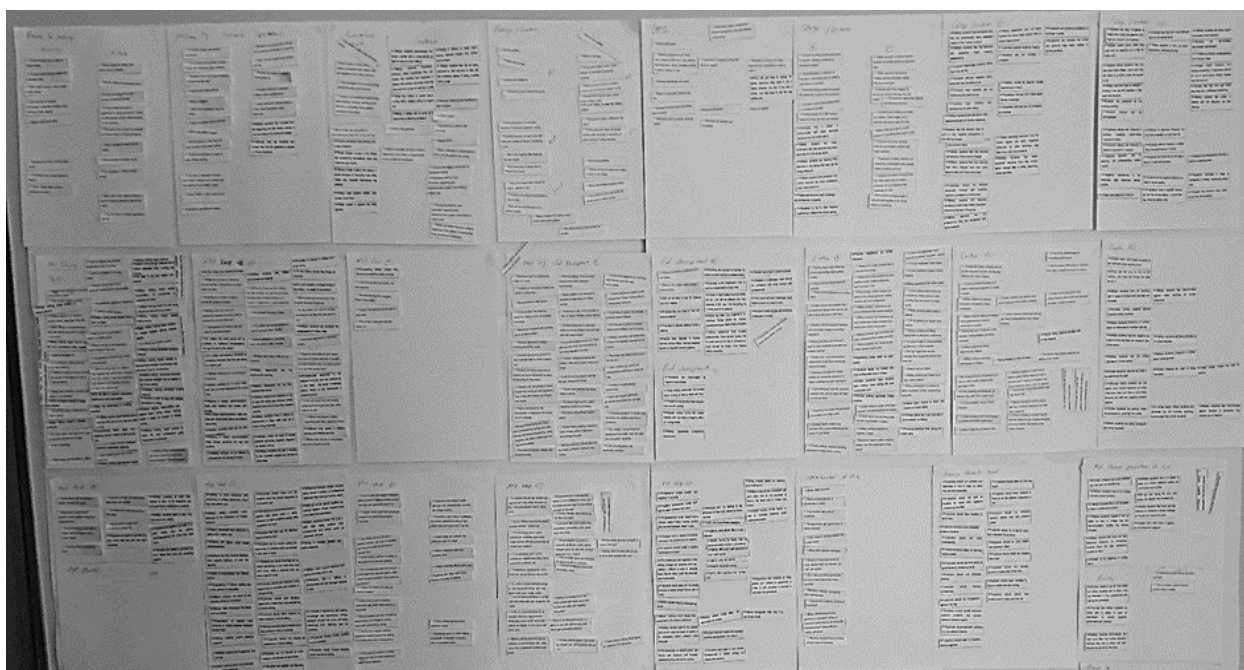
Figure 2.5: Sorting during focused coding

Ser No	Participant	Open coding	Focused coding
20	FGS1-1	S1-203 Military authority affects nursing care	Military authority affecting nursing care
		S1-204 Being spoken to in a disrespectful manner in front of patient for closing IVs that were running empty in a room to which she was had not been allocated	Students being addressed disrespectfully in front of patient Students feeling offended
		S1-205 Feeling offended; she did not want to go into that room again	Avoiding patients
		S1-206 Concerned that trust of patient was jeopardised; concerned about what patient must think of her	Patients losing trust in students

Figure 2.6: Example of focused coding

Up to this point, each data set was analysed and coded separately to do justice to both the data-source triangulation and the method triangulation. By the time the researcher had completed the focused coding of the fourth focus-group interview (FGS2), no new concepts were emerging. The researcher next integrated the focused codes of FGS1, FGS2 and the CIN, and also those of FGL1 and FGL2.

At this stage of the data-analysis process, the data fragments had to be re-organised to distinguish between the dominant and less dominant ones, to relate categories to subcategories, and to specify the dimensions and properties of each category. Strauss and Corbin (1994) refer to this step as axial coding. Charmaz (2014:148) however considers axial coding to be a cumbersome step that may limit the researcher's vision

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and delay analytical progress. Her approach, as adapted by the researcher, differs from that of Strauss and Corbin (1994) in the sense that moving from focused coding to theoretical coding should be an emerging strategy rather than a procedural application.

2.6.4.3 Theoretical sorting

As a result of Charmaz's stance on axial coding, the researcher proceeded with theoretical sorting. Theoretical sorting entailed the comparison of categories at an abstract level. It provided the researcher with the means to create and to refine both theoretical links and the theoretical integration of the categories (Charmaz 2014:216). The process of theoretical sorting involved the identification of similarities and differences between codes, then clustering codes that fit together in more abstract patterns or categories. Categories were further refined by a process of checking the fit of each category with the coded data that it represented and also with each of the other categories and thus the entire data set. Checking the fit resulted in the grouping of concepts that shared central features or characteristics with one another and this gave rise to the emergence of categories and, in some cases, subcategories that were labelled, defined and described (Figure 2.7).

Context	Focused codes	Subcategory	Category
Military environment	Complying and accepting	Regulated	Restrained environment
	Conforming		
	Grievances not readily, easily voiced		
	Being bound by accommodation rules		
	Being bound by the military disciplinary code		
	Being bound to military norms and values		
	Inconsistent application of rules		
	Difficult to understand culture, processes		
	Routine interferes with private life	Routinised	
	Inspections		
	Restrictive	Restrictive	
	Freedom limited		

Figure 2.7: Example of theoretical sorting

At this point, the data were handed to two independent coders for validation. The findings of the independent coders were considered and where there was consensus between the two, the codes and categories about which there had been consensus were incorporated into the findings of the researcher. No significant differences in the

analysis of the data between the researcher and the two independent coders were found.

2.6.4.4 Diagramming

Diagrams in the form of maps, charts and figures provide a visual representation of the categories and their relationships (Charmaz 2014:218). In this study, diagrams increased the researcher's ability to see the scope, direction and properties of concepts and categories.

Figure 2.8 depicts an example of the mind maps that were used during the data-analysis process and description of the findings. The example also explains the keys that were used to describe the elements and their interactions.

In Chapters 3 and 4 especially, the mind maps were used to highlight the hidden elements and their influences on professional socialisation as identified from the data. The yellow stars represent the concepts identified as hidden elements and the flags the influence of that element on professional socialisation, blue for positive and red for negative influences.
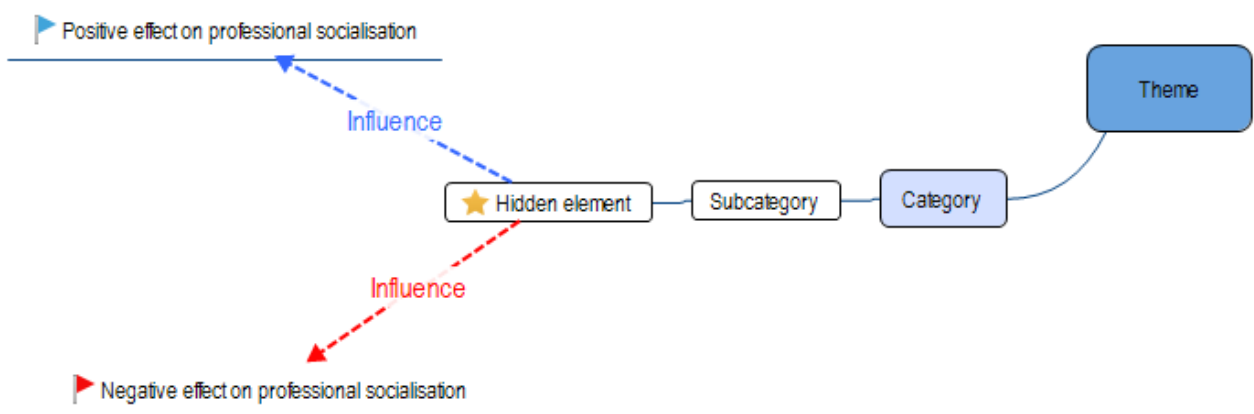
Figure 2.8: Example of a mind map and related keys

2.6.4.5 Theoretical integration

In reality, theoretical integration commences with the collection of the first data item and culminates in blending the abstract theoretical scheme into a final grounded theory

(Birks & Mills 2011:114-116, 176). Although the product of this study was a substantive model and not a theory as such, the process of integrating the emergent categories and themes into the model was followed throughout the study. During theoretical integration, the categories were reviewed and synthesised until themes started to emerge that captured the issues, processes and relationships identified in the earlier phases of analysis. These themes added precision and clarity to the data and served to make the analysis coherent and comprehensible. Figure 2.9 provides an example of one of the tentative themes that emerged during theoretical integration.

Theme 2: Nursing knowledge and skills acquisition		
Focused codes	**Subcategories**	**Categories**
Humiliating management of poor performers	Management of poor performers	Adverse teaching skills, strategies and practices
Discriminatory management of poor performers		
Individual academic problems being overlooked		
Not receiving additional academic support	Lack of guidance and support	
Not being given clarification		
Not being guided		
Showing lack of interest	Academic ineptitude	
Showing lack of knowledge		
Contradictions between theory and practice		
Being inaccessible	Non-availability	
Being unapproachable		
Being unavailable		
Subjective assessment	Negative assessment practices	
Transgressing assessment policies		

Figure 2.9: Example of theoretical integration

2.6.4.6   Theoretical coding

Theoretical coding is a sophisticated level of coding that follows the codes selected during focused coding. The purpose of theoretical codes is to theorise the data, to be integrative and to lend form to the focused codes by telling an analytic story that has coherence (Charmaz 2014:150). Theoretical codes are advanced abstractions that enhance the explanatory power of a substantive model. Birks and Mills (2011:126) maintain that metaphors, as figures of speech, can be used as theoretical codes where there is sufficient fit between the metaphor and the grounded theory. Metaphors may help to explain a theory or, in the case of this study, a substantive model, by clarifying relationships and providing labels for various components. Figure 2.10 contains an example of the use of a metaphor as theoretical code.

Theme	Categories	Subcategories
Theme 1: "You're in the army now!" Military acculturation	Career choice	Motives
		Preconceived ideas
		Career prospects
	Military training	Military indoctrination
		Negative communication
	Military socialisation	Military culture
		Corporate identity
	Military environment	Regulated environment
		Restricted environment

Figure 2.10: Example of theoretical coding

2.6.4.7 Theoretical sensitivity

Theoretical sensitivity reflects researchers' level of insight both into themselves and the area they are researching, and is a reflection of their intellectual history and experience (Birks & Mills 2011:11). Theoretical sensitivity provides the researcher with the ability to recognise and extract elements relevant to the emerging theory from the data. Theoretical sensitivity may potentially be enhanced by, for instance, the use of literature, the use of questioning or by drawing upon personal experience. Theoretical sensitivity may increase as the research progresses (Birks & Mills 2011:59). The researcher's professional experience, theoretical knowledge, and also some insight into the participants' concerns provided a baseline for theoretical sensitivity, which was applied during data analysis.

2.6.4.8 Intuiting, memo-writing and reflexivity

Intuiting requires the researcher to become totally immersed in the phenomenon under investigation and involves paying strict attention to the participants' descriptions without being side-tracked by criticism or opinions. Through intuiting the researcher becomes the tool for data collection (Streubert & Carpenter 2011:81). Intuiting is promoted by the use of memo-writing and reflection. Birks and Mills (2011:52-53) not only regard reflexivity as a key strategy to promote quality in grounded theory methods, but also as a tool for monitoring methodological congruence and a mechanism for tracing interactions with participants and data. Reflexivity stems from the act of writing and then critically analysing what was written. Birks and Mills (2011:53) state that memo-writing could provide a record of reflexivity, especially if feelings and actions and their influence on thinking are captured and an analysis of impact and outcome is incorporated. This

implies a regular systematic task with a view to building upon and learning from previous efforts. The researcher exercised reflexivity throughout the study by keeping notes that captured thoughts and ideas about the data and the findings and which aided in rendering them more concrete, structured and manageable. The researcher however rarely reflected on personal feelings and thoughts in writing. This more often happened either subconsciously, in the course of peer reflection or during discussions with the supervisor.

2.6.4.9   Constant comparison

Constant comparison or constant comparative analysis arises as a result of concurrent data collection and analysis, which is a unique feature of grounded theory (Birks & Mills 2011:94). The researcher applied constant comparison by continuously comparing initial codes, concepts and categories with one another in an effort to identify both similarities and differences. This method ensured the researcher's continuous engagement with the data and contributed to the generation and development of conceptual categories that aided in the abstraction of the substantive model.

2.6.4.10 Theoretical sampling

Charmaz (2014:192-212) defines theoretical sampling as "seeking pertinent data to develop your emerging theory". Theoretical sampling is a distinctive feature of constructivist grounded theory. The need for theoretical sampling is informed by constant comparative analysis by making the researcher aware of issues that require expansion, clarification or confirmation (Birks & Mills 2011:69-70). In this study, theoretical sampling was applied by analysing the field notes and transcripts of each focus-group interview and using the resultant findings to direct the course of each subsequent focus-group interview.

2.6.5   Data integration

The objective of Phase 2 of this study was to integrate the findings of Sample A and Sample B obtained during Phase 1. The detailed findings of Phase 1 are discussed in Chapters 3 and 4. The data integration process entailed comparing the themes, categories and subcategories obtained from of each sample, eliminating duplications

and incorporating differences. Sample A initially yielded four themes and nine categories and Sample B four themes and 12 categories. Further theoretical integration followed until there were four themes and 17 categories. In Chapter 5, the integrated findings are discussed in the context of the existing literature.

During data integration, in accordance with the principles of symbolic interactionism, the researcher focused on participants' descriptions of those symbols in their surroundings that they found meaningful, on how they interpreted these in terms of symbolic meaning, on the processes of meaning-modifying interactions between participants – including their self-interaction – and the context within which these processes took place.

2.6.6 Model development

Phase 3 of the study involved the development of a substantive model. A detailed discussion on this process follows in Chapter 6. In order to ensure rigour and trustworthiness, the researcher provided the tentative model to a panel of expert reviewers for evaluation. The expert reviewers were selected, on recommendation by the study supervisor, based on their expertise and experience in nursing education, research, model development, grounded theory methodology and military strategy. The researcher developed an expert reviewer package containing an overview of the study, the tentative model, a description of the tentative model and an evaluation tool. Each expert reviewer was requested via email to evaluate the model. The expert reviewer package is available in Annexure J.

2.7   ETHICAL CONSIDERATIONS

Research involving human participants requires careful consideration of ethical issues that may emanate from the study. The researcher considered the three primary ethical principles on which research must be based, namely beneficence, respect for human dignity and justice as articulated in the Belmont Report (Polit & Beck 2016:139). This was done to ensure that the research was based on mutual trust, acceptance, cooperation, promises, well-accepted conventions and expectations (De Vos et al 2011:113).

2.7.1 Beneficence

The principle of beneficence requires that participants be protected from harm and discomfort. The researcher thus has the obligation to avoid, prevent or minimise risk, harm or discomfort whether it be physical, emotional, psychological, spiritual, social, economic or legal. The potential for emotional and psychological discomfort existed due to the strong ranking system of the military. The researcher attempted to curb this by insisting that all participants should wear civilian clothes during the focus-group interviews and that participants should avoid making use of ranks when addressing each other or the facilitator. The researcher did not foresee that any participant would be harmed but attempted to eliminate physical discomfort by finding a conducive venue for the focus-group interviews. Participants were encouraged to communicate any of the aforementioned forms of discomfort to the researcher so that these could be addressed immediately. Beneficence further entails the obligation to ensure maximum benefit to the participants. It is hoped that the participants will benefit from their contribution to this study when the findings are shared and the model implemented (De Vos et al 2011:1156, Polit & Beck 2016:139).

Participants also have the right to be protected from exploitation. The researcher thus has the obligation to protect vulnerable groups or people with diminished autonomy such as children and the mentally challenged from being exploited (De Vos et al 2011:115, Polit & Beck 2016:139). The students and even some of the nurse educators who participated in this study might have felt vulnerable because of the position of authority that the researcher held at the Nursing College. So as to forestall fears of potential exploitation by the researcher, participants were, through informed consent, ensured that they were in no way obliged to participate and would not be victimised as a result of not participating. The researcher guarded against using any form of exploitation. Protecting participants from exploitation also involved the avoidance of the use of power relations to benefit the study. The hierarchical nature of the SAMHS Nursing College put the researcher in a position of power. A person who had no ties with the military co-facilitated the focus-group interviews to neutralise the potential influence of existing power relations.

2.7.2 Respect for human dignity

To guarantee respect for human dignity, the right to self-determination was incorporated in the letter of information given to potential participants prior to the study. The right to self-determination included the right to decide voluntarily to participate in the study, to withdraw at any time without fear of any consequences, to ask questions or to withhold information.

Respect for human dignity means that participants have a right to full disclosure. This implies that the full nature of the study must be made known to the potential participants (De Vos et al 2011:117, Polit & Beck 2016:140). Prior to signing the informed-consent form, the researcher briefed the potential participants regarding the nature of the study and what would be expected of them. Detailed information was also contained in the letter of information provided to all potential participants (Annexures G and H).

2.7.3 Justice

Potential participants have the right to fair selection, and the selection of the study population in general and participants in particular should be based solely on the research requirements (Polit & Beck 2016:141). Given the nature of the study, selection was purposive and voluntary.

In order to honour the participants' right to fair treatment, the researcher avoided the non-prejudicial treatment of people who declined to participate, and showed sensitivity towards and respect for the beliefs, habits and lifestyles of participants from different backgrounds and cultures.

Respect for privacy entails the maintenance of anonymity and confidentiality (De Vos et al 2011:119, Polit & Beck 2016:141). In order to maintain anonymity and confidentiality, participants were able to choose their own pseudonyms during the focus-group interviews. The researcher further ensured that all references to names were omitted from all documents. Recordings and transcripts are now being kept in a locked cupboard. All participants also signed a code of confidentiality (Annexures G and H) which stated that they undertake to refrain from disclosing any personal identifiable information that may come to their knowledge with regard to co-participants during the

course of the study. The issue of confidentiality was reiterated during the setting of group norms prior to commencing with the focus-group interviews.

2.7.4 Respect to the scientific community

Respect to the scientific community entails scientific integrity. This implies researcher competence, accuracy and honesty (De Vos et al 2011:123). In addition to applying the principles of trustworthiness, the researcher avoided plagiarism by acknowledging sources through proper referencing and ensured that the research process complied with academic and scientific standards. All findings were accurately and truthfully reported.

In order to ensure institutional protection, the researcher obtained ethical clearance from the Department of Health Studies Higher Degrees Committee at UNISA (see Annexure A), permission from the SAMHS Nursing College (see Annexure B), Defence Intelligence (see Annexures C and D) and from the 1 Military Hospital Research Ethics Committee (see Annexures E and F) to conduct the study. Permission from these institutions did not require that the name of either the Nursing College or the Military Hospital be removed.

2.8 RIGOUR

With a view to ensuring the quality of the study, the researcher applied strategies aimed at enhancing trustworthiness.

Rigorous grounded theory research is characterised by openness, relevance, adherence to a philosophical perspective, epistemological and methodological congruence, thoroughness in respect of data collection and data analysis, and the researchers' self-understanding (Brink et al 2012:126; Grove, Burns & Gray 2013:58). The researcher used intuiting to remain open to and aware of the meaning that the participants attached to their experiences. The process of intuiting was aided by making field notes and writing memos. Self-understanding refers to the researcher's insight into her own subjectivity related to the phenomenon being studied and the ability to prevent bias from interfering with the voices of the participants (Grove et al 2013:28). The researcher employed bracketing to set aside any preconceived ideas or beliefs about

the participants' experiences by reflecting on potential biases and preconceptions and by discussing these with her supervisor.

Quality in grounded theory research is characterised by researcher expertise, methodological congruence and procedural precision (Birks & Mills 2011:34-39). As a novice to grounded theory research, the researcher acknowledged her limited experience of this particular method. This problem was surmounted by engaging in rigorous preliminary readings on grounded theory methods and by engaging with experts on this method. The researcher made use of expert reviewers to evaluate the model. The researcher was further able to draw on her proven experience and skills in terms of research and of critical and analytical thinking to undertake this research.

Methodological congruence implies that there is a match between the researcher's philosophical stance, the purpose of the research and the methodological approach. By establishing her own philosophical position as described in Section 2.2, the researcher was able to identify with and apply a constructivist approach so as to reach the objectives of this study.

Ensuring procedural precision involves not only the maintenance of an audit trail and the management of data and resources, but also the demonstration of procedural logic. The researcher aimed to establish an audit trail by making use of notes to record any thoughts or decisions relating to the research process and by saving all versions of the data and findings as they evolved. All the sources of raw data, transcribed data, analysed data, findings and references were systematically and logically sorted and saved.

In addition to the above, the following strategies to enhance trustworthiness as supported by authors such as Lincoln and Guba (1985, 1999 in De Vos et al 2011:419-422), and Creswell and Miller (2000 in Creswell 2014:201) were applied.

2.8.1 Credibility

Credibility reflects how confident the researcher is with the truth of the findings. Credibility is synonymous with internal validity (De Vos et al 2011:419). The imperative of validity in qualitative research requires that the researcher, the participants and the

reader consider the findings of a study to be accurate (Creswell 2014:201). In this study, internal validity was enhanced by the application of constant comparative analysis. Other strategies aimed at increasing credibility included prolonged engagement with the participants, which meant that the researcher spent a considerable period of time with the participants during the focus-group interviews to enable her to gain an in-depth understanding of their experiences. The researcher also made use of space triangulation by collecting data from different sites. Data-source triangulation was done by collecting data from different groups of people and method triangulation by collecting data by means of focus-group interviews and critical-incident narratives. Peer debriefing was yet another strategy used to ensure credibility. It required that the researcher constantly verify the research process with her supervisor. Credibility was lastly enhanced by making use of member-checking during the course of which the analysed data were presented to participants, this providing an opportunity for further inputs and comments.

2.8.2 Transferability

Transferability or external validity refers to the extent to which the findings can be applied to other contexts (De Vos et al 2011:420). Transferability was ensured by applying purposive sampling to ensure information-rich participants. The researcher also provided in-depth, detailed descriptions of the context, the research process and the findings to assist other researchers to evaluate the applicability of the data to other contexts. Transferability was lastly ensured by making use of data triangulation and participant validation.

2.8.3 Confirmability

Confirmability refers not only to the extent to which the findings, conclusions and recommendations are supported by the data but also to the extent of congruence between the researcher's interpretation and the evidence (De Vos et al 2011:420-421). For confirmability to be achieved, findings must reflect the participant's voice and the conditions of the inquiry, not the researcher's biases, motivations or perspectives. The researcher applied bracketing, as discussed in Section 2.8 to set aside any preconceived ideas and to be open to the perceptions of participants. Confirmability was further achieved through establishing an audit trail as discussed in Section 2.8. The

researcher also made use of independent coders as alluded to in Section 2.2.6.4. Lastly, member-checking was done by presenting the tentative categories to the participants. The researcher arranged to meet separately with the nurse educators and the students who had participated in the study. The findings pertaining to each respective group were then shared with that group and the participants were given an opportunity to add any additional thoughts or to correct any misinterpretation. The researcher used this data-validation process to confirm that the findings were a true reflection of the participants' inputs.

2.8.4 Dependability

Dependability denotes the consistency of the findings of the study if it were to be replicated with the same participants in a similar context. The concepts *dependability* and *reliability* can be used interchangeably (De Vos et al 2011:421). Creswell (2014:201-203) proposes qualitative reliability as indicative that the research approach is consistent across different researchers and different studies. To ensure reliability, all the steps of the research procedure were documented to enable other researchers to replicate the study. Transcripts were moreover checked for obvious mistakes, and codes were consistently defined and cross-checked.

From a grounded theory perspective, reliability is concerned with demonstrating that the researcher has not invented or misrepresented the data or not been careless in data recording and analysis (Brink et al 2012:126; Carcary 2009:14). With a view to enhancing reliability, the researcher conducted the research process in a transparent manner by reflecting on and outlining all the procedures that had led to the research findings. The researcher also carried out the data-collection processes consistently and made use of an expert co-facilitator to verify the procedures and findings. All inputs by participants were included in the data and considered during data analysis. The researcher's interpretations of the findings were supported by meaning units from the data. Reliability was further ensured by applying method triangulation and by keeping and audit trail.

2.8.5 Authenticity

Authenticity signifies the degree of accuracy with which the researcher was able to capture the feelings and the tone of the participants' accounts of their lived experiences (Brink et al 2012:127). An authentic study has the ability to sensitise the reader to the issues being depicted (Polit & Beck 2014:323). In an effort to provide an authentic account of the findings of this study, the researcher made use of verbatim quotations to substantiate the findings and also applied theoretical sensitivity to communicate her interpretations of the findings as accurately as possible.

2.9 SUMMARY

In this chapter, the researcher justified the use of the constructivist grounded theory method in this study by elucidating her philosophical stance on the ontology, epistemology, axiology and rhetoric of research. What followed was a discussion of the research approach, the research design and the reasoning behind the decision to develop a substantive model. The execution of the study was described by means of an explication of the population, the sampling, the data-collection techniques, the data analysis, the ethical considerations and the measures to ensure trustworthiness.

Chapter 3 offers a discussion of the research findings of the data collected during Phase 1 from Sample A.

CHAPTER 3

RESEARCH FINDINGS OF THE DATA COLLECTED DURING PHASE 1: SAMPLE A

3.1   INTRODUCTION

Chapter 2 provided a detailed explanation of the research process followed up to the point where data from all data sets were analysed. In this chapter, the researcher discusses the findings of data collected from Sample A during Phase 1. The objectives of Phase 1 were, on the one hand, to establish the nurse educators' existing knowledge, their attitudes and their perceptions regarding military and nursing professionalism, and, on the other, to identify the elements of the hidden curriculum in a military teaching and learning environment, and to determine how the hidden curriculum influences students' professional socialisation.

The rest of this chapter will reflect on the themes, categories and subcategories that emerged during the analysis of the transcribed data, supported by the relevant meaningful units from Sample A.

3.2   FINDINGS

Data were collected from two separate focus-group interviews conducted with nurse educators (Sample A) partially to achieve the objectives of Phase 1. Only two of the 15 participants in Sample A were males. Most of the participants were older than 40 years, which, while indicative of the ageing population of nurses, also happens to be realistic in the sense that nursing education is often the second career of professional nurses with many years of clinical experience. All the participants had more than five years' experience in the Defence Force, if not at the Nursing College itself. Six of the participants had more than ten years' experience in nursing education in the Defence Force.

After an introductory explanation of the focus of the study, namely the hidden curriculum and its meaning, the focus-group interviews commenced with the following invitation that served as a stimulus for a free and open discussion: "*Let us hear your views,*

thoughts, feelings, and experiences regarding this unique military environment and the influence it may have on the professional development of our students."

From the initial coding, 347 codes emerged after duplications had been eliminated. As the researcher moved from initial coding through focused coding to theoretical coding, data were sorted, recoded and re-categorised several times in accordance with their fit with the conceptual clusters that emerged.

In this Chapter, each section is preceded by a table summarising the theme, categories and the subcategories. Each subsection concludes with a mind map of the relevant category that not only illustrates the identified hidden elements but also their influence on professional socialisation. An example of the mind map with the corresponding keys was supplied in Chapter 2 in Section 2.6.4.4.

Although the study specifically focused on the professional socialisation of the students in a military teaching and learning environment and the opening statement of the focus-group interviews with nurse educators indicated it as such, the nurse educators often related their personal experiences and used their own frames of reference to bring across a point. The nurse educators would refer to themselves at times and then again to the students in particular. In some instances, they would refer to *us*, which could be inclusive of themselves and the students. During data analysis, the concepts and meaningful units were selected, which, from the researcher's interpretation, seemed specifically to relate to, be applicable to or might have an influence on the students.

Table 3.1 indicates the main themes that emerged from Sample A.

TABLE 3.1: MAIN THEMES FROM SAMPLE A

Theme 1	Military acculturation
Theme 2	Professional knowledge acquisition
Theme 3	Clinical skills acquisition
Theme 4	Professional role conflict

3.2.1 Theme 1: Military acculturation

Acculturation entails learning the appropriate behaviour of a host culture (Global Perspectives Consulting, 2013). Military acculturation is thus the process of being introduced to military life, of learning the traditional content of the military culture and of assimilating its practices and values. The categories that emerged from the data encompassed aspects related to the transition from civilian to soldier, namely military training, military socialisation and the military environment (Table 3.2).

TABLE 3.2: THEME 1: MILITARY ACCULTURATION (SAMPLE A)

Theme	Category	Subcategory
Military acculturation	Military training	Military indoctrination
		Negative communication
	Military socialisation	Military culture
		Professional identity
	Military environment	Regulated environment
		Hierarchical environment

3.2.1.1 *Military training*

When joining the Defence Force, all soldiers need to attend some form of military training. Nursing students undergo basic military training prior to commencing their nursing training. Military training emerged as a category during the nurse educators' accounts of their own experiences of military acculturation and also their observations and interpretations of the students' experiences. The subcategories associated with military training are military indoctrination and negative communication.

From the participants' point of view, military training serves to introduce military norms and values, which in turn dictates how the students should conduct themselves as soldiers. They agreed that military training mostly has a positive effect on the students in terms of instilling discipline.

> *So coming back to the point of our socialisation of our students, so, we train them from the MSDS point when we select them from [those] that become nursing students. We train them on military values, military norms. When they come into the nursing environment that is how they are expected to behave, whether their counterparts behave otherwise than they do, they are expected to behave in a soldiering manner. So, the … the soldier aspect is the one that overtakes the overall blanket of, in terms of discipline, behaviour, norms and things.* (FGL1–1:10, 11)

In my own view, I can say that the influence could be both positive and negative. In a positive way in the sense that … behaviour and or discipline-wise it moulds them to be, to a certain extent, to be more disciplined. (FGL1–2:23)

Since the primary function of a military nurse is to be operationally deployable, the participants concurred that military training develops a student to be a good professional soldier. Military training is essential to prepare military nurses to provide operational support and to function under stress.

… because as nurses within the Defence Force we are providing a support function. For you to be prepared, remember it is a war situation, for you to be prepared to function in there, you must know exactly what happens during war. You must under the same stresses that those people are going to be. Because it is pointless bringing a medic and then two days later you are sent home because you cannot cope with all those bombs and shells that are landing next to you. So it is something … it prepares you. It does not only prepare [you] in that way, because in those courses sometimes you sit there and do casualty or you calculate how many casualties are you going to get if you get into that war. So it is a professional development in a way. You gain a lot of that. You gain a lot of how to function. That is the most important thing that I have seen on all the courses, how to function under stress; because they actually put you really under stress. (FGL2–1:149,150)

The participants maintained that, along with the specific soldiering skills acquired during military training, such training aids in the development of many professional attributes that students need to acquire, among which leadership skills, communication skills, writing skills, critical-thinking skills, managerial skills, decision-making skills and planning skills.

However when it comes to military courses, I do believe that it makes us and it adds to our professionalism because these military courses teach us leadership. They teach us many skills. It is also about being a leader and a good leader, about communication. Also about writing. (FGL2–2:144)

I wanted to say, another positive also is that, in a way, the military teaches you critical thinking skills. Because we also have those exercises which we do in the bush. (FGL1–3:141)

Military has got its own way of, you know, making that people, you know, got to teaching them to make or sort of encouraging them to make decisions. Like when you are doing formative, there is a session that they called 'orders'. So during orders they will just give you a scenario that there is a … the enemy is where so many kilos, so men, you have got this troop, you must plan this war so that you can defeat that enemy. So, in a way, they give you a … you know, the latitude of making decisions of planning and doing everything. (FGL1–5:165)

Then there I am taking in that formative there is management and is a lot there. You know, the real management like planning, decision making, you know there are so many things that they are teaching them there. (FGL2–5:155)

Lastly, in addition to the aforementioned, military training also proves to contribute to some personal attributes like self-empowerment, endurance and independence.

I wanted to say, additional to the courses, the part that I like most is the endurance part of it. They teach you to know, to do it yourself. You realise as an individual that you are the best asset in the universe. For me I salute to whoever that introduce this course because in a way it is more empowering, not as a soldier, but as a person. (FGL2–6:154)

There are positives from our students in terms of being self-dependent. At … I mean the training that they undergo, taking an 18-year-old who has been at home with the parents all along, taking them to the bush where there is no parent, there is no one. They had to depend on themselves. (FGL1–1:168)

3.2.1.1.1 Military indoctrination

Multiple references were made to the term *brainwashing*, which was seen to be a result of military training. Military indoctrination, as part of military training, is a critical component in the transfer of military culture, customs and traditions. Indoctrination has a negative connotation to those who value independent thinking. Usually associated with brainwashing, the concept provokes images of docile subjects uncritically following the orders of an authority figure (Payne 2014). According to the participants, the way in which students are indoctrinated during military training results in them blindly following orders, thereby preventing them from questioning possibly illegal orders or potentially harmful instructions.

When it comes to taking orders we are taught to follow. Whether we go to the wall, you don't ask why are we going to the wall. We all go to the wall. If the order is given, you will do it. Now you have to care for this patient and the doctor says to you give the patient this Lasix. The person has now been so brainwashed, he is not even going to ask the rationale behind the Lasix because his order is to give it to the patient. (FGL1–8:40,41,42)

The military kind of relatively brainwash you. That is actually what they are doing, you know. (FGL2–3:65)

Until such time you are now socialised with military things, then you start to withdraw because [in] some way, somehow, there is brainwashing of some kind which for me it becomes a problem. Coming to … to saying sometimes it is a problem with us medics. (FGL2–6:97)

The participants mainly had a negative view of indoctrination, suggesting that it generally leads to cognitive conditioning. Their argument was that indoctrination has an adverse effect on cognitive development and thus also on learning since it instils a fear in students of asking questions, thus hampering inquisitiveness and inhibiting independent thinking.

> *You are even scared to raise some of the things. So, there is just this conflict.* (FGL1–8:79)

> *At the same time, that thing of saying you follow orders, you do, then you will complain later, it is also killing them like to be assertive professionals. Because, like the colleagues have already said, when they are in … in the wards, they are not questioning.* (FGL1–8:58)

Yet another consequence of military indoctrination is behavioural conditioning. The participants clearly felt that this prevents students from developing into caring individuals. It also causes them to take orders without questioning or arguing about them.

> *So in a way now this person comes from that military environment into being a nurse. A nurse primarily, the essence of nursing is caring. Now you have to take that person who was conditioned to think in a certain way, in a military way, you have to now mould this person into becoming a caring individual. That is a challenge.* (FGL1–3:37,38,39)

> *You take the student that comes from the military and the student that come from the civilian situation, there is just a lot of … of … of difference in terms of, you know, standing up, being assertive and being responsible and asking questions. Like when doctors give orders, you will find that our student they don't even ask anything, it is because the way we have been socialised to say you take orders as they are, you don't ask.* (FGL1–7:47,48)

> *They are not … they don't open up because of how they were taught at the basic, basic. That you must just only listen. Don't argue, don't, don't argue.* (FGL2–7:40)

According to participants, military indoctrination serves to deprive one of one's humanity and leads to depersonalisation, specifically causing a loss of identity and individuality. Two concepts, namely de-humanisation and de-emotionalisation, therefore emerged from the following comments made by the participants. Particularly disconcerting is a tendency to overlook the individual person behind the uniform and rank.

> *In those two years, if someone were started there as well and come through the process of the military you are being taught solely in those, in that time, to*

be a soldier. You are not special. No one is special. We are all the same. (FGL1–3:35,36)

When we do our military training, we are trained to be this firm kind like person. (FGL1–3:85)

Our students now, with this culture and the civilian culture, because you are placing them here in the military environment and also outside, they would say outside there in the civilian world they are treating us like human beings. But here at xxxx they are treating us like objects. (FGL1–3:93)

Part of military training involves repeating drills to the extent that their execution becomes automatic or habitual. According to the participants, they adopt the mindset of a soldier and thus find it difficult to separate these habits from their professional roles. To some, this is a positive aspect, but it can also be negative in the sense that the military attitude may dominate the caring attitude.

Those principles, they get imbedded in us and … which is a positive thing. (FGL1–6:139)

Like she say, you know you have that mindset of soldiering. (FGL1–8:146)

Because in the military it is like they train you, it is like a drill. Some other things they just come automatically, even if you want to be caring. But you know you [are] groomed in that way, that I have to be like this. That is why, half the time the military dominates your caring personality in a way. (FGL1–8:174,175)

Participants also indicated that they find it difficult to separate their military mind-set from their home environment as a result of the habitual execution of military drills.

I think we, it gets so drilled into us that even at home you can't carry, you just find yourself automatically carrying your bag on left hand. (FGL1-6:133)

I don't know if it is in my mind, by just being a military person or a soldier I feel like it is like in my house…. So somehow being groomed from the military it is like in my house I feel like a soldier. (FGL1-8:145)

3.2.1.1.2 Negative communication

Unfortunately, negative communication was seen to be a particularly adverse aspect of military training. The participants felt very strongly about the unacceptable way in which soldiers communicate, indicating the shouting, swearing, loud use of voice and the harsh militaristic communication style to be demeaning, offensive and unprofessional. It

would seem that the use of military language and tone of voice is often adopted as the norm when addressing students.

> *So, I still remember when I was in the office and then out here, soldiers marching out there, the new recruits and they were shouting at them. They were swearing at them. I said, "What is this environment?"* (FGL1–2:94)

> *That autocratic way of saying you have to do it this way, and talking loud and having that … that authoritative way, it really affects me as a person. So if it affects me, and I have been a student in this military since baby, how is it not affecting our students?* (FGL2–2:63)

> *… the language is totally unacceptable for, you know, in our profession that language we don't utilise. People are … they have made it a norm that this is the language that we utilise in the profession, and that is totally unacceptable ... So, but … for in that environment of professionalism and you … it is unacceptable and that is when people become offended where you saw people actually retaliating, forgetting about the rank and whatever, because it is totally unacceptable.* (FGL2–6:115,116)

> *Because of our ranks we have got the tendency of imposing … of even the approach that we use when you communicate with them, it is really demeaning.* (FGL1–2:219)

> *So but the way of talking, the language, it … it offends.* (FGL2–6:116)

Figure 3.1 provides a summary of the hidden elements and their influence as identified from the category *military training*.
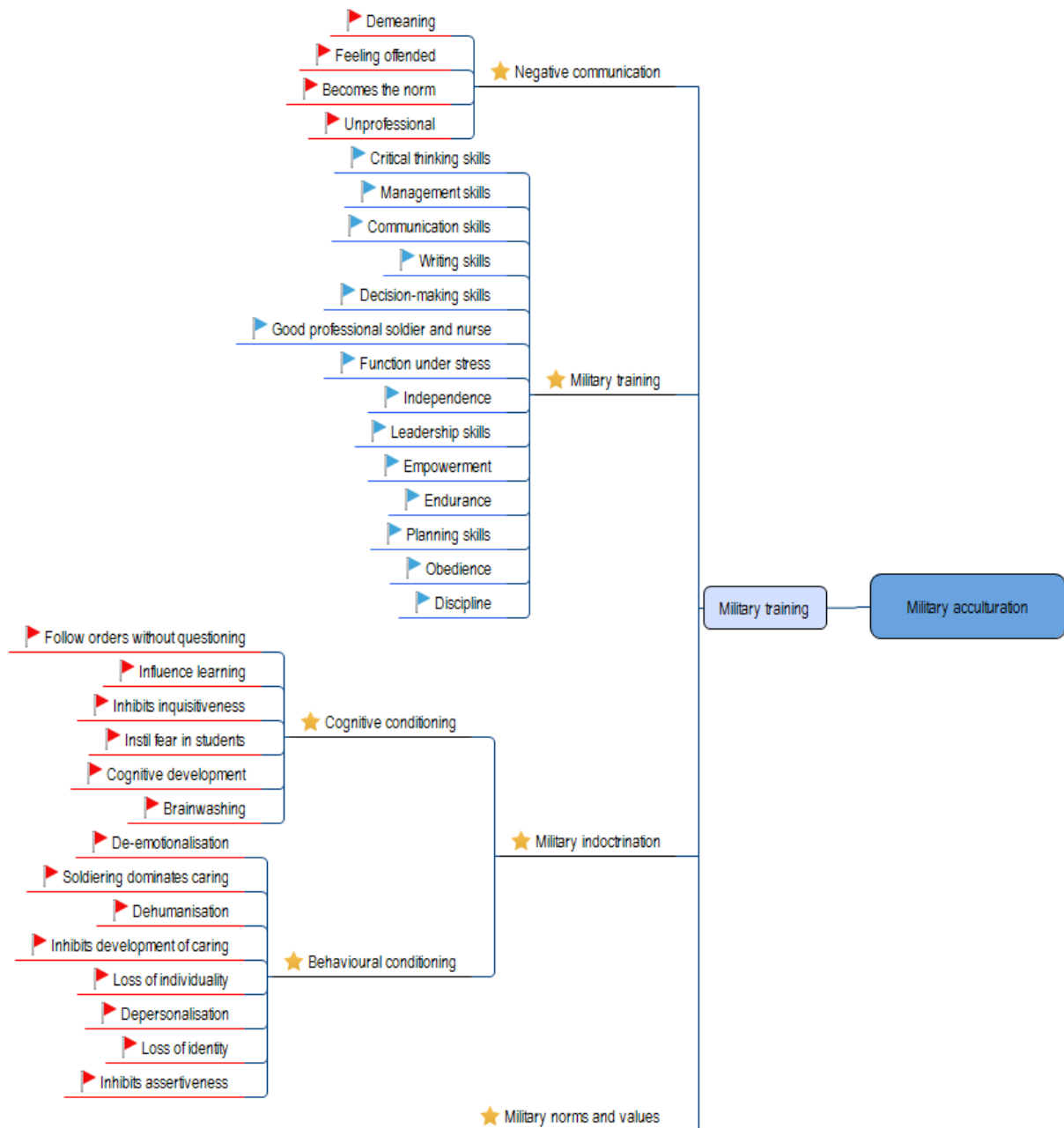
Figure 3.1: Mind map of the category *military training* (Sample A)

3.2.1.2 *Military socialisation*

Military socialisation, to which Cobb, Sluss, Muraca, Brown, Salter and Rutter (2011:1) also refer as *soldierisation,* involves the process of relinquishing the civilian culture and adopting the military culture.

3.2.1.2.1 Military culture

The participants shared the view that irrespective of its current mission, the organisation remains unique and that military culture will remain as long as there are military nurses to protect the professional status of the military.

> *Well, we are in the military and it has got a unique culture. It has got unique norms and standards. Every organisation has its own culture. That prescribes the behaviour.* (FGL2–4:21,22,23)

Adopting the military culture can be seen as the primary outcome of military socialisation and also reflects what military training aims to achieve. Military culture comprises many different facets that are often interwoven, for example, military conduct, customs, etiquette, protocol and courtesy.

The participants concurred that the military culture makes a positive contribution to students' professional development, especially in terms of their behaviour and disciplined conduct.

> *So, the culture really contributes positively in the image of the Defence Force because of the way they conduct themselves.* (FGL1–2:21)

> *What I like about the military culture is that they influence our students in a way that they have got a certain way of behaving. They behave differently from the civilian students.* (FGL1–2:15,16)

The participants mentioned many examples of military culture and its contribution to the professional socialisation of students. As a result, students usually appear neat and exhibit good manners.

> *Wearing of uniform is part of socialisation.* (FGL1–4:30)

> *In other institutions, people just put on what they have.* (FGL1–4:44)

> *… when they go to the mess, they must always be in uniform, full uniform. Whether you are off or you are working or you are in class, when you go to the mess you must put on [a] uniform.* (FGL1–4:81)

> *We also get a chance of getting gala dinners and whatever as an experience. It form as part of socialisation so that when we start being a real soldier, you know how to behave.* (FGL1–6:134)

> *You can't eat while walking.* (FGL1–6:137)

… or answer the phone while walking. FGL1–4:138

Whenever they are moving from point A to point B, they must always like … talking about the squad. (FGL1–4:82)

Military culture is vital in terms of maintaining discipline and also refers to good manners and politeness in dealing with other people. Courteous behaviour provides a basis for developing good human relations. Other aspects of military culture include saluting, using the correct form of address when communicating with higher-ranking members, paying respect, standing to attention when the National Anthem is being played and saluting the flag.

> *But, as part of socialisation, our students they learn that when they are attending class they first go in before the lecturer comes in. When the lecturer comes in, the students have to stand up.* (FGL1–4:28)

> *… you will learn that you are supposed to salute your senior. You have to respect your senior.* (FGL1–4:84)

The participants made reference to the need for compliance with military rules and regulations, to how these shape the students in terms of being disciplined and showing respect, to how they relate to the historical image and conduct of nurses, and to the consequences of failing to adhere to them. Military discipline not merely involves complying with a set of rules and regulations drawn up for the purpose of preserving order in the organisation. It also involves cultivating the habit of instantaneous and instinctive obedience under any and all circumstances. Military culture provides the foundation for military discipline (Moss 2013:242-243).

> *Personally, I think it is a profession, or each place that has got rules and regulations. Unfortunately, if you are in the military there are certain rules and regulations that you are supposed to follow. This is also emphasised probably in the military training that this is how things are done in the military.* (FGL2–1:13,14)

> *So in the military we have got a perspective of you comply now and you complain later.* (FGL2–1:7)
> *Discipline is emphasised in the military. It is why my colleague there has said our student they are valued outside [in the] private sector if they decide to resign because of the discipline and also respect.* (FGL2–1:32)

> *We must look into the nursing profession nowadays and the days when we trained. There were rules. If a Matron was coming, you were supposed to stand aside and let the Matron pass. Those are the things that the military instil on that. I don't think there is something wrong with the military itself in instilling discipline because that is how the process are supposed to occur in the military.* (FGL2–1:17,18)

Charging is there for broken the rules whatever. Then you are going to a military court. There they can take [away] your rank or whatever. So, you do not want to find yourself into a difficult situation. So, you will have to ask and adjust. (FGL2–1:212)

3.2.1.2.2 Professional identity

Part of professional socialisation entails adopting the identity of both the profession and the organisation. Participants' references to concepts such as commitment, appreciation and passion summarised their sense of ownership in terms of military culture and professional identity.

That is another positive side of military, because they really teach you how to be like that and the part of discipline again comes in. So, you will be sort of committed. (FGL1–5:125)

… but really, military … somehow with this discipline [in] those days while it was still not so diluted. Really, you will appreciate its discipline. (FGL2–5:133)

The thing is, as I mentioned before … is that I will not sommer exchange my military uniform for something else because the military groomed me. (FGL2–3:161)

I had this passion of being a soldier from a very early age. (FGL1–6:154)

I actually think the military is good to me and I like the military. (FGL2–3:64)

Figure 3.2 provides a summary of the hidden elements and their influence as identified from the category *military socialisation*.
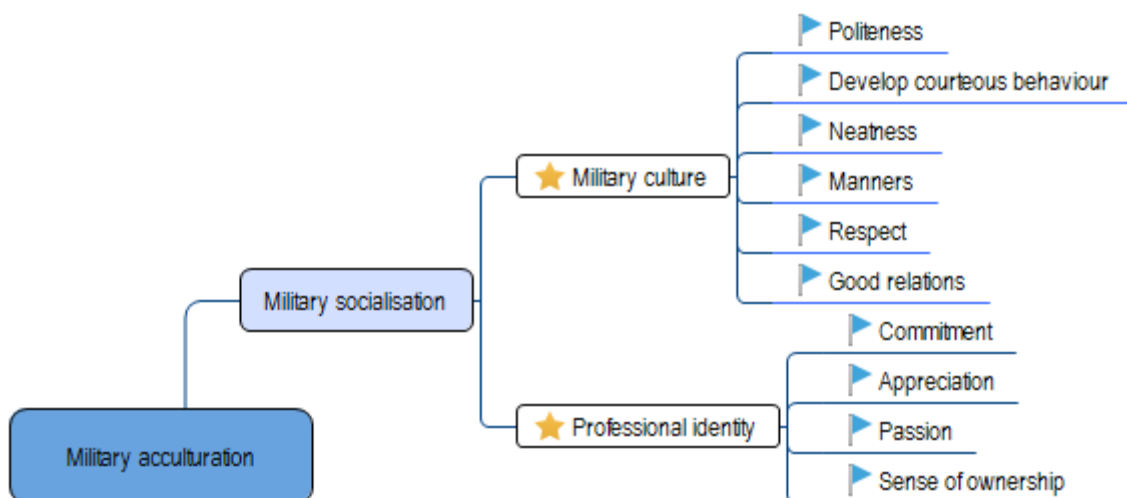
Figure 3.2: Mind map of the category *military socialisation* (Sample A)

3.2.1.3 Military environment

The category *military environment* encompasses the characteristics of the environment in which military acculturation takes place. The military environment has been identified as being both regulated and hierarchical. It is analysed here in terms of, on the one hand, the rules and regulations that govern it, and, on the other, in terms of its hierarchical structure.

3.2.1.3.1 Regulated environment

Numerous references were made to the strict rules and regulations related to the military environment. The military environment is considered to be a regulated environment because of the rules and regulations that all members are obliged to obey. Part of the maintenance of discipline and order in a military environment is dependent on all members obeying the rules and regulations.

> *Each place that has got rules and regulations. Unfortunately, if you are in the military there are certain rules and regulations that you are supposed to follow. This is also emphasised probably in the military training, that this is how things are done in the military*. (FGL2–1:13,14)

> *Every organisation has its own culture. That prescribes the behaviour. That prescribes the rules we have to obey by*. (FGL2–4:23)

According to the participants, the regulated environment in which students find themselves serves to disempower them. Various restrictions imposed by the military environment emerged during the focus-group interviews, for example that military students are not allowed to strike as a means of expressing their dissatisfaction with something, this being considered illegal in the Defence Force. This restriction does not apply to civilian students.

> *As you compare them, like you will find that you will get report that at xxxx the students have strike, they don't want this type of a lecturer or what. They can, they can act for something that they don't want. But with our student, they don't … they will never take a way of saying they are going to strike or whatever. They will rather maybe find a way of … of putting their grievances on the table*. (FGL2–1:56,57)

> *There are certain things in certain ways in which things are done in the civilian nursing colleges, which are not necessarily done in our military nursing college. So, that sort of causes a bit of a conflict, because they want things to be done in that way. For example, I would say in terms of the SRC.*

The SRC in the civilian college, you know, it has that huge power in terms of deciding whether the classes can go on today or the classes will not go on today. In the military that is not allowed. There, there is no way that the SRC will now come up and say the classes are not going today, on today, because we are dissatisfied. (FGL1–1:3,4,5,6)

As a result of the regulated environment and also the need for obedience and compliance, the participants were of the opinion that they generally are unable to make autonomous decisions and that their opinions are often not considered. The result is that when nurse educators are not able to express themselves, the students also do not learn how to do this. This inhibits the professional development of both nurse educators and students.

Your decisions are always undermined or not really taken into consideration. Irrespective of the experience that we have or irrespective of the qualifications that we have, they were really not taking [these] into consideration. (FGL1–6:190)

So, in my opinion, it definitely has a hampering effect on the professional development of the students as well as us as, as lecturers. Being the example for the students you remain in this, let's call it the circle or this loop. So, I mean if we don't, if we cannot really say our opinion or feel free to do so, how would the students learn to? (FGL2–2:11)

The regulated environment also implies that members are not allowed to challenge or question decisions, refuse orders or act without an instruction and that command lines must be followed for all communication. Although this is considered part of military discipline, participants believed that it results in students not learning to be either assertive or inquisitive.

When it comes to taking orders, we are taught to follow. Whether we go to the wall, you don't ask why are we going to the wall. We all go to the wall. If the order is given, you will do it. (FGL1–7:40)

Because now in the Defence Force you don't have to query, you don't have to ask questions. We talk about orders. (FGL1–3:24)

Now we are coming into this environment where you are supposed to talk when you are told to talk. You don't just start to talk. (FGL1–7:71)*At the same time, that thing of saying you follow orders, you do, then you will complain later, it is also killing them like to be assertive professionals. Because, like the colleagues have already said, when they are in … in the wards, they are not questioning.* (FGL1–5:58)

… it was very frustrating because what I discovered was they really follow lines of communication. You can't just do a thing, do a thing or if I want to see [a] professor, I have to follow if there is sequence. It must go from ... All of these people must know that I will be coming to you. Sometimes, it is time

consuming because from the civilian side we know that the Matrons, they all use open-door policy. But here, an open policy is not acceptable, they have to follow lines of communication. (FGL1–6:188,189)

3.2.1.3.2 Hierarchical environment

Military organisational structures are hierarchical in nature, comprising different levels, with each level varying in terms of importance and authority. The participants reflected that the organisational structures are such that non-health professionals may be in charge of health facilities and health professionals and that the person does not necessarily act in the best interests of the profession or the patient, which results in professional dilution.

> *If you look on your military health clinics, who is the person that is in charge there? It is a military practitioner, it is not a nurse, it is not a doctor. Now, that person is taking decisions about the profession. He knows nothing. All he knows is how to shoot, how to march and all those things. Of course, the decision that are going to be made, they are not going to be for the benefit of the nursing profession or of any medical profession because that person has got no clue.* (FGL2–1:127)

> *There are times when you are led by somebody who does not have insight into the nursing education.* (FGL2–6:78)

> *But, you do get people who doesn't know, know that role of the medics that wants to interfere in your work as being a profession. You know, it comes back again go people, unqualified people who doesn't have a clue what our …* (FGL2–3:109)

The hierarchical organisational structure of the military has been formalised by the use of military ranks. Military ranking and military customs and etiquette go hand in hand. The issue of rank is however considered to be a factor that contributes to the fact that students are reluctant to ask questions and moreover creates confusion in terms of ethical decision making.

> *Don't say I will only ask the sister or what. During ward rounds, ask this doctors. Try by always to know what is happening, everything that is happening in the unit. They tend to have this mentality of you know, you know that order thing and what is sort of holding them back a bit; but especially during their first years of training.* (FGL1–5:59)

> *… the issue of ranks also come into play when you are taught to respect a higher ranking. So, … currently, they are now COs. When higher-ranking officers come into the ward, you have been taught to respect this person. We have spoken about orders. So here comes this General, he is asking me as a CO about the private's condition in the ward. Do I now ...? We have spoken*

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about the patient's right. Do I respect the patient's right to privacy and confidentiality or do I respect the higher-ranking officer who is asking me to divulge the person's private information and give [the information]? (FGL1–3:118,119,120)

The participants were adamant that the ranking system gives rise to a top-down approach that makes them feel oppressed but also leads to them to oppress the students.

> *Yes, you felt oppressed and hence it created some conflict within you. Now, when we relay that to our students [that] it is because of the ranking structure … it happens sometimes that we oppress them, right? Consciously or unconsciously we do oppress them. That is a negative emotion and that can make you react in a negative way.* (FGL2–4:54)

> *You are down there, down there you are.* (FGL1–7:77)

> *I also find that the military and specifically the ranking kind of hampers the professional development in a certain extent. It is about being assertive. It is about, you know, kind of giving your opinion about something. I think the students, it is definitely there. It is even in the hospital. They are kind of scared to … to really stand up for themselves because of that. I see it even at work in … in our professional situation where you would like to give your opinion. But that opinion is … is kind of … it is not taken into consideration; let's put it that way. Because whatever the higher rank says, it goes. So, in my opinion, it definitely has a hampering effect on the professional development of the students as well as us as … as lecturers.* (FGL2–2: 8,9,10,11)

The military hierarchical ranking system also affects command and control, which, according to the participants, result in military rank taking precedence over professional rank, professional experience, professional qualifications and academic qualifications.

> *I would say in another way again, somebody coming in the ward or I would say a visitor visiting the patient, they know these ranks. They will go to the one-pip Lieutenant who doesn't know anything and say but you know help me with this and this and this and overlook the others who are actually more senior, but because of the rank. So the rank actually disadvantages the, you know, it disadvantages the profession in terms of … in the military the rank is given higher attention than the professionals, the professionality itself.* (FGL1–1:131)

With rank, however, also comes the abuse of power, which counters efforts to instil professional values and degrades the true military culture of respect and discipline.

> *So, instead of instilling what you want to enforce or instilling that professional value, you are actually like brainwashing people and you order them because, 'It is my way or the highway' and that is ordering. Some people will*

do it out of, not respect really, they will actually do it because you know that rank is … is talking. (FGL2–3:70,71)

Figure 3.3 provides a summary of the hidden elements and their influence as identified from the category *military environment*.
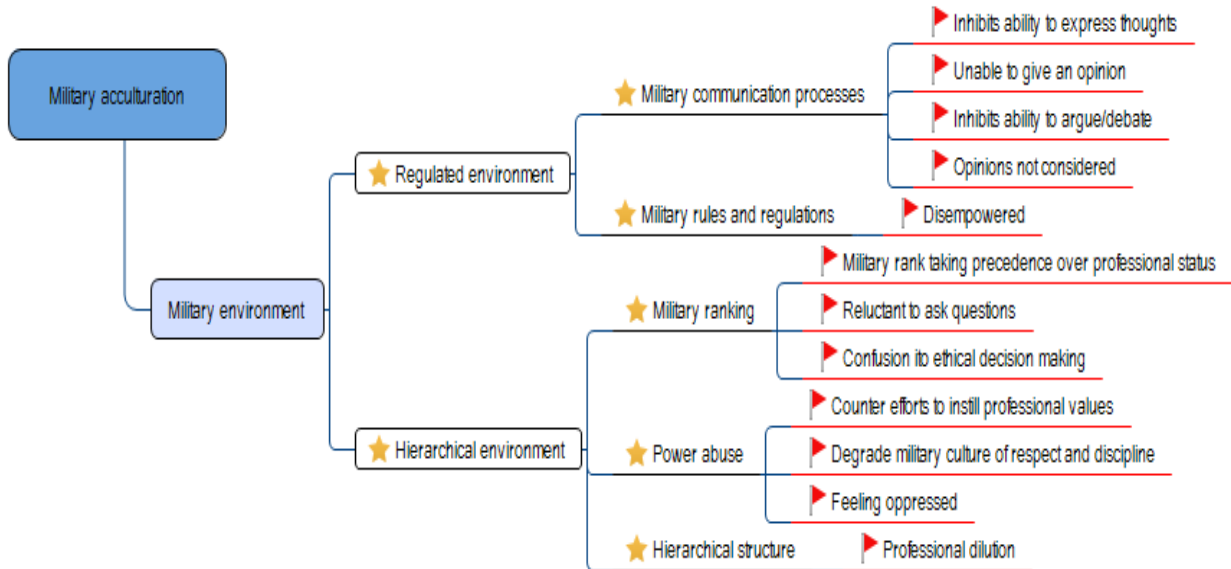
Figure 3.3: Mind map of the category *military environment* (Sample A)

3.2.2 Theme 2: Professional knowledge acquisition

Professional knowledge acquisition was identified as a theme to illustrate the process of teaching and learning the theory of nursing. Given that knowledge acquisition also takes place within a military environment, categories that emerge from the data include the roles of military nurse educators, environmental factors unique to the military environment that have an influence on theoretical learning and multigenerational influences as indicated in Table 3.3.

TABLE 3.3: THEME 2: PROFESSIONAL KNOWLEDGE ACQUISITION (SAMPLE A)

Theme	Category	Subcategory
Professional knowledge acquisition	Roles of nurse educators	Nurse educators' awareness of having to act as role models
		Nurse educators' awareness of having to instil nursing professionalism
		Nurse educators' awareness of having to instil military professionalism
	Military influence	Non-nursing duties
		Operational involvement
		Structural environment
	Multigenerational influences	

3.2.2.1 Roles of nurse educators

The participants acknowledged their roles in the professional development of the students whom they teach – this giving rise to the category *roles of nurse educators*. Three roles have been identified as subcategories, namely *acting as a role model*, *instilling nursing professionalism* and *instilling military professionalism*.

3.2.2.1.1 Awareness of having to act as role model

From the focus-group interviews, it is clear that the nurse educators are aware of their duty in respect of having to act as role models to the students. They emphasised the importance of role modelling so as to teach students the most appropriate ways of handling certain situations, and thus of leading by example by themselves doing what they expect the students to do.

> *We are supposed to be the teaching aids ourselves. Students have to learn from us. Is this the way of doing things? We have to be their role model. We have to show them how to do things. So they instead of identifying a role model in our working environment, they identify role models in the civilian world.* (FGL1–2:90,91, 92)

> *For me it is also role-play. I mean being a role model in those. In other words. they need to see it from the Sisters in the wards that this is how you will manage a difficult patient whether it is a General or whether it is just a difficult patient. So, for me, that socialisation is about us doing accompaniment and teaching our students, and, of course, learning from the registered nurses in the wards.* (FGL2–2:119)

> *But now the lecturer comes … that came from outside, does not understand the military. The students are taking advantage nè? These lecturers admitted to me that it is their fault. They understand for the first time what it means.* (FGL2–2:113)

3.2.2.1.2 Awareness of having to instil nursing professionalism

The participants acknowledged their role as nurse educators of having to instil nursing professionalism and having to use more concrete everyday scenarios as a teaching strategy to teach students ethical decision-making skills to boost their confidence and encourage increased assertiveness.

> *So it is up to us, the facilitators, the lecturers, to … you know, to give them a guidance of how to be a professional because we are really training them to*

be real professional nurses. So, it is up to us to guide them in the correct direction. (FGL1–5:62)

But I think it is upon us as lecturers and teachers to say to them, to teach them the critical thinking, to teach them to be assertive. (FGL2–1:19)

Yes, it teaches them discipline slash submissiveness. But I think the onus is on us to teach them, shall I say the finer aspects of a professional nurse. Like he said, that of being assertive and that of critical thinking, and that of, you know, really being, having the confidence to interact with other people on a professional level. (FGL2–4:28,29)

I think [the] problem sometimes is coming up with abstract scenarios. You know sometimes when you think about the ethical decision making, you think of someone that is dying or something like that. You forget it is simply about the person getting the pressure sore, and you do something. That is an ethical dilemma. You do something about things like … the small things … you stop thinking very abstract and far away. The same thing about the General's wife demanding to be seen now and you have to … You know if we bring those things, simple things that are day-to-day things that we encounter, then that would also boost the confidence and the assertiveness of students. (FGL2–1-5:125)

3.2.2.1.3 Awareness of having to instil military professionalism

Although their core function as nursing educators is to develop students as professional nurses, the participants are aware of their role of having to be knowledgeable about military aspects and also to instil military professionalism. Also important are disciplining students as part of developing them and the need for new nurse educators to be properly acculturated into the military, to understand how things are done and why, and then to act in accordance with the way in which students are trained.

I really believed that I had to discipline the students and I managed to mould them. They are real professional nurses today. (FGL1–2:194)

I think my experience with teaching in the military is that [it] is an environment that allows a lecturer to pass on the knowledge that he or she has in terms of the discipline of our students … we are the ones who are supposed to guide them to become the soldiers, the military nurses of tomorrow. (FGL1–2:12,13,14)

But it becomes our responsibility to say but in the military this is how it has to be. As part of our responsibility to develop them, some of them, I can't say some of them, but the majority of them do change into what we would like to have at the end. (FGL1–2:18,19,20)

The difference would be the core, the core function. Me, I came here as a nurse educator. That is my core function. I have to develop this

*student as professional nurses. But because I am in the military set-up
I have to know what military entails, what I must do.* (FGL2–6:143)

Figure 3.4 serves to summarise the hidden elements and their influence as identified
from the category *roles of nurse educators.*

Figure 3.4: Mind map of the category *roles of nurse educators* (Sample A)

3.2.2.2 *Military influence*

The interference of military duties with academic programmes is one of the main
concerns raised during the focus-group interviews.

3.2.2.2.1 *Non-nursing duties*

The participants felt especially strongly about non-nursing duties taking precedence
over nursing training. Nurse educators and students are often expected to participate in
military activities such as parades, irrespective of the fact that they should be in class.

> *We find that being in the military in terms of the compliance – it lies very
> heavily on the students. Like, they will be having classes, they are writing
> exams today. But now … the Surgeon General has got a parade. The Chief
> of the SANDF has got this. So what happens to the students? The classes
> must be rearranged. It doesn't work the other way around. Even if you say
> but the students are writing exams ... you need to work out how this will, will
> happen, how this will affect the students … So it is a very, very difficult issue
> for us as well as educators looking at how we value education. But then, at
> the military, you are a soldier first, then you are who you are. But the soldier
> is the first thing that you need to uphold first.* (FGL1–1:110,111,112)

> *… being taken out of [a] course for a parade … of course does not
> make sense because the students have specific hours …* (FGL2–
> 2:83,84)

I know we are in the military, so we do need to comply … However when we have parades or there is this military functions that interfere with the training. In my opinion, [it] is also negative when students are forced to be removed from the classroom … I mean, the students are … where, in comparison to the outside world that will not occur. (FGL2–2:31,32)

3.2.2.2.2 Operational involvement

On occasion, it happened that the SAMHS were involved in humanitarian operations that also had a clinical angle. The participants had mixed opinions about the withdrawal of students from the classroom to participate in these operations. While some considered the exposure to be beneficial to the students by potentially providing clinical learning opportunities, others were concerned about the implications in terms of lecture periods, clinical hours and the possible extension of training.

I think the worst scenario was when the college had to close up because students and the personnel who had to deploy out there because nurses were on strike. So, it means you are a soldier first and then the rest. We had to find ... That also affected both the theory block and the clinical block and we are just confused and all that. (FGL1–1:113,114)

… Because if I can remember where I was during the strike and what happened, and we all know the history behind it. But they kind of look up to the soldiers because they kind of look up to where the carers come you know, they care for us. They really care. (FGL2–3:73,74)

But I wanted to say about the strikes is that I feel our students actually have an advantage because, yes, they are taken out of the class maybe, but when they go out on these strikes they learn something, you know? They really get to learning opportunities and experiential that they wouldn't have had otherwise. So, for me, that is a good thing you know? (FGL2–2:82)

Because taking the student at a time of strike and you say, because time of strike is not about go and experiencing or learning, it is about go and rescue limb and life. So … the other point again, xxxx is saying it is about hours. If that student she was in class for a period of a certain hours or for whatever, or she was somewhere, she has lost the hours for that period. Therefore, the students' course has to be extended because maybe she was in labour but now she was taken to … And again, there she was not accompanied because there must be an accompaniment and … Yes maybe, ja. (FGL2–5:86)

3.2.2.2.3 Structural environment

One participant mentioned that the military structures prevent professional growth and development. Like most other organisations, the military organisational structure is

pyramidal, which has a limiting effect on the vertical mobility of the members and leads to professional stagnation and super specialisation.

> *I think you have made an important distinction regarding the … the structures which I fully agree with you when you say it is about us. For me, it is one of the things that prevents us to develop as professionals, to grow in other fields.* (FGL2–6:99)

Participants regarded military routine which forms part of the structural environment as unconducive for adult learning. Each unit follows a specific unit routine in terms of scheduled times. For the SAMHS Nursing College, unit routine implies that lectures are scheduled from 07:45 to 16:15. The participants are of the opinion that a more adult approach to learning should be followed and that the students should not be kept in the classroom for the entire day.

> *If I may say, I think we need to also change our way of thinking when it comes to the students have to be in class from this time until that time. I mean they are adult learners.* (FGL2–2:85)

Figure 3.5 provides a summary of the hidden elements and their influence as identified from the category *military influence*.
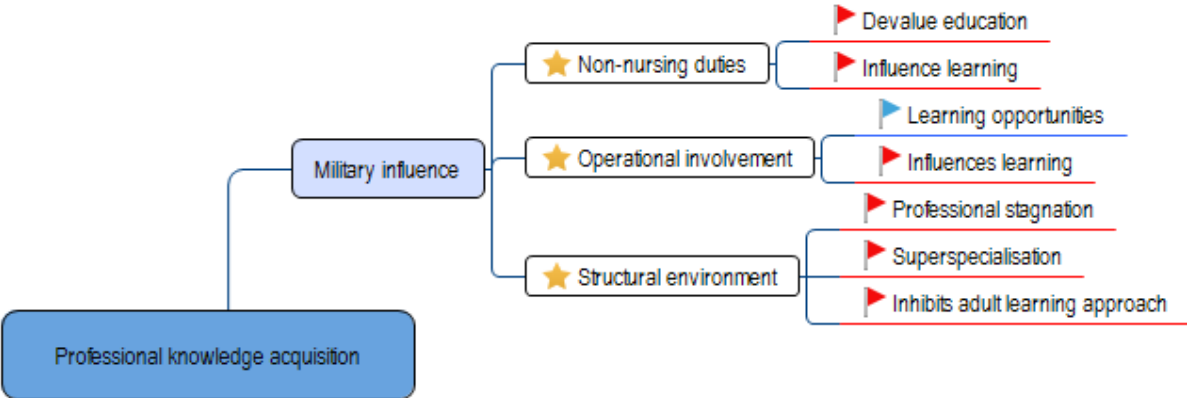
Figure 3.5: Mind map of the category *military influence* (Sample A)

3.2.2.3 Multigenerational influences

Students' ages generally range between 18 and 22 when they enter the Defence Force. The subcategory of multigenerational influences emerged as a result of the discussions that revolved around the different generations of students with which nurse educators

deal and the challenges confronting each generation in terms of adaptability to the military environment. According to the participants, the younger Y-generation find it more difficult to adapt to the restrictions posed on them by the military environment and that, as a result, they display a greater number of behavioural problems.

> *Some of them, not all of them, after being professional … you see that, yes, they are well disciplined ... But those who are Y generation, you can even see them when they are professional that they are Y-generation.* (FGL2–5:36)

> *The kids of nowadays … what we must mend in the military is the Y-generation. Yes we teach them the discipline, but … we have to allow them to … to … to sort of like criticise, but not in a bad manner. Most of the time, especially when they go higher, we start to complain about their behaviour.* (FGL2–5:37)

The generation gap between some of the nurse educators and their students also seems to be an issue. Apparently, the older nurse educators are more rigid in their teaching methods, which are not necessarily compatible with the learning needs of the Y-generation. This rigidity might result in students not reaching their full potential as nurses.

> *I feel [that] the military environment in which we provide training do not stimulate our Y-generation. I think, in our minds, we have become so set in our thinking that … that when we train, we have the baby-boom generation in mind. Hence we expect [a] certain attitude, submissiveness from them. I think we are forgetting that this Y-generation is actually so different and we do not adjust our thinking. Hence our actions are still the same. Therefore, there is a discrepancy in … in relating to the Y-generation. That is where perhaps we cannot develop them to their full potential because of the discrepancy.* (FGL2–4:47,48,49,50)

> *I think it is a generation gap and a technological gap if I can call it that. Because the kids of today are so technologically wise and actually I think we must change to a certain extent in a way in which … Now in the military, if I may bring something totally different, we are really got this challenge with Internet, about the security of having the Internet. We are challenged with resources. I think that has also got a huge influence maybe on trying to fit into this Y-generation. You know in our classes … we sometimes don't even have a laptop. I mean Internet is not available freely to us, never mind to the students. So looking at that, I think it does have an influence on the professional development of the students. Looking at the environment in which they are, compared maybe to a student from the university that has got this freely available.* (FGL2–2:52)

Figure 3.6 provides a summary of the hidden elements and their influence as identified from the category *multigenerational influences*.
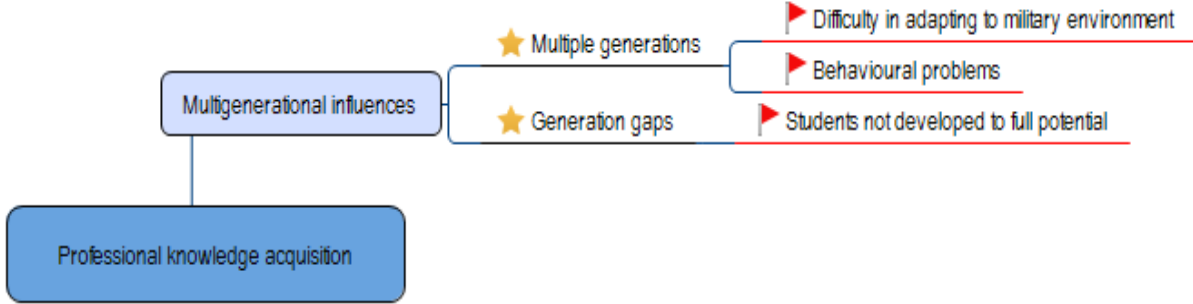
Figure 3.6: Mind map of the category *multigenerational influences* (Sample A)

3.2.3 Theme 3: Clinical skills acquisition

With a view to exposing them to clinical learning opportunities and enabling them to practise the skills required to become proficient professional nurses, students are placed in a variety of healthcare facilities. In addition to placing students with the military healthcare facilities, the SAMHS Nursing College also has Memoranda of Agreement regarding student placement with several other governmental and also with a number of private healthcare facilities. The data make it evident that there are some quite contrasting perceptions and opinions when it comes to comparing the experiences of students in these different environments. This is why a distinction is made between the military clinical learning environment and the civilian clinical learning environment as categories of Theme 2. These two categories and their subcategories are reflected in Table 3.4.

TABLE 3.4: THEME 3: CLINICAL SKILLS ACQUISITION (SAMPLE A)

Theme	Category	Subcategory
Clinical skills acquisition	Military clinical learning environment	Learning opportunities
		Exploitation of power
		Autocratic approach
	Civilian clinical learning environment	Perceptions of military students
		Influence of civilian exposure on military students' behaviour
		Comparison between military students and civilian students

3.2.3.1 Military clinical learning environment

The military clinical learning environment denotes the selected Military Hospital at which students are placed for their clinical exposure. This 249 bed facility (SAMHS 2016a) provides a holistic range of healthcare services exclusively to members of the Defence Force and their dependants.

3.2.3.1.1 Learning opportunities

As a result of the average bed-occupancy of 38% (SAMHS 2016a) and also the specific nature of the patient population making use of the particular facility as depicted in the quote below, the military facilities at which students are placed for clinical practise tend to impose restrictions on how much exposure students are given. The concern occasioned by this situation is evident from some of the remarks made during the respective focus-group interviews, hinting that the students are disadvantaged by the lack of learning opportunities.

> *At the same time, the military clinical learning environment … I think in a way it disadvantages our students because there are some procedures or conditions that the military environment does not have. You find that you are teaching, let's say surgery, whilst you see the gunshots, you will see all. You will never see a stab wound most of the time. will teach them, you tell them about the disembowelment and all those things. They will complete their training without seeing those things. In military casualty, you will.* (FGL1–5:142)

The participants further emphasised the importance of clinical accompaniment as contributing towards the professional socialisation of students.

> *Accompaniment and the students learning in my opinion from us is a huge part of their professionalism.* (FGL2-2:112)

> *So for me that socialization is about us doing accompaniment and teaching our students, and of course learning from the registered nurses in the wards* (FGL2-2:119)

3.2.3.1.2 Exploitation of power

As within the training environment discussed earlier (section 3.2.1.3.2), the issue of rank and the concomitant exploitation of power also surfaces in the military clinical learning

environment. Students are appointed as Candidate Officers (COs), which in the strictly hierarchical military organisation leaves them without any authority whatsoever. As a result, the participants felt that the students are often confronted with choosing between doing what they know is right and doing what they are instructed to do. The participants considered this to have a negative influence on students' development.

> *The issue of ranks also come into play when you are taught to respect a higher-ranking [officer]. So, you are … currently they are now COs. When higher-ranking officers come into the ward, you have been taught to respect this person. We have spoken about orders. So, here comes this General. He is asking me, as a CO, about the Private's condition in the ward. Do I now ...? We have spoken about the patient's right. Do I respect the patient's right to privacy and confidentiality or do I respect the higher-ranking officer who is asking me to divulge the person's private information and [then] give [it]? So, then, you are also now in a conflicting situation.* (FGL1–3:118,119,120)

> *I am not so sure that our students – when they qualify, they are ready to take charge of the ward because of that rank differences in the training environment.* (FGL1–2:128)

Stemming from the above, the ranking system is deemed to be one of the main challenges with regard to ethical practice. The participants acknowledged that nurse educators have a role to play in teaching students that patients have to be treated according to their needs and not their rank.

> *Another problem is that you as a nurse, you are trained to prioritise to triage in the … like for instance in Casualty. The problem is that in the Defence Force when this General comes in, whether he comes in walking and looks healthy and all that, just with a headache, then the General has to be seen first before this critical patient that needs to be seen by the health professionals.* (FGL1–2:129)

> *I mean, whether you are a General, patients are treated according to priority. So, I mean, that is how you teach our students. Whether the patient comes in and is a General's wife that is pregnant and the other wife has got a blood pressure of 180/100 whether it is a Corporal, who do you give attention to first? Obviously, the patient that is more ill. But that again depends on how we teach our students. For me it is about being an example, and then seeing the decision making done by you. For me it is really about seeing what we do, because that is mostly how students learn, by looking at what we do.* (FGL2–2:119,120)

3.2.3.1.3   Autocratic approach

Participants experienced the autocratic communication style and the habit of enforcing things on subordinates as being problematic. These aspects are moreover transferred to the military clinical learning environment – to the detriment of patient care.

> *We then don't consider the patient in what the patients might want or need. We just decide I am going to do this for you. There is no input from the patient. Maybe even the, the information that should then be given to the patient is not given to the patient in order for him or her to can make a decision. We sort of like … because of our autocratic [style], our thinking as military people, we just want to do. We then don't consider the patient in what the patients might want or need.* (FGL1–3:68)

Figure 3.7 provides a summary of the hidden elements and their influence as identified from the category *military clinical learning environment*.
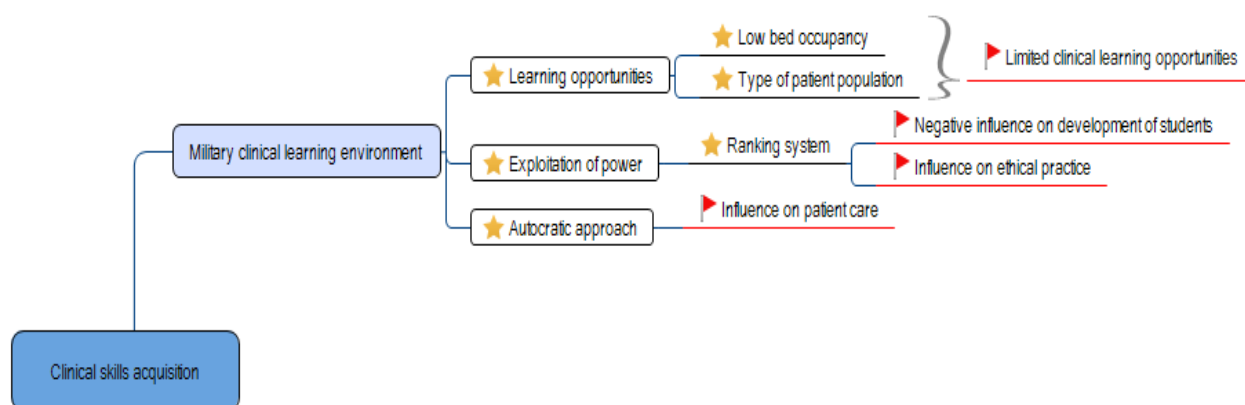
Figure 3.7: Mind map of the category *military clinical learning environment* (Sample A)

3.2.3.2   Civilian clinical learning environment

Students are also placed at civilian clinical facilities to gain the necessary clinical exposure and experience as a result of the limited learning opportunities in the military clinical facilities. This interaction with civilian healthcare professionals and civilian students inevitably leads to comparison and the forming of perceptions of one another. The participants reflected on their observations regarding the experiences of military students in the civilian clinical facilities.

3.2.3.2.1 Perceptions regarding military students

Participants maintained that there is a perception that the military students are less professional and knowledgeable than their civilian counterparts. This is so because military students working in military clinical facilities have less exposure to different disease profiles than do their non-military counterparts working in civilian clinical facilities.

> *But now, you go to xxxx, all of a sudden this thing called Marasmus is real. It was something that was in the book, but now it is actually real. Is it not that … that … if you insists that behaviour to … to … for them to look as if they are not so well professionalised or they are not well conversant with the other.* (FGL2–1:44)

In general, it is quite evident that, in spite of the negative perceptions articulated above, the military students project a very positive image in the civilian clinical facilities and that they are held in high regard because of their discipline, general conduct, punctuality and neatness.

> *What I like about the military culture is that they influence our students in a way that they have got a certain way of behaving. They behave differently from the civilian students. That is also observed by the civilian nurses out there. Our students are the type of students that all the other clinical facilities, the civilian facilities, would love to have our students. That is because of the culture of the military that our students are having when they are practising out there.* (FGL1–2:15,16,17)
>
> *So, the culture really contributes positively in the image of the Defence Force because of the way they conduct themselves. They are in demand out there. The outside facilities, they always request us to send our students there because of the culture.* (FGL1–2:21,22)
>
> *In fact, many of the registered nurses from the outside actually applaud us on … on how well our students are disciplined.* (FGL2–2:30)
>
> *They behave differently from the civilian students. That is also observed by the civilian nurses out there. Our students are the type of students that all the other clinical facilities, the civilian facilities, would love to have.* (FGL1–2:16,17)
>
> *You know what, our things [are] helping our students to be real professional people. As we have indicated from the beginning, that our students are highly valued in a civilian life if they happen to apply because of the part of the discipline.* (FGL1–4:121)

3.2.3.2.2 Influence of civilian exposure on military students' behaviour

Participants were unanimous in their view that exposure to the civilian clinical learning environment generally has a negative effect on the behaviour of military students. This may possibly be due to their interaction with the civilian students. The result is that students start demonstrating un-military behaviour that runs counter to how they have been trained to behave and that they attempt to follow the example of their civilian counterparts. Such behaviour causes conflict between nurse educators and students and seems to inhibit professional growth.

> *If you remember, most of us we go and complain of their wrong behaviour when they are at their third year. Then, at that time, they interact with the outside world. Most of our student [are] at the third-year level, they are now starting to go out to other hospitals. Whereby they are, there is interaction of, with other students. Now it … it brings an influence of the behaviour which we were not used to, to our student. Then that is when we say we are not even sure if they are growing professionally because we are seeing now this different behaviour which we are expected in the military the student shall behave.* (FGL2–7:41)

> *… they start interacting with their counterpart students at other civilian nursing colleges. There are certain things … in certain ways in which things are done in the civilian nursing colleges which are not necessarily done in our military nursing college. So, that sort of causes a bit of a conflict, because they want things to be done in that way.* (FGL1–1:2,3,4)

3.2.3.2.3 Comparison between military students and civilian students

When comparing the military students with the civilian students, both positive and negative aspects emerged. According to the participants, military students are better than civilian students in terms of discipline and following orders.

> *I think if we compare our students to the other students in the other colleges we will find that … when it comes to discipline, when it comes to following orders … But I think we have got a better product when it comes to those things.* (FGL2–1:15,16)

On the other hand, military students do not compare well with civilian students in terms of assertiveness, a sense of responsibility, inquisitiveness and self-confidence. The lack of these is ascribed to the nature of the military culture and the enforcement of discipline and obedience, which leads to what is perceived as respect and submissiveness.

The one thing that I have observed, when you are coming from the civilian world, comparing to the military environment, what I have seen with the military students, they are more … I don't know whether somebody would be saying respectful or submissive. For, for me I have seen submissiveness, which is regarded as discipline in the military. For me, it is not okay, because if I need a student, especially where there should be a debate of some kind. (FGL2–6:1,2,3,4)

You take the student that comes from the military and the student that come from the civilian situation, there is just a lot of … of … of difference in terms of, you know, standing up, being assertive and being responsible and asking questions. Like when doctors give orders, you will find that our student they don't even ask anything, it is because the way we have been socialised to say you take orders as they are, you don't ask. (FGL1–7:47,48,49)

But other things like self-esteem, self-confidence, I think those things sometimes fall through the rug because of the nature of the culture. (FGL2–4:26,27)

The participants also regard the civilian students to be better than the military students in terms of cognitive abilities such as demonstrated in debating. Probably, this is also ascribable to the tendency found among military students of being scared to speak up and of being submissive rather than assertive.

I think that our students are a little bit disadvantaged in terms of that when we compare them to outside, to the civilian students We … we do see the scale tipping towards the civilian. I mean, the scale being higher in terms of perhaps cognitive functioning, and that is debating. (FGL2–4:26)

Figure 3.8 provides a summary of the hidden elements and their influence as identified from the category *civilian clinical learning environment*.
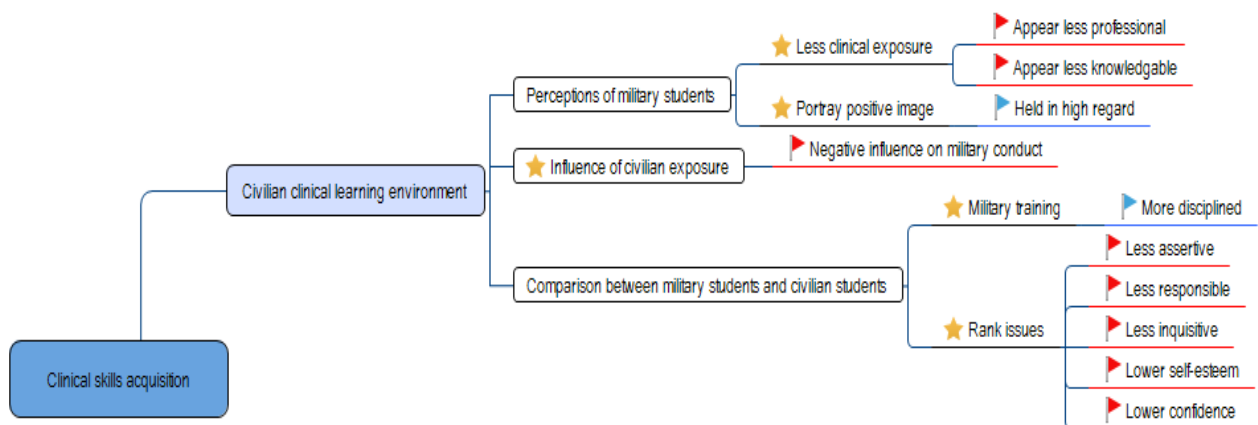
Figure 3.8: Mind map of the category *civilian clinical learning environment* (Sample A)

3.2.4 Theme 4: Professional role conflict

The most controversial theme that emerged was the aspect of duality as experienced in practising two professions simultaneously. Table 3.5 provides a summary of the category and subcategories of Theme 4.

TABLE 3.5: THEME 4: PROFESSIONAL ROLE CONFLICT (SAMPLE A)

Theme	Category	Subcategory
Professional role conflict	Dual roles	Acceptance of military requirements
		Professional contradictions

3.2.4.1 Dual roles

The category *dual roles* refer to the professions of nursing and soldiering, which military nurses are called on to practise simultaneously.

According to the participants, having simultaneously to assume both the role of soldier and of nurse poses a challenge and often creates role conflict. Over a period of time, they have been able to integrate these roles and to distinguish when it is appropriate to assume which role, depending on the situation.

> *I have been telling myself that I am not a soldier, I am a nurse. I am not a soldier. I even said that in front of my students: 'Hey, leave me alone I am not a soldier, I am a nurse', and all of that. They will go then you are a Captain. I say yes I have got a rank but I am a nurse, I am not a soldier. But now, as I was growing in the Defence Force, I had this … it is a two-in-one at the end. I cannot separate myself from being a nurse or that civilian part of me. Then, because the Defence Force have identified a soldier in me, now I have to be a soldier.* (FGL1–2:195,196)

> *So, ja, there are times when I have to … there are times when I am still a nurse. I am still that person, caring person. But then, when coming to discipline, that is where now I become a soldier and is that rank now.* (FGL1–2:197)

> *It is like the nursing profession take [away] your military assertiveness, it makes you being something like a caring person, whilst in the military it is like you have to be a bold or a strong person, especially with the ranking of an officer. For example, it is like when you are in a difficult situation and you are an officer, troops can cry, but you as an officer, you can't cry, you see? So it is like they take you from being a strict person, I would say, and then now being a caring person. In that way, it is like at some stage it contradict. So, it makes somehow two people in one person.* (FGL1–8:172,173)

For the first months that adjustment was really difficult for me. It was difficult in a way that I have been in a civilian world for … forever. When I came here this beautiful ladies that I have seen with this brown uniform, then I have to come in ... You know, there was just this, this role conflict. (FGL1-7:157,158)

3.2.4.1.1 Acceptance of military requirements

Participants maintained that becoming a military nurse has been a choice, which implies that both roles have to be adopted and practised. No distinction is made between different musterings in terms of military duties in the sense that nursing professionals are not exempted from military duties.

If I just look at our deployment issues, yes I choose the military. I, I love my uniform, I chose it and I know when I made decision when I joined the military I had to take everything that comes with it. (FGL2–3:69)

But my problem is the interference of military into the professional development of the student where we are treated as equal irrespective of the expectations of the courses that we are doing. (FGL2–6:79)

3.2.4.1.2 Professional contradictions

Many contradictory aspects surfaced amongst the participants while discussing their dual professional roles. These contradictions are the cause of confusion among nurse educators. The participants mainly related the contradictions to governance, professional conduct, command and control, professional roles, humaneness, professional ranks, assertiveness, leadership, authority and ethical principles.

- *Governance*

Participants claimed that the military regulations to which they are additionally subject are often at variance with the nursing-specific professional regulations. Members of the SANDF are subject to the dictates of the Defence Act, no. 42 of 2002 (South Africa 2002), the Military Disciplinary Code and the Code of Conduct, all of which regulate the professional conduct of a soldier. All military nurses, on the other hand, are also subject to the Nursing Act, no. 33 of 2005 (South Africa 2005) and its regulations, which, in turn, prescribe the professional conduct of a nurse.

> *On the other side, we teach them from their first year, we talk about the scope of practice, nè, as a professional nurse, this is your scope of practice ... Then we talk about R387. We talk about acts and omissions. So, it becomes a contradicting when this person has to follow the military principles and at the same time follow the professional principles. So some way they ... Ja, confusion.* (FGL1–6:53)

- *Professional conduct*

Participants claimed that military expectations often outweigh professional expectations because nurses are not sufficiently assertive and that they therefore fail their patients. In the Defence Force, rank plays a hugely important role in terms of how for example seating will be arranged at functions or who will be served first. A higher-ranking member will always take precedence over one with a lower rank, and if a soldier fails to respect this, he/she will be regarded as disrespectful and ill-disciplined. In the nursing profession however, patients are prioritised according to their health needs. If a nurse fails to treat patients based on their needs, it will be regarded as professional or ethical misconduct.

> *… to a certain point, you have to stand up for your patient care, because that is at the end of the day your profession. That is what you want to do. Because your patient comes first, irrespective whether the military tells us that rank comes first or a soldier comes first, because that is what they tell us. They tell us you are a soldier first and then your profession. I have heard that many times in my lifetime, soldier first before profession. But if we don't teach them assertiveness, if we don't teach them that, you know, you have to be the advocate for your patient.* (FGL2–3:105)

> *We still have, as a profession we have to please and explain at the Nursing Council if something goes wrong. But you also have to go please and explain in the Colonel's office for office bearing. So, we need to bring in that emphasis back than to teach our students that assertiveness, because unfortunately a lot of them don't know it. They don't know where to draw a line sometimes.* (FGL2–3:106)

- *Command and control*

Command and control are the means by which a military commander recognises what needs to be done and sees to it that appropriate actions are taken during military operations. As a result of the many dual professions in the SAMHS, a distinction has been made between military command and functional control. A commander is assigned military command by virtue of rank and appointment, while a healthcare professional in control of a professional grouping is assigned functional control.

Participants felt that where a non-healthcare professional is appointed in a command position, even at a lower rank than that of the healthcare professional, the commander often imposes his/her authority on healthcare professionals and interferes with their professional functions.

> *There are times when you are led by somebody who does not have insight into the nursing education. He doesn't have that knowledge that you are expected to do this many hours. You are expected to do this. But my problem is the interference of military into the professional development of the student where we are treated as equal irrespective of the expectations of the courses that we are doing.* (FGL2–6:78,79)

- *Professional roles*

Although both the military and the nursing professions are seen as disciplined professions, the participants seemed to experience difficulties when they need to discipline a student at the one moment, and need to act as caring role models at the next.

> *Then, now you are calling the student in to charge the student because they have done something wrong, they contravened the rules and regulations that they were supposed to abide by. Now, on the other side, now that caring personality comes up … Then you go on but why did you do such a thing, you know, you are not supposed to be doing this. You are supposed to be trying to do this way, this way. So the roles now … the student is now confused. You have just finished disciplining the student in that soldiering manner to say this will not be allowed, I have charged you. The next second you have changed completely. You are now this caring motherly … It is very difficult.* (FGL1–1:108,109)

In line with the above, the participants also experienced conflict between being a disciplinarian but also a teacher. They regarded their core function as being that of a nurse educator and find it difficult to discipline students in a military fashion at the same time.

> *The difference would be the core, the core function. Me, I came here as a nurse educator. That is my core function. I have to develop this student as professional nurses. But because I am in the military set-up, I have to know what military entails, what I must do.* (FGL2–6:143)

> *I think again, just to get that kind of a balance becomes very problematic or a bit difficult because you find yourself as a lecturer the student has committed, you know, something. You have got to enforce some discipline. In a soldiering way, we call it charging the … the … the student.* (FGL1–1:105,106,107)

Participants also maintained that they find it difficult to switch between a military attitude and a caring attitude, thus to be emotionally undemonstrative as a soldier but empathetic as a nurse.

> *Then I will push students to come back to the hospital and how there they were a soldier and they had to do the military things and have to be this strong an assertive type of person. But now, they come back and you have to be this caring type of person. So somehow it actually also … If you are not strong enough, if you don't know that I cannot cross this line, I don't know … I think it is very confusing sometimes*. (FGL2–3:72)

> *It is like the nursing profession take your military assertiveness, it makes you being something like a caring person, whilst in the military it is like you have to be a bold or a strong person, especially with the ranking of an officer. For example it is like when you are in a difficult situation and you are an Officer, troops can cry, but you, as an officer, you can't cry, you see? Then you are from that environment you are groomed as an officer. It is like, even though I am sympathising with you, you can't see it, you know? Then how are you going to believe it to can say I am really sorry about, I mean, what I am telling you right now, it is just that I can't show it. You know what I mean? So, it is like they take you from being a strict person, I would say, and then now being a caring person. In that way, it is like at some stage it contradict. It is like Colonel was saying, you have to charge this student. Then you are taking this student and you are there. You are the Captain, you are saying this and this and this, you know, with this appearance. Then later, it is like, 'but why did you do that, you know you are not supposed to do?'. So, it makes somehow two people in one person.* (FGL1–8:172,173)

- *Humaneness*

Participants are aware to the fact that students regard themselves as being treated like objects in the military environment as opposed to being treated like human beings in the civilian environment.

> *Our students now, with this culture and the civilian culture, because you are placing them here in the military environment and also outside, they would say outside, there in the civilian world they are treating us like human beings. But here at xxxx, they are treating us like objects.* (FGL1–2:93)

- *Professional ranks*

Military nurses are given both a military rank and a professional rank. The military rank does not always reflect the professional level nor does the professional rank always reflect the military seniority. To participants, this situation poses a challenge in terms of command and control. The examples given mostly involved scenarios in which students

were expected to take charge of a ward and lower categories of nurses with more experience but lower ranks refused to take orders from the students. In another scenario, a qualified professional nurse has not done the Officer's Formative Course and can therefore not be promoted in the military though he/she is functionally more senior than a newly qualified nurse who has completed the course and has been promoted to a more senior military rank.

> *That is where the conflict my colleague was talking about [arises] because you find that the staff nurses are the Corporals. Our student, now, they are on their third year, they are on their fourth year, they are COs. Now they have to give orders to the staff nurses of which they refuse [to do]. That had affected nursing care in a very, very [negative] way.* (FGL1–8:130)

> *In addition to the negative, concerning training of our nurses, we are giving them the CO rank, which is lower than the Sergeant, the Corporal and the rank. We are developing our students to become professional nurses. People have to take instructions from them. It becomes easy when they are still in their first year because they are just learning the basics and all that. They go to ... As soon as they reach their third year, we are training [them] to be Unit Managers. These people with these higher ranks than theirs, they have to take instructions from them. Now it becomes that conflicting situation again. Obviously, this higher rank is not going to take instructions from the lower rank. I think that disadvantages our students.* (FGL1–2:127,128)

> *I would say in another way again, somebody coming in the ward, or I would say a visitor visiting the patient, they know these ranks. They will go to the one-pip Lieutenant who doesn't know anything and say but you now help me with this and this and this and overlook the others who are actually more senior, but because of the rank. So the rank actually disadvantages the, you know, it disadvantages the profession. In terms of in the military, the rank is given higher attention than the professionals, the professionality itself.* (FGL1–1:131)

- *Assertiveness*

The participants felt strongly that assertiveness is a skill that should be instilled in students in order for them to be advocates for their patients, but agreed that being a disciplined, obedient soldier however requires nurse educators and students to be submissive rather than assertive.

> *Also, it is also about decision making. You know, like I wanted to also say to my friend that it took me a prayer that I have to be submissive. You know, because if I feel this is not for … it is not right or most of the time, I would say I am guilty of saying [that] my way is the only way, you know? So it is because, I think it is because of that military culture that I was indoctrinated in. So like, really, it was difficult to just listen and taking also somebody's*

view, like oh, maybe seeing it this way. Let me also maybe look at it the other way. Maybe it is going to be right. But really it is. (FGL1–8:147)

The one thing that I have observed, when you are coming from the civilian world, comparing [it] to the military environment, what I have seen with the military students, they are more … I don't know whether somebody would be saying respectful or submissive. For, for me I have seen submissiveness, which is regarded as discipline in the military. For me it is not okay, because if I need a student, especially where there should be a debate of some kind. (FGL2–6:1,2,3,4)

- *Leadership*

Participants often experience conflict when different leadership styles are applied. Whereas the Defence Force is generally seen as an autocratic organisation, the nursing profession is seen as being more democratic.

Then there are times where it becomes difficult for them, because with Defence Force we, in the military way, we deal with, I can say autocrats. This one person's rule throughout. You don't have to get inputs from other people. Whereas, in the nursing profession, they are taught that you can't manage without other people's inputs, you can't manage without … Management by surprise is not allowed, whereas in the Defence Force it is possible, management by surprise. So there are parts where there is, you know, contradiction when you compare the military and the civilian. (FGL1–2:26,27)

When you are looking at administration, what do I now referring to as management… different types of leadership styles, there is a time and you cannot use one of them at the same time. There is a need for you to be autocratic. That is when you are giving instructions. This is a real life situation. Somebody's life is in danger or if not, my life is going to be in danger. I don't want anybody to say anything. I say this thing must be carried out. You see, you are becoming autocratic. But, if the situation is such that there is no emergency [and] life … somebody's life is not involved, then democratic, you see. (FGL1–4:123)

- *Authority*

Authority is bestowed on a person by virtue of rank or position. In both the Defence Force and in the civilian sector, it is customary to show respect to a person of higher authority. According to the participants, in the Defence Force, authority, however, tends to instil fear rather than respect.

I remember when you were a professional nurse at the civilian, you will be in the ward controlling everything, doing something. But, you know you have got this Matron who will come and, for rounds. But when he come, you stand up showing respect, but not a fear. (FGL2–5:75,76)

I was scared of everybody as a student. I hardly ever asked any questions, okay, because that is really the way I was taught. You would have a lecturer in front standing on a pedestal, and that is how myself as a student … So, I was very scared to ask anything or do anything wrong. (FGL2–2:61)

So, what is happening is, in a way, a rank instils fear to individuals. It is worse if you … you were not socialised in the military. (FGL2–6:95)

- *Ethical principles*

The governance of the two respective professions, the Defence Act, no. 42 of 2002 (South Africa 2002) and the Nursing Act, no. 33 of 2005 (South Africa 2005) automatically provides the ethical guidelines in accordance which each professional is expected to practise. When it comes to military discipline and conduct, the broader military community tends to emphasise that military healthcare professionals are soldiers first and foremost. One participant however tried to put this in perspective by pointing out that, in a conflict situation, when lives are at stake, healthcare professionals are obliged first to defend themselves and their comrades.

When they say you are a soldier first and you are a professional after, it is usually about the war situation. If you were to be in a war, specifically in the area where you are being attacked and people, enemies [are] advancing. Now, the most important thing is to defend your territory, which means you are going to put the medic down and take your rifle, you defend your territory. Then, after that, you treat the injured. (FGL2–1:123,124,125)

Participants were concerned regarding the principles of beneficence and non-maleficence as taught to students, as opposed to what they are taught during Basic Military Training in terms of musketry and warfare.

Then there is also the aspect of, I don't know [whether] it relates, but, do no harm. Beneficence, non-maleficence. You are taught to shoot here. You go to the shooting range and you are given a weapon. We have been there, we have done it. Now you come here and you have to care and you have to treat. (FGL1–3:43)

Furthermore, the controversial issue of the rights of soldiers – or rather their lack of such rights – was contrasted with the rights of nurses and of patients.

They say our … you don't have the right as a soldier. This is our culture you know, our rights are taken off. But in a nursing profession, we teach students the patients' rights and the nurses' rights. (FGL1–6:98)

Lastly, in terms of ethical principles, participants debated the ethical conflict that students often experience when confronted with a military order or instruction from a higher-ranking officer, one which may be in contravention of the patient's right to privacy and confidentially.

> *The issue of ranks also come into play when you are taught to respect a higher-ranking [officer]. So, you are currently … they are now COs. When higher-ranking officers come into the ward, you have been taught to respect this person. We have spoken about orders. So, here comes this General, he is asking me as a CO about the Private's condition in the ward. Do I now ...? We have spoken about the patient's right. Do I respect the patient's right to privacy and confidentiality or do I respect the higher-ranking officer who is asking me to divulge the person's private information and give [the information]?* (FGL1–3:118,119,120)

Figure 3.9 provides a summary of the hidden elements and their influence as identified in the category *dual roles.*
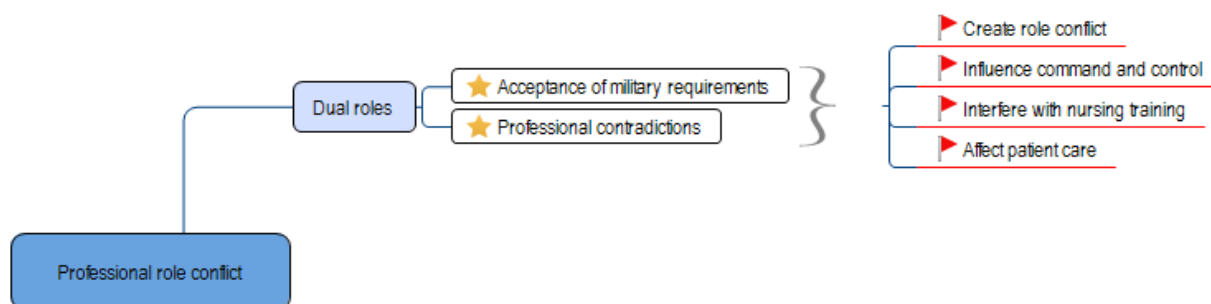
Figure 3.9: Mind map of the category *dual roles* (Sample A)

3.3   SUMMARY

This chapter has dealt with the findings from data extracted from the focus-group interviews with nurse educators. Four themes, nine categories and 22 subcategories emerged from the findings. The categories and subcategories were supported by meaningful units from the focus-group interviews. All of the themes, categories and subcategories were presented by mind maps to illustrate the identified hidden elements and their influence. The following chapter deals with the consolidated findings of the focus-group interviews conducted with the students and also those obtained from the critical-incident narratives.

CHAPTER 4

RESEARCH FINDINGS OF THE DATA COLLECTED DURING PHASE 1: SAMPLE B

4.1 INTRODUCTION

This chapter will discuss the findings of the data collected from Sample B during the course of Phase 1 of the research by reflecting on the themes, categories and subcategories that emerged during the analysis of the transcribed data, supported by the relevant meaningful units.

The objectives of Phase 1 were to explore the existing knowledge, attitudes and perceptions of students with regard to military and nursing professionalism, to identify the elements of the hidden curriculum in a military teaching and learning environment, and to determine how the hidden curriculum influences students' professional socialisation.

4.2 FINDINGS

Data were collected from Sample B by means of focus-group interviews and critical incident narratives. Two focus-group interviews were conducted with the participants. The ages of the 12 students who volunteered to participate in the study ranged between 21 and 30 years. The gender distribution – seven females and five males – is representative, since, at the time of the research, the college had an almost equal population of male and female students. This is ascribable to the fact that although nursing is generally considered to be a largely female profession, being a soldier is considered to be a more male profession.

After an introductory explanation of the focus of the study, namely the hidden curriculum and its meaning, the following invitation was extended to the participants at the commencement of each focus group: *"Let us talk about how you experience your military and nursing training in this unique military environment and the effect thereof on your socialisation as a professional nurse."*

For the critical incident narratives, each participant was provided with a notebook and broad guidelines to describe any incidents related either to their theoretical or to their clinical learning experiences, to reflect on the thoughts and the feelings provoked by the incident and to discuss how the incident may have influenced them professionally. Nine out of the 12 participants returned their notebooks. The findings of the focus-group interviews and critical incident narratives were integrated as illustrated in Figure 2.2.

As a result of constant comparison, the researcher arrived at the same themes as discussed in Chapter 3. However, the differences in perceptions and experiences between the two data sources led to the formulation of different categories and subcategories. Sample B produced 546 initial codes. The presentation of this chapter follows the same pattern as the one followed in Chapter 3: each section is preceded by a table summarising the categories and subcategories and each subsection concludes with a mind map of the relevant category that illustrates not only the identified hidden elements but also how these influence professional socialisation. The main themes that emerged from Sample B are reflected in Table 4.1.

TABLE 4.1: MAIN THEMES FROM SAMPLE B

Theme 1	Military acculturation
Theme 2	Professional knowledge acquisition
Theme 3	Clinical skills acquisition
Theme 4	Professional role conflict

4.2.1 Theme 1: Military acculturation

Theme 1 was labelled *military acculturation* because the participants referred to their experiences both prior to and during military training. Table 4.2 provides a summary of the categories and the subcategories of Theme 1.

TABLE 4.2: THEME 1: MILITARY ACCULTURATION (SAMPLE B)

Theme	Category	Subcategory
Military acculturation	Military as career choice	Ulterior motives
		Preconceived ideas
		Career prospects
	Military training	Military socialisation
		Developing a military professional identity

4.2.1.1 Military as career choice

During the focus-group interviews, the participants shared their "stories", that is, what had influenced their decision to join the Defence Force, what they had known and thought about the Defence Force, and what their aspirations had been.

4.2.1.1.1 Ulterior motives

This subcategory was labelled *ulterior motives.* Since not all the participants had joined the Defence Force because they had wanted to, other factors often influenced their decision. Financial considerations turned out to be the deciding factor. Some of the participants indicated that they had not been able to pursue their studies at a university or other tertiary institutions because they could not afford to do so.

> *I had an opportunity to go to varsity but then they were, like, I had a bursary. So, my brother … as the family said, they said, like, I love things. So, they were like even if you are in varsity you know you are going to be asking for things and we can't, we won't be able to provide for you. So, rather go and study and make your own money and then we will take it from there as a stepping stone.* (FGS1–3:51,52)

> *Okay, myself, after finishing matric, I never thought about nursing or military. I wanted to be becoming a optometrist. So, I didn't get the opportunity because the bursary is not easy to get them if you didn't get level sevens because I was a moderate student.* (FGS1–5:103,104)

For some participants, the Defence Force or being a soldier or a military nurse had not been their first career choice and they had thought of using the opportunity as a stepping stone.

> *I never thought about nursing or military. I wanted to be becoming a optometrist.* (FGS1–5:103)

> *Growing up, I also didn't like nursing, nurses, anything that has to do with nursing. From the rural areas I was from, I always wanted to see myself up there, maybe doing those careers that everybody thinks they are high paying [careers] and you will have money, have a nice car, you know?* (FGS1–6:132,133)

Then there were those participants who mentioned that they had been influenced by friends or family.

So one of my friend who I matriculated with, with him, he got recruited in infantry, became a private there. So that guy is the one who … who motivate me about military. I said, I wanted to come to military. He told me, like, 'If you want to stay in [the] military, maybe you must study something'. (FGS1–5:105)

When I first came to the military, I had an experience because my brother is in the military as well. But he is my brother, he is in the military as well. He is the army. The thing that my brother never told me he was like, you are going to have a pass, what is this pass town, town pass, every now and then, because he wanted me in. (FGS1–3:49,50)

4.2.1.1.2   Preconceived ideas

The data clearly indicated that most participants had no idea what they were letting themselves in for. They acknowledged that they had been unprepared, uninformed and initially very confused as they had different ideas of what was awaiting them.

When I left home, I never knew … First of all, when I applied and got into nursing, I never thought when I was approached that don't you want to join the military. At first, what came into my mind was shooting and killing and fighting only. I never had an idea because I come from a small town whereby we don't see soldiers around us at all, not even one. (FGS1–1:2,3)

When I came to military I didn't know nothing. (FGS1–2:34)

While most participants did have some idea of what working in the Defence Force would entail, various factors had shaped their individual preconceived ideas. One participant indicated that he did not want to join the Defence Force because of negative preconceptions obtained from the media.

Then I didn't want to come [in] the first place because of when I visualised the military soldiers with the exposure that I have seen watching movies, documentaries, I was like, that is the involvement I didn't want to see myself in. (FGS1–4:79)

4.2.1.1.3   Career prospects

The participants shared many positive perceptions, mainly about career prospects. These included having employment opportunities, earning a salary and incentives, having promotional and career development opportunities, having a range of career possibilities, working in other military facilities and having travel and deployment opportunities.

Because the military, I think, gives us opportunities. You don't get stuck as a nurse. You can continue studying something else. If you want to be a medical doctor, you can leave your nursing, go to be a medical doctor. You can specialise around the field of nursing. (FGS1–6:233)

I will get to see the world, like visit our African countries. I would love to provide my hands to help our fellow brother and sisters out there in those countries. So those are the … basically, the things that … except for the money that will make me stay in the military. (FGS1–1:248)

I think staying in the military will be the best thing because you also get to see the world. You get to travel wherever you want to go. You can go to Cape Town, KZN, anywhere. Then you can explore. They don't tie you down to a chair. (FGS1–6:236)

There were participants who acknowledged that when they had realised what being a military nurse would entail, what it could mean for their futures, they became motivated and expressed feelings of gratitude and appreciation.

I will thank, I will thank [the] military so much. Now I believe I have been groomed to be a professional. Now I can go outside there, not only to help people but also to seek more information using my professionalism. (FGS1–2:326)

I thank the Lord for everything. When I came to military, I didn't know nothing, I didn't believe in myself. (FGS1–2:33)

Figure 4.1 provides a summary of the hidden elements and their influence as identified in the category *the military as career choice*.
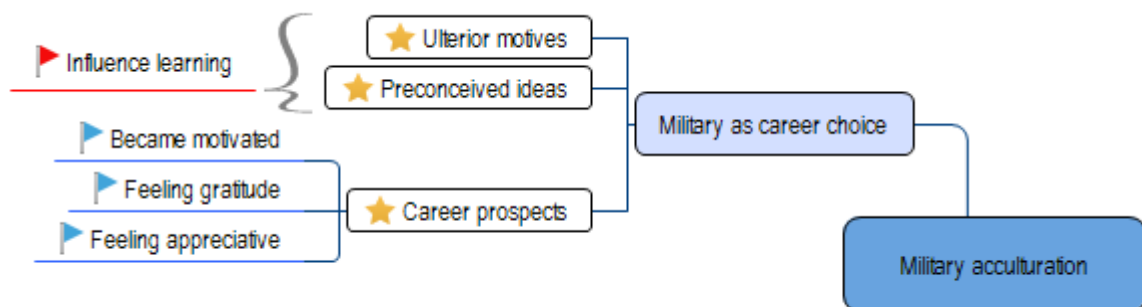
Figure 4.1: Mind map of the category *the military as career choice* (Sample B)

4.2.1.2   Military training

As stated in the previous chapters, students are expected to undergo basic military training prior to commencing their nursing training so as to assist them to adapt and be

integrated into the military organisation and culture. Because of numerous references during the course of the focus-group interviews to participants' experiences regarding military training, the concept *military training* was named as a subcategory of military acculturation.

4.2.1.2.1 Military socialisation

Participants mostly experienced basic military training as positive and referred to the value it added to their personal and professional lives. In general, the participants acknowledged that military training assisted them in accepting the military culture, in developing into soldiers, and being inducted into and internalising military norms and values. Military dress regulations aided in personal grooming.

> *On the other hand, just remember when you are in Rome, you do as the Romans do. So, whether you come with a positive mindset that you want to change things, you are just going to conform to their norms and their values and just do things the way they do it.* (FGS2–1:285)
>
> *From basic training, I think, they have been grooming us to be the kind of people that we want, they want us to be. Especially that [the] military has cultures, norms and values and we have to live up to that.* (FGS2–2:290)
>
> *The military basically taught us, because there are regulations how … like, dressing regulations. You will find that with my experience I have, you will find that most … in the public sectors, the nurses will go with long hair, like not making a 'pony' or something there. But in the military, being a military student or a military nurse, you know your hair must be neat. You must be made a 'pony', no Cutex (for infections). The military for me, basically, it taught me how to be neat.* (FGS1–5:175,176)

The participants also declared that they had not only learnt respect for authority but also obedience. They had moreover learnt to take responsibility for both their own mistakes and those of the group. This contributed to the participants' realising the value of teamwork and teaching them how to work together as a team.

> *I have learned how to respect authority. Not that I didn't have, I didn't know how to respect authority before I came to the military, but it wasn't as though … as I learned when I came into the military. Especially in basic training, you have to salute everyone you meet or brace up to everyone you meet. Also teamwork, you have to respect, because you can't have teamwork if you don't respect people around you.* (FGS2–2:90,91,92)
>
> *Most of all that I have learned [that] what is important in military culture is your respect and to be obedient. In the squad, you have to listen, no matter*

who is in front of you, you must respect that person and be obedient. (FGS1–2:184,185)

Here in [the] military, you are living … that punish or die for other people mistakes. So I accepted that [to be] so, and grew up with it. But I had a nice experience there. (FGS1–5:114,115)

What I love about [the] military is teamwork. We need that most in nursing. Nursing is about teamwork. You cannot nurse a patient, the whole ward for being alone. So I say my professional development, it really, really helped me. (FGS1–6:324)

Some participants indicated that military training definitely contributed to building their character by learning to be disciplined, to be strong and to cope with challenges. This was accomplished by learning from their mistakes and by developing self-confidence.

Where discipline is [a] daily activity and however builds one's character and future. (CIN–5:76)

After all, I felt like we are going to be suppressed all the time and live in fear during the four-year nursing studies. This has taught me to be strong and know sometimes there are hurdles along the race track. These improved my character. (CIN–9:142)

Even though I do something wrong, I know, you know what, this is wrong. Then it hit you and then you are like, okay, I will try to rectify it the other time. Then you won't repeatedly do the same thing that is wrong because you develop a conscience from the discipline they give you. (FGS1–6:146)

The most important thing what I think is helping me in the nursing profession is confidence. Since, as xxxx has mentioned, that during our basic training all of us we were civilians, basically. We had our own attitudes and our own way of doing things. As they saw that if you are going forward with the same attitude, you are not going to be successful. So, they drilled it into us that certain things has to be applied, like respect for others. So, through all that kind of training, I gained confidence because I learned how to carry myself and how to act towards others and also how to respect that. (FGS2–1:71)

But, they, in the military, even the way they teach us how to conduct ourselves in the outside world, it really, it gives one confidence. (FGS1–4:86)

Other attributes that were ascribed to the fact of military training included determination, endurance, resilience and patience.

From my side, I think determination. I have learned to, I don't know … maybe it is determination or what, but maybe you will understand when I say it. Like if you have a goal, maybe when we went there, our aim it was to finish the basic training. Then when we get there, you might think it is just going to be a smooth road, but when you get there you experience a lot of … It is cold, you have to sit outside, you have to walk while it is raining. You have to sleep outside. You have to run for your food. So, I have learned that no matter what

in my life or wherever in my profession, no matter the obstacles, one thing I will forever know is that I am going to reach there. Because in Basic, when … that you finish with Basic, even though there were obstacles and there were tough times, you manage. So, in life, it is much easier now. (FGS2–6:84)

The military helped me to be strong. Emotionally and physically, it strengthened me. Through basic training, we had to go through things that I never thought in my life I will go through physically and emotionally. We had this corporal; he will punish you by just making you look at the wall for an hour without moving on attention. So, that way, I had to be emotionally strong. I will cry but I had to be emotionally strong. (FGS2–2:78)

For me it is patience … So then, in a way, it helped me to be … have patience. Even now, when I am in the ward, I am very patient with my patients because I can tolerate different kinds of patients. (FGS2–3:75)

The use of harsh language during military training is 'traditional' and serves the purpose of letting recruits know immediately who is in command. The communication style makes for clear instruction by directing the recruits' actions. Though it is often loaded with sarcasm and swearing, communication is precise, direct and brief. Being addressed in this manner ensures that recruits will learn to listen and respond to instructions. The participants however took a negative view of the way they were spoken to.

I didn't like the insults. (FGS1–6:151)

4.2.1.2.2 Developing a military professional identity

Part of professional socialisation entails adopting the identity of the profession and the organisation. Concepts such as pride, passion, love, camaraderie and sense of belonging emerged from the data as evidence that military training assisted the students in developing a strong military professional identity.

I love [the] military. I will stay. You know, even at home they only ask you what do you do in the military. You know mos, most of guys, you don't say, 'I am a nurse'. So, I will tell them, 'I am an important soldier, I preserve life, guys. I am a nurse in [the] military.' (FGS1–2:253,254,255)

Wearing the uniform is such an honour and I love nursing. So I love [the] military and I love nursing. (FGS2–2:216)

I think that [the] military thing is within me. I'm born to be a soldier. (FGS1–5:130)

But also, it is helping for some of us. It is helping because you feel you are not, you do not feel alone. You feel like there is someone who cares. (FGS2–2:259,260)

But, as time went by, through training and being a group that is together, because if you are all alone in basic training it is either you can make it or it can make you or it can break you. So, I was fortunate to have colleagues such as these ones that we stood up together. We would sing songs that will uplift our spirits even if it is so painful. (FGS1–2:7,8,9)

Figure 4.2 is a summary of the hidden elements and their influence as identified in the category *military training*.
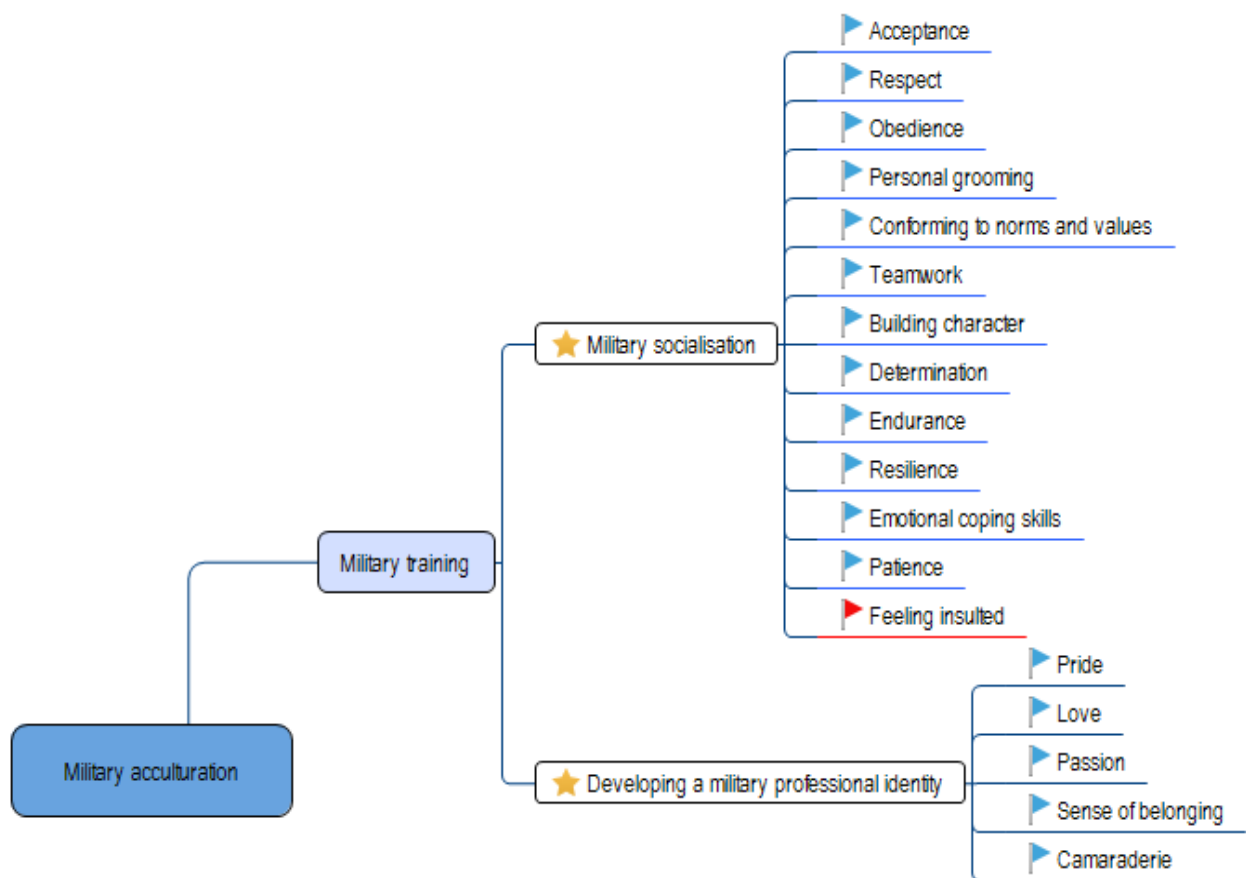
Figure 4.2: Mind map of the category *military training* (Sample B)

4.2.2 Theme 2: Professional knowledge acquisition

Professional knowledge acquisition refers to theoretical teaching and learning, with an emphasis on the classroom set-up. This theme emerged in response to statements made regarding the participants' academic experience, their interactions with the academic staff and challenges surrounding the fact that the theoretical learning

environment is situated within a military environment. Table 4.3 displays the categories and subcategories related to the theme *professional knowledge acquisition*.

TABLE 4.3: THEME 2: PROFESSIONAL KNOWLEDGE ACQUISITION (SAMPLE B)

Theme	Category	Subcategory
Professional knowledge acquisition	Nursing as career choice	Ulterior motives
		Preconceived ideas
	Teaching ethos	Management of poor performers
		Guidance and support
		Academic incompetence
		Assessment practices
	Interaction between students and nurse educators	Negative approach
		Negative communication
		Indifference
		Being judgmental
	Power and authority	Indiscriminate use of rank
		Being tyrannised by nurse educators
		Unjust treatment of students
		Condescending attitude displayed by nurse educators
	Professional nurse role models	Nurse educators demonstrating passion
		Breach of confidentiality
		Association with students and favouritism
	Learning environment	Adverse conditions
		Regulated environment
		Restrictive environment
		Punitive environment
		Prejudiced environment
		Military influence

4.2.2.1   Nursing as career choice

The participants' narratives also included what had led them to apply for nursing training and what they had thought and had known about nursing as a profession.

4.2.2.1.1   Ulterior motives

There were those participants who acknowledged that nursing had not been their first career choice. Some mentioned alternative careers they would rather have chosen, while others had chosen nursing just to secure employment. In some cases, participants had applied for purely financial reasons.

> *… Matric, I never thought about nursing or military. I wanted to be becoming a[n] optometrist.* (FGS1–5:103)
>
> *Growing up, I also didn't like nursing, nurses, anything that has to do with nursing. From the rural areas I was from, I always wanted to see myself up there, maybe doing those careers that everybody thinks they are high paying*

[careers] and you will have money, have a nice car, you know? (FGS1–6:132,133)

So that guy, [he] is the one who, who motivate me about [the] military. I said I wanted to come to [the] military. He told me, like, 'If you want to stay in [the] military, maybe you must study something'. So he gave me the SAMHS form, I checked there the two-year nursing, four-year nursing because I wanted a job. I thought about maybe let me go to [the] four-year nursing course. I will be having four years working at least earning some salary. (FGS1–5:105,106)

I am here for the money. I am from an underprivileged family, so I need to support my family back at home, and you know, for them to have bread on the table. That was what nursing was for me before then. (FGS1–6:134)

Some participants however either saw nursing as a calling from the start or became devoted and committed as they grew in the profession.

… when Major was asking the question why are we here, I said this is a calling. I believe it is a calling. I never applied like everyone else. I just went on that day where those who applied where called in. Then my results were checked there, [I was] interviewed and got in. (FGS1–1:152,153)

… nursing is that … it is the foundation to every profession in the world. As a nurse, I became an adviser and people take my advices into head meaning that I have the power to build or destroy an individual. (CIN–1:1)

The love for nursing and being a member in the DOD (Department of Defence) grew in me and that's when I realised I'm in the right profession. (CIN–1:71)

4.2.2.1.2 Preconceived ideas

With regard to the participants' perceptions of nursing professionalism, most indicated that they had had false expectations. There were those who had had negative preconceptions owing to previous negative experiences. Some had perceived nurses to be lazy and others admitted that they had underestimated what it actually took to be a nurse.

I used to have maybe negative attitude towards nurses, even at home, like those people are not working there because where I come from it is one clinic and a lot of people. When I go there maybe for headache, you will stay there until maybe 16:00 until they close. Sometimes they won't help you. I was saying I never become nurses because this people are lazy. (FGS1–5:126)

I assumed that military nurses are very disciplined. As soon as I started studying nursing, I realised that the expected high level of discipline was a misconception. I saw soldiers, especially nurses/nursing students displaying barbaric behaviour and treating others, mainly patients ill. (CIN–8:123)

… people think anyone can be a nurse and it does not take anything to be one. (CIN–1:11,12)

Figure 4.3 provides a summary of the hidden elements and their influence as identified from the category *nursing as career choice*.
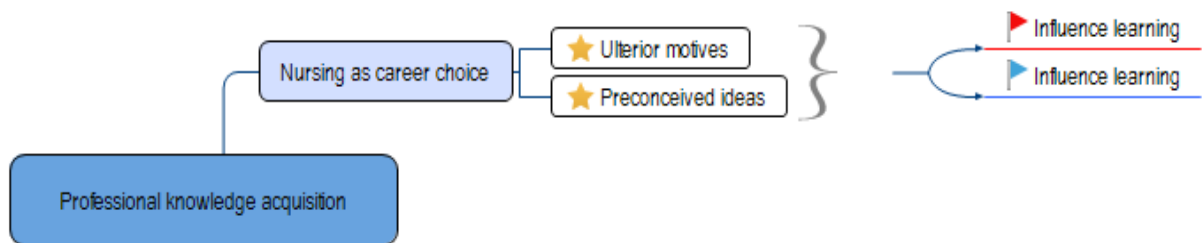
Figure 4.3: Mind map of the category *nursing as career choice* (Sample B)

4.2.2.2   Teaching ethos

Teaching ethos as a category refers to the skills, strategies and practices used by nurse educators during the theoretical teaching and learning phase. The category originated as a result of the frequent references made by participants with regard to how they experienced the manner in which they were taught and managed by the nurse educators.

4.2.2.2.1   Management of poor performers

Participants considered nurse educators' management of poor performing students to be humiliating and indiscriminate. Their view was that the nurse educators should refrain from addressing poor performers in front of the class and rather deal with them separately.

> *But when you are marking as a lecturer, you see, but this student is lacking here and here. Instead of saying, 'Write a memorandum' or 'You, you don't know anything', just try to call the student aside, or even without showing the class. Because once you show the class that this one is the one who is always failing, they will know this one doesn't know anything. So, just try to maintain confidentiality with the student.* (FGS2–6:192,193)

They further indicated that nurse educators should attempt to identify individual academic problems and then provide additional academic support.

So, just try to maintain confidentiality with the student. Call them one by one, saying, 'Come, I can see you are struggling here and here, what is your problem, what don't you understand?' Then try to give the student extra work to do. Even though you don't pressure them saying, 'No, I want it tomorrow', just say, 'In your own time just do one, two, three activities'. Just try to see if maybe they can learn from that. (FGS2–6:192,193,194)

The participants experienced nurse educators as being impatient with underperformers, feeling that they needed to make more effort in getting to know and understand their students and that they should treat each of them differently.

When it comes to theoretical, I will learn to be patience with the student because all of us, even here you can give us a test now, you can't get fifty, fifty. Some will get hundred. So you have to understand certain student, know your student. I don't have to treat the student the same way. (FGS2–6:189,190)

4.2.2.2.2 Guidance and support

Participants referred to occasions on which they had been academically supported by nurse educators who either provided them with advice or gave them positive reinforcement. This served to create respect for the nurse educators in question, motivated the students and resulted in professional growth.

Then coming into nursing, then I remember we went to class. I remember I wrote my first test in IGNS and I got forty something percent. I was so depressed and I was so stressed because normally from high school, I am one of the people, when I write a test, I never got fifties, less than sixty, at least. So, it depressed me a lot. Then my lecturer, the IGNS lecturer told us, 'Guys, when you write you must make sure you always rationalise. If there is no rational then what is that? Why are you doing that?' So it didn't make sense then until I grew in nursing. So, I will say that lecturer, I respect her even today because she is one of the people who made me grow into this profession. Because I know with anything that you do in nursing, even if I give this typical bottle of water to a patient, I know there is a reason behind that. (FGS1–1:15,16,17,18)

I was so scared because I didn't want to disappoint my family. I didn't want to fail. I asked Major, 'Major, what if you want to pass and you fail?' People, they laughed in class. Major said, 'No, my child, you will make it, you will pass'. I told myself, I will pass. Then it is when I saw the light. (FGS1–2:42,43)

There were however participants who felt that they were not receiving adequate guidance from the nurse educators. It was mentioned that nurse educators were

abusing their power and authority instead of guiding the students. The participants felt threatened and believed that this negatively influenced their learning.

> *The lecturers, our lecturers they are our mothers. They are supposed to guide us and so on. It is just that they are just misusing the power, the authority they have. So, it is … I will put it in this way. We are learning from them, but then even though we don't learn it in a good way.* (FGS2–4:252)
> *Maybe they should be using kind words to actually guide us, not threatening words to do that.* (FGS2–2:257)
>
> *The lecturers, our lecturers they are, our mothers they are supposed to guide us and so on.* (FGS2–4:252)

Participants were also of the opinion that nurse educators had to work on their professional relationships with students by being more understanding.

> *So, for me, I will try to have a professional relationship with the student, try to understand what they are saying.* (FGS2–6:176)

A lack of guidance was further identified by some participants who indicated that they were considered to be ill disciplined when they asked questions, with the result that clarification was never given on things they did not understand.

> *They have these, not all of them, but they have this tendency of when you ask a question, they will say that we are ill disciplined. So, with me, I was kind of like in trouble for that, the word ill-disciplined. I was like, how would say, when someone ask a question, you will say that they are ill disciplined? I believe that you wouldn't ask a question if you don't know the answer or maybe if you wanted clarity.* (FGS1–5:298)

According to the participants, nurse educators were often either unavailable, inaccessible or unapproachable. This resulted in insufficient academic support and negatively influenced their interaction with their educators.

> *When you call them and ask for to make an appointment with them, they were unreachable. You couldn't even find one lecturer to call and consult with.* (FGS2–4:137)
>
> *… we tried calling, making appointments with the tutors two were unreachable and one did respond but when we had to meet, no one showed up what we were told is that the college staff is going out and they are busy preparing for that.* (CIN–3:38)

They further maintained that newly appointed nurse educators from the civilian sector changed after a while and thus also became unapproachable.

… they are all right when they come to the college; but within two, three months down the line, they change completely. Like those other … those other people, they are not easy to confront. You can't even socialise; not socialise, but interact with them as we need, as we are student. Again, they are our mentors, kind of, so, we need to have an interaction with them. (FGS2–2:282,283)

4.2.2.2.3   Academic incompetence

Nurse educators were also perceived to be incompetent because they either displayed a lack of interest or a lack of knowledge. Participants moreover experienced contradictions between theory and practice.

So, what I learned from them is that they were not … they were not that interested in teaching us that … from what I was getting from them. They just came and they just talked and talked and then we are done. They don't dwell much into the subject that we are doing. (FGS2–4:136)

But it is something that we have been telling our lecturers when we do nurses regulations because it is contradictory. We always tell them, what you are teaching us when we go to military institutions, health institutions, it is very contradictory. (FGS1–1:224)

4.2.2.2.4   Assessment practices

Participants' perceptions were that how they were being assessed academically depended on their military conduct.

Because now, if I am putting right marks and everything now, they are going to check how I behave and all that. (FGS2–2:293)

They further accused nurse educators of failing to adhere to the assessment policies by providing certain students with the exact scope of assessments. The nurse educators were also accused of unethical assessment practices because they revealed assessment results to some students before these were officially published. This affected student nurses' relationships of trust with nurse educators and their peers.

There was an incident whereby we were writing our final examination in 3rd year the paper was Midwifery. Later at night, the day before we write, a certain student receive a scope this was a direct scope about the paper we were going to write, so she send it to a friend and told that friend never to send it to others, but we don't know each other well that friend has sent it to the other person until everyone got it and it eventual got back to the person

who got it from the tutor and later after we got results, the story came out about the person who started this thing and [the] Midwifery tutor. (CIN–3:44)

Even recently it happened, before we got our semester results we knew that some of the students are go to re-write before the results came out, this other student I was working with have a close relationship with the tutor. A Midwifery tutor, so she called her and ask what is happening and she told her that two of the students are going to re-write and the rest have passed. (CIN–3:45)

Figure 4.4 provides a summary of the hidden elements and their influence as identified from the category *teaching ethos*.
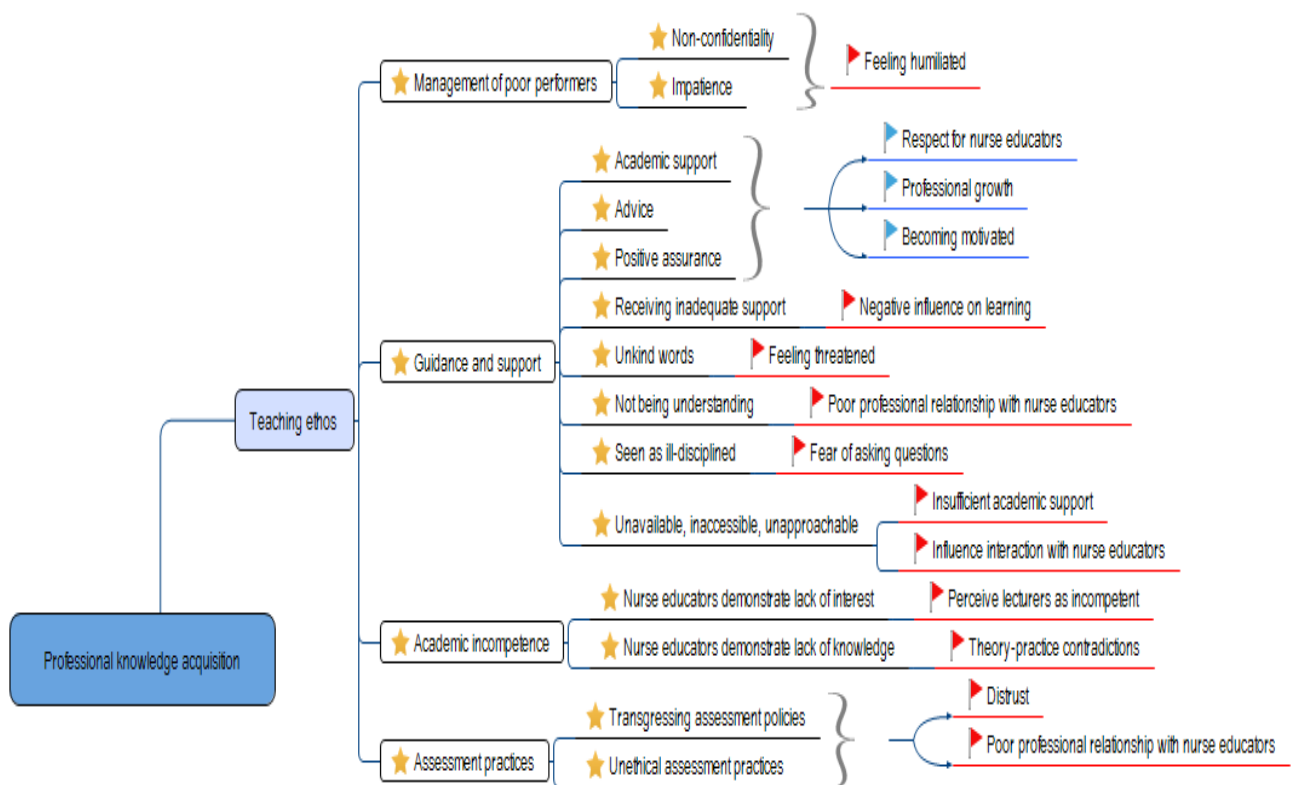
Figure 4.4: Mind map of the category *teaching ethos* (Sample B)

4.2.2.3   *Interaction between students and nurse educators*

Many statements were made regarding the interaction between students and nurse educators. In general, interaction was experienced as being negative, which resulted in students adopting a negative attitude towards the educators. The interaction between students and nurse educators includes the way in which students are approached by nurse educators, the way in which nurse educators communicate with students and the negative attitude adopted by nurse educators towards students. The negative

interactions experienced by participants, were also evident from statements regarding nurse educators being indifferent and judgemental towards students.

4.2.2.3.1 Negative approach

Participants believed that they were being underrated in the sense that they were being denied the right to be assertive, that their opinions were not being acknowledged and that their inputs were being disregarded and underestimated.

> *Sometimes they don't take our assertiveness as … You are not being assertive, you are being disrespectful and you are defending yourself. You are not standing up for yourself. That is why I am saying, sometimes we put our profession last and we say military first.* (FGS2–6:112)

> *I only developed this negative attitude towards my seniors because of the incident [that had] happened. I was trying to be assertive, to understand or what is the problem or how did it come about, why is it happening. So, I ended up being in trouble for that.* (FGS1–5:297)

> *… the college will tell/ask you as a student [to] write or compile things that you would like to have or see changes in the future. A list of about three to four pages will be written, among those written things none will be change, then we ask ourselves, what's the point of giving the college lists after lists of things we want but, at [the] end, nothing is being done about it.* (CIN–3:36)

4.2.2.3.2 Negative communication

Participants indicated that, in communicating with them, nurse educators were often negative, degrading and discouraging and that the students often received rude and sarcastic responses from nurse educators.

> *… they are telling you that they have been there fifteen years ago and you will never in a million years be equals to them.* (FGS2–2:110)

> *During the office bearing, I tried to explain something, and someone said to me "We know people like you who try to act smart, they never finish this course.* (CIN–9:147)

> *Then the tutor or the lecturer is already telling you that, 'I am going to set a re-exam and you are all not going to make it because if you are failing'.* (FGS2–2:129)

> *Later during the day a student asked the lecturer a question. The lecturer started changing and asked the whole class "Are we here to question or challenge her intelligence?" We kept quiet no one answered.* (CIN–9:148)

4.2.2.3.3 Indifference

Indifference probably best captures the attitude to which the participants were referring when stating that they had experienced the nurse educators as uncaring, unsympathetic and impatient.

> *I won't say we lack education that is being given fully, but during tests or examinations when some of us students want to go for remedial, that's where you will see that other tutors they don't care.* (CIN–3:37)

> *When it comes to theoretical, I will learn to be patience with the student because all of us, even here you can give us a test now, you can't get fifty, fifty. Some will get [a] hundred. So you have to understand certain student … know your student.* (FGS2–6:189,190)

4.2.2.3.4 Being judgmental

This subcategory was derived from participants' comments that nurse educators treated them on the basis of preconceived ideas and that they were being labelled and being discussed with other nurse educators who did not even know them.

> *… it is like there is someone who mostly focuses on our personalities, each and every one. Then, after, that person will just go, let's just say, xxxx and xxxx, they are our lecturers, they just go and then tell them, you know what these people are like this and this and this. By the time they come to class to teach us, they will just tell you this is how you guys are without even, how can I say, ja interacting with you. They will just come with that mindset that you guys are like this and this. They don't even know you; that you are like that. You just heard it from someone else.* (FGS2–4:286,287)

The subcategory was further based on the participants' perceptions that no matter whether they did something good or something bad, performed well or poorly, negative opinions about them would not change.

> *… you know, back or deep inside your heart, this thing doesn't matter. Either way, I can do good or bad. They will still see me the same way as that person.* (FGS2–6:164)

Participants also felt that there was a perception that they were disrespectful or defensive, when, in fact, they were trying to be assertive.

> *Sometimes they don't take our assertiveness as … You are not being assertive, you are being disrespectful and you are defending yourself. You*

are not standing up for yourself. That is why I am saying sometimes we put our profession last and we say military first. (FGS2–6:112)

One participant also related an instance of where his integrity had been brought into question by the nurse educator.

So, there was one instance where actually I was seriously sick and I went to the sickbay. Then, when I came back, I went to class and say no to the lecturer, 'I am back from the sickbay', he say, "No, just go to the college and tell them where were you …" Then it was fine. I went to the college. I was with my other friend … They think it is like we planned it. (FGS2–6:118)

Figure 4.5 provides a summary of the hidden elements and their influence as identified from the category *interaction.*
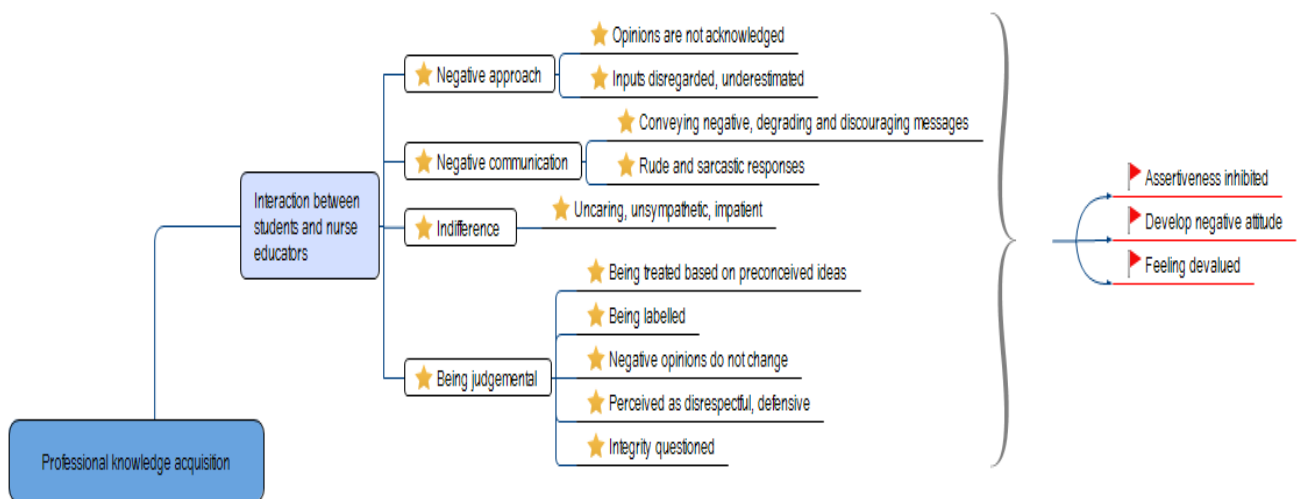
Figure 4.5: Mind map of the category *interaction between students and nurse educators* (Sample B)

4.2.2.4 *Power and authority*

The general abuse of the power and authority related to rank elicited feelings among the participating students of being domineered over, intimidated, threatened and victimised by the nurse educators. They indicated that they had often felt uncomfortable and that this hampered both communication and interaction with nurse educators.

4.2.2.4.1 Indiscriminate use of rank

The indiscriminate use of rank was identified as a subcategory because the participants mentioned how they were constantly reminded that they were talking to a person with a higher rank. They moreover referred to incidents in which they had felt that the respect owed to a person with a higher rank had not been earned and in which higher-ranking officers had not practised what they had preached.

> *But here, even though you are respectful [in] the way you are talking, they will just say, 'Don't forget, I am a colonel, don't forget I am a …' So, it is difficult for you as a student to sit in a class where every time you have to be reminded that, 'Don't forget, you are also a soldier'.* (FGS2–6:241)
>
> *These two incidents really showed one that authority is being used in a wrong way and compliments are being demanded though the very person demanding them is not giving any.* (CIN–5:85)
>
> *Another incident in the MHTF. The higher ranks "officers" like to correct people while themselves are doing wrong things. Eg you find two Colonels hugging and kissing in uniform and they see a "CO" not drilling they chop his/her head off. One Major was on course here she complained about the student not paying compliments to the seniors, but they were not forming up when they go for tea or lunch or accommodation.* (CIN–6:101)

In the participants' view, members in positions of authority were using the power bestowed on them to control their subordinates by demeaning them and inflicting punishment on them for things of which they had not been guilty.

> *I don't know whether because of the use of power, because of they have power, that must probably think alright they really have that much control and whatever they say, you must execute. In the military, they say you must comply now and complain later. But some of the things they are really …, really down treating us because of ehh, you get punished or maybe you get discriminated because of something that you never did before.* (FGS1–4:99)

4.2.2.4.2 Being tyrannised by nurse educators

The subcategory *being tyrannised by nurse educators* emerged because of instances in which participants had felt that they were being intimidated, threatened or victimised by nurse educators.

> *Then the tutor or the lecturer is already telling you that, 'I am going to set a re-exam and you are all not going to make it because if you are failing … if*

you are going to fail the exam it means you are no longer challenging the exam, you are challenging me.' (FGS2–2:129,130)

A lecturer, while students were trying to be assertive or trying to, she just told them, 'Don't forget, your future is in my fingertips'. So you see, sometimes, you just start thinking of such words once you … Even though you have a concern or you see certain things you just have to … It is not that you are intimidated; it is just that you are threatened. (FGS2–6:108)

They are telling us someone is sitting at home not having a chance where [as] you are. Maybe they should be using kind words to actually guide us, not threatening words to do that. (FGS2–2:257)

4.2.2.4.3   Unjust treatment of students

The following extract demonstrates one participant's view that students were not being treated consistently by the nurse educators. The participant related an example of where some students who had played truant suffered no consequences, while others, who had legitimate reasons for being absent, were punished.

> *Even If I have a medical appointment, I will just have to wait. Because if you do such things and then you see or now it is this person, now nothing has been done, even they disappeared for the whole day without coming to class. Then the lecturers they don't even say anything or even ask where were you. They just say, 'Write a memo where were you'. They show the paper, they just say, 'Okay, it is fine'. But you, they even go to an extent that they go to the sickbay and check.* (FGS2–6:119)

4.2.2.4.4   Condescending attitude displayed by nurse educators

This subcategory refers to nurse educators who are either patronising or arrogant. The participants cited nurse educators who demonstrated intellectual superiority in dealing with the students, which made the latter feel uncomfortable.

> *Especially if they are telling you that they have been there fifteen years ago and you will never in a million years be equals to them. So, you see that everything is influencing how me must talk to them, how we must interact with them.* (FGS2–2:110,111)

> *The lecturer started changing and asked the whole class "Are we here to question or challenge her intelligence?" We kept quiet no one answered. She then continued to tell us that "Never in a million years will he like her." It taught me that in the future I must try to motivate student, rather trying to use my superiority to make them uncomfortable.* (CIN–9:148,149)

Figure 4.6 provides a summary of the hidden elements and their influence as identified from the category *power and authority.*
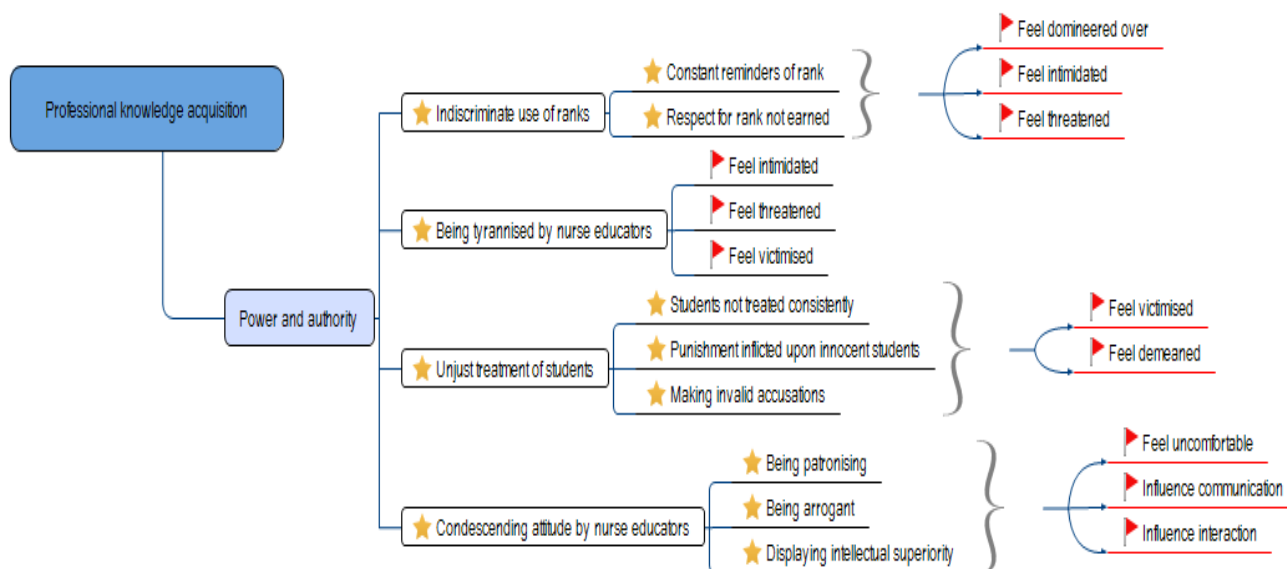
Figure 4.6: Mind map of the category *power and authority* (Sample B)

4.2.2.5   Professional nurse role models

As a category, *professional nurse role models* presents the aspects identified during the focus-group interviews. The category includes both positive and negative role models.

4.2.2.5.1 Nurse educators demonstrating passion

The participants acknowledged the efforts and the contribution of nurse educators in respect of developing the participants' love of nursing, by demonstrating a passion for what they were doing.

> *So, I think we have, even our lecturers, they will contribute that they would put that much effort on us. It really help us a lot to develop that love to the patient and to be able to intervene.* (FGS1–5:339)

> *You find lecturers that really go all out and you can see they are passionate about teaching. They also give you that thing that when you meet a patient with this condition you get so excited that I know this and I know how to approach this.* (FGS2–3:158)

4.2.2.5.2 Breach of confidentiality

Participants indicated that distrust was generated as a result of breach of confidentiality. Cases were mentioned of students discussing each other with nurse educators or of nurse educators sharing with other educators what they had been told in confidence.

> *Others that who are favourable to other tutors they will tell them about other students, mostly what is happening in their lives, we hear this things in class, whereby you will find that we did something wrong then the tutor will be mad and start telling us about our life, things that are personal of which you will never thought that your tutor or lecturer will know about.* (CIN–3:46)

> *With the lecturers we have at the college, sometimes I feel that on some lecturers there is no confidentiality. As a nurse, I believe in confidentiality and I tend to take the negative thing they do to positive. I will make an example. You, as a student, you sometimes get to … like, how can I say, express your feelings to a lecturer, how you feel, maybe situations at home. Then you tell the lecturer this and this is happening. This is what my family is going through. You feel that this is basic, something that is very private, that you only need to disclose to only one person. Not the whole college must know. But to find that the lecturer, the other lecturer comes maybe for another subject, you talk maybe for the lecturer of IGNS where the lecture for midwifery comes, she probably say something to you that you can pick up that these people were talking.* (FGS1–3:178,179)

> *There is no confidentiality when a student goes to a lecturer and tell. Tomorrow you hear another lecturer telling you about the same, exact same thing that you were talking to this person about.* (FGS2–5:243,244)

4.2.2.5.3 Association with students and favouritism

Participants revealed that nurse educators' familiarity with students and favouritism were common phenomena that made the participants feel negative and left them with the perception that these would negatively affect their own academic outcomes. They also regarded socialisation between nurse educators and students to be unprofessional.

> *The other thing that makes me negative when coming to the relationship that we build with tutors is that the tutors becomes more involve with other students, they select their own students that they like more.* (CIN–3:43)

> *Some of us feel less likely loved so that where you will have to push hard and try not to be in their wrong shoes.* (CIN–3:46)

> *If a student is not liked by a lecturer because of your behaviour or sometimes just who you are you will end up failing.* (CIN–8:129)

> *Sometimes I see some lecturers are not professional. You, it is like you socialise with that certain students and then in class you expect them to*

respect you and they disrespect you and then you end up seeing it is the whole class, but it is the same friends of yours who you are chatting with on WhatsApp. (FGS2–6:278,279)

Figure 4.7 provides a summary of the hidden elements and their influence as identified in respect of the category *professional nurse role models*.
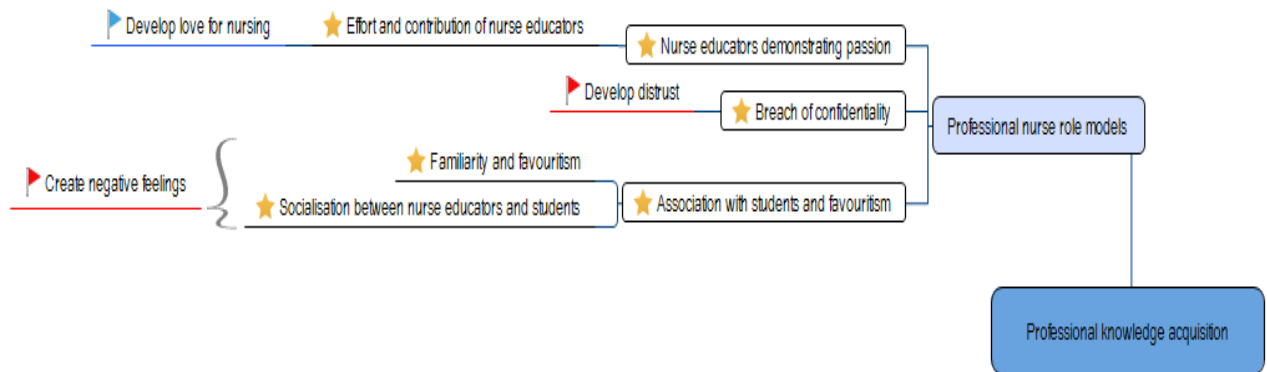
Figure 4.7: Mind map of the category *professional nurse role models* (Sample B)

4.2.2.6   Learning environment

The learning environment itself, that is, the physical space within a military area to which the students are confined for study purpose, emerged as a category because of the numerous references made to their experiences in this environment.

4.2.2.6.1   Adverse conditions

Participants referred to the poor state of lecturing facilities, especially the fact that classrooms had no air-conditioning, which resulted in venues being either very hot in summer or very cold in winter. This state of affairs would make it difficult for students to concentrate. They also compared the military facilities with those of civilian colleges and agreed that the military facilities were not conducive to learning.

> *Having with, also with our … how can I say, with our classes like that environment, eish, since first year, it has been a challenge. But then maybe because of the financial strains or maybe in financial the military or something, I don't know, but then the classes that we are utilising, some, especially when it is too hot then it is not conducive, or even if it is cold it is not conducive also. I think if maybe the structure wise if it can be fixed.* (FGS1–4:320)

The other thing is that actually the facilities and the place of ... When it comes to the facilities, since I got here the classes have been the same and you are always seeing the same things. So, meaning, if I have to come back and do, or maybe someone just tell me, 'You know what, there the class is this way', I won't go ... Because you find outside you sit and maybe you will find these chairs or this or this nice auditorium ... Even after lunch here you don't want to go to class because it is hot, you are sleepy. So outside, it is air-conditioning ... you can even ... the place is not for learning. (FGS2–6:294,295,296,297)

4.2.2.6.2   Regulated environment

The learning environment, because it was in a military area, was considered to be regulated. Students were expected to wear uniforms and were bound by the military disciplinary code, military norms and values, and the military authoritarian system.

I never expected to be taught by a military captain or a lecturer who is wearing uniform, you know. All these things that you were taught to salute, when the lecturer comes in the class you must stand up and all those. I never expected that. I thought that we will just go in class like people in varsity and have the same experience as them. Not having to come seven minutes before time. All those things you learn from Basics. (FGS1–3:55,56,57)

I know one of the most difficult things of doing nursing through the military is that in the military there is always someone who is on top of you. Not necessarily your boss, but there is always someone who ... whether it is your instructor or your lecturer or your officer commanding, but there is always someone who is controlling you. (FGS2–1:249,250)

Participants experienced their training environment to be too militaristic. Numerous comparisons were made with other tertiary institutions. It was mentioned that at other tertiary institutions, students were not expected to be punctual; they could miss class altogether if they wanted; they did not have to stand up or salute the lecturer and they did not have to sit in class for the entire day.

I thought that we will just go in class like people in varsity and have the same experience as them. Not having to come seven minutes before time. All those things you learn from basics. Seven minutes before time in class. Like if you want to go to class, you go to class; if you don't want to, you just relax. I thought it was going to be something like that. You get to the military, you get to go to class seven minutes before time. You get to .. and the lecturers comes in, you salute. You get to come to class every day up until 16:15. (FGS1–3:55)

The participants further compared the amount of time they spent in class with that of some tertiary institutions. Since military students are paid employees of the Defence

Force, they are expected to be on duty for a full day of eight hours and for 40 hours a week, whether this be in a classroom or in the clinical facilities. Those students living in military accommodation are expected to report for inspection at 06:00 once a week.

> *… outside, you go to class and maybe from eight to ten then you will have the other one. So here you are from … you are going to class from 07:00 to 16:00. Sometimes you will find on a Thursday it is inspection. You woke at 04:30, somehow you continue the whole day, you are tired … So it is very difficult to concentrate while you are tired in class. So, I think outside, it will be much easier if you just wake up at your own time, you go to class, come back, you relax.* (FGS2–6:251,252,253,254,255)

> *You get to come to class every day up until 16:15 because you get … I don't know, is it [because] you get paid for those hours or something like that?* (FGS1–3:55)

4.2.2.6.3 Restrictive environment

Participants experienced the military environment as being very restrictive. They felt that the military routine interfered with their private lives, that they were not free and that they could not do what they wanted to – all circumstances that gave rise to much frustration.

> *As my colleagues said, you have got to salute, you have to stand inspection, you have close weekends. There is something at home happening that is important and you feel you have to be there. Maybe they are doing a ceremony like African cultures that is determined to help you get somewhere, cleanse you or something. But then, suddenly, the RSM decides it is a close[d] weekend, you cannot go anywhere. You must stay in that place. You will be frustrated. The whole family will be frustrated because all their planning just goes where, to nothing. Then things like, they always talk about it, the environment in which we study. I never got an opportunity to go to college, university, whatever after Matric. I didn't have [the] money to study further. I didn't know about the available education funds out there. So, you find that you are in class, you are not free.* (FGS1–6:148,149)

The military accommodation and the fact of having to share a room were mentioned by one of the participants. Members living in military accommodation were also exposed to random raids by the Military Police. Participants felt that their privacy was being invaded, their freedom inhibited and that they were being deprived of feeling like a real student. They suggested that it might be easier to study at a civilian institution where they would be able to control their own routine.

Being away from family, having a lot of work here, hey it is all like here I don't have even anyone to support me. These things they are too much, like, they are giving you a lot of work. You don't have no one to, to … So, you are having only [one] roommate. Sometimes things are not good in the room. Everyone has got his own way. Eish, it was a problem. (FGS1–5:120,121,122,123)

Also, where you are staying, you don't feel like a student. Because some of the times while you are sleeping someone just come with the master key and open your door. So, you don't have that freedom or actually that privacy for yourself. So, you are still … At least sometimes you might just … even though you are students. Or maybe if the college can say, let's have our own living quarters outside the military formation, then it might be better. Because you will find when you are sleeping … Even some, all of us, we are not the same. Some may be … that is why maybe from my side I see some of the things, that is why they are happening there [at] the formation … is because they are saying, don't come with alcohol. But, in the university, you don't find such things. The student you will hardly find them fighting or breaking things because they are allowed to do certain [things]. (FGS2–6:301,302,303)

4.2.2.6.4 Punitive environment

Being subject to military rules and regulations, participants acknowledged that infringement of these would lead to some form of rectification or to disciplinary action of some kind, which they however perceived as punishment. They nevertheless agreed that it contributed to their becoming very disciplined. Yet, they disagreed with the tendency to generalise when only one had violated a rule.

You learn like for every mistake you do, you have to get punished for it. Even if it is the mistake of this guy, I will be punished for that guy['s] mistake even if I didn't do it. So, it [is] something that I accepted like moving along with everybody. Here in [the] military, you are living that punish or die for other people mistakes. (FGS1–5:111,112,113,114)

The positive thing is that you get to, you get to be so disciplined that you know if you do something wrong they will start calling the College now. Then they will [be] telling [you] about DD1s, they will charge you if you don't come to work. (FGS1–3:62)

4.2.2.6.5 Prejudiced environment

This subcategory emanated from the statements made by participants regarding the tendency of addressing negative behaviour rather than giving recognition for positive behaviour. In the students' experience, only mistakes were noticed, they never received recognition, irrespective of what they did and the good in them would never be recognised. This situation contributed to feelings of disappointment and negativity.

What I have noticed is that they concentrate more on the negative things the students do, more than the positive. (FGS1–1:345)

I felt threatened and as much as I do my work as hard as possible but some of the good things we do are not being recognised and you always get a blanket approach punishment for things that I did not do. This made me feel like what's the point of trying if only the bad things are being noted and given so much attention than positive things. (CIN–2:33)

I was so disappointed because I remember that the whole week we were doing the correct thing, so they are [so] used to looking at our mistakes that they forget to compliment [us] when we do right thing. They make us negative. (CIN–6:100)

The data clearly indicated that participants also felt that they were being discriminated against because of their gender. Male participants raised the issue of gender stereotyping and discrimination. Being both a soldier (a male-dominated profession) and a nurse (a female-dominated profession) complicated the socialisation process. Some male participants indicated that they were ashamed of acknowledging that they were doing nursing. They also expressed feelings of self-doubt and also doubted whether they had made the right decision.

One of the reasons I won't come here again is that, okay, on the outside it also happens that as a male, if people find out that you are doing nursing, they tend to call you names and they have this kind of attitude towards you like what you are doing it is, it is not for you, it is meant for ladies. Meaning you, you are almost like a lady or you want to be like a lady. In the military, it is worst because here you … on a daily basis you meet and you work with people who consider themselves to be proper soldiers. You get skydivers. You get someone who is [in the] artillery. When there is a war or something, they are the ones who are in the front line. So now, when, when we mix together, when they see us, when they speak to us, they just have this thing of making you feel small. I … just yesterday, there were these ones, who were doing PT course. It was supper time, they pass there and then we were standing there. When they look at us, they just see lots of ladies. They will start making comments [like], 'Oh help me I am sick', things like that. So, in the military, it is more difficult, because on a daily basis … You even start doubting yourself and doubting the decisions you made. (FGS2–1:305,306,307,308,309)

You know, even at home, they only ask you what do you do in the military. You know mos, most of guys, you don't say, 'I am a nurse'. (FGS1–2:254)

The female participants raised the issue of becoming pregnant while studying. Currently, the students' study contracts are temporarily suspended to allow them to take maternity leave. This however implies that the semester during which they are on maternity leave must be repeated and their study contracts are automatically extended. The participants could not reach agreement on what happens to students in the civilian

sector when they fall pregnant. They however indicated that the College made them feel as if their pregnancy was a mistake and that, as a result, they felt discriminated against.

> *… if one of the female students have a baby, on the outside it won't be a big issue. But in the Defence Force, it seems like if you make a mistake, it is wrong.* (FGS2–1:229)

> *I have learned that firstly, on what you were saying about being pregnant while you are still in the course, they do terminate your course. That is why they end up hiding their pregnancies or doing whatever, giving birth today and coming back the following day.* (FGS 2–2:231,232)

> *Then on the issue, the thing that I was addressing about making a mistake and more specifically about ladies when they fall pregnant. One thing you must remember, on the outside there you pay for yourself, you go at your own time. If you make a mistake by failing or falling pregnant, you go and re-apply the next year. There is no limit to how many times you can go, as long as you pursue what you want to do.* (FGS2–1:230)

4.2.2.6.6 Military influence

One of the participants expressed the opinion that the nurse educators were focusing on soldiering rather than on nursing and that the College was focusing on less important things, such as whether they were correctly dressed or moving to the class in a squad rather than on nursing training.

> *During the course of my studies I have been elected to serve on the student representative council 3 times. This meant working closely with the management of the college. This was a good experience but taught me something important. The most important aspect for them is soldiering while nursing comes second. If that's the case surely nursing won't benefit.* (CIN–8:133)

> *Professionally they hold you back, they focus on less important things (according to me) rather than developing you for the reason you are here.* (CIN–8:134)

An aspect that surfaced repeatedly was that military activities interfered with nursing training. Both students and nurse educators are often expected to leave nursing training for the sake of a military parade, military deployment or other non-nursing activities.

> *I would prefer to study nursing outside [rather] than here in the military because there is a lot of activities happening here. Sometimes you are in class [and] they expect you to go to parade to do what, what. It is a lot of activities involved when you are in class doing nursing.* (FGS1–5:246)

Figure 4.8 provides a summary of the hidden elements and their influence as identified in respect of the category *learning environment.*
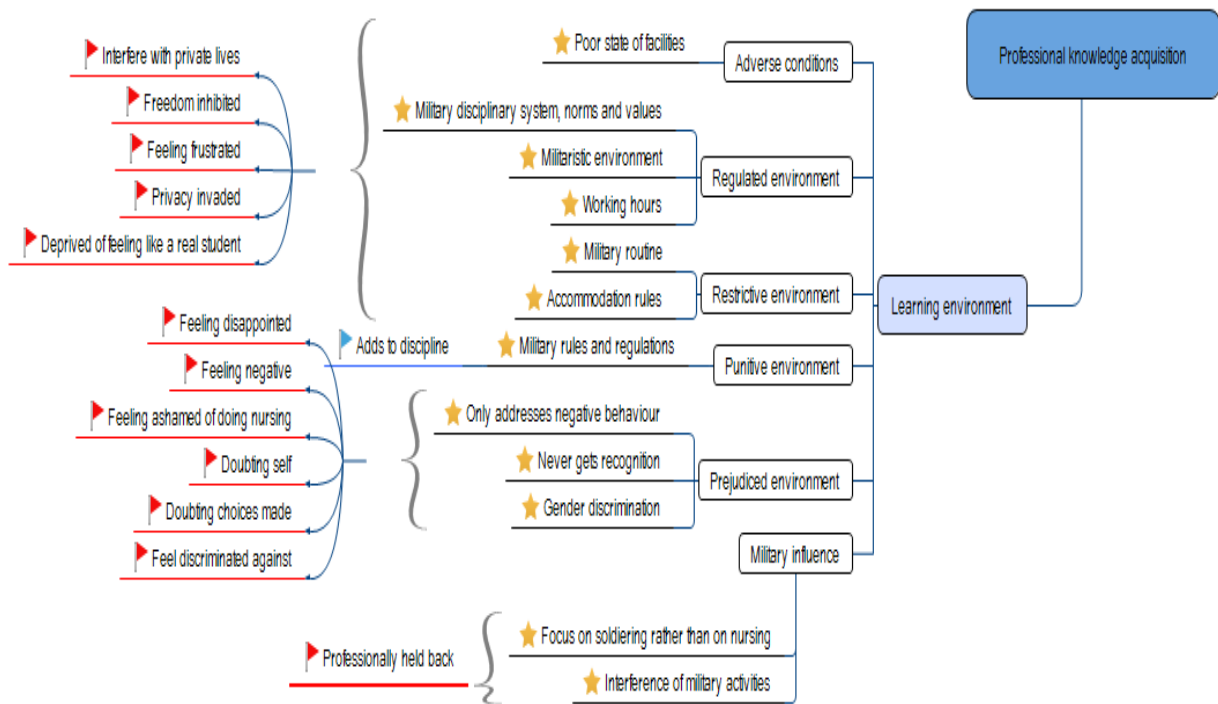
Figure 4.8: Mind map of the category *learning environment* (Sample B)

4.2.3 Theme 3: Clinical skills acquisition

Military students are placed at both military and at civilian clinical facilities to gain the necessary clinical exposure and to equip them with the practical skills required by the South African Nursing Council. During the focus-group interviews, participants were constantly comparing their experiences in these facilities. Three categories were thus developed, of which two make distinction between the military clinical learning environment and the civilian clinical learning environment. The third category reflects statements related to nursing professionalism in the clinical learning environment in general.

TABLE 4.4: THEME 3: CLINICAL SKILLS ACQUISITION (SAMPLE B)

Theme	Category	Subcategory
Clinical skills acquisition	Military clinical learning environment	Working environment
		Patient interaction
		Learning experiences
		Negative approach
		Abuse of rank
		Unprofessional conduct
	Civilian clinical learning environment	Professional role modelling
		Patient care
		Attitude and behaviour towards military students
		Perceptions of military students
		Learning opportunities
		Self-approval based on comparison with others
		Absence of military influence
	Professionalism	

4.2.3.1   Military clinical learning environment

The category *military clinical learning environment* refers to the selected military hospital at which students were placed. The subcategories relate to students' experiences while working in this facility.

4.2.3.1.1   Working environment

One of the positive aspects mentioned was that students felt familiar with the expectations of the facility, which led to mutual respect.

> *In the military, I will say that in the military institutions, here in the hospitals, there is mutual respect because you know what you should do. You know what to expect.* (FGS1–3:76,77)

Participants also agreed that compared with the civilian facilities, the working conditions were better and so were the service delivery and the patient care.

> *I told her, 'I am in the military and it is so different because we train under people with a positive attitude unlike in the public sector, we take good care of our patients, our working conditions are better, so even the service we deliver is up to [a] good standard.* (CIN–1:13)

Participants mentioned that, as they were in a cultural diverse environment, they had to learn to accept and respect patients and colleagues from all cultures. A degree of cultural incompatibility did however exist, which made it difficult to get along. It was also mentioned that culture played a role in terms of favouritism.

So, basically, I am going back to the issue of culture. When you go through a military, you meet all these different kinds of people. Not all of you, you are going to get along. (FGS2–1:266,267,268)

So with that, being a soldier and anybody being a nurse that you have to firstly try to understand or accept the fact that all of us we have different cultures. Then by doing so, you have to learn to respect those cultures; because when you are a nurse you deal with different kind of patients on a daily basis and most of the time they differ each day. So if you don't understand or you don't want to respect someone else's culture, it is going to be difficult as a nurse to care for the individual because basically you don't care how do they feel. (FGS2–1:2,3,4)

In my case you will find that if the in-charge in the unit for that time is of the Sotho background and I also am, then we get along just fine compared to other of the different background. (CIN–3:50)

Participants indicated that they experienced the military clinical learning environment as being rigid and constrained in the sense that they felt that their opinions were not required, and that they were not allowed to speak up or use their own initiative. They further indicated that this prevented them from reaching their full potential as nurses.

… if you are a student, it is like you are nothing. That is how I felt it or maybe my experience. It is like, you are nothing at all. You can't say anything or you don't know much. The doctors here would … it is only a few of them that will take your opinion, ask you what you think or something like that. (FGS1–1:162,163)

… they tell you, 'No, you are a student, you don't know anything'. In that way, they don't motivate us. At least when we are in the clinical they must give us that thing the students are here to learn, let's give them an opportunity to voice out their opinions. So, they make it difficult for us. We can't even … Sometimes you go to a ward and you leave without even learning. (FGS2–6:16,17,18)

Basically, since we are supposed to develop and gain knowledge and experience from whatever we are doing, be it gaining from the military to use in our nursing profession … So now I want to, to gain confidence and learn how to be assertive, they take it and put it into a box. So basically, what they are doing is that they are preventing us from reaching our full potential. (FGS2–1:117)

Participants also believed that they were not allowed to make mistakes, and that if they did, they were being demeaned and shouted at by the clinical staff.

… or maybe if you make a mistake, we are still student, we are learning. Maybe if we make a mistake, nè, instead of like having that room for you … like mistakes and everything, nè, because we are always being supervised … we are supervised, you know this one. If you don't know something, you go and ask. But even that is a challenge. So now, if you make a mistake in the patient like, okay, I was supposed to give you this for that, then they, I don't

know … Maybe it is because of the rank that we have that makes them to approach us in that way. (FGS1–4:202)

Now, when you come there as a student and you do some mistakes, it is like you are nothing and you will feel so bad because someone will even be shouting at you like you are doing nothing. (FGS2–2:55)

In terms of clinical, I would involve my students more in the ward, give them the initiative to do, to make mistakes in the ward, not always be behind them and saying do this, do this, but give them that floor to experience how they are supposed to experience. (FGS2–5:184,185,186,187,188)

Participants indicated that they were happier to go back to a ward where they were being given positive feedback and acknowledgement from the staff for what they had done.

As a student, I will be happy to go to that unit because I know tomorrow, when I come back from work, at least I will have learnt something or at least the sister could have told me something positive You acknowledge your student. Don't only focus on you … you took an hour lunch. You will say, 'Hey, you have been doing this and this', acknowledging the students. At least you can help some positive influence in there. (FGS2–6:208,209,210)

Participants observed that nurses were not acknowledged by other members of the multidisciplinary team and that that made them feel inferior.

Being a nurse can be difficult at times because other people in the multidisciplinary team can make you feel little or like you are less experienced, even if you have been in the profession for long, a newcomer intern doctor can pretend as if he he/she can steer the ship in the right direction than you just because you are [a] nurse, and people think anyone can be a nurse and it does not take anything to be one. (CIN–1:10)

4.2.3.1.2   Patient interaction

One participant shared the experience that she had had while nursing wounded soldiers from the deployment areas. She related her feelings when they had shared their experiences with her, thereby showing trust in her.

… there was an incident within the military where we had our soldiers injured in Central African Republic. So, I was fortunate that I was allocated in Ward 15. So, the ward was cleared. All our patients were sent to another ward. Then those patients they all came to us. So, it was quite a nice experience because I met the big people of the SANDF, the generals and all that. Not anybody can meet the General of the whole SANDF, but I got an opportunity to be at least in the same room as them or being next to them. Also nursing those, those patients and talking to them, share them, trusting you to share their experiences what they went through wherever they were. So it was quite

> *… I felt like a real soldier at that time, even if I was not in deployment.* (FGS1–1:28,29,30,31)

Another participant related how a patient's gratitude had inspired him to be more committed to the patient and how the patient's recovery had served to motivate him.

> *Then it was like each and every day when I came to work, I am glad you are here.* (FGS1–2:44)

> *I am telling you, when I saw that patient was healed and he was okay … Always every time when I came to work, I was always in that room or in that patient's room, and preaching until that patient, one day you will be walking. I believe by the strength of God you will stand up. I am telling you guys, I show him that I care, the patient was up and about. He was active again and he went home healthy. I was motivated. I was like, wow, I like this thing, I love nursing.* (FGS1–2:45,46,47,48)

During the focus-group interviews, lengthy discussions revolved around the attitudes of patients in the military clinical facilities as compared with those in the civilian facilities. Firstly, reference was made to patients who had refused to be treated by students. This circumstance not only denies students opportunities for learning but also makes them scared to enter patients' rooms, which affects their confidence.

> *With my experience, once, when nursing this other patient, a VIP patient here in the military institute, xxxx this patient said that she doesn't really wants to be nursed by a CO. It comes back again with the ranks in the military. She told me that she would rather be nursed by a Captain than a CO.* (FGS1–3:180)

> *… because if you are taking care of, let's say, for instance, a colonel or a major and they know you are a CO because you are wearing your rank, nè?. The same approach applies. When they come to you, you said no, no, use your, like she said … 'I don't want to be treated by you, I want to be treated by someone else'.* (FGS1–4:201)

Numerous examples were given of patients making unreasonable demands of nurses, expecting that everything had to be done for them and thinking that they each deserved special treatment. Yet no appreciation had been shown.

> *Some is like, they are lazy, they just don't want to help here, especially in the military. They expect you to do everything for them. When you tell them maybe you must lift them, they, they must lift their bodies just to help. They don't want to do that. They expect you to do everything since you are a CO.* (FGS2–2:56)

> *Ja, like, in the military, some patients they don't appreciate you being there for them, helping them.* (FGS2–2:57)

> *But here, in the military, it is like they have been … it is like these people they take [the] military or as a private hospital or something whereby just everything must just be concentrated on them.* (FGS2–2:61)

One participant related how a patient had expected to be addressed in her home language. When the student had been unable to understand her, she was accused of being 'useless'.

> *Then the patients started using their own home language. That way even though my fellow colleague couldn't hear what the patient is saying … luckily for me I could hear some certain words what that patient was saying. Then my fellow colleague said, 'I don't understand'. Then they asked her, 'Why are you here in the military whereas you don't know this language? You must just still resign today because you are useless to us. You can't even understand what you are hearing'.* (FGS2–6:62,63)

The issue of rank and how patients with higher ranks are treated or expected to be treated also elicited a number of examples from participants. The allocation of higher-ranking patients to private rooms with better furniture, equipment and food was one of example of discriminatory treatment based on rank.

> *But here, especially when we … they can call from casualty that the Colonel or General, whoever is coming. During handover, they will emphasise again [that in] this room and this room there is [a] Colonel, there is [a] General, whoever, whoever. This room is a private room, [a] VIP [room] for [a] General, whoever.* (FGS1–5:211)

> *When I was doing my second stage in 2013 and placed xxxx I nursed a patient who was in room 2 (VIP). The first time when I entered the room I thought I was in one of the expensive hotel rooms! The room had a television, radio, nice couch, beautiful, or with a glass and white cups and fresh flowers. The patient was also eating different food from the other patients, much more appetising!* (CIN–4:54)

The following extracts illustrate participants' experiences involving patients who had expected or demanded preferential treatment on the basis of their rank. In one instance, a patient had demanded to be helped first because he had had a higher rank than the patient with whom he had been sharing a room. In another instance, a General had demanded to be addressed by his rank and had refused to be treated by students. One participant indicated that an attitude of this nature made it difficult for students to perform their duties and that they were wary of entering the rooms of patients with high ranks.

I remember, I was nursing this … there were patient, it was a Private and a Sergeant Major. So, the private called me first and I was attending the Private. The Sergeant Major called me, 'CO, CO, please come help me'. I was like, 'Sergeant Major, I will, I will attend to you. Let me just finish with the Private here'. He was like, 'But I am a Sergeant Major here!' Then I waited, I [waited] patiently that … done everything with the patient then I go to Sergeant Major. I am like, 'Sergeant Major, you must learn to be patient, that is why you are here'. He was like, 'But CO, you must treat [patients] according to the ranks. You can't see I am … I am having a higher rank, you must tend to me first'. (FGS1–2:208)

I was in xxxx, nursing a "patient" whose rank was a General. According to him, he was supposed to be treated like a general not a patient which makes our work so difficult. He demanded that we address him with his rank not patient. He also did not like it when students nursed him as he was too superior to be nursed by people who did not know what they were doing. This made me sad and confused in a way. Because we are supposed to be learning but how do we learn if we being push aside? We were supposed to be treating a patient not a General. (CIN–6:90)

… if the patient has a higher rank, then they accept to be treated special than the other, the other patients. So, for me to carry out my work is difficult because, when I go into their room, I feel scared to do some of the things because they always complain. (FGS2–3:9)

One participant had had an experience involving a General who, even as a patient, was still 'commanding' the ward.

Once you go there that General is having that mentality of his owning everyone in the ward even though he is [a] patient and I am [a] nurse.(FGS1–5:212)

Even patients who were only related to higher-ranking officers had demanded preferential treatment.

Because, for example, we were working in [a] gynaecological clinic and then a General's wife, even if the person is not [in the] military, just because she is married to a General now, she must be recognised. So, most patients in gynaecological they all come in, they take the file, first come first serve. So, she came in, she is like, 'Can I see doctor so and so?' Then we were like, 'Okay, do you have an appointment?' That is the question you should ask. You cannot just say okay, 'He is [in] Room 11. You do have an appointment?' Then the answer was like, 'Do you know who I am?' You see, those things, now, I am a General's what, what, wife and whatever. It is like the General's wife or the General cannot sit in the queue; whenever they come they should just go in that time. So, it is something that is so difficult to deal with.(FGS1–1:225)

Participants indicated that they had found it difficult to nurse patients when they were expected to consider the ranks of the patients before they could treat them.

I feel that in the military, as a nursing student or as a nurse, how it has affected my profession is that you have to be a soldier and a nurse at the same time; especially when we are working in the … like in xxxx. You find people of higher ranks. There you have to consider their ranks before you can treat them. Let's say it is [a] General who come in, you have to salute or acknowledge that person as [a] General, not as [a] patient who … who … then you have to acknowledge that person as General whatsoever, General whatsoever name. So I think sometimes starting, let's say, you didn't even check the name of the patient or maybe you didn't acknowledge first the rank of that person, when you get there patient ma-ma-ma or patient so-so sorry. Then that patient get offended that you are not respecting their ranks. (FGS2–2:5,6,7)*

4.2.3.1.3 Learning experiences

The smaller patient population of military clinical facilities results in fewer clinical learning opportunities for students.

> *I … our … will say that patients, our military patients, they are not that much as if they are in the public sector. [In the] public sector you nurse a lot of patients.* (FGS1–3:64)

As a result of the smaller patient population students are competing for limited learning opportunities.

> *Even the students also, you find you are allocated with a, let me just use this, selfish students. You know what I am saying? Maybe you will find … Like when they allocate us in the allocation according to where you are going, you are going [to] xxxx, they will just, say maybe ten people are going to xxxx. Then it is postnatal, antenatal and labour. Then they will divide three, three, three and the other ones will be four because we, we are ten. Then you will find some students, they know you haven't done certain procedures but then just because they want to be there, they want to be done a certain procedure, they don't care. Even [if] you agree on the first day that we are going to rotate, maybe after two days, three days, you find some other students, what they are doing is they are telling you, 'No, we are not going to move. I am going to work here up until we leave'. So, sometimes, it becomes difficult for some [of] us to work with such people in certain institutions. Those students are very selfish. They don't want to understand, at least each and every one of us must at least have that opportunity to see what is happening in a certain ward.* (FGS2–6:36)

Participants felt that clinical staff were not allocating them according to their clinical objectives, which made it difficult for them to meet these objectives. They felt that they were being assigned duties outside their level of training and thus not being afforded opportunities to learn and to practise their clinical skills.

I don't know how … how to put it, but some of them, they … they just … even when they have to delegate [to] you, sometimes they won't consider your objectives. (FGS1–1:167)

… let me say, for an example, when we are in the second stage nè, we are supposed to do medication. But, in the second stage, they will also allocate us to do the vital signs and the urine testing and everything. Yes, it is still our scope of practice, but then we have to get exposure to do the medication and everything. Then it becomes a problem when you are in the third stage, wherever we have to know how to manage the unit and everything. So; because we are in the third stage, that is when they try to put us on medication, and then we still struggle with medication. Even today, we are in fourth stage but it is still a problem because we didn't start at second stage. (FGS2–3:196,197)

Yes, it was a chance for us to learn more and take charge but we were not meeting our objectives because that is when they would allocate us for medication, vital signs and so on. We were still expected to do all that as we are nurses in the making and had to excel in those tasks but we were not given the opportunity to manage the ward. (CIN–4:73)

The participants noted that some professional nurses did not enjoy nursing and that their negativity was transferred to students.

In a hospital setting you come across professional nurses who don't enjoy the profession itself, they don't like it. So, when you are at work, they are transferring that negativity to you. They don't want to teach you things that you are supposed to do. They don't care about your whereabouts, whether you are inside the ward or moonlighting outside. (FGS2–1:124,125)

The negative interaction between nurse educators and students was discussed in Section 4.2.2.4. According to the participants, the negativity they had been experiencing in the classroom had been influencing their clinical experience and, ultimately, patient care. In line with the above, participants also indicated that certain nurse educators had had a negative effect on them when they had visited the clinical areas because they had continued with their negative attitude and their negative communication style in communicating with students.

Then, when now, a person is already telling that you are never … [you are] going to fail, you becomes negative, as xxxx was saying. You are already negative and you don't care anymore, especially if you find that you have a reassessment and someone told you that you are going to fail even if you write that reassessment. Now you go there with a negative mind[set] that even if I study, the sister say I am going to fail anyway. Then you think again, in the military, my course is going to be terminated. Then you are negative. This thing is actually not affecting only your professionalism, also your life. Do you think you are going to be like as respectful as you were, as positive as you were towards your patient? Are you going to give them the support as you would give them before this person told you that if you fail you are not

going to make it anyway? So, I think, theoretically, it is affecting us negatively when especially the person is saying all those negative things they are saying to us. (FGS2–2:132,133,134)

The things that we meet along the way, like the challenges and the negativity, it changes our mindset. Then when we go there to the practical, it becomes difficult for us to do this. That is why I can't say that most of the time you will find us outside maybe because of the things that you would … like in the ward. Because you become negative from the theory part, so then you also take it to the clinical. (FGS2–3:220,221)

Sometimes if they can say that lecturer is coming to clinical. So your whole day's experience then it is spoiled, it is going to affect the patient care. Because, when she gets there she still continues that attitude from class, she comes with it there starting to shout at you, 'Hey, what, what … Why are you doing this, why are you doing?' So after she leaves, you are going to have a … well, then your day is spoiled, you are negative. (FGS2–6:139,140)

The participants observed that professional nurses were not willing to teach students and that they showed no interest in them, which left the perception that they did not care about them either.

But, some of them is like they don't commit their time to students, especially if you come to terms like coming into contact with some other condition that you don't understand that much. Some of them they don't dedicate their time to educate students. (FGS1–4:96)

They don't want to teach you things that you are supposed to do. They don't care about your whereabouts, whether you are inside the ward or moonlighting outside. (FGS2–1:125)

One participant remarked that some of the professional nurses were too busy to answer their questions, while another shared a positive experience he had had with staff members who had been willing to teach and to take time to answer his questions.

Some of them are too busy to even answer you. (FGS1–1:163)

Then they showed me and I settled in. It was a very nice experience. They do give you that time of like, when you ask a question, then they explain back. (FGS1–4:94,95)

The negative attitude towards teaching was also evident from the following extract. This is an indication that when students make mistakes they are not shown how to correct such mistakes.

He didn't even try to teach me so that next time I will have the right thing. All along I thought nurses are kind, loving and caring people. Hence it is [an] academic hospital I was expecting learning to take place not shouting me as I

were at street. That incidence killed me inside. My confidence was low. Self-esteem became so low because that person make me look like a fool. (CIN–7:108)

4.2.3.1.4 Negative approach

Negative approach as a subcategory includes references to negative communication, negative attitudes displayed towards students and the negative treatment of students. One participant acknowledged that the manner in which professional nurses had approached students had, in turn, influenced his attitude towards them.

> *But then with … I always have the problem with the way they approach students. This really disturbed me [and that is] why I'm having this attitude towards the Captains and even the Majors in the hospital.* (FGS1–4:97)

Another participant indicated that the negative approach had made them see the professional nurses in a different light which made learning difficult.

> *That is the approach that we mostly receive as students, as my colleague was saying. So really, the approach and the use of rank sometimes is not that necessary for you to remind a student every time that you are just a nurse here, you must do this, you must do this. You are not supposed to do this because you are a CO and everything. It really makes us to view them in a different way. They really put challenge in learning because when you want to learn, you don't know something, you must ask your senior.* (FGS1–4:193,194,195,196)

Two participants mentioned that students had rather absented themselves from the ward because of the way they had been treated and spoken to. Students felt that they had been made to feel worthless.

> *It is not like, they don't want to work when you find them sitting outside. [It] is because of the certain things that are being said to us. Even though when we go to clinical, you will still find it is the same situation. So, it becomes difficult for us to be in that place. So, you will rather just go and sit in your own space because whatever you can do, it is not going to make any difference. They make us feel like we are small, we are nothing.* (FGS2–6:145)

> *… if you are a student, it is like you are nothing. That is how I felt it or maybe [it is] my experience. It is like, you are nothing at all.* (FGS1–1:162)

The following extract illustrates that military students in the military clinical learning environment experience staff as being mean to them and calling them stupid. At civilian facilities, they have quite a different experience.

You would discuss a condition with that doctor and share ideas. Why doctor you are doing this? He won't be so mean to you or say you are stupid or whatever, unlike in the military. (FGS1–1:164)

Participants also felt that, akin to the situation in the theoretical learning environment, only their mistakes were being noticed, no matter how hard they tried or what good things they did.

… as much as I do my work as hard as possible but some of the good things we do are not being recognised and you always get a blanket approach punishment for things that I did not do. This made me feel like what's the point of trying if only the bad things are being noted and given so much [more] attention than positive things. (CIN–2:33)

Participants related various instances of where they had felt that they had been at the receiving end of negative communication, such as when a professional nurse had addressed a student disrespectfully in front of a patient.

Then the Captain was working in xxxx, I think. So I was going into every room even though I am not allocated. So, I was closing her drips. She was doing medication. They were running air and I was closing them. When she came in, I can't remember what she said, but she said something very disrespectful … what, what, what…! The way she talks, she … she doesn't have an approach, the specific Captain I am talking about. So I felt offended. I was also doing her a favour because I closed the drips. It is her room where she is working and they were running air. So that approach, it affected me so badly, such that I didn't want to go into that room anymore. (FGS1–1:204,205)

On numerous occasions, students were wrongfully shouted at by professional nurses or staff nurses for mistakes the seniors had themselves made or for those of other students.

Now, when you come there as a student and you do some mistakes, it is like you are nothing and you will feel so bad because someone will even be shouting at you, like, [even if] you are doing nothing [wrong]. (FGS2–2:55)

It was in xxxx. The sister in charge at that time on a Wednesday morning just after handing over she shouted at the students about how irresponsible they are and how she does not wish to be nursed by us in the future as we were so confused about what she is referring to. We were then told that the whole issue was about a student who was found sleeping on the previous shift. For me this incident is not in line with my perception of a professional nurse because as a senior you do not just shout at your subordinates about things they did not do; you can just inform them and educate them about it. (CIN–2:30)

One of the senior sister/professional nurse, the in charge at that time was making students' lives and work place to be miserable and full of hardships

every day. She would burst into screams, shouting [to] the students if ever she finds them in groups in the patients rooms or sitting down, it was as if one need to do be busy every time non-stop even though the routine time is done or yet to come. I was on this point one developed resistance towards her specifically and ignore all the shouting and the screams on the passage. (CIN–5:80)

Then they sent me at theatre to accompany the patient. I knew it that it is not my scope of practice as first year to hand over the patient. Hence I didn't had a choice and saw it as [a] learning opportunity for me to hand over patient. As I went there at theatre with porter and it was my first time to be there, I was scared because I didn't know how to hand over patient then. Then I found this other staff nurse who was not friendly at all. I tried to hand over to him. He was shouting at me in front of patient. (CIN–7:106)

The following extract contains accusations of students playing truant, of them taking advantage or taking chances. According to the participants, these are generalisations based on individual students' behaviour.

Even when one request some days off in the wards or ask for one's duties to be changed, it becomes a big issue as the in charge or seniors (Captain) respond by saying "Students like to take chances and advantages of the kindness of the Captains" and would say "Students like to stay away from work for no reason". (CIN–5:86)

Participants related more of their experiences that further demonstrated that all students were being treated alike and that negative behaviour was generalised to include all student nurses.

I always have the problem with the way they approach students. This really disturbed me, why I'm having this attitude towards the Captains and even the Majors in the hospital … Because of one thing that I do believe in is if one person make a mistake you do not have to generalise. You say you students you are doing this. Because of it can be one student but then the rest may not have done, not done that or maybe have the same perception of a mind or ideas of whatever the student did. So, I always had the problem with the way they generalise things. They say, 'You student[s], you do this …' They will treat [you] as if … like you are the person that did whatever this student did. I always have a problem when every time that happens, I will always address it. You don't have to address us as like a group if maybe one person did a mistake. If I come to you and I request something, you do not have to deny me that opportunity of granting that permission because of the previous student of whatever they did. (FGS1–4:97,98)

It was in xxxx. The sister in charge at that time on a Wednesday morning just after handing over she shouted at the students about how irresponsible they are and how she does not wish to be nursed by us in the future as we were so confused about what she is referring to. We were then told that the whole issue was about a student who was found sleeping on the previous shift. For me this incident is not in line with my perception of a professional nurse because as a senior you do not just shout at your subordinates about things

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they did not do; you can just inform them and educate them about it. (CIN–2:29)

One participant related an incident in which he had been unfairly accused of lying.

She asked me why am I not writing the report, I was surprised because I was writing. She said I must leave the ward if I don't want to be there. I showed her my paper that I was writing, she said I'm lying, so many were just standing there she said nothing to them, it really hit me hard. (CIN–9:145)

Another indicated that she had been accused of being lazy and that this had made her hesitant to ask questions.

So, how is it that you are going to ask our senior to have more knowledge if maybe our seniors they are using their rank and everything, using negative words on us saying, 'You shouldn't …', 'You are lazy'. (FGS1–4:196)

4.2.3.1.5 Abuse of rank

The following extracts demonstrate that the participants considered the military culture of ranking and authority to be demeaning.

So, I am thinking that within [the] military, you get this authority, these ranks. They are the ones that are putting us down as nurses. (FGS1–3:181)

That is the approach that we mostly receive as students, as my colleague was saying. So really, the approach and the use of rank … Sometimes [it] is not that necessary for you to remind a student every time that you are just a nurse here. (FGS 1–4:193)

One participant also related an incident where she had been expected to salute a higher-ranking officer who had walked past the treatment room while the student had been preparing patients' prescriptions.

I remember when I was in my second year and allocated in xxxx. That day I was so excited because I had been allocated for medication with one of the comm.-serve. At around 9 o'clock in the morning we went to prepare in the treatment room that is to take patients prescriptions to the pharmacy for the medication we needed for the day and night duty as well. The comm.-serve left me in the treatment room to fetch one of the patient's file when the Colonel passed by and asked me why I didn't pay the compliment – at the time I was still busy preparing that I didn't notice that there is someone who was passing by the door, but when the Colonel approached me I immediately apologised and saluted. For me I believe that Military somewhere and somehow interfere with nursing because when I'm in the ward I'm focusing

> *more on the patients and providing them with quality nursing care and for me to do that I need to fully focus on my work.* (CIN–4:65)

Even visitors to the wards have been seen to pull rank and to overrule the nurses. In one instance, a higher-ranking officer visiting his wife just passed the nurses' station without greeting the staff, only to find that his wife had been moved to another room. When he returned to the nurses' station and the participating student requested that he report to the nurses' station first, he replied that he was a Major and could come as he wanted. On another occasion, a General insisted on visiting a relative outside visiting hours and when requested to wait in the waiting area until visiting hours, he told the staff that he was a General, that he could visit at any time and accused the staff of being guilty of insubordination.

> *… the Major came in past the nurses when they were still sitting there, going to Room 12. Then [it] happened that … find out that my wife is not here. He came back. When he came back, he did not even … ehh … greet or … ehh … or say hallo to anyone. He just said, 'I am looking for my wife, where is she?' He mentioned her name. After that, the thing that I did is because of we are taught respect, even in class we are told you must respect the next person before you say whatever to the patient nè … So, this Major, the first thing that I did was like, 'Good morning, how are you?' 'I am well, thank you'. Even before he can even reply, I said, 'Your wife is at Room 5. But the next time when you come in, please don't just come in and pass us here as if like we are nothing or something'. Then he said to me, 'You know what CO, I am a Major, I can come anytime I want'. Joo, that clearly shows … ehh … most of … of our military, not only the nurses, but most of the military personnel, they like using the authority, like to enforce or whatever they like.* (FGS1–4:188,189,190,191,192)

> *I was working in xxxx where a man came in the ward visiting his relative. The issue was that it was not visiting time but he came 17h15 during routine time. He came to the console and asked to see the patient when we told him that it is not visiting time yet but we will request this patient to see him outside in the waiting area. He started shouting asking us if we know who he is, He is a General we do not refuse his request. The Captain in charge of the ward tried to explain to him properly but he kept pulling ranks and telling the staff members how insubordinate they are. He can come and visit any time he wants.* (CIN–2:23)

4.2.3.1.6 Unprofessional conduct

According to the participants, professional nurses were taking advantage of students. They related examples of where the professional nurses had relaxed while students had been working or had done nothing all day long, and had not assisted with patient care.

In xxxx what I noticed is that the nurses who are qualified they take advantage of the students. … when they see us students they sit down there at the nurses bay and dwell much in their conversations the whole day, you won't see any nurse from an enrolled to registered nurse on the floor helping student with nursing care. (CIN–3:52)

It wasn't easy though because we were doing almost everything as students and it wasn't nice to see someone relaxed while the rest of us sweat in [the] patient's room working. It was sad to see that someone can actually come to work and just decide to seat down the whole day or avoid work that needs more focus eg back and pressure care. (CIN–4:75)

Participants felt that the professional nurses were more concerned with having them conform to military norms and values than with their patient-care competence.

The most important thing for them as soldiers is to … for you to conform to their norms and to their values, forgetting that basically you are here for patient care. (FGS2–1:227)

Another example of unprofessional conduct mentioned by participants amounted to favouritism in that registered nurses gave unfair preferential treatment to certain students at the expense of others.

In hospital my case is that if you don't have a professional/registered nurse who favours you the most, then your clinical stage will be difficult. (CIN–3:48)

Figure 4.9 provides a summary of the hidden elements and their influence as identified in respect of the category *military clinical learning environment*.
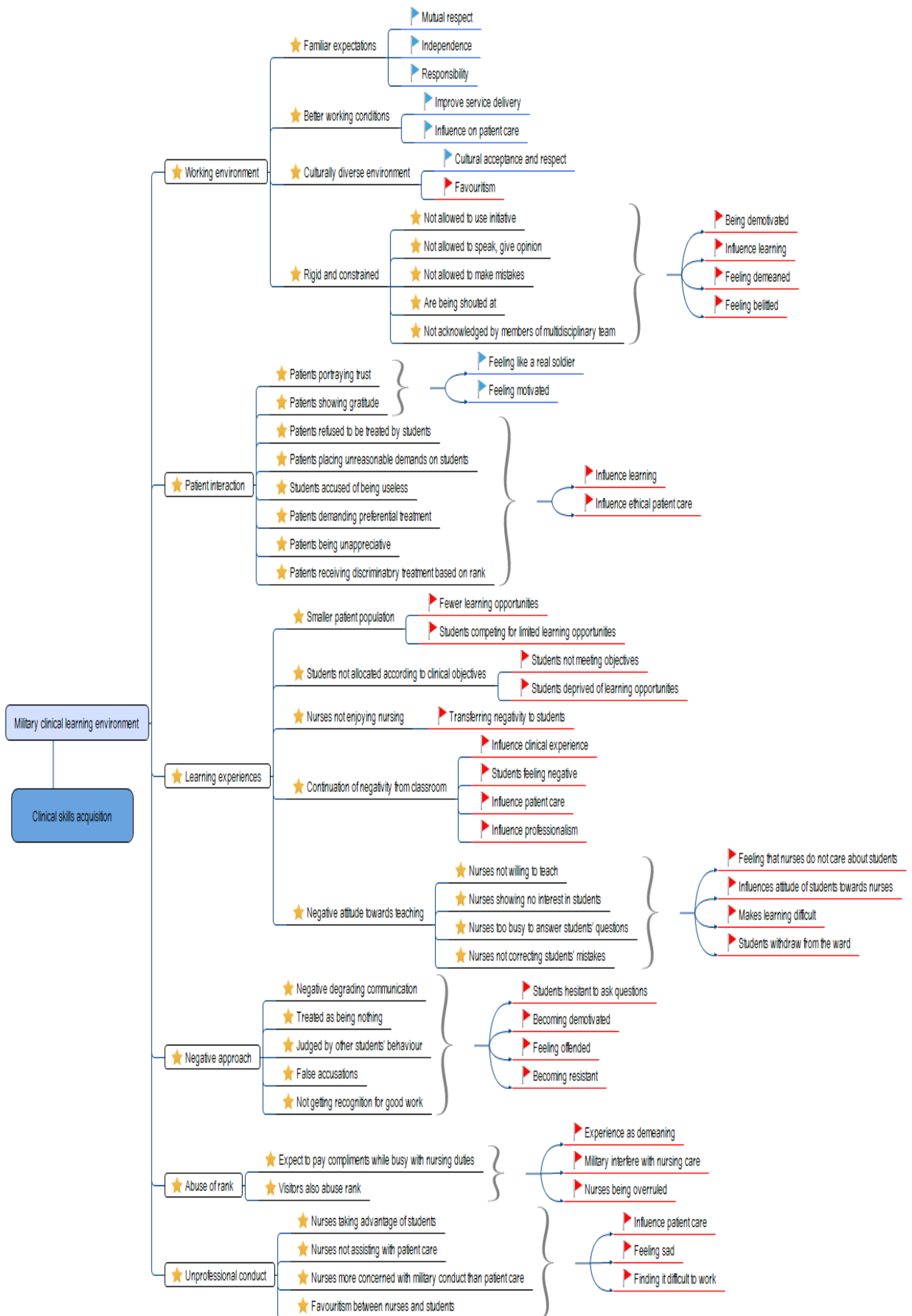
Figure 4.9: Mind map of the category *military clinical learning environment* (Sample B)

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4.2.3.2 Civilian clinical learning environment

4.2.3.2.1 Professional role modelling

One participant commented on the professional conduct of a civilian professional nurse whom she had observed and expressed the wish to be like her.

> *Even if I don't know, then maybe just one sister in that clinical area I am allocated in, when I look at her, I would see myself like … okay with the behaviour or the conduct that she is portraying, then I would like to be like her.* (FGS1–1:21)

Other professional traits that participants recognised in civilian professional nurses included the fact that they were more patient and more approachable.

> *Then there was this one sister; if I can mention the institution, it was in xxxx. Then the sister came, apparently I was next to her. She asked this patient nicely, 'Why didn't you book?' Then the patient said, 'No, I was scared'. The way she approached her, she didn't respond and say like with anger or insults or things like that that I have observed with the other sister before.* (FGS1–1:23)

> *My experience outside from xxxx and xxxx … From the time that I was working there, I would say really my experience was different. I feel that like when we are in Far East the sisters there they were very open to us, giving us a chance.* (FGS2–5:33)

Another aspect of professionalism on which participants commented was the generally unkempt appearance of the civilian professional nurses. It was suggested that they were not neatly dressed and that their hair had not been tied back.

> *You will find that with my experience I have … you will find that most in the public sectors, the nurses will go with long hair, like not making a pony or something there. But in the military, being a military student or a military nurse, you know your hair must be neat.* (FGS1–3:176)

> *For me, I see myself professionally as more mature than them because I am … I will be more neat than them.* (FGS1–6:283)

The use of languages other than English in the civilian facilities was considered to be inhibiting. Participants did not feel that they were part of those facilities.

> *The language will be the main factor that separates us if the Xhosa's are of majority in the ward and you don't know a single word, they will talk to you in*

Xhosa as if you will hear what they are saying. This happened while I was working at xxxx during night shift, I paired myself with two other colleagues of mine who are Xhosa's, when we reach the Antenatal unit all of the registered nurses working in there were speaking Xhosa, so apparently everyone was speaking this language except me and it was difficult to work in there, you can't join the conversation, even they work using these language and you don't understand anything they say, so you become left out and you won't get the necessary knowledge or your outcomes won't be met. (CIN–3:51)

Participants also noted that some of the civilian professional nurses were failing to fulfil their teaching roles. It was reported that students were often left unsupervised and that specific tasks were not being delegated to them. Instead of being shown how to do certain things, they were shouted at for not doing them correctly.

I was once singled out in a medical ward because I was the only soldier working there. I was left unsupervised and not even delegated. I felt like I am worthless because they did not know my work quality. Nurses are supposed to be teachers amongst other thing but the professionals in xxxx are not. They basically influenced my professional growth negatively just because of my military uniform. (CIN–8:136)

Then they will not try to show you in the right way. They just shout and everything. (FGS2–3:31)

One participant further considered the civilian students to be unprofessional since they had failed to show the necessary respect to the professional nurses and would leave the ward whenever they wanted to.

My view on this is that, also as students, I have noticed their behaviour and the way they conduct themselves among their seniors. It is like they don't respect the professional nurses who are supposed to be their supervisors. They just go whenever they want. (FGS1–1:270)

4.2.3.2.2 Patient care

Participants were very disappointed with the demonstrated level of patient care in the civilian facilities and specifically highlighted the unacceptable way in which patients were treated and spoken to.

But there are times that whereby I saw certain behaviours from nurses that it didn't really … When I look at that, I will make an example like especially in midwifery you will find patients who are maybe unbooked patients, then they come there in labour. It is so painful sometimes, some sisters the way they treat those people, because some are teenagers. (FGS1–1:22)

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And you can even see by the way the staff there are, they are very negative towards patients. I think if we were … at least, we have got this chance to learn how to be supportive and loving and giving the nursing care towards our patients through [the] military. They … I think, they never got that chance. Even the students, they are already as rude as the staff members are now from xxxx because that is where we have interaction with other students in xxxx. They are so rude to the patients as the staff members are now. (FGS2–2: 234,235,236)

But I think out of my own evaluation, I think it is the old nurses that we are still having those old nurses. They are the ones, I think they are impatient and they shout. (FGS1–1:263)

4.2.3.2.3 Attitude and behaviour towards military students

The participants indicated that they had found civilian professional nurses to have negative attitudes towards military students and that they had not been well accepted in the civilian facilities.

Being a nursing student in the Military is not always easy as civilian nurses tend to ill treat us and isolate us. This can be due to many factors but at the end of the [day], it is wrong and we as military nursing students are being disadvantages. In xxxx we are treated like outsider. I was once singled out in a medical ward because I was the only soldier working there. I was left unsupervised and not even delegated. I felt like I am worthless because they did not know my work quality. Nurses are supposed to be teachers amongst other thing but the professionals in xxxx are not. (CIN–8:135)

They don't give, like they, it is like you are not even there. They don't even orientate you, and maybe when you speak up they will say, 'No, this is not military'. Because when I go to a new ward in xxxx, they will orientate me before anything else. No, if you voice up that they will tell you, 'No, this is not [the] military, now you have to manoeuvre yourself around the ward'. (FGS2–2:27)

So, when we get there [and] then people are negative towards us, we also become like that, because then everything that you do it will be like everything is wrong. (FGS2–329,330)

They also felt that military nursing students were being unfairly treated by the civilian students in the sense that the civilian students would be on duty for only a short while and would then disappear, leaving the military students to do the work.

The students, the outside students, when I compare them to us, they … I don't know, they misuse us in a way. In the morning, they will be there pretending to be working. But after tea, once they go for tea you will never see them. (FGS1–1:266,267,268)

The participants agreed that the fact that they had been wearing military uniforms may have been the reason why they felt that they had been treated like foreigners and differently from the civilian students in the civilian facilities. They moreover had a sense that the civilian personnel might also have felt intimidated by the military uniform.

> *Then I must mention that when I were in the outside institutions some students from other colleges, government colleges, they liked to, I don't know it if is undermining or something, sometimes they treat us, it is like we are foreigners of something. They don't take us we are the same, we are all nursing students just because we are wearing this uniform, they think we are getting so …* (FGS1–1:157,158)

> *Sometimes even it can put us in trouble because people they get intimidated somehow.* (FGS1–4:92)

The participants referred to the fact that the civilian staff often discouraged military students from behaving in a military manner in terms of rising when a senior person entered the room, reporting to a professional nurse in charge first thing when reporting for duty and addressing senior staff by their ranks and surnames. The civilian staff indicated that the military students had to adopt the civilian way of doing things.

> *What I wanted to say actually was, it is not that difficult. It is just that compared to all civilian and military, it is like she said, they want us to behave not in a military way towards them. So we have, we have to be in a civilian way to them. So, whatever we are taught in the military, we are not supposed to portray it to the civilians.* (FGS2–4:24)

> *They will tell you no this is not military, you must do things the way we do it.* (FGS2–2:25)

4.2.3.2.4 Perceptions of military students

The participants were of the opinion that the civilian personnel generally appeared to be uninformed and ignorant regarding the military. In the participants' view, civilian personnel had the perception that soldiers did not study, that they were less educated, that military students earned more money and that they were more privileged than civilian students.

> *So, we love comparing ourselves with them. But then, I don't believe that they actually know more. But I believe that they take soldiers as … You know it is like being stereotyped, like, I was like that even before I joined the military. It starts off with the person not even thinking that in the military people study. People don't know that in the military people study. They believe you, we are*

just wearing a uniform, you are just a soldier, you know nothing. (FGS1–6:275,276,277)
They don't take us we are the same, we are all nursing students. Just because we are wearing this uniform, they think we are getting so much money. (FGS1–1:158)

Then they will call us, 'Ah, these are Zuma's children'. But they say to you in Sotho, 'Bana ba Zuma'. So, it will feel so awkward, like we don't treat them, we don't put them inferior or something. (FGS1–1:159,160)

As is evident from the following extracts, the participants also experienced other negative perceptions of the civilian personnel regarding military students, including that they are incompetent, irresponsible and not knowledgeable.

Then the sister started shouting at me in front of the patients saying, 'You are incompetent, you are irresponsible', and stuff like that. (FGS1–3:72)

I will say with the students outside, they believe … I don't know they have got this belief that they know, they know more than us. (FGS1–6:272)

The participants however observed that the following positive characteristics of military students – their discipline, punctuality, hard work and respect – did not go unnoticed by the civilian personnel.

You come before time because you are a military nurse. Unlike the public sector, you can come around maybe past seven, but here you know you stick to time. Everything is about time in the military. There is discipline and that. (FGS1–3:61)

The military is really working on the professionalism and they are really grooming us. You will find that when you are outside that even the sisters working there they even ask, 'Where can I get the forms? I want my niece to apply. You guys are so disciplined. You are on time every time. You always work. You know you respect elders'. (FGS1–6:331,332,333)

I must say the sisters in charge there … because we normally go [to] xxxx for maternity. They really respect their military students. (FGS1–1:265)

Then the sister was commenting, 'Ah, you trust this ones, they navy uniform, they call them navy. Rather send the military student because at least they will do it. I trust them. These ones are always dodgy'. (FGS1–1:269)

The professional conduct of the military students also seemed to have impressed patients in the civilian facilities. The participants reported feeling respected, appreciated and trusted by the patients.

Another nice experience that I have had, especially wearing the military uniform … When you are in the clinical sector, when we get there, some

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patients would sit having a problem and then there will only maybe … Let's say maybe you as a military student, you went out for lunch or you were doing whatever, they would wait for you until you are done, and that will be the time they will express, 'I am having one, two, three and four'. Then you ask, 'Why couldn't you tell anybody?' Maybe you see this thing it is not something, you shouldn't have stayed with this pain for, since 08:00 and you are only reporting it now at 12:00. Then you ask, 'Why didn't you tell the other sister that was in the ward'. Then they will say, 'No, joo, we are so scared of them'. Things like that. They will say all these negative things. Or they will say, When we look at their faces, we are just so scared to even ask for anything'. Then that thing it makes us, it make me as a military nurse feel good that at least we are making a difference out there. When they see this uniform, they get so excited that military students are here. (FGS1–1:25,26,27)

What we are doing right now, our public, our community out there, they really appreciate us. (FGS1–1:348)

4.2.3.2.5 Learning opportunities

Participants acknowledged the fact that they had received more clinical exposure in the civilian facilities than in the military facilities. This was due to the size of the patient population and also the types of cases they encountered in the civilian facilities. This assisted them not only to gain more knowledge and experience but also enabled them accurately to identify patient problems so as to be able to take suitable action.

Every time when you see there is a problem there you must attend at it that moment. So with me, I have developed this love of … I like going to the patient and ask them, Are you fine? What is the problem?'. Then when they say something, then I will take it from that moment and then we try to help as much as possible as I can. (FGS1–5:337,338)

Even now, I wish maybe they could implement that idea that I remain in the military but I do my Comm Serve in the public hospital. Because there you get to … you get to be stimulated mentally, your skills, clinically, everything unlike being here [where] you will end up, I think you will end up being rusted. (FGS1–1:252)

The participants were of the opinion that some civilian professional nurses were more inclined to teach them and were also giving them more freedom to use their own initiative than the military professional nurses.

So, she was so patient with me, you know, showing me everything step by step and giving me initiative in the ward. So, I … I didn't experience … I feel, now … I feel that it is better to work outside than in the military setting. (FGS2–5:34,35)

Even the doctors contributed to their training by respecting their opinions and by discussing patients with them.

But, or when I got an opportunity, especially [in my] third year and fourth year to go and work in xxxx and xxxx, there the doctors they don't say, 'You are a student'. They just take you are a nurse and they respect your opinion. You would discuss a condition with that doctor and share ideas. 'Why, doctor, [are] you are doing this?' He won't be so mean to you or say you are stupid or whatever, unlike in the military. (FGS1–1:164)

Peer support was found to play a big role in the participants' learning experiences. The participants acknowledged that despite the differences between them and the civilian students, they were also learning from each other. They also mentioned how they had shared experiences with one another on the way back from work.

But there are those that they are fine, we work together, we share our experiences. 'How are things in your side? How are things?' Our side we do things this way. Then we learn from each other. (FGS1–1:271)

At times, the sisters will give you an opportunity to diagnose and say [that] the next patient is yours. So, you would do everything to this patient, assessing the patient from head to toe. So, you know it was quite a nice experience. When you come back from work in the bus, we are just talking that, 'Joo, I got an opportunity to do this today'. (FGS1–1:20)

4.2.3.2.6 Self-approval based on comparison with others

The participants constantly compared themselves with the civilian students and agreed that they compared well in terms of knowledge. They however considered themselves to be more mature and more professional than their civilian counterparts.

So, we love comparing ourselves with them. But then, I don't believe that they actually know more. (FGS1–6:275)

For me, I see myself as being more matured than them. I don't know why. Maybe it is because of the environment that I am in and having to stick to time and stuff. For them, I take them as kids. (FGS1–6:282)

You know that in the military you are very neat because I see them more professionally. I develop more than them. (FGS1–6:284)

I can say they are having lot of, like exposure to things more than us. Them, they have been given opportunities to go to work in private hospitals and what, what. But, us, we lead them with professionalism, like we said. (FGS1–2:295,296)

The participants also considered themselves to be providing better patient care than their civilian counterparts.

> *So, I personally feel that at least [the] military, it is grooming me to be something else before I can go and be exposed outside. Now, when I go there, I am different with them. Even the way I give … Even if I had to wear blue and white, I will be, I will still be different with them because of the way I will be giving my nursing care to my patients.* (FGS2–2:237)

> *Even you with the patient, they like saying that, 'You guys, you put more attention on us'.* (FGS1–5:335)

4.2.3.2.7 Absence of military influence

The participants agreed that the absence of military influences, for example channels of command and military ranks, in the civilian facilities, made it easier for them to be both assertive and to communicate.

> *If you go outside, you will feel comfortable, even though, when you have to become assertive.* (FGS2–2:240)

> *I think that the other advantage outside or something that will influence you in a good way towards your studies, and that is that outside, they don't have these, a lot of channels to speak to.* (FGS2–5:243)

> *I told them, 'I am leaving'. Some of them cry, saying they never received a better care like we gave. Then I noticed we cared more about our patient and we were free to show how much we care by nursing them to the best of our abilities without fearing ranks.* (CIN–6:93)

Figure 4.10 provides a summary of the hidden elements and their influence as identified in respect of the category *civilian clinical learning environment*.
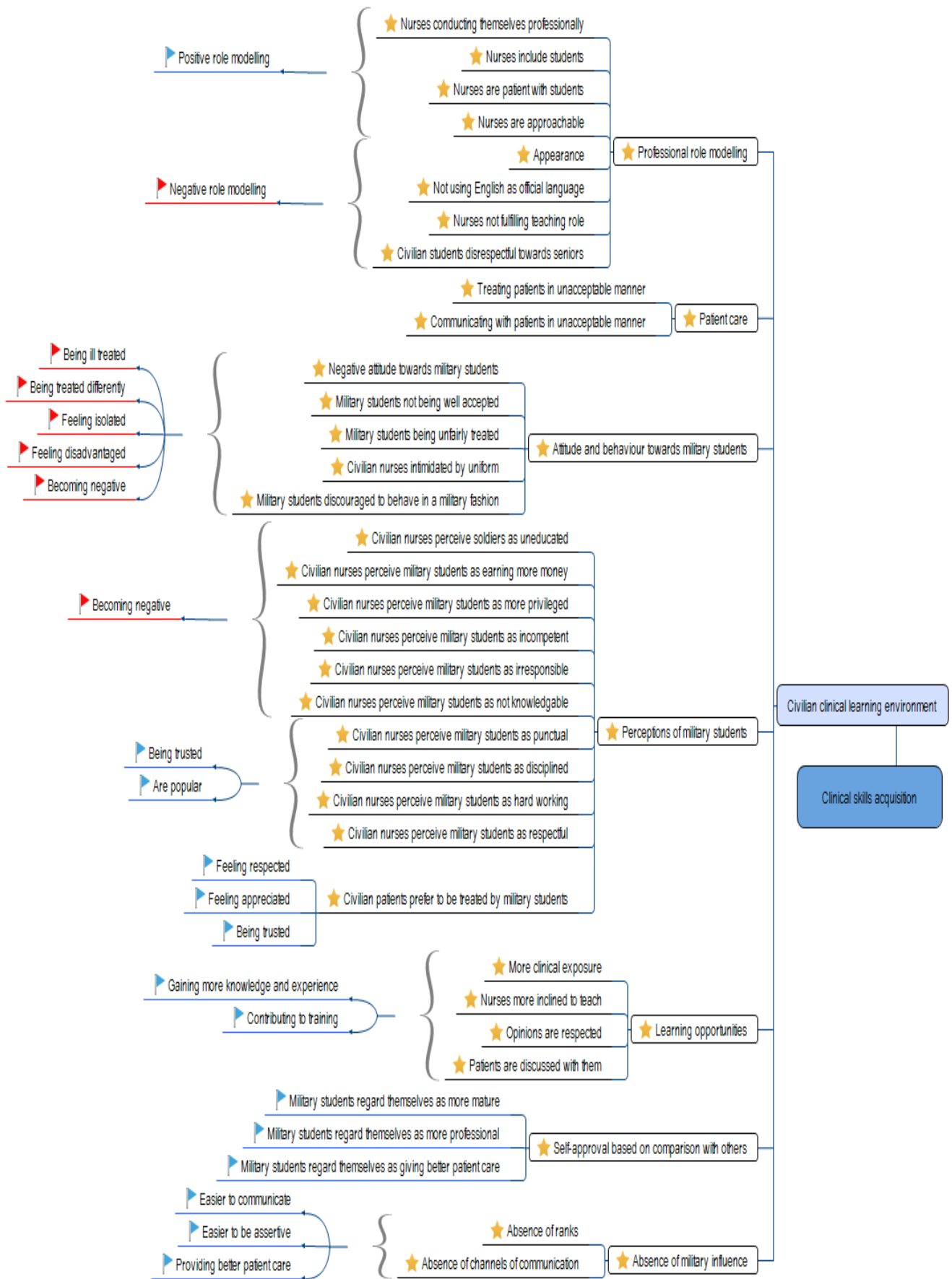
Figure 4.10: Mind map of the category *civilian clinical learning environment* (Sample B)

4.2.3.3 Professionalism

Experiences stated by participants relating to nursing professionalism in the clinical learning environment in general included references to developing independence, responsibility, stress management skills and passion.

> *Because, as a nurse, we have independent roles. So you don't need to go and ask someone to help you. So, you just have to take all the responsibilities to yourself. So, I learned to be more independent.* (FGS2–6:96)
>
> *Nursing teaches me the art of talking because I get to interact with a lot of diverse individuals on a day-to-day basis and [this] helps me manage stress and general life-hardships better since I can relate to other people, patients or even colleagues.* (CIN–1:9)
>
> *So, even when I am working there, people are being recognising me that he can do nursing because I was doing [it] with passion. I didn't came here like, [I] love nursing, but I developed love for nursing along the way. This nursing I can feel it, I can do it, you see.* (FGS1–5:131)

Figure 4.11 provides a summary of the hidden elements and their influence as identified in respect of the category *professionalism*.
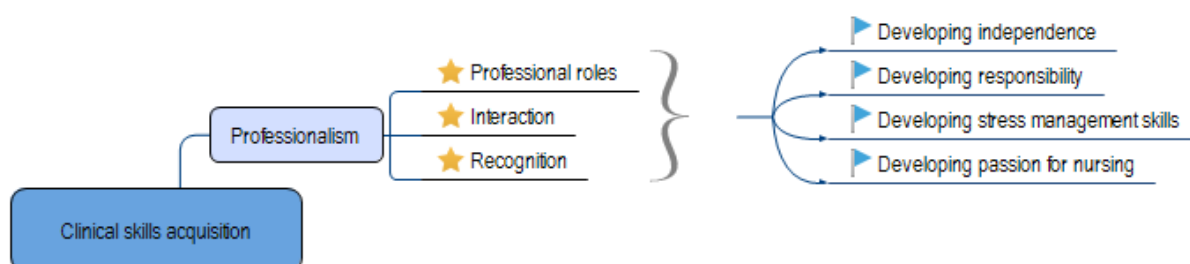
Figure 4.11: Mind map of the category *professionalism* (Sample B)

4.2.4 Theme 4: Professional role conflict

Table 4.5 provides a summary of the category and subcategories of Theme 4.

TABLE 4.5: THEME 4: PROFESSIONAL ROLE CONFLICT (SAMPLE B)

Theme	Category	Subcategory
Professional role conflict	Dual roles	Unprepared to deal with dual roles
		Conflicting and confusing
		Affecting the nursing profession

4.2.4.1 Dual roles

Sample B (Section 3.2.4.1) also raised the issue of having simultaneously to fulfil the roles of a soldier and a nurse.

4.2.4.1.1 Unprepared to deal with dual roles

The participants firstly indicated that nurse educators had not sufficiently prepared them to deal with fulfilling dual roles as nurses and soldiers.

> *What they do is like, they are teaching us that a higher rank … Okay now, they are in the military, we must respect the higher ranks not per se … They are not actually teaching us how to interact with them. But they are actually teaching us to just be, to just be scared of them. Yes, scared of them.* (FGS2–2:116)

4.2.4.1.2 Conflicting and confusing

Although the participants acknowledged that being a soldier and a nurse should go hand in hand, they found this difficult. They further indicated that these dual roles were causing confusion. At times, they were treated like soldiers and expected to behave like soldiers and at others, they had to be nurses and act like nurses.

> *Because now, whenever, whoever decides to feel or is feeling like we should be in the military, they will behave like we are in or they will treat us like we are in the military. They change, all of a sudden, you must be a nurse and you must act like a nurse.* (FGS2–2:113)
>
> *But not, even when someone is approaching, you – maybe with a higher rank – they must consider that you are a nurse in the military. It means [that] you are a soldier and a nurse. So, they must give you that approach of a nurse and a soldier in [the] military because once you are approaching me as a soldier, I am going to respond like a soldier. When you are approaching me like a nurse, I am going to respond like a nurse. Now, if you are coming to me and you are expecting me to be a soldier, now I am behaving like a soldier and then you blame me for not being a nurse or for not showing. Or, you are coming to me, you are approaching me as a nurse and then I respond as a normal nurse and then you are expecting me to be like a nurse and a soldier at the same time. That becomes difficult also.* (FGS2–2:114)

One participant mentioned that she generally found it difficult to switch roles when moving between the military and the civilian environments.

For me it is a bit challenging because, for example, like now, we are doing theory and then most, like … like most of our theory, we are doing it on a military base. So, every day now and on we met different ranks. So, and then from there, because when you go to clinical, it is a different setting. It is not like … it is in a military base. So, we also go to the civilian ones also. So, it is a bit challenging, if I can say so. It is … You have to adapt to a different environment again. (FGS2–4:10)

4.2.4.1.3 Affecting the nursing profession

Another expressed the view that the military profession took precedence over the nursing profession, a circumstance that detrimentally affected the latter.

I feel that in the military, as a nursing student or as a nurse … how it has affected my profession is that you have to be a soldier and a nurse at the same time; especially when we are working in the, like in xxxx, xxxx and xxxx. You find people of higher ranks. There you have to consider their ranks before you can treat them. (FGS2–2:5,6)

For the same reason it was agreed that having these dual roles made it difficult for them to assert themselves.

Because what I feel is that we put military first and then our profession that we are into, and put it last. So it becomes very difficult to say, to become assertive. (FGS2–6:104)

Figure 4.12 provides a summary of the hidden elements and their influence as identified in respect of the category *dual roles*.
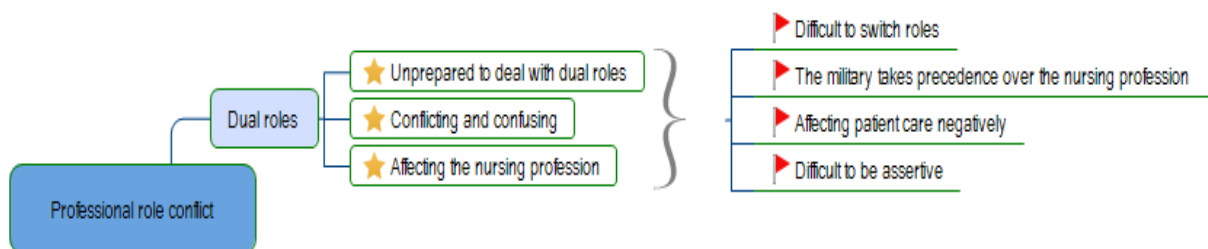
Figure 4.12: Mind map of the category *dual roles* (Sample B)

4.3 SUMMARY

Chapter 4 dealt with the four themes, the 12 categories and the 44 subcategories derived from data obtained both from the focus-group interviews with the students and from their critical-incident narratives. Mind maps further illustrated the hidden elements and their influences as identified during data analysis. The following chapter will provide the integrated findings from Sample A and Sample B.

CHAPTER 5

DISCUSSION OF THE INTEGRATED FINDINGS AND LITERATURE CONTROL

5.1   INTRODUCTION

In this chapter the researcher discusses the integrated findings of Chapter 3 and Chapter 4 with a view to presenting one set of findings based on data obtained from the nurse educators (Sample A) and from the students (Sample B). Concepts have been further refined and duplicate concepts eliminated to elicit meaning from the findings. In this chapter, for the sake of clarity, reference will be made to nurse educators and students, and not participants anymore. A mind map illustrating the combined interactions and the relationships between the integrated categories and subcategories of a particular theme precedes each section.

The existing literature has informed both the discussion and the interpretation of each of the themes. Using the thematic and categorical concepts identified in Chapters 3 and 4 as key words, searches were conducted in the following databases:

- Academic OneFile
- CINAHL Plus
- EBSCOhost
- Elsevier
- Emerald eJournals
- Google Scholar
- Ovid MEDLINE
- ProQuest
- PubMed
- Sage Premier
- Sagepub
- Science Direct
- Scopus
- SpringerLINK
- Wiley Online Library

5.2. INTEGRATED FINDINGS

Four themes were derived from the findings of Phase 1. The metaphors used to name each theme were chosen to resonate with experiences that relate to a uniquely military contextual environment. These will be clarified during the discussion.

- Theme 1: You're in the army now! – military acculturation
- Theme 2: Off to boot camp – professional knowledge acquisition
- Theme 3: Off to the battlefield – clinical skills acquisition
- Theme 4: Fighting a dichotomy – professional role conflict

Whereas themes 1 to 3 represent the processes through which students move to become professional military nurses, Theme 4 originated as a result of the dual roles that both students and nurse educators are expected to fulfil.

Table 5.1 contains a summary of the four themes with their categories and subcategories.

TABLE 5.1: SUMMARY OF THE FOUR THEMES

Theme	Category	Subcategory
Theme 1: You're in the army now! – military acculturation	Military as career choice	Motives
		Preconceived ideas
		Career prospects
	Military training	Military indoctrination
		Negative communication
	Military socialisation	Military culture
		Professional identity
	Military environment	Regulated environment
		Hierarchical environment
Theme 2: Off to boot camp – professional knowledge acquisition	Nursing as career choice	Motives
		Preconceived ideas
	Multigenerational influences	
	Role of nurse educators	Awareness to act as role model
		Awareness to instil nursing professionalism
		Awareness to instil military professionalism
	Interaction between nurse educators and students	Devaluing students
		Negative communication
		Negative attitude
		Indifference
		Being judgemental
	Teaching ethos	Management of poor performers
		Guidance and support
		Academic incompetence
		Assessment practices
	Power and authority	Indiscriminate use of rank
		Tyrannising
		Unjust treatment
		Condescending attitude
	Military teaching and learning environment	Adverse conditions
		Regulated environment
		Restrictive environment
		Structured environment
		Punitive environment
		Prejudiced environment
Theme 3: Off to the battlefield – clinical skills acquisition	Clinical learning environment	Learning opportunities
		Professional role modelling
		Attitude towards military nursing students
		Patient interaction
		Rankism
		Experience of students in the civilian clinical learning environment
Theme 4: Fighting a dichotomy – professional role conflict	Dual roles	Duality
		Acceptance of dual requirements
		Professional contradictions

5.2.1 Theme 1: You're in the army now! – military acculturation

In the Army Now is a song by the South African-born Dutch duo Rob and Ferdi Bolland, and was originally recorded in 1981 (Samson 2000). After each verse of the song, the sentence, "You're in the army now!" is repeated. The rest of the lyrics give a good idea of what life in the army was like when the song was written and first recorded.

The metaphor was chosen to symbolise the processes of military acculturation, of being introduced to military life, of acquiring the traditional content of the military culture and of assimilating its practices and values. The metaphor was deemed appropriate in that the categories that emerged from the data encompassed aspects related to the participants' transition from civilians to soldiers.

The integrated findings of Sample A and Sample B generated the categories and subcategories reflected in Figure 5.1.
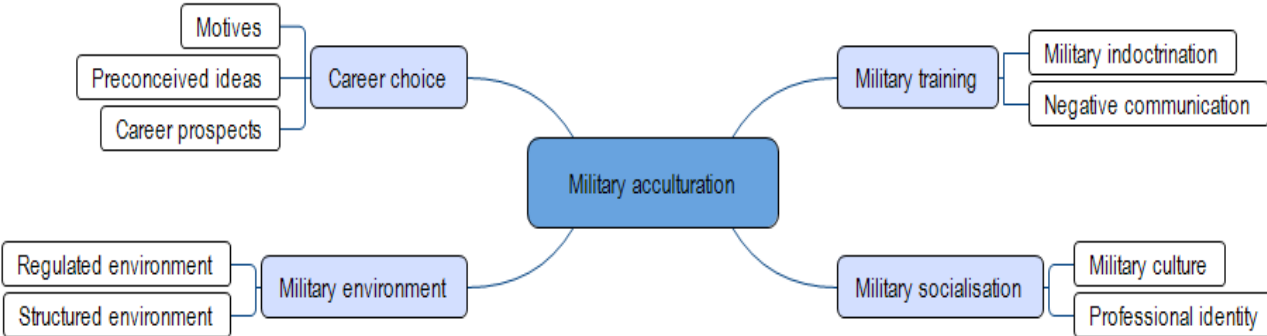
Figure 5.1: Mind map of Theme 1

5.2.1.1 *Military as career choice*

Students' decision to choose the military as a career forms the starting point of their journey towards becoming professional military nurses. It was evident from the data that in most cases, being neither a soldier nor a nurse had been the primary consideration. It was rather that they had lacked either other better opportunities, or the necessary finances (Section 4.2.1.1.1). Their reasons for choosing the military as a career most probably had an influence on students' experiences throughout their training.

The students' journeys had further been influenced by their prior knowledge regarding a career in the Defence Force and thus whether their choice to join the Defence Force had been an informed one (Section 4.2.1.1.2). The positive career prospects mentioned by the students might have been convincing factors, irrespective of whether it had been their first choice (Section 4.2.1.1.3). Some of the nurse educators made reference to their own choice to join the Defence Force, as one mentioned that she will not exchange her military uniform for something else, since she feels that the military has groomed her. Another nurse educator indicated that she had a passion for being a soldier from a very early age (Section 3.2.1.2.2). From the findings it is clear that nurse educators and students' have very different reasons for choosing the military as a career.

Occupational calling refers to an occupation to which a person feels drawn and finds meaningful within the broader context of life. Gazica and Spector (2015:1) maintain that people desire more of work than merely material benefits and that they want their work to be personally rewarding. The findings of this study did not corroborate Gazica and Spector's statement in that students mostly indicated that they had just wanted a job and earn a salary. It can thus be deduced that the students did not consider a military or nursing career to be a calling. One participant, for example, stated that after completing Matric, she had never considered the military or nursing as a career. According to certain studies (Duffy & Sedlacek 2010:27–41, Duffy, Allan & Dik 2011:74–80, Duffy, Dik & Steger 2011:210–218), participating in meaningful work is associated with positive life-, job-, and health-related outcomes. Meaningful work also results in greater career maturity, in the ability to make career decisions, in self-efficacy, academic satisfaction, in more pronounced career and organisational commitment and in job satisfaction. Meaningful work also leads to lower levels of intent to withdraw, depression and stress (Gazica & Spector 2015:1-2).

There are a number of theories of career exploration and development. Super's theory (1957) of career development (Long 2012:45-46) is the one most widely adopted by career counsellors today. According to Long (2012:45-46), Super (1957) proposed that career preferences and competencies change with time and experience, this leading to the development of the concept of vocational maturity, in which people pass through five developmental stages during their lifetime. In the growth stage, people build a general understanding of the world of work and the need to work. In the exploratory stage, people try out a variety of occupational choices through classes, work

experiences and hobbies. In the establishment stage, people acquire the entry-level skills for their chosen occupation and focus on expanding their knowledge and expertise. The maintenance and the decline stages are focused on career advancement and, ultimately, retirement.

The exploratory stage of Super's (1957) theory (Long 2012:45-46) corresponds most closely to the experience of the students when they collected information about the military as career in order to build an understanding of the skills sets and qualifications required (Section 4.2.2.1). The students mostly seemed to have acquired their information from informal sources, like friends and family. One participant indicated that a friend who had been in the infantry had encouraged him to join the Defence Force, while another's brother had already been in the Defence Force (Section 4.2.1.1.1). According to Super (1957), five factors are associated with the exploratory stage that help students to select appropriate career choices and to advance to the establishment stage, namely decision-making skills, long-term planning skills, knowledge and use of information resources, general information about the culture, rules and etiquette of the world of work, and lastly, detailed information about occupations (Long 2012:45-46). The findings indicate that students seemed to lack the skills or the resources to obtain knowledge and information about a nursing career in the Defence Force. The only reference one participant had was what he had seen on television, while another had never seen soldiers and had thought that a military career was only about fighting, shooting and killing (Section 4.2.1.1.2).

The Defence Force, besides running marketing and recruitment campaigns, also has numerous exhibitions to provide members of the public with information that may assist them to make informed career choices. These opportunities are however not always accessible to everyone. A further attempt to ensure that applicants choose military nursing as an occupational calling and that they are indeed suitable candidates, is made during the selection process, using psychometric tests and interviews as tools. It has however over time been established that these measures are ineffective.

5.2.1.2   *Military training*

The students mostly reported that their military training had been a positive experience. The data revealed that military training provided students with valuable experiences and

skills such as the value of group cohesion and teamwork, self-motivation, obedience, respect, personal grooming, endurance, confidence, independence and self-reliance, resilience, determination, patience and discipline (Section 4.2.1.3.1). From the nurse educator's point of view, military training not only has a positive effect on the students in terms of instilling discipline and providing an important functional element of preparing them as soldiers for operational deployment. Military training also contributes to the development of many functional attributes such as the development of leadership skills, communication and writing skills, critical-thinking skills, managerial skills, decision-making skills and planning skills in students (Section 3.2.1.1).

Military training forms the essential link between being a civilian and becoming a soldier and it serves as tool to facilitate military socialisation. The purpose of military training is to familiarise new members with military skills, rules and customs, such as saluting, wearing the uniform properly, physical fitness, marksmanship and some combat procedures. New recruits also learn to work to ensure the success of the group. Emphasis is placed on obeying the military hierarchy, following the directions of instructors and other superiors and executing orders efficiently and unquestioningly. Military training can be physically and emotionally demanding and is designed to promote physical stamina, instil discipline and also the respect for authority that is necessary to enable recruits to succeed in the military (SANDF 2010).

According to Lieberman, Karl, Niro, Williams, Farina, Cable and McClung (2014:1113-1123), most basic military training courses are designed to improve the recruits' physical fitness and their cognitive and social skills to equip them to perform their duties effectively. The key objectives of military training include ensuring that recruits will work effectively as a team and follow orders. A fundamental goal of basic training is that of ensuring recruits are committed to collective group values and behave accordingly. The training environment is designed to transform recruits into soldiers who are competent to perform their assigned duties and who are committed to their organisation.

Lieberman et al (2014:1115) suggest that military training develops practical skills that have substantial cognitive components. These include land navigation, marksmanship, battle drills, and simulated casualty evacuations, activities intended to develop cognitive capabilities such as decision making, problem solving and situational analysis. Most of these activities require integration of multiple cognitive functions. Skills such as

memorisation, problem solving, decision making and rapid response to relevant stimuli are implicit aspects of training soldiers to react to simulated battle scenarios. All of these attributes correlate significantly with the findings of this study.

Daneshfard and Zakeri (2012:44-63) conducted a quasi-experimental study on military recruits, which comprised pre- and post-tests to evaluate the effects of military training on the development of soldiers' personality skills. They reported a significant difference in terms of the development of perfection seeking, communicational skills, self-confidence, programming, responsibility, personal experience and teamwork skills. In a similar study by Maleki, Sanei, Borhani and Ghavami (2012:195-200), the results indicated a significant increase in the post-test stage of emotional balance, self-sufficiency, extroversion, dominance, self-confidence and sociability.

The findings of the abovementioned studies compare well with the findings of the present study, confirming that military training indeed contributes to the development of various personal and cognitive attributes and skills.

5.2.1.2.1 *Military indoctrination*

Reference has already been made in Chapter 3 (Section 3.2.1.1.1) to the view of Payne (2014) that military indoctrination, as part of military training, is associated with images of docile subjects uncritically following the orders of an authority figure.

The nature of military training is such that it subjects the recruits to many drills or the repetition of actions without them being allowed to question it. According to the nurse educators, the resultant negative effects of indoctrination, and of cognitive and behavioural conditioning adversely affect students' critical-thinking skills, decision-making skills, independent thinking ability, creativity and innovative ability, which ultimately affect their cognitive development and, in turn, have a negative effect on learning. Other adverse effects of indoctrination mentioned by the nurse educators are the depersonalisation, dehumanisation and de-emotionalisation of students and a resultant loss of identity and individuality (Section 3.2.1.1.1). The students did not identify any adverse experiences related to military indoctrination.

Rose (2014) offers a very different perspective on what it means to be indoctrinated. According to him, rather than creating mindless zombies, the military produces a form of altruistic communal integration that creates a sense of solidarity and significance among its members. He explains that to indoctrinate means to bring individuals into alignment with a specific doctrine. To make his point, he uses the four most commonly listed core military values of duty, loyalty, integrity and courage. Duty is the most altruistic of these values since it demands that a soldier should place the mission requirements above personal considerations. Loyalty is related to duty and requires not only personal allegiance to the country, but also faithfulness to fellow soldiers. Duty also dictates loyalty and therefore respect for authority. Integrity solidifies the personal altruistic commitment of soldiers to moral principles and obligations. Courage ensures that these altruistic principles and obligations are carried out in practice. He concludes his article with these words: "Military indoctrination goes beyond learning to obey. Military indoctrination facilitates a feeling of community. Rather than erasing one's sense of identity, it gives members a collective identity. Rather than diminishing one's sense of individual significance, the collective identity increases one's sense of significance" (Rose 2014).

The abovementioned opposing views held by Payne (2014) and Rose (2014) on military indoctrination can be used to adapt military training as such, so that the negative effects are minimised and the positive effects optimised.

5.2.1.2.2 Negative communication

Both the nurse educators (Section 3.2.1.1.2) and the students (Section 4.2.1.3.1) find the tone and content of the communication used by the military instructors during military training to be demeaning and unprofessional. Although they feel offended by it, the habit has unfortunately been transferred to the nurse educators and has influenced the way in which they address students.

Shouting, harsh language and even cursing are historically part of military training. Davis (2014) explains that yelling, often in the most personally offensive manner possible, is the easiest way to get a person who is unaccustomed to performing under stress to take action. It trains them to block out the noise, the fear and the stress and just do what they need to do. Judging by the input of the nurse educators and the

students, it would appear that this style of communication has become the norm, the way people spoke to one another in the military.

5.2.1.3   Military socialisation

Once the students have decided to join the Defence Force, they are faced with the process of being integrated into a new culture. The nurse educators agreed that the military culture is unique (Section 3.2.1.2.1). Burk (1993:32) aptly maintains: "The military, many would say, is a unique institution because its mission is the fighting of wars, and war places unique demands on those who serve, not only in the midst of war but also as they prepare for war."

The present section specifically addresses the unique military organisational culture into which students must be socialised. This will be combined with the acquisition of a military professional identity.

Dalenberg (2013) holds that proper positive adjustment into any military organisation and culture is crucial for new members rapidly to adapt to the requirements, as this softens conflicts between generations and stimulates solidarity and group cohesion. The value of military training in terms of creating group cohesion and establishing teamwork was confirmed by the students (Section 4.2.1.3.1). Uttal (1983) provides a clear and comprehensive perspective of organisational culture as being a system of shared values (what is important) and beliefs (how things work) that interacts with the people, the structures and the systems of an organisation to produce behavioural norms (the way things are done) (Motilewa, Agboola & Adeniji 2015:297-300). The nurse educators' perceptions clearly resonated with Uttal's definition (Motilwa et al 2015:297) when they stated that nursing students were trained in military values and norms and that they were expected to behave in a soldiering manner (Section 3.2.1.1). The students also demonstrated adequate understanding of military socialisation when they stated that "… you are going to conform to their norms and values and just do things the way they do it …" (Section 4.2.1.3.1). Although beliefs as such were not specifically addressed, multiple references were made to processes, rules and regulations that dictate how things in the military should be done by nurse educators (Sections 3.2.1.2.1 and 3.2.1.3.1) and by students (Sections 4.2.1.3.1 and 4.2.2.6.4).

5.2.1.3.1 Military culture

The Centre for Strategic and International Studies (2000:xviii) defines military culture as the integration of "values, customs, traditions and their philosophical underpinnings that, over time, has created a shared institutional ethos". Military culture provides a common foundation for those in uniform and common expectations regarding standards of behaviour, discipline, teamwork, loyalty, selfless duty and the customs that support those elements.

According to Burk (1999:447-461), there are a number of generic cultural elements that are applicable to militaries at large, but points out that one must remember that culture is a dynamic, evolving entity, shaped by historical experience, the culture of the broader society and the operational context in which the military is employed. Take, for example, the SAMHS Nursing College as a micro-organisation. It can be said that the military culture that currently exists at the College was shaped by history, especially if one takes into account that nurses have been trained in the military since 1945. Since the SAMHS Nursing College is part of the SANDF and situated within a military environment, its military culture has evolved and changed as the military culture of the broader organisation changed, specifically when one further bears in mind the political changes that have taken place in society at large and in government. As for the effect of the operational context on the military culture of the College, it can safely be deduced that the shift from conventional warfare to peacekeeping, disaster management and humanitarian assistance has also impacted on the focus of the College in terms of the combat readiness of both the nurse educators and of the students. As such, the nurse educators concurred that military socialisation develops a student to be a good professional soldier and is essential to prepare military nurses to provide operational support and to function under stress (Section 3.2.1.1). The students also agreed that military socialisation assisted them in accepting the military culture, in developing into soldiers, and being inducted into and internalising military norms and values (Section 4.2.1.2.1).

Burk (1999:447-461) identifies a number of essential elements that constitute military culture, namely discipline, professional ethos, ceremony, etiquette, protocol and customs, cohesion and *esprit de corps.*

- Discipline

The nurse educators commented on the manner in which students conduct themselves as a result of military culture (Section 3.2.1.1) and also drew a distinction between the conduct of military students and that of civilian students (Section 3.2.1.2). The students agreed that being socialised into the military culture taught them to be disciplined (Section 4.2.1.2.1) and that they became so disciplined that they knew when they did something wrong (Section 4.2.2.6.4). The students also observed that, in comparison to their civilian counterparts, their discipline, punctuality, hard work and respect did not go unnoticed by the civilian personnel. (Section 4.2.3.2.4). Fink (2010:211) describes discipline as a means of social control that is enforced by authority. Military discipline refers to the orderly conduct of military personnel. A high level of discipline begins with instruction and is perfected through repetitive drill that turns the desired action into habit. The aim of discipline is to minimise confusion by imposing order. Discipline entails compliance with rules, acceptance of orders and authority, and the way the organisation deals with disobedience by overt punishment (Soeters, Winslow & Weibull 2003:242). According to Motilewa et al (2015:297), organisational culture enables new members to distinguish between appropriate and inappropriate behaviour.

- Professional ethos

Professional ethos refers to the normative understandings defining a military's corporate identity and its code of conduct. It emphasises bravery, loyalty and commitment to the state, technical knowledge, effective leadership, willingness and skill, and moral competence (Fink 2010:212-213). Motilewa et al (2015:300) point out that organisational culture has been found to create a feeling of identity among employees and a sense of commitment to the organisation. From the data it can be inferred that nurse educators and students have adopted the professional ethos of the military organisation as evident in Sections 3.2.1.2.2 and 4.2.1.3.2.

- Ceremony, etiquette, protocol and customs

The nurse educators provided numerous examples of adherence to military customs, etiquette and protocol in the day-to-day activities and interactions between themselves and the students (Section 3.2.1.2.1). The students acknowledged the value of military

ceremony, etiquette, protocol and customs in terms of wearing a uniform, being neat and well-groomed and displaying respect to seniors (Section 4.2.1.2.1), but they also felt that some aspects of military etiquette, protocol and customs interfere with their academic development (Section 4.2.2.6.2) and nursing training (Section 4.2.2.6.6), their personal lives (Section 4.2.2.6.3) and clinical learning experiences (Section 4.2.3.1.5).

Fink (2010:213) points out that outside war, the ceremonial displays and etiquette that characterise military life are the most readily observable elements of military culture. Etiquette governs correct or acceptable behaviour, protocol is the set of rules and regulations that prescribes good manners, and military customs are social conventions stemming from tradition and which are enforced as unwritten laws. Ceremony, etiquette, protocol and customs are all acts of respect and courtesy when dealing with other people in military life and during official ceremonies and have evolved as a result of the need for order and also for the mutual respect and a sense of fraternity among military personnel. They have an extremely important role to play in terms of building morale, *esprit de corps*, discipline and mission effectiveness.

- Cohesion and *esprit de corps*

Morale is one of the most important contributors to military effectiveness and is a product of cohesion and *esprit de corps*. While cohesion refers to the feelings of identity and camaraderie that soldiers entertain for one another, *esprit de corps* refers to the commitment and pride soldiers hold for the military organisation at large (Fink 2010: 214). Little (1964:195-224) quoted the then United States Army Chief of Staff, Edward Meyer, who defined unit cohesion as "the bonding together of soldiers in such a way as to sustain their will and commitment to each other, the unit, and mission accomplishment, despite combat or mission stress". Evidence of cohesion and *esprit de corps* was found in comments made by nurse educators (Section 3.2.1.2.2) and by students (Section 4.2.1.3.2). Motilewa et al (2015:298) also point out the influence of organisational culture on employee motivation, on morale and goodwill, on productivity and efficiency, on quality of work, on innovation and creativity, and on employees' attitudes.

Further drawing on the findings of this study and on the work of Soeters et al (2003:240-243), the following additional elements and cultural aspects specific to military organisations were identified.

- The communal character of military life

This aspect relates to how far the control of the organisation extends to various aspects and stages of personal life. The institutional orientation of the military renders matters such as leisure time, family affairs, living conditions, high salary and career prospects relatively insignificant. Commitment to military life and the values the military stands for tends to create an overlap between military and personal life, which transforms the job into being a part of communal life. Students clearly failed to see it in the same light as Soeters et al (2003:240) as is evident from their comments regarding the structured and restricted environment within the organisation (Sections 4.2.2.6.2 and 4.2.2.6.3). The nurse educators however maintained that becoming a military nurse has been a choice, which implies the acceptance of military requirements. No distinction is made between different musterings in terms of military duties in the sense that nursing professionals are not exempted from military duties (Section 3.2.4.1.1). The nurse educators also indicated that they find it difficult to separate their military mind-set from their home environment as a result of the habitual execution of military drills (Section 3.2.1.1.1).

- Hierarchy

The military is extremely structured in terms of its organisational and hierarchical composition. Hierarchy is related to the bureaucratic character and authoritarian ideology of military life and refers to the importance of rules and regulations in the organisation. Military organisations traditionally demonstrate a strong social order based on vertical, power-related classifications and regulations. According to the nurse educators, the authoritarian nature of the military resulted in the negative communication they had encountered (Section 3.2.1.1.2) and also in the autocratic approach they considered to have been transferred to the military clinical learning environment (Section 3.2.3.1.3). The autocratic leadership style was further identified as one of the contradictory elements present in the generally more democratic nature of nursing (Section 3.2.4.1.2). Although the students indicated that the military hierarchy taught them to respect authority (Section 4.2.1.2.1), they had strong views regarding the

abuse of the power and authority related to rank in the theoretical learning environment (Section 4.2.2.4) as well as in the military clinical learning environment (Section 4.2.3.1.5).

- Chain of command

Chain of command suggests a downward flow of directives aimed at the execution of orders, hence introducing discipline and control. Chain of command operates as a direct behavioural control mechanism, which provides indirect cues concerning what is acceptable and important in the organisation (Vrey, Esterhuyse & Mandrup 2013:121). Following the chain of command and the lines of communication result in nurse educators believing that the military environment is extremely regulated and disempowering (Section 3.2.1.3.1). Students, on the other hand, regard the absence of military authority and channels of command to be why they prefer to work in the civilian clinical learning environment (Section 4.2.3.2.7). According to Motilewa et al (2015:298), chain of command as part of military culture is also seen as a management tool by means of which selected rites, stories, symbols and values are used to control and direct employees, to enhance performance and improve individual satisfaction. It also serves as a basis for communication and mutual understanding.

The military is highly authoritarian and ranks and responsibilities are clearly delineated. It establishes an organisational boundary system, maintaining in-group and out-group relations that regulate professional and personal relationships. It is these boundaries that are often disregarded and considered to be a display of familiarity and favouritism both between nurse educators and students (Section 4.2.2.5.3) and between professional nurses and students (Sections 4.2.3.1.1 and 4.2.3.1.6). The nurse educators did not raise the issue of familiarity or favouritism during the focus-group interviews. Where the relationship between members violates the customary bounds of acceptable behaviour it is also called fraternisation. Staal and King (2000:698-705) describe how power imbalances in the military are evident in the emphasis on rank. They further explain that the reason why the military devotes so much attention to the avoidance of fraternisation is that it entails the risks of depreciation of the superior's authority, of causing conflict of interest or of fostering concern about favouritism among the other members in their immediate vicinity.

Scrutiny of the definitions of organisational culture and military culture cited earlier and also of the elements of military culture derived from the findings of this study, makes it clear that the unique cultural factors, attributes, artefacts, customs, traditions, concepts, values and beliefs typical of the military and that are used to cultivate a distinctive military culture, undeniably distinguish the military from other public or private organisations.

5.2.1.3.2   Professional identity

Part of professional socialisation entails adopting the professional identity of both the military and nursing. Nurse educators' references to concepts such as commitment, appreciation and passion summarised their sense of ownership in terms of military culture and professional identity (Section 3.2.1.2.2). Concepts such as pride, passion, love, camaraderie and sense of belonging emerged from the data as evidence that military training assisted the students in developing a strong professional identity (Section 4.2.1.2.2).

Professional socialisation involves guiding students to make personal commitments to their chosen profession and to gradually develop a sense of belonging to the specific professional group. This commitment leads to actions and attitudes that are described as "thinking like a nurse" (Melrose et al 2015:59).

According to Adams, Hean, Sturgis and Macleod Clark (2006:55-68), the professional socialisation of an individual comes about through critical experiences where procedures and rules experienced by students or novice professionals trigger the construction of a professional identity. This suggests that the knowledge derived from the role models about the profession, as well as the student's own experiences, are central to professional socialisation and identity development. The influence of role models on the professional socialisation of students is discussed in Sections 5.2.2.3 and 5.2.3.4 of this chapter.

5.2.1.4 Military environment

The nurse educators identified the environment in which military training takes place as being regulated (Section 3.2.1.3.1) and hierarchical (Section 3.2.1.3.2). This implies that both nurse educators and students are being subjected to the rules and regulations that govern it and its hierarchical structure.

5.2.1.4.1 Regulated environment

According to the nurse educators, the regulated environment in which students find themselves serves to disempower them as a result of the various restrictions imposed by the military environment (Sections 3.2.1.3.1 and 3.2.1.3.2). The nurse educators were also of the opinion that they generally are unable to make autonomous decisions and that their opinions are often not considered. The students also commented on the regulated and restricted environment, but with specific reference to the theoretical learning environment (Sections 4.2.2.6.2 and 4.2.2.6.3) and the military clinical learning environment (Section 4.2.3.1.1). This is further discussed in Sections 5.2.2.4.2 and 5.2.3.1 of this chapter.

The researcher was unable to find any literature that specifically deals with the nature or the characteristics of the military environment or its influence on recruits. However seen from a learning environment point of view, it is important to realise that the SAMHS Nursing College – whose primary objective is to provide nursing education – is situated in an environment in which military training is the prime objective. The learning environment is further discussed under Theme 2: Knowledge acquisition.

5.2.1.4.1 Hierarchical environment

The hierarchical nature of the organisation means that the environment is structured. The implications that emerged from the data include the autocratic leadership style and the effect of the ranking system, as discussed earlier, and professional dilution. Nurse educators expressed concern about the organisational structures, which are such that non-health professionals may be in charge of health facilities and of health professionals. This, in turn, implies that the person does not necessarily act in the best interests of either the profession or the patient, which leads to professional dilution

(Section 3.2.1.3.2). As mentioned in Section 5.2.1.3.1, the students indicated that the military hierarchy taught them to respect authority (Section 4.2.1.2.1), but they had strong views regarding the abuse of the power and authority related to rank in the theoretical learning environment (Section 4.2.2.4) as well as in the military clinical learning environment (Section 4.2.3.1.5).

In the previous section, the concept *military hierarchy* was briefly described as part of military organisational culture. According to Jans (2014:121), the military's adherence to hierarchy relates to its "acceptance of implicit and explicit authority distinctions in professional and social relationships". Authority figures direct and control the organisation, and their leadership and authority are based on formal status and seniority that should be clearly visible. Though Jans (2014:121) concedes that outsiders may see the display of authority, channels of command and ranks as petty, he nevertheless cautions that there is far more to authority than that. Command roles and badges of rank imply professional obligations that go beyond the mere leadership and control of subordinates. It is as much a system of mutual service and self-respect as it is one of perceived oppression, submissiveness and subordination. Jans (2014:122) further states that the simultaneously bureaucratic and autocratic nature of the military is based on rules, and that support and loyalty are owed to a position rather than to a person. The strength of a military hierarchy is attributable to its role in times of crisis, danger and uncertainty, conditions that are, after all, the reason why the military exists.

5.2.2 Theme 2: Off to boot camp – professional knowledge acquisition

In its literal form, *boot camp* is the military reference to basic military training during the course of which new recruits are prepared for all the elements of military service: physical, mental and emotional. It provides them with the basic tools that they will need to perform the military roles that they will have to perform for the duration of their military service (Today's military 2015). This literal meaning has already been incorporated in Theme 1, under the category "military training" (Section 5.2.1.2). Student nurses, however, must also be prepared and equipped for service in healthcare facilities.

The metaphor *off to boot camp*, allocated to Theme 2, symbolises the processes taking place in the theoretical learning environment whereby students are taught the knowledge and skills necessary to execute their roles as nurses. Categories that

emerged from the data include nursing as career choice, multigenerational influences, nurse-educator-student interaction, teaching ethos, the learning environment, power and authority disempowerment, military influence, the roles of military nurse educators, and the physical environment.

As was already mentioned in Chapter 1 (Section 1.4), the teaching and learning environment of the SAMHS Nursing College is situated within a military environment. The military teaching and learning environment stands in stark contrast to that encountered in the civilian environment, for example, a residential university.

Figure 5.2 is a mind map of the integrated findings of Theme 2: professional knowledge acquisition

5.2.2.1   Nursing as career choice

Career choice was also discussed in Theme 1 with regard to the students' motives for and preconceptions of a career as soldier in the Defence Force. The dilemma in which the nursing profession in South Africa finds itself, is evident from the array of negative newspaper articles describing the shortage and emigration of nurses, the declining healthcare system, the poor working conditions and the misconduct and incompetence of nurses (Oosthuizen 2012:53). This leaves the question as to why anyone today would still choose nursing as a career.

5.2.2.1.1 Motives

Some of the students were honest in admitting that it had been just another career opportunity based on their financial situation and their need to earn a salary (Section 4.2.2.1.1). It seems as if these students had chosen the military as a career, which, by default, had included a course in nursing. Others acknowledged that they had used the opportunity as a stepping stone towards something else. Currently, very few students still see nursing as a calling (Section 4.2.2.1.1). The nurse educators made no specific reference to their motives for becoming nurses, but from some of the comments made, it could be deduced that they thought of themselves primarily as nurses and not soldiers (Section 3.2.4.1).
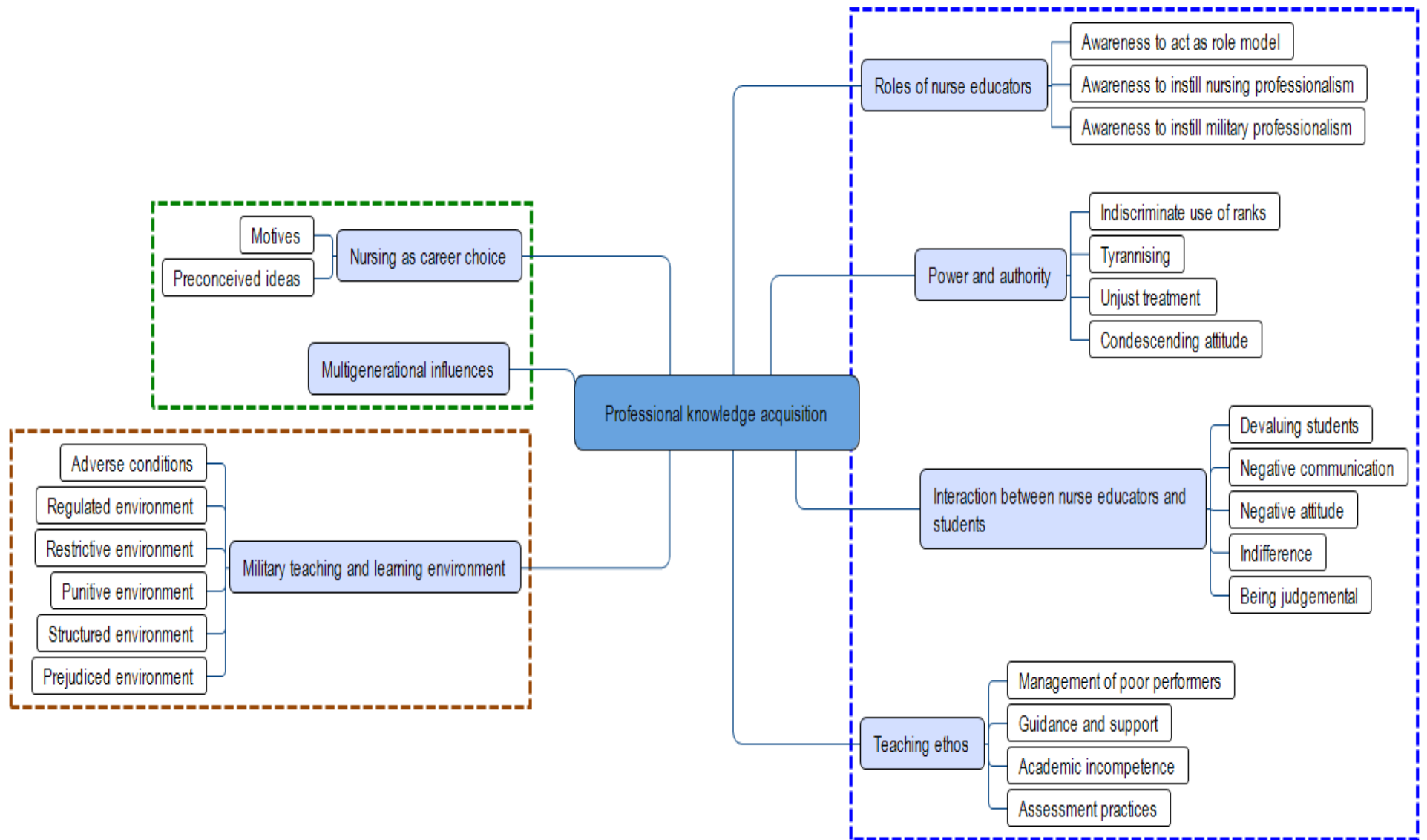
Figure 5.2: Mind map of Theme 2

According to Price, McGillis Hall, Angusb and Peter (2013:305), there are numerous influences on career choice across the life span, in particular during childhood and adolescence, such as gender-role orientation, personality, educational experiences, and parental and peer interactions. Students' responses made it evident that some of them had based their career choices on these influences (Sections 4.2.1.1 and 4.2.2.1). Being in a position to learn about the attributes of a particular profession early on in life not only has been linked to career choice, but has also been associated with professional socialisation, career transition and job satisfaction.

5.2.2.1.2 Preconceived ideas

Influences on the decision to enter the nursing profession include gender, experiential knowledge, self-concept and an altruistic desire to help others. Price et al (2013:306) assert that the traditional views of nurses and of nursing as caring and nurturing remain prevalent and continue to influence decisions to enter the profession. Historically, career choice in nursing was associated with a vocational calling to perform a virtuous role that centred on characteristics of kindness, compassion and caring. It is noted that most students still chose nursing as a career despite their misconceptions or negative preconceptions regarding nursing (Section 4.2.2.1.2). The fact that a military career is more male dominated and a nursing career more female dominated probably contributes to the ulterior motives that became evident in this study.

Jirwe and Rudman (2012:1616-1623) distinguish between active and passive motives for becoming a nurse. The first of two main active motives is a desire to help people (altruism), which refers to "an early career choice, something a person has always wanted to be, a desire to work with people, to make a difference, and help others". The second active motive is work related, which includes financial reasons, job security, diversity in the job and being part of a team. The passive motives imply that nursing is not the first choice of career, but is based on recommendations from someone else to become a nurse or having friends who have gone into nursing. The findings of the present study correlate strongly with the work of Jirwe and Rudman (2012). In this study, more students acknowledged that they had chosen nursing because of the active reason of work-related motives, namely financial reasons and job security but also because of the passive motives mentioned in Section 4.2.2.1.1. Jirwe and Rudman (2012:1616) further indicate that the motives for choosing a certain career influence

educational outcomes and affect subsequent professional socialisation, effective functioning in the new professional role and health.

5.2.2.2   Multigenerational influences

The nurse educators mentioned the different generations and the generation gap between themselves and the students as a challenge in terms of education and training (Section 3.2.2.3). The following table provides a summary of the different generations as described in the literature (Schroer 2015).

TABLE 5.2: GENERATIONS

Generation	Year born	Current age
Baby Boomers	1946–to 1965	50–69
Generation X	1966–1976	39–49
Generation Y	1977–1994	21–38
Generation Z	1995 onwards	0–20

The students who enter the Defence Force through the MSD System are between the ages of 18 and 22, thus falling somewhere between the Y- and the Z-generation. The nurse educators indicated that they experienced the Y-generation as being more rebellious, more assertive and, in a sense, less disciplined.

According to Lower (2008: 80-85), the Y-generation can be identified by the fact that they like to be entertained and stimulated. They are highly adaptable and adept at multitasking and therefore tend to bore easily. They are progressive thinkers and are able to process new information quickly. These attributes may explain why the students in this study displayed much frustration with nurse educators in terms of the latter's perceived academic incompetence (Section 4.2.2.2.3) and with the regulated theoretical (Section 4.2.2.6.3) and clinical (Section 4.2.3.1.1) learning environments for inhibiting their freedom. The students were also frustrated with the professional nurses in the clinical learning environment who had not been willing to teach them and who, allegedly, had not shown any interest in them (Section 4.2.3.1.3). Members of the Y-generation are eager to embrace change and are constantly looking for new approaches when seeking the next challenge, which explains why the students' are often perceived to be challenging authority (Section 3.2.2.3). Lower (2008:80-85) also believe that the Y-generation maintain high standards and excel at teamwork. Students'

descriptions of how they had coped during basic military training by working together as a team and also the fact that they stressed the importance of teamwork in nursing attested to this (Section 4.2.1.3.1). The students' acknowledgement of the culturally diverse environment they are in, their acceptance of and respect for patients and colleagues from all cultures, and their intolerance of favouritism based on culture resonate strongly with Schroer (2015) who maintains that the Y-generation is incredibly sophisticated and much more racially and ethnically diverse.

Hansen (2015) has a less complimentary view of the Y-generation. He published a list of ten commonly held perceptions or misconceptions of this generation: they are spoiled, lazy, have poor work ethics, have little respect for authority, are self-centred and individualistic, have unrealistic expectations, are not committed to work, are not loyal to employers, are lacking in social skills and are needy. Although the students in this study acknowledged that the military had taught them to respect authority (Section 4.2.1.3.1), they were quick to express their dissatisfaction with the manner in which such authority is abused (Sections 4.2.2.4 and 4.2.3.1.5). A lack of commitment and loyalty to the organisation may be reflected in the fact that most of the students in this study indicated that they had chosen the Defence Force and nursing as a career for financial reasons or because of a lack of other options and that they were only using the opportunity as a stepping stone (Sections 4.2.1.1 and 4.2.2.1).

Though Hansen's (2015) assessment may explain the perceptions of the nurse educators with regard to the current students, it is however important to note that the same labels cannot be pinned to all people of a certain generation/group. Individuals must still be judged on their own merits.

Bearing in mind the aforementioned characteristics of the Y-generation, the challenge then is how these students should be recruited, trained and retained for the nursing profession.

The generation gap between most of the current nurse educators and the students became most apparent when the nurse educators indicated that their way of thinking, their teaching strategies and their expectations stood in strong contrast to the characteristics generally attributed to the Y-generation. Nurse educators' ignorance of modern technology and the inadequate provision of technology and Internet access

were also mentioned as factors responsible for widening the generation gap between students and educators (Section 3.2.2.3).

During the focus-group interviews, the nurse educators suggested that one way to surmount the generation issue would be either for the current nurse educators to align themselves with the new generation or for management to rejuvenate the academic staff component by appointing younger nurse educators (Section 3.2.2.3).

Hutchinson, Brown and Longworth (2012:447) contend that the nursing curricula of the future need to be developed in a way that is sensitive to the technological learning needs of the Y-generation. It is suggested that a more individualistic approach to teaching and learning be followed to meet students' individual expectations and to make allowance for their impatience. A strong mentoring relationship with nurse educators and professional nurses in the theoretical and clinical learning environments is further held to have a pivotal influence on the education of the Y-generation.

5.2.2.3   The roles of nurse educators

The nurse educators were well aware of their duties in respect of having to act as role models and to instil both nursing and military professionalism in students (Section 3.2.2.1). They also mentioned a few examples of how this is or should be done, for instance to lead by example, to use role play, to do accompaniment, to make use of scenarios, to boost the students' confidence and teach them assertiveness (Section 3.2.2.1.1), but then also to discipline them (Section 3.2.2.1.2). However, judging by students' responses, they seem to have been dissatisfied with how nurse educators were fulfilling their roles. Except for one student's comment that nurse educators had demonstrated passion (Section 4.2.2.5.1) and a few references to nurse educators who had provided some advice and positive assurance (Section 4.2.2.2.2), the rest of the students' accounts only revealed negative experiences regarding and criticism of the nurse educators (Sections 4.2.2.2, 4.2.2.3, 4.2.2.4 and 4.2.2.5).

It is however not unusual for students to be overly critical of their educators. Salminen, Minna, Sanna, Jouko and Helena (2013:1376-1381) conducted a study to assess the competence of nurse educators based on their own evaluations and those of nursing students, educational administrators, nurse leaders and nurse mentors. Whereas the

nurse educators rated their own competence highest in all of the five competency areas, other participants were less impressed and the nursing students turned out to be the most critical in their evaluations. The competencies and the descriptors used in the study by Salminen et al (2013b) are summarised in Table 5.3.

TABLE 5.3: NURSE EDUCATOR COMPETENCIES (SALMINEN ET AL 2013b)

Competence category	Content
Nursing competence	• Taking responsibility for one's actions • Having a broad view of nursing • Encouraging students to integrate theory and practice • Making active use of the literature and research in the field
Pedagogical skills	• Encouraging students to constantly search for new knowledge • Encouraging students to think critically • Guiding students to self-evaluation • Guiding students to develop their decision-making skills
Evaluation skills	• Being fair in one's assessments • Offering constructive feedback • Being honest in providing feedback • Assessing one's own competence
Personality factors	• Being consistent • Being prepared to admit one's mistakes • Being open-minded • Being flexible
Relationships with students	• Treating students equally • Being honest • Encouraging mutual respect • Taking students seriously

In 2014, The South African Nursing Council published the "Competencies for Nurse Educators" (SANC 2014). This publication contains a list of seven domains, each with core competencies and specific competencies that serve as guidelines for nurse educators. Table 5.4 displays only the domains that have direct relevance to the present study. These are supported by applicable references to the findings of the study.

TABLE 5.4: COMPETENCIES FOR A NURSE EDUCATOR (SANC 2014)

DOMAIN 1: SCHOLARSHIP OF TEACHING AND LEARNING		Applicable reference
Facilitate learning	• Shows enthusiasm for teaching, learning and nursing, which serves to inspires and motivates students • Implements a variety of teaching strategies appropriate to student needs, desired student outcomes, content and context • Utilises appropriate educational theories and principles, including evidenced-based practice in the facilitating of	A student responded that she was taught to try to motivate students rather than be superior (Section 4.2.2.4.4). Nurse educators regards themselves as committed and passionate (Section 3.2.1.2.2). Nurse educators were seen as being incompetent because they displayed a lack of interest (Section 4.2.2.2.3).

		learning
	• Recognises and effectively manages multicultural, gender and educational background influences on teaching and learning	Nurse educators were seen as being incompetent because they displayed a lack of knowledge and students experienced theory-practice contradictions (Section 4.2.2.2.3).
	• Uses information technologies skilfully to support the teaching-learning process	Additional clinical learning opportunities were created to enhance clinical exposure and experience (Section 3.2.3.2).
	• Demonstrates skilled oral, written and electronic communication in all learning contexts	
	• Demonstrates critical and reflective thinking and creates opportunities for students to develop their critical-reasoning skills	Nurse educators acknowledge their role of having to instil nursing professionalism and having to use more concrete everyday scenarios as a teaching strategy to boost students' confidence and encourage increased assertiveness (Section 3.2.2.1.2).
	• Uses personal attributes (e.g. caring, confidence, patience, integrity and flexibility) that facilitate learning	Nurse educators acknowledge that the older nurse educators are more rigid in their teaching methods, which are not necessarily compatible with the learning needs of the Y-generation (Section 3.2.2.3).
	• Develops collegial working relationships with students, faculty colleagues and clinical facility personnel to promote positive learning environments	
	• Maintains knowledge of professional practice needed to help students prepare for contemporary nursing practice	Nurse educators maintain that they find it difficult to switch between a military attitude and a caring attitude, thus to be emotionally undemonstrative as a soldier but empathetic as a nurse (Section 3.2.4.1).
DOMAIN 2: ACADEMIC AND STUDENT MANAGEMENT		**Applicable reference**
Facilitate student development and socialisation	• Identifies individual learning styles and unique learning needs of all students	Students indicated that nurse educators should try to identify individual academic problems and provide additional academic support accordingly (Section 4.2.2.2.1).
	• Develops students' capacity to use educational resources that help meet their individual learning needs effectively Provides effective educational counselling and support in order to help students meet their educational and professional goals	Students felt that nurse educators were often unavailable, inaccessible or unapproachable. This resulted in inadequate academic support (Section 4.2.2.2.2).
	• Fosters the cognitive, psychomotor and effective development of students	Nurse educators agree that the regulated environment inhibits inquisitiveness (Section 3.2.1.3.1).
	• Assists students to develop the ability to engage in thoughtful and constructive self- and peer evaluation	Nurse educators feel that the ranking system gives rise to a top-down approach that makes them feel oppressed but also leads to them to oppress the students (Section 3.2.1.3.2).
	• Acts as a role model for students with regard to professional and community activities, including, but not limited to, involvement in professional organisations, engagement in lifelong learning and community engagement and advocacy	Nurse educators are aware of their duty in respect of having to act as role models to the students. They emphasise the importance of role modelling so as to teach students the most appropriate ways of handling certain situations, and thus of leading by example by themselves doing what they expect the students to do (Section 3.2.2.1.1).
		The nurse educators experience conflict between being a disciplinarian but also a teacher (Section 3.2.4.1).
Use assessment and evaluation strategies	• Uses a variety of strategies to assess and evaluate learning in the cognitive, psychomotor and affective domains	Students had the perception that they were being assessed academically based on their military conduct (Section 4.2.2.2.4).
	• Implements evidence-based assessment and evaluation strategies that are appropriate to the student and to learning goals	Students accused nurse educators of failing to adhere to the assessment policies – providing certain students with the exact scope of assessments – and also of unethical assessment practices by revealing the assessment results to some students before these had been officially published (Section 4.2.2.2.4).
	• Uses assessment and evaluation data to enhance the teaching-learning process	
	• Provides students with timely, constructive, and thoughtful feedback	

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DOMAIN 7: PROFESSIONAL, ETHICAL AND LEGAL PRACTICE		Applicable reference
Ethical practice	• Uses ethical principles and moral reasoning for decision making with respect to own professional practice areas or where ethical issues affect the broader healthcare team • Demonstrates competence in dealing with ethical and human-rights challenges in own area of practice • Demonstrates professional integrity, probity and ethical conduct • Maintains confidentiality and security of health information in accordance with professional codes, statutes and regulations	Various instances of unprofessional conduct and ethical misconduct were mentioned, i.e. association with students (Section 4.2.2.5.3). Students indicated that distrust was generated as a result of breach of confidentiality. Cases were mentioned of students discussing one another with nurse educators or of nurse educators sharing with other educators what they had been told in confidence (Section 4.2.2.5.2). Nurse educators consider military ranking as creating confusion in terms of ethical decision making (Section 3.2.1.3.2). Nurse educators acknowledge their role of having to teach students ethical decision-making skills (Section 3.2.2.1.2). Nurse educators acknowledge that they have a role to play in teaching students that patients have to be treated according to their needs and not their rank (Section 3.2.3.1.2). Nurse educators are concerned regarding the principles of beneficence and non-maleficence as taught to students, as opposed to what they are taught during Basic Military Training in terms of musketry and warfare (Section 3.2.4.1). Nurse educators are aware of the ethical conflict that students often experience when confronted with a military order or instruction from a higher-ranking officer, one which may be in contravention of the patient's right to privacy and confidentially (Section 3.2.4.1).

As regards these sets of competencies listed by Salminen et al (2013b:1376-1381) and the SANC (2014), there seems to be a strong mismatch between students' experiences as described in Chapter 4 and some of the specific competencies that nurse educators are expected to have. The nurse educators had very little to say about their own competencies, especially in terms of the facilitation of learning and the assessment and evaluation strategies.

De Swardt (2012:192) purports that the professional socialisation of student nurses is an important aspect in the education and training programme that involves a complex process of socialisation that has to be addressed holistically. As such, De Swardt (2012:192) recommends a variety of creative teaching, facilitation and assessment strategies for example reflection in the teaching and learning environment, problem-based learning, peer-group learning, clinical role modelling and the use of mentors and preceptors in creating a supportive learning environment.

5.2.2.4 Interaction between nurse educators and students

The following subcategories emerged in Theme 2: nurse educators' negative approach when dealing with students (Section 4.2.2.3.1); nurse educators' negative communication style in their dealings with students (Section 4.2.2.3.2); nurse educators' indifference (Section 4.2.2.3.3); nurse educators' judgmental attitude (Section 4.2.2.3.4); nurse educators' indiscriminate use of rank (Section 4.2.2.4.1); nurse educators' tyrannising students (Section 4.2.2.4.2); nurse educators' unjust treatment of students (Section 4.2.2.4.3); and nurse educators' condescending attitude towards students (Section 4.2.2.4.4). According to the literature, all of the foregoing point to incivility. Incivility is an umbrella term that includes violence, unethical behaviour, bullying and verbal abuse (Edwards & O'Connell 2007:26-35, Gallo 2012:62-66). Edwards and O'Connell (2007:28) have devised a typology of abuse or incivility, which is reflected in Table 5.5.

TABLE 5.5: TYPOLOGY OF ABUSE/INCIVILITY

Type of abuse/incivility	Description
Verbal abuse	• Using offensive language or innuendo • Sexist, racist or patronising remarks • Telling racist, sectarian or sexually suggestive jokes • Inappropriate or intimate questioning, uninvited, unreciprocated, unwelcome behaviour of a sexual nature • Derogatory statements of a sexual, racist or sectarian nature • Propositions and offensive remarks • Name-calling, including personal comments about physical looks • Language that belittles a person's abilities • Spreading malicious rumours or hurtful gossip
Written abuse	• Written abuse such as letters, faxes or emails (often anonymous)
Physical abuse	• Unwanted physical contact • Explicit physical threats or attacks • Suggestive gestures (such as mimicking the effects of a disability) • Unnecessary touching or assault • Stalking that occurs at work or outside of work, but is related to work
Intimidation	• Slander • Conduct that belittles in some way, such as being shouted at • Intrusion by harassment, spying, following • Unnecessary closeness • Apportioning blame wrongly

Screening of the relevant literature revealed that more often than not, students are the culprits when the abovementioned types of behaviour occur (Diener 2015; Gallo 2012:62-66; Ibrahim & Qalawa 2016:118-126). The data collected in the course of the present study did not however produce any evidence that military students had made themselves guilty of uncivil behaviour. This can probably be ascribed to the fact that

they are subjected to strict military rules of conduct and disciplinary measures. That the educators could also be guilty of uncivil behaviour, is very unfortunate, but can, in turn, in the context of this study, be ascribed to the military culture and the accompanying issues of rank, authority and power as discussed in Theme 1 (Section 5.2.1).

According to Gallo (2012:62-66), nurse educators are not immune to behaving uncivilly. The students in Gallo's study identified several instances of behaviour that they had perceived to be uncivil, namely loss of patience, incompetence, rude condescending remarks, poor teaching style and poor communication. Other instances of incivility by nurse educators reported by Gallo (2012:64) include cancelling class without warning, being unprepared for class, showing disinterest in the students or class and not being available outside of class.

Incivility among nurse educators is no new phenomenon, neither is it unique to the SAMHS Nursing College. Clark and Springer (2007:7-14) conducted a study to investigate nursing students' perceptions of incivility in nursing education. They found that behaviour among nurse educators most often reported as uncivil had involved making condescending remarks, put-downs, rank pulling or demonstrations of superiority. Nurse educators were also distant or cold towards students as well as inflexible. The class would be punished for one student's behaviour and nurse educators would be unavailable outside of teaching time. Furthermore, nurse educators would refuse or be reluctant to answer questions, would be unprepared for class and would make statements about being disinterested in the subject matter. Lastly, Clark and Springer (2007:7-14) found that nurse educators would ignore disruptive student behaviours, would not speak clearly, and would cancel class without warning. What is significant is that many of the behaviours cited by Clark and Springer (2007:7-14), Edwards and O'Connell (2007:28) and Gallo (2012:62-66) correspond to the behaviours of the nurse educators as identified by the students in the present study.

5.2.2.5   Teaching ethos

As regards teaching ethos, Halstead (2013:5) reports some of the ethical challenges that confront nurse educators. These include academic dishonesty of students and peers, incivility among and between students, nurse educators, and/or administrative personnel, the spreading of unfounded, damaging rumours and instances of breach of

confidentiality. In this study, however, the aspects mentioned by the students and categorised as *teaching ethos* (Section 4.2.2.2), were how poor performers were managed (Section 4.2.2.2.1), a lack of guidance and support (Section 4.2.2.2.2), academic incompetence (Section 4.2.2.2.3) and unethical assessment practices (Section 4.2.2.2.4). They are confirmation that ethical issues in nursing are by no means limited to the clinical setting, but that nurse educators also face numerous ethical dilemmas in the teaching and learning environment.

Ethical competence, according to Salminen, Metsämäki, Numminen and Leino-Kilpi (2013:133), is regarded as part of a nurse educator's work and professional competence. It refers to ethical knowledge and its implementation, the nurse educator's aim and ability to make sound and justified moral choices in relation to the good of students and colleagues, and the ability to act responsibly in response to own ethical choices.

In a study conducted by Salminen et al (2013a:134), nursing students indicated that nurse educators should be fair and honest, should value confidentiality in educator-student relationships, should treat the students as equal human beings, should respect the students, and be fair and honest with regard to student assessments. The same study also revealed that students most often experienced a lack of equality between the nurse educators and the students (Salminen et al (2013a:133-137). The students also felt that nurse educators who were in positions of authority vis-à-vis the students, treated students inequitably and also that some nurse educators applied rules differently to different students. Then there were problems pertaining to student evaluations that were considered to have been unfair. Some students thought that their views and opinions were not appreciated and that the nurse educators treated them disrespectfully. These students moreover believed that the nurse educators did not defend students in difficult situations and that they were not understood on a human level. There is a strong correlation between the findings of the study by Salminen et al (2013a:133-137) and the present study regarding students' experiences and perceptions with regard to nurse educators. Specific areas of correlation between the students in their study and those of the SAMHS Nursing College are as follows: unjust and unfair treatment of students (Section 4.2.2.4.3); unfair assessment practices (Section 4.2.2.2.4); students feeling underrated in the sense that they are denied the right to be assertive; that their opinions are ignored; that their inputs are treated with

disdain and underestimated (Section 4.2.2.3.1); and that they considered nurse educators to be indifferent and uncaring (Section 4.2.2.3.4).

The clearly unethical behaviour of nurse educators as experienced by the students in this study is ascribable to factors originating from military training, military indoctrination and the nature of the military environment as discussed in Theme 1 (Sections 5.2.1.2 and 5.2.1.4).

5.2.2.6   Power and authority

What is further striking is that Clark (2008b:5) also describes some of the same effects of incivility as those reported by the students in this study. These include diminishing confidence, interference with learning and academic inquiry, experiencing feelings of powerlessness, feeling dehumanised, distressed and desperate (Sections 4.2.2.2, 4.2.2.3, 4.2.2.4 and 4.2.2.5). According to Clark (2008b:5), these behaviours and the resultant feelings stem from the power differential between nurse educators and students, and from nurse educators' abuse of authority and rank. In light of the above, Clark (2008b:5-6) refers to Fuller's (2006) concept of *rankism*, namely "the abuse of power based on a person's rank and position and [that] occurs when people abuse their power to demean or disempower those they outrank". These findings of Clark (2008b:5-6) correlate strongly with the findings of this study as described in Chapter 4 (Sections 4.2.2.4.1, 4.2.3.1.1, 4.2.3.1.2, 4.2.3.1.5). The issue of rank thus extends beyond the Defence Force.

5.2.2.7   Military teaching and learning environment

According to Abbott (2014), *learning environment* denotes the diverse physical locations, contexts and cultures in which students learn. This includes the culture of a learning institution, its dominant ethos and characteristics, including how individuals interact with and treat one another and finally, the ways in which educators arrange the educational setting to facilitate learning. Since the qualities and characteristics of a learning environment are determined by a wide variety of factors, institutional policies and governance structures may also be considered elements of a learning environment. Abbott (2014) further argues that learning environments have both a direct and indirect influence on student learning, which includes their engagement in what is being taught,

their motivation to learn, and their sense of well-being, belonging and of personal safety. Phrases such as positive learning environment or negative learning environment are commonly used in referring to the social and emotional dimensions of an institution.

From the findings it was clear that mostly the students (Section 4.2.2.6) but also the nurse educators (Section 3.2.2.2) found various aspects of the military teaching and learning environment to be less conducive to professional knowledge acquisition. These aspects are discussed in the following sections.

5.2.2.7.1 Adverse conditions

Students did not regard the military teaching and learning environment to be conducive to learning as a result of adverse conditions, for example, the poor infrastructure (Section 4.2.2.6.1). Not only should the physical space be comfortable in terms of seating, lighting and ventilation, but the multigenerational influences discussed earlier should also be borne in mind (Section 5.2.2.2). Ideally, the teaching and learning environment should accommodate the cultural, technological and emotional needs and trends of the Y-generation as to optimally enhance learning.

Said, Rogayah and Hafizah (2009:16) cite Bloom's (1964) description of the educational or learning environment concept namely "the conditions, forces, and external stimuli which challenge on the individual". Bloom (1964) referred to physical, social, as well as intellectual forces and conditions that may influence students' learning outcomes.

According to Said et al (2009:15), the main objective in any nursing programme is to produce nursing graduates who can provide comprehensive care and treatment to the community. A good approach to the systematic design of a learning environment can lead to positive outcomes for graduates. The learning environment is not limited to student-educator interaction, teaching and learning activities, and having good physical structures and facilities but it also has to accommodate students' psychosocial and emotional needs. A further factor which contributes to adverse learning conditions is the influence of military activities on learning programmes. This was raised as an issue by both students and nurse educators. The nurse educators felt especially strongly about non-nursing duties taking precedence over nursing training for example the expectation to participate in military activities such as parades (Section 3.2.2.2.1). The withdrawal of

students from the classroom to participate in operational activities elicited mixed feelings from the nurse educators, since some considered the exposure to be beneficial to the students by potentially providing additional clinical learning opportunities, while others were concerned about the implications in terms of the loss of lecture periods, clinical hours and the possible extension of training (Section 3.2.2.2.2).

5.2.2.7.2 *The regulated, structured and restrictive teaching and learning environment*

The structured and regulated nature of the military environment has already been discussed under Theme 1 in this chapter (Section 5.2.1.4). The influence exerted by these factors on teaching and learning should however not be disregarded. In addition to being structured and regulated, the students re-emphasised the contrast between the military teaching and learning environment and that of a civilian college or university. The military teaching and learning environment is restrictive: military students are more subjected to control in that they have to remain in class for long hours (Section 4.2.2.6.2), they feel that their private lives are being interfered with, that their privacy is being invaded and that their freedom is being inhibited (Section 4.2.2.6.3).

Though both nurse educators and students voiced their discontent with having to adhere to military routine, their reasons differed. The students objected to the following aspects of military routine: having to attend inspection and roll-call parades at certain times, and to be in the classroom for the rest of the day until 16:15. They objected because they firstly compared themselves with their peers at non-military institutions that were not so strictly bound to routine and, secondly, they felt that their freedom was being inhibited (Sections 4.2.2.6.2 and 4.2.2.6.3). The nurse educators agreed that instead of being required to adhere to a strict military routine, a more adult learning approach should be considered (Section 3.2.2.2.3).

Some authors use the terms adult learning, self-directed learning and andragogy interchangeably. The term pedagogy previously denoted child education and andragogy adult education. In his guidebook for students and educators on the topic of self-directed learning, Knowles (1975) labels pedagogy as teacher-directed learning and andragogy as self-directed learning. Knowles (1975) asserts that, where new, unfamiliar content is involved in the teaching of children and adults, the term pedagogy is appropriate; where adults or children have some background regarding the content,

andragogy is the appropriate term. Andragogy is thus the underlying philosophy and self-directed learning the way andragogy is to be implemented. According to Spies, Seale and Botma (2015:2), Knowles, Holton and Swanson (2005:64-68) use the concept andragogy to explain the conditions and principles for adult learning, which includes that adult learners

- have independent self-concepts and are thus led by self-directedness;
- draw on their accumulated reservoir of experience, which has a bearing on learning;
- have learning needs that are influenced by social roles;
- are problem-centred and want to apply new knowledge immediately;
- need to know why they have to learn something before participating in learning; and
- are motivated to learn by internal rather than external factors.

Whether an undergraduate student should be considered an adult who is capable of meeting these conditions and upholding these principles, is debatable. Brookfield (1986) and Carlson (1979) define adults as individuals who have attained the chronological and legal status of adulthood, with all the rights and responsibilities it entails (Conaway 2009:44). Whereas modern society views adulthood as commencing at age 21, much of adult education literature however maintains that adulthood is reached only after the age of 25 (Spéder, Murinkó & Settersten 2014:873-898). As mentioned in Chapter 1 and Section 5.2.2.2 of this chapter, the students of the SAMHS Nursing College are in the age group 18–22.

There are factors other than age that may define a person's maturity. From the findings it became apparent that military training definitely had an influence on the personal growth of students as is evident from comments by nurse educators (Section 3.2.1.1) and students (Section 4.2.1.2) alike. Conaway (2009:47-52) states that adult learners should not be seen as a homogeneous group of people, since many extraneous factors may have an influence on maturity such as level of education, socio-economic status, prior positive or negative educational experiences, and individual uniqueness. She therefore divides students into three adult age categories, namely emerging adults (18–25), young adults (26–39) and mature adults (40–59). Students of the SAMHS Nursing College can thus, according to Conaway (2009:47), be classified as emerging adults.

Emerging adulthood is the first stage of adulthood. This stage comprises individuals who – though they have discarded the dependency of childhood, which is structured by school and parental frameworks – have not yet assumed the responsibilities of adulthood, which is structured by social roles involving work, family and society (Conaway 2009:47). This author suggests that without dependence and a structured framework, emerging adults are self-focused, self-oriented and free of normative expectations or structured social roles. This relates to the findings of the present study in the sense that the military students still long for the freedom they had prior to entering the Defence Force, as is evident from the comparisons made with their civilian counterparts (Section 4.2.2.6.2). They feel that their privacy is being invaded and that their freedom is being inhibited (Section 4.2.2.6.3). The identity of the emerging adult borders on adulthood while retaining many characteristics of adolescence, as if to prolong or extend high-school and undergraduate lifestyles. Conaway (2009:48) considers this trend to be detrimental and inhibitive towards work-life readiness, a key element of the andragogic philosophy. Emerging adults maintain an exploratory, experimental view of their world in an attempt to balance the limited responsibility of independence while continuing to rely on adults. This state is referred to as semi-autonomy or, in andragogic terms, semi-self-directedness. According to the nurse educators however the younger Y-generation, for example, finds it more difficult to adapt to the restrictions posed on them by the military environment and that, as a result, may benefit from a more adult learning approach (Sections 3.2.2.3, 3.2.2.2.3). The students also considered themselves to be more mature and more professional than their civilian counterparts (Sections 4.2.3.2.1 and 4.2.3.2.6).

A literature review conducted by Draganov, Andrade, Neves and Sanna (2013:86-94) on the use of andragogy in nursing, revealed that the use of self-directed learning among undergraduate students, especially in the initial stages of the course, was not effective because students wanted the teacher to take the lead, probably out of habit from traditional teaching.

From the discussion, it can be deduced that although both nurse educators and students experience military routine as restrictive in terms of academic time utilisation, the students are not completely ready to be taught solely in accordance with andragogic principles. Periods with self-directed learning activities may therefore be incorporated

into the programme to develop students as adult learners but also to give them some form of freedom to utilise some of their time as they prefer.

5.2.2.7.3 The punitive teaching and learning environment

The teaching and learning environment can be regarded to be punitive based on students' remarks that they suffer punishment for transgressing military rules and regulations, and that they are subjected to generalised punishment, even if an individual or small group were guilty of something (Section 4.2.2.6.4). Although the nurse educators made no remarks regarding the punishment of students, they still regarded the military environment, regulated by rules and regulations, as disempowering, and that the need for obedience and compliance prevents students from making autonomous decisions and from becoming assertive and inquisitive (Section 3.2.1.3.1).

Where a group of people is punished as a result of the behaviour of one or more other person(s) it is referred to as collective punishment. In traditional militaries, collective punishment or group discipline is used to ensure high levels of coordination among well-drilled units in formation during combat (Fink 2010: 211).

An online discussion forum, Military Times (2011), agrees that collective punishment is an acceptable means of instilling discipline and group cohesion while soldiers are doing basic training. It serves as a means of making use of peer pressure to sort out transgressing behaviours and it is believed to contribute to camaraderie and teamwork. The Forum (Military Times 2011) however proposes that collective punishment never was, nor will be, the right way to handle anything. Personal responsibility and accountability are crucial aspects. Those who do follow the rules and act appropriately should not be subject to disciplinary measures. Constant application of collective punishment will eventually lead to resistance to and resentment of authority, deterioration of attitudes and a lowering of morale.

5.2.2.7.4 The prejudiced teaching and learning environment

The issue of gender prejudice was broached by male and female students alike (Section 4.2.2.6.6).

According to Reinecke (2014:ix), in 2014, male nurses comprised 6,8% of the professional nurses registered with the South African Nursing Council. Naidoo (2015) reported that 91413 nurses in South Africa were female and 5302 were male. This constitutes a male population of 5,48%. Unfortunately, the specific professional category of nurse was not indicated in the second data set. At the time of data collection for this study (between January and April 2015), the gender ratio at the SAMHS Nursing College was 39% males to 61% females (SAMHS 2016b). Available statistics from the USA reveal that 35.5% of Army nurses, 30% of Air Force nurses and 36% of Navy nurses are males while only 6% of the nurses in the civilian sector are males (Boivin 2002). This indicates that more male nurses prefer to work in the military sector than in the civilian sector.

According to Boivin (2002), a random sample of male nurses gave the following as predominant reasons for entering the military: fast and well-defined career tracks, generous educational benefits, guaranteed roles in leadership – even at the beginning of a military career – unparalleled opportunities for travel and adventure, and the camaraderie among nurses and other members of the healthcare team.

Abushaikha, Mahadeen, AbdelKader and Nabolsi (2014:263-269) reported on the academic challenges and perceptions of male nursing students in Jordan. The students felt that they were being discriminated against in that females were favoured over male nursing students. They complained about heavy schedules and study loads that prevented them from participating in extracurricular activities and from maintaining an active social life. They further expressed negative stereotypes and views of nursing as being inferior to medicine, being a predominantly female profession and thus an unsuitable career option for males. Besides encountering negative views and stereotypes from other people, their own male colleagues also bombarded them with negativity. The students themselves complained of negative self-images, about the negative views of male nursing students and about a resentment of nursing. There is a strong correlation between the perceptions of the male nurses in Jordan and those of the male students in this study. The latter students indicated that the challenges they had experienced in terms of their gender included name-calling, being belittled and being questioned about why they had chosen to become nurses. This resulted in them doubting themselves, their career choice and in making them ashamed to acknowledge that they were nurses (Section 4.2.2.6.6).

The participating female students raised the issue of becoming pregnant while studying and indicated that the organisation was treating them as if falling pregnant had been a mistake. They moreover felt that they were being punished by the organisation by having their study contracts temporarily suspended. The students deliberated about the difference in management between them and civilian students, but could not agree as to whether civilian students were managed differently (Section 4.2.2.6.5). Based on several studies conducted on the high pregnancy rate among the female populations of higher education institutions (Coetzee & Ngunyulu 2015:1-7; Mamhute 2011; Tladi & Jali 2014:275-283) it can be deduced that there seems to be general concern regarding the phenomenon. Between 2012 and 2015, the SAMHS Nursing College had a reported pregnancy rate of 34,5% (SAMHS Nursing College Senate Report 2016). The current policy on the management of pregnant students, SAMHS Nursing College Standard Working Procedure (SWP) No 13 of 2005 as revised in 2010, states that pregnant students must take maternity leave from two to four weeks prior to their expected date of delivery for a total period of four months. This SWP is in accordance with the Department of Defence Instruction (DODI) No 19 of 2000 on the Management of Leave for Defence Act Personnel. The policy implies that pregnant students must forfeit academic periods and also formative and summative assessments, and thus cannot proceed to the next semester or academic year. As employees of the Department of Defence, students sign a study contract that stipulates that they must work back the equal number of years that they studied. Taking maternity leave automatically extends these contracts. The SAMHS Nursing College follows this policy to ensure the well-being of the mother and the baby, to provide them with an opportunity to bond and to make arrangements for care when the student has to return to the College. As is evident from the data, students are usually not in favour of this policy. This issue did not feature during the focus-group interviews with nurse educators.

No other literature could be found on the unique situation that arises when military nursing students fall pregnant. However, literature on the management of pregnant civilian nursing students reports diverse arrangements, ranging from being forced to take a three-year break from training to take care of themselves and their babies – as is the case in Zimbabwe (Bvekerwa, Choto & Shonhiwa 2011:53), to being accommodated as far as practicable to allow the student to complete her programme of study, providing academic standards are upheld (The University of Nottingham 2016).

5.2.3 Theme 3: Off to the battlefield – clinical skills acquisition

The battlefield or war zone, where actual fighting takes place, is where soldiers apply the knowledge and skills drilled into them during military training. On the battlefield, soldiers fight for the preservation of their own lives, those of their comrades and of citizens. Depending on the operational situation, the battlefield can be either within the borders of one's own country or within another country.

The metaphor *off to the battlefield* was chosen to represent the clinical learning environment where students are sent to apply the knowledge and skills they acquired in the theoretical learning environment. Symbolically, the metaphor also suited the context in which healthcare professionals often fight for the lives of patients, patients fight for their own lives and, as was sadly evident from the codes and concepts that emerged from the data, healthcare professionals and patients also quarrel among themselves.

In Chapters 3 and 4, a distinction was made between the military clinical learning environment and the civilian clinical learning environment due to both the numerous categories and subcategories that emerged and the many contrasts identified between these two environments. For the purpose of this discussion, the categories are combined to eliminate duplicate categories. However, where strong contrasts exist between the two environments, these are highlighted during the discussion.

Figure 5.3 offers a mind map of Theme 3.
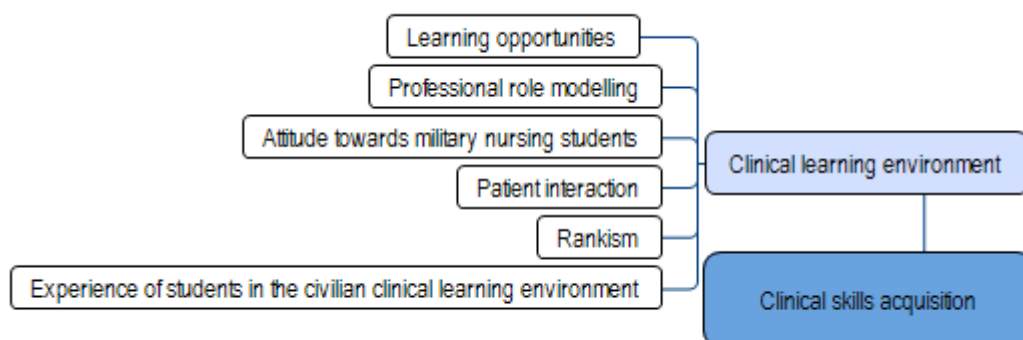
Figure 5.3: Mind map of Theme 3

5.2.3.1 Clinical learning environment

Teaching in clinical settings confronts students and nurse educators with challenges that differ from those encountered in the classroom. The clinical learning environment is complex, demanding and unpredictable (Gaberson & Oermann 2010:ix). A major determinant of the effectiveness of clinical teaching is the context in which it occurs and also the role of the clinical nurse educator. Military students are exposed to two very different clinical learning environments and therefore also two very different experiences. The following section describes students' experiences in the military and the civilian clinical learning environments.

5.2.3.1.1 Learning opportunities

Meaningful learning situations is a crucial element of an effective clinical learning environment (Papathanasiou, Tsaras & Sarafis 2014:57-60). To experience meaningful learning situations implies that quality placements are required to provide students both with opportunities for clinical skills development and with a bridge between theoretical and clinical learning (Newton, Jolly, Ockerby & Cross 2010:1371-1381).

The military clinical facilities at which students are placed for clinical practice provide them with fewer clinical learning opportunities, a circumstance that is due to the smaller patient population, lower bed-occupancy rates and the nature of the patient population making use of the facilities. The nurse educators agreed that, as a result, the students are disadvantaged (Section 3.2.3.1.1). Students thus compete for limited learning opportunities (Section 4.2.3.1.3). Conversely, in the civilian facilities, students receive much more clinical exposure where the patient population is larger and the cases are more varied (Section 4.2.3.2.5). According to Kaphagawani and Useh (2013:181), the lack of challenging learning opportunities accounts for some of the negative experiences that may affect students' learning.

Besides identifying a lack of learning opportunities in the military clinical learning environment, students also perceived an unwillingness among professional nurses to teach (Section 4.2.3.1.3). As students need to be guided and supervised in order to become competent practitioners, a lack of supervision and guidance may result in students learning incorrect procedures and thus failing to become competent. This often

results in frustration and a loss of interest in the nursing profession (Kaphagawani & Useh 2013:182). It is therefore not at all surprising that the military students stated that they often left a ward without having learnt anything (Section 4.2.3.1.1) and that they would rather absent themselves from the ward because of how they had been treated (Section 4.2.3.1.4).

Only one student in the present study referred to a positive experience he had had with staff members who had been willing to teach him and to take time to answer his questions. The data revealed that the professional nurses in the military facilities were generally negatively disposed towards teaching. This is evident from observations made by the students to the effect that professional nurses had shown no interest in them, causing them to feel that they did not care about them. In addition, they were always too busy to answer students' questions and did not allow them to make mistakes and when they did, they were not corrected but rather shouted at (Section 4.2.3.1.3). Although nurse educators emphasised the importance of clinical accompaniment as contributing towards the professional socialisation of students (Section 3.2.3.1.1), no further discussions on the topic emerged.

Supervision by professional nurses and nurse educators and the resulting interpersonal relationships are regarded as the most important factors that influence the clinical learning environment (Chuan & Barnett 2012:192). The discussion on the attitude towards military nursing students (Section 5.2.3.1.3) alludes to the overtly negative interpersonal relationships that exist, especially between students and professional nurses. Also included in Theme 2 (Section 5.2.2.4) were the negative interactions between students and nurse educators in the theoretical learning environment. Students mentioned that the negativity they experienced in the classroom had an influence on their clinical experience and that certain nurse educators had a negative effect on them when they visited the clinical areas (Section 4.2.3.1.3).

Another indication of the negative disposition to teaching found in the military clinical learning environment lies in the fact that students are often not allocated in line with their clinical objectives, resulting in duties being assigned to them that are beyond their level of training (Section 4.2.3.1.3). This denies them opportunities to learn and to practise clinical skills that are indeed in line with their level of training. Gaberson and Oermann (2010:116-117) explicitly state that clinical assignments should be selected

inter alia according to the learning objectives, but also students' needs, interests and abilities. Kaphagawani and Useh (2013:182) further suggest that students have to be given opportunities to practise different tasks to gain confidence, become perfect and learn from the mistakes they make. This suggestion supports the statement by Henderson, Cooke, Creedy and Walker (2012:299-302) referred to earlier that learning takes place if students are given the opportunity to practise real nursing by doing, by getting involved in providing holistic patient care and not simply by performing a series of tasks.

It was evident though, that some professional nurses in the civilian clinical learning environment preferred rather to be more patient with students and also to give students more freedom to use their own initiative. It was also mentioned that the civilian doctors contributed to the students' training by respecting their opinions and by discussing patients with them. It was however mentioned that civilian professional nurses had not fulfilled their teaching role in that they had by left students unsupervised and had neglected to delegate tasks to them (Section 4.2.3.2.5).

Issues relating to the gap between theory and practice surfaced in the findings in the subcategory *academic incompetence* (Section 4.2.2.2.3). Being expected to practise in the ward what they had been taught in theory was often reported to be a source of conflict between professional nurses and nurse educators, which further not only contributed to poor interpersonal relationships but also caused confusion among students. The nurse educators made no mention of the theory-practice gap or their interpersonal relationship with professional nurses.

Given the students' overall experience of the clinical learning environment, it became clear why they feel they are being prevented from reaching their full potential as nurses, leaving them unmotivated, unconfident, unassertive and often leaving the ward without having gained any knowledge or skills (Section 4.2.3.1.1).

5.2.3.1.2 Professional role modelling

Nurse educators and professional nurses have an all-encompassing influence as role models throughout the students' clinical learning experiences.

Perry (2009:36-44) notes that the actions and interactions of nurses working in clinical settings are constantly observed by patients, family members, students and other nurses. Wittingly or unwittingly, their words and actions become living lessons that can potentially influence the behaviours and attitudes of others in either positive or negative ways.

Although the nurse educators were well aware of their duties in respect of having to act as role models and to instil both nursing and military professionalism in students as was discussed in Section 5.2.2.3, students made no specific reference to positive role models in the military clinical learning environment. Instead, they maintained that professional nurses had been taking advantage of students by relaxing while students had been working and that they had not assisted with patient care. They further related that professional nurses had been more concerned with having students conform to military norms and values than with patient care. Another example of unprofessional conduct was favouritism, that is, that professional nurses gave unfair preferential treatment to certain students at the expense of others (Section 4.2.3.1.6).

One student noted that she had observed positive professional conduct by a professional nurse in the civilian clinical learning environment and expressed the wish to be like her. Some other positive professional traits that students recognised in civilian professional nurses included that they were more patient and more approachable than the military professional nurses (Section 4.2.3.2.1).

The civilian clinical learning environment however also abounds with examples of negative role models. Students commented on the appearance of the civilian professional nurses. It was suggested that they had an untidy appearance and that their hair was not tied back. The non-use of English as the lingua franca in the civilian clinical learning environment was also considered an inhibiting factor in respect of being incorporated into that facility. Students were very disappointed with the level of patient care in the civilian clinical learning environment and singled out the unacceptable way in which patients were treated and communicated with (Section 4.2.3.2.1).

Melrose et al (2015:42) effectively summarise the characteristics of professional role models by challenging the reader to view the clinical learning environment through the eyes of students. These authors contend that students perceive effective role models as

individuals who demonstrate caring behaviours, who are calm during stressful experiences, who exercise patience and who demonstrate enthusiasm for their profession and for teaching. Effective role models are approachable and can help students to feel less anxious and more confident. Students appreciate role models who make themselves available, who take the time to answer questions without seeming annoyed, and who provide students with time to debrief and discuss issues. Students prefer role models who are not controlling or overly cautious. Students value respectful collegial relationships with their role models. Students want to feel empowered by their role models. This includes enhancing their confidence, involving them in making decisions and setting goals, making learning meaningful and helping them to become more autonomous. Effective role models care about their students and invite approaches that best support the students' learning style. Effective role models support students in identifying their personal strengths and working with students to build on these strengths. Effective role models affirm students' efforts, share positive messages and create supportive dynamics. Effective role models also redirect students when their work is unsatisfactory or off track.

A comparison of the characteristics of professional role models pinpointed by Melrose et al (2015:42) and the experiences of the students in the present study reveals that the students identified numerous incidences where the nurse educators and/or the professional nurses had failed dismally in their responsibility of having to act as professional role models.

Table 5.6 compares the characteristics of professional role models as summarised by Melrose et al (2015:42) with some examples of the experiences of the military students in the present study.

TABLE 5.6: CHARACTERISTICS OF PROFESSIONAL ROLE MODELS VERSUS STUDENTS' EXPERIENCES/PERCEPTIONS

Characteristics	Students' experience/perceptions
Demonstrate caring behaviours	Various references to nurse educators and professional nurses who demonstrate indifference (Sections 4.2.2.3.3, 4.2.3.1.1, 4.2.3.1.3)
Exercise patience	Nurse educators and professional nurses are impatient (Sections 4.2.2.2.1, 4.2.2.3.3, 4.2.3.2.2).
Demonstrate enthusiasm for their profession and for teaching	Nurse educators and professional nurses are negative and do not enjoy their work. Certain nurse educators have a negative effect on students when they visit the clinical areas because they persist with their negative attitude and negative communication style (Section 4.2.3.1.3).
Are approachable, make themselves available	Nurse educators are often unavailable, inaccessible or unapproachable (Section 4.2.2.2.2).
Help students to feel less anxious and more confident	Situations in the clinical learning environment were said to affect students' confidence (Sections 4.2.3.1.2, 4.2.3.1.3).
Make the time to answer questions without seeming annoyed	Some students are considered to be ill-disciplined when they ask questions and are thus not given clarification on what they do not understand (Section 4.2.2.2.2). Professional nurses are too busy to answer their questions (Section 4.2.3.1.3).
Are neither controlling nor overly cautious; helping students to become more autonomous, making students feel empowered	Students are not allowed to make mistakes and if they do, they are demeaned and shouted at by the clinical staff (Sections 4.2.3.1.1, 4.2.3.1.4)
Ensure respectful collegial relationships	In general, interaction between nurse educators and students is negative and results in students developing a negative attitude towards the educators (Section 4.2.2.3.1). Nurse educators should work on their professional relationships with students by being more understanding (Section 4.2.2.2.2). Failure to adhere to assessment policies affects the relationship of trust with nurse educators and with their peers (Section 4.2.2.2.4).
Affirm students' efforts	Only mistakes are noticed. Students are never given recognition, irrespective of what they do and the good in them is never acknowledged (Sections 4.2.2.6.5, 4.2.3.1.4).
Share positive messages	Nurse educators often give negative, degrading and discouraging feedback that is rude and sarcastic (Section 4.2.2.3.2). Negative communication is experienced in the military clinical learning environment where they are accused of being stupid or are rudely/disrespectfully addressed in front of a patient (Section 4.2.3.1.4).
Create supportive dynamics	Nurse educators are often unavailable, inaccessible or unapproachable, which results in insufficient academic support (Section 4.2.2.2.2).

5.2.3.1.3 Attitude towards military nursing students

The atmosphere in the ward is influenced by factors such as cooperation, attitude, morale and the friendliness of the staff, and also by the interpersonal relationships between staff and students. Ward atmosphere directly influences learning because it determines whether students believe their presence is appreciated and whether they will be provided with learning opportunities (Chuan & Barnett 2012:192).

Students in this study reported a general prevalence of negativity, especially in the military clinical learning environment. They noted that some professional nurses did not seem to enjoy nursing and that the professional nurses' negativity influenced the students (Section 4.2.3.1.3).

Chuan and Barnett (2012:193) maintain that students' satisfaction is largely influenced by their experience of the clinical learning environment, especially when they are treated with respect, have effective mentors, receive constructive feedback on performance and are included as a part of the clinical team.

Anthony and Yastik (2011:140-144), in a study on nursing students' experiences in the clinical learning environment, identified three reasons for dissatisfaction among students: exclusion, where students felt they were in the way and that nurses did not accept responsibility for them; hostility or rudeness, which led to students questioning their commitment to nursing, and dismissiveness, where nurses often ignored and walked away from students.

There is a strong correlation between the findings of the present study and those conducted by Anthony and Yastik (2011:140-144). The present study revealed that negative communication, negative approaches and negative treatment caused much dissatisfaction among military students. Students mentioned instances of where they had been addressed disrespectfully in the presence of patients (Section 4.2.3.1.4) or even shouted at (Sections 4.2.3.1.1 and 4.2.3.1.4) and where they had been told that they were stupid (Section 4.2.3.1.4). They also complained that only their mistakes were noticed (Section 4.2.3.1.1), that they were often judged by other students' behaviour, that they were often falsely accused of truancy, were lazy or were lying (Section 4.2.3.1.4). These experiences relate to the concept of incivility discussed in Theme 2 (Section 5.2.2.3). It is evident that nursing students experience a wide range of uncivil behaviours throughout their training, in both the theoretical and the clinical learning environments.

Babenko-Mould and Laschinger (2014:145) maintain that the clinical learning experiences and well-being of students may either be positively or negatively affected depending on the health of the workplace itself and on their exposure to negative workplace behaviours. If their clinical learning experiences are stressful, their self-

confidence and often their emotional health are undermined. Examples of incivility as cited by Babenko-Mould and Laschinger (2014:146) include covert forms of aggression and violence, such as rude comments, thoughtless acts and negative gestures. This corresponds strongly to the military students' experiences summarised above. According to Babenko-Mould and Laschinger (2014:145), power plays a central role in incivility and therefore those who have a lower status (the students) than that of the instigator (the professional nurses) are more likely to experience incivility. The issue of rankism once more surfaces.

As regards the negative atmosphere that exists in and students' dissatisfaction with in the military clinical learning environment, the students mentioned that the way in which they were approached by the professional nurses made them see these nurses in a different light and that this was influencing their attitude towards the professional nurses. It also made them rather withdraw from the ward and it made learning difficult (Section 4.2.3.1.4). Students also indicated that they were happier to go back to wards where they had been received positive feedback and acknowledgement from the staff for what they had done (Section 4.2.3.1.1).

Students further indicated that they experienced the military clinical learning environment as being rigid and constrained in the sense that they felt that their opinions were irrelevant, that they were not allowed to speak up or use their own initiative (Section 4.2.3.1.1). As a result of the regulated environment and also the need for obedience and compliance, the nurse educators were of also of the opinion that students generally are unable to make autonomous decisions and that their opinions are often not considered (Section 3.2.1.3.1).

In similar vein, Robinson, Rodriguez, Sammons and Keim (1993:1149-1150) found that military nurses perceived their work environments as allowing for little autonomy and having fewer opportunities for involvement in decision making and innovation. These authors (1993:1150) ascribed these experiences to the structured and highly ordered nature of a military setting. Because the military command structure is by nature ordered and hierarchical, it is generally understood that one relinquishes a certain degree of autonomy when one enlists in the military. Similarly, in the military, most decisions are made by those with higher ranks. This serves to limit the decision-making power and also the opportunities of the lower-ranking students to be innovative.

Another factor identified as influencing the clinical learning environment was students' observation that nurses enjoy little recognition by other members of the multidisciplinary team, which makes them feel inferior (Section 4.2.3.1.2). This situation is clearly not unique to the military environment (Irajpour & Alavi (2015:99-104); Regan, Laschinger & Wong (2016:54-61); Smith, Lavoie-Tremblay, Richer & Lanctot (2010:271-278). It is also related to what Bleich (2014:108-109) describes as rankism. The only mention made by nurse educators with relation to interprofessional collaboration stems from the reference to command and control issues where a commander may have a lower rank than that of the healthcare professional or when the commander imposes his/her authority on healthcare professionals and interferes with their professional functions (Section 3.2.4.1.2).

Interprofessional attitudes are a reflection of professionals' perceptions and views of members of other professions and interprofessional collaboration has been identified as a key priority in terms of delivering safe, quality health services (Irajpour & Alavi 2015:99).

The study by Irajpour and Alavi (2015:99) revealed that some nurses have strong feelings and perceptions about the behaviour of other professionals and that these feelings influence how they communicate with one another. Insufficient mutual awareness between health professionals was identified as the main cause of negative attitudes towards nurses. Irajpour and Alavi (2015:99) ascribe these findings to an insider-outsider approach, that is where each group of healthcare professionals has its own specific set of professional worldviews, attitudes and beliefs, and it thus prefers to communicate intraprofessionally.

5.2.3.1.4 Patient interaction

Although the students reported having had some positive experiences with military patients, such as that patients had demonstrated trust and also gratitude, most of the narratives revealed that students had found the attitudes of military patients difficult to deal with. The positive experiences resulted in the students feeling respected, appreciated and trusted, while such experiences also made them feel more motivated and committed. The negative experiences involved refusal to be treated by students, unreasonable demands, expectations of preferential treatment and failure to express

appreciation. Rank also played a significant role in how students were approached by patients. The result was that students felt that they were being denied learning opportunities, that they found it difficult to nurse patients, that they were wary of entering patients' rooms and that they had lacked confidence (Section 4.2.3.1.2). While Gaberson and Oermann (2010:118) acknowledge the importance of students' feelings, it is vitally important that patients' needs be considered and their wishes respected in planning clinical learning opportunities for students. Clucas and Chapman (2014:681) concur that, irrespective of the context, the expectation is that nurses should treat patients with respect, regardless of how the latter behave and what their background happens to be.

5.2.3.1.5 Rankism

As within the theoretical learning environment discussed earlier (Section 5.2.2.3), the issue of rank and the concomitant exploitation of power also surfaced in the military clinical learning environment. Fuller (2004) not only acknowledges that earned rank can be a source of gratification and joy as a result of the satisfaction of being appreciated for demonstrating talents, skills and abilities, but also recognises the benefits of rank as an essential tool in management in that it promotes efficiency, productivity and selectivity in guiding people. The positive use of rank in the clinical learning environment can influence learning positively in terms of the risk individuals are willing to take in front of peers, and in fostering communication and relationships of trust (Bleich 2014:109). Unfortunately, according to the nurse educators, military rank is taking precedence over professional rank, professional experience, professional qualifications and academic qualifications (Section 3.2.1.3.2).

The ranking system was considered to be one of the main challenges confronting students in the military clinical learning environment. Nurse educators acknowledged that having no authority, students often have to choose between obeying an order from a higher-ranking person or remaining true to the ethical principles of nursing care and the patient's rights to privacy and confidentiality (Section 3.2.3.1.2). The exploitation of power in the military clinical learning environment stretches as far as students being expected to salute a higher-ranking person who enters the ward while the student is involved in performing nursing duties and even to visitors to the wards who use their rank to overrule nurses (Section 4.2.3.1.5).

These examples of exploitation of power in the military clinical learning environment serve to explain why students agreed that the absence of military influence in the civilian clinical learning environment made it easier for them to be assertive and to communicate, since, under those circumstances, they were not expected to follow channels of command and there were no military ranks to fear or respect (Section 4.2.3.2.7).

Rankism is however not exclusive to the military environment. Bleich (2014:108-109) maintains that healthcare workers of all types experience abuse of rank for self-benefit and gain over others and that rankism devalues and undermines the workforce contributions of all professionals.

5.2.3.1.6 Students' experience in the civilian clinical learning environment

The students indicated that they also had experienced a negative attitude towards themselves in the civilian clinical learning environment and stated that, generally, they were not well accepted in the civilian facilities. This behaviour, and the fact that they had been treated differently, they ascribed to their military uniforms, which may have intimidated civilian personnel. The civilian personnel also discouraged military behaviour and indicated that the military students had to adapt to the civilian way of doing things (Section 4.2.3.2.3). In a study conducted by Lekalakala-Mokgele and Caka (2015:4) on facilitative and obstructive factors in the clinical learning environment, it was found that wearing military uniforms in civilian clinical facilities was considered to obstruct learning. Participants in their study indicated that they had felt marginalised when referred to as soldiers and not nurses, that condescending remarks made by other nurses had embarrassed them and that they had sensed that patients felt uncomfortable in their presence.

Both nurse educators and students were constantly comparing military students with civilian students. Table 5.7 is a summary of what the students and the nurse educators themselves considered to be the main differences.

TABLE 5.7: COMPARISON OF MILITARY AND CIVILIAN STUDENTS

Military students	Civilian students
Have less clinical exposure (Section 3.2.3.2.1)	Have more clinical exposure (Section 4.2.3.2.6)
Appear to be less professional (Section 3.2.3.2.1)	Are more assertive (Section 3.2.3.2.3)
Appear to be less knowledgeable (Section 3.2.3.2.1)	Are more responsible (Section 3.2.3.2.3)
Are less educated (Section 4.2.3.2.4)	Are more inquisitive (Section 3.2.3.2.3)
Earn more money (Section 4.2.3.2.4)	Are more confident (Section 3.2.3.2.3)
Are more privileged (Section 4.2.3.2.4)	Compare better in terms of cognitive abilities (Section 3.2.3.2.3)
Are incompetent (Section 4.2.3.2.4)	Are less professional (Section 4.2.3.2.1)
Are irresponsible (Section 4.2.3.2.4)	Are disrespectful towards their superiors (Section 4.2.3.2.1)
Project a very positive image (Section 3.2.3.2.1)	Leave the ward whenever they want to (Section 4.2.3.2.1)
Are held in high regard (Section 3.2.3.2.1)	
Are more disciplined (Section 3.2.3.2.3)	
Are more punctual (Section 4.2.3.2.4)	
Are hard-working (Section 4.2.3.2.4)	
Are more respectful (Section 4.2.3.2.4)	
Are more mature (Section 4.2.3.2.6)	
Are more professional (Section 4.2.3.2.6)	
Provide better patient care (Section 4.2.3.2.6)	
Are neater (Section 3.2.3.2.1)	

The nurse educators (Section 3.2.3.2.1) and military students (Section 4.2.3.2.3) agreed that civilian professional nurses held negative perceptions about the military students. These were ascribed to the civilian professional nurses' ignorance regarding the military. Moreover, many of the military students' negative traits were attributed to the issue of rank. No relevant literature comparing military students and civilian students could be found. The researcher can only postulate that the differences result from the influence of military training discussed in Theme 1 (Section 5.2.1.2).

Students' reference to peer support was mainly situated in the process of military acculturation where they depended on one another during military training (Section 4.2.1.3.1), but the students nevertheless acknowledged that despite the differences between them and the civilian students, they did share experiences. They were able to learn from one another and they also shared their experiences with one another when returning from work (Section 4.2.3.2.5). According to Chuan and Barnett (2012:193), peers are valuable resources, and are able to help, support and contribute to one another's learning. The nurse educators made no mention of peer support, although it is regarded as a valuable support strategy.

The often opposing views and experiences of nurse educators and students in this study, as discussed in the preceding sections on the clinical learning environment, strongly correlates with the findings of a study conducted by De Swardt et al (2014:1-13) that also reveals discrepancies in the views of professional nurses and students regarding the professional socialisation of students. Whereas professional nurses identified themselves as being approachable, having sound levels of knowledge and providing clinical supervision, students however experienced limited support from the professional nurses in terms of their learning. Students identified role models they did not wish to imitate. While professional nurses highlighted the ill-disciplined behaviour of students, the students in turn experienced professional nurses as insensitive and excluding them from learning opportunities. Despite this negative picture of the professional nurse, students indicated that there were some professional nurses who were exemplary role models and clinical supervisors (Section 4.2.3.2.1).

5.2.4   Theme 4: Fighting a dichotomy – professional role conflict

A war is usually fought for a specific cause, whether it be for freedom, religion or resources, and then usually between two or more parties. In the context of this study, another kind of war is being waged: the war between two professions. A dichotomy is defined as "a division or contrast between two things that are or are represented as being opposed or entirely different" (Oxford Dictionary 2015). The emergent data suggest a strong contrast between simultaneously being a professional soldier and a professional nurse. *Fighting a dichotomy* therefore seemed an apt metaphor for the issue of dual roles and the effects of duality. Figure 5.4 presents a mind map of Theme 4.
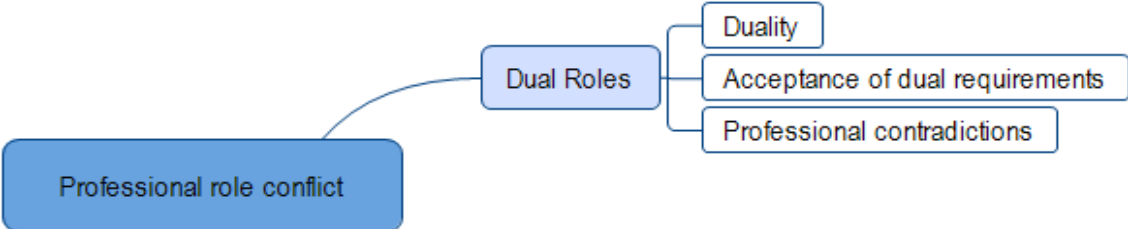
Figure 5.4: Mind map of Theme 4

5.2.4.1   Duality

The nurse educators (Section 3.2.4.1) as well as the students (Section 4.2.4.1) recognised their dual roles by virtue of being a military nurse. This often creates role conflict and leads to professional incongruity between being a nurse and being a soldier. Whilst the nurse educators indicated that they, over a period of time, have been able to integrate these roles and learnt to distinguish when it is appropriate to assume which role, depending on the situation (Section 3.2.4.1), the students felt that they were not sufficiently prepared to deal with fulfilling both roles. The students generally found it conflicting and confusing to switch roles when moving between the military and the civilian learning environments (Sections 4.2.4.1.1and 4.2.4.1.2).

5.2.4.2   Acceptance of military requirements

The nurse educators maintain that becoming a military nurse has been a choice, which implies that both roles have to be adopted and practised. No distinction is made between different musterings in terms of military duties in the sense that nursing professionals are not exempted from military duties (Section 3.2.4.1.1).

While being an employee of the SANDF automatically subjects a person to the Defence Act, no. 42 of 2002 (South Africa 2002), being a student or nurse educator professional with the South African Nursing Council likewise subjects members of the SAMHS Nursing College to the Nursing Act, no. 33 of 2005 (South Africa 2005). All uniformed members of the SANDF are also subjected to the Code of conduct for uniformed members of the South African National Defence Force (SANDF 2016) and all nurses, upon completion of their training, commit to The Nurses Pledge of Service (SANC 2016). One can thus argue that military nurses accept the requirements of having to practise dual professions when entering the profession but that there is however no professional code which serves as overarching framework for the professional conduct of a military nurse.

The aforementioned paragraph validates the fact that nurse educators and students are often expected to participate in military activities, even though it interferes with nursing training. One of the students expressed the opinion that the nurse educators were focusing more on soldiering rather than on nursing, whilst another indicated that she

would rather study at a civilian institution as a result of all the military expectations (Section 4.2.2.6.6). The nurse educators also debated the deployment of staff and students for humanitarian operations in terms of the value of clinical exposure versus the implications on lecture periods, clinical hours and the possible extension of training (Section 3.2.2.2.2).

5.2.4.3   Professional contradictions

Most of the topics around moral dilemmas and role conflict related to dual loyalties in the Defence Force that have been discussed in the literature (Griffiths & Jasper 2008:92-99; Messelken 2015:43-46; Olsthoorn, Bollen & Beeres 2013:79) have been described against the backdrop of wars, violent conflict and operational deployment. After all, that is what soldiers, and by extension, military nursing students, are trained for.

The past few decades have seen a significant transformation in the structure of military conflict, the types of operation and the setting of the operational theatre worldwide. This transformation has not only been accompanied by a dramatic decline in global warfare and interstate conflict but also by the eruption of a multitude of intrastate conflicts ranging from civil wars and guerrilla wars to national liberations and ethnic conflicts (Kalyvas, 2009). These changes have brought about a significant shift in focus from conventional warfare to peace enforcement, peacekeeping and border control. Also included are protection from abnormal eventualities such as natural disasters, crime and violence, other non-state violence and internal threats to the constitutional order of the country. This evolution of the security concept, referred to as military-operations-other-than-war (MOOTW), brought about a change in both the identity of the military officer and in the primary roles of military healthcare professionals (Kalyvas, 2009).

The changes in the primary roles of military healthcare professionals may explain why most of the professional contradictions experienced by nurse educators and students (summarised in Section 3.2.4.1.2). refer not only to the moral and ethical dilemmas that one would expect to encounter in a combat zone, but mostly to day-to-day issues during times of peace Table 5.8 provides a summary of these contradictions.

TABLE 5.8: PROFESSIONAL CONTRADICTIONS

Topic	Soldier		Nurse	Applicable reference
• Governance	Defence Act, no. 42 of 2002	vs	Nursing Act, no. 33 of 2005	Participants claim that the military regulations to which they are additionally subject are often at variance with the nursing-specific professional regulations. Members of the SANDF are subject to the dictates of the Defence Act, no. 42 of 2002 (South Arica 2002), the Military Disciplinary Code and the Code of Conduct, all of which regulate the professional conduct of a soldier. All military nurses, on the other hand, are also subject to the Nursing Act, no. 33 of 2005 (South Africa 2005) and the regulations, which, in turn, prescribe the professional conduct of a nurse. (Section 3.2.4.1.2).
• Command and control	Military command	vs	Functional control	The military hierarchical ranking system also affects command and control, which, according to the participants, result in military rank taking precedence over professional rank, professional experience, professional qualifications and academic qualifications (Section 3.2.1.3.2). A commander is assigned military command by virtue of rank and appointment, while a healthcare professional in control of a professional grouping is assigned functional control (Section 3.2.4.1.2).
• Professional roles	Disciplinarian	vs	Carer	Although both the military and the nursing professions are seen as disciplined professions, the participants seem to experience difficulties when they need to discipline a student at the one moment, and need to act as caring role models at the next (Section 3.2.4.1.2).
	Disciplinarian	vs	Teacher	participants also experience conflict between being a disciplinarian but also a teacher. They regard their core function as being that of a nurse educator and find it difficult to discipline students in a military fashion at the same time (Section 3.2.4.1.2).
	Emotionally undemonstrative	vs	Empathetic	Participants also maintain that they find it difficult to switch between a military attitude and a caring attitude, thus to be emotionally undemonstrative as a soldier but empathetic as a nurse (Section 3.2.4.1.2).
• Humaneness	Being treated as an object	vs	Being treated as a human being	According to participants, military indoctrination serves to deprive one of one's humanity and leads to depersonalisation, specifically causing a loss of identity and individuality. Two concepts, namely de-humanisation and de-emotionalisation, therefore emerge from the following comments made by the participants. Particularly disconcerting is a tendency to overlook the individual person behind the uniform and rank (Section 3.2.1.1.1). Participants are aware to the fact that students regard themselves as being treated like objects in the military environment as opposed to being treated like human beings in the civilian environment (Section 3.2.4.1.2).
• Professional ranks	Military rank	vs	Professional rank	The military hierarchical ranking system also affects command and control, which, according to the participants, result in military rank taking precedence over professional rank (Section 3.2.1.3.2). Military nurses are given both a military rank and a professional rank. The military rank does not always reflect the professional level nor does the professional rank always reflect the military seniority (Section 3.2.4.1.2).
• Assertiveness	Being submissive	vs	Being assertive	On the other hand, it military students do not compare well with civilian students in terms of assertiveness, a sense of responsibility, inquisitiveness and self-confidence. The lack of these is ascribed to the nature of the

Topic	Soldier		Nurse	Applicable reference
				military culture and the enforcement of discipline and obedience, which leads to what is perceived as respect and submissiveness (Section 3.2.3.2.3). Assertiveness is a skill that should be instilled in nursing students in order for them to be advocates for their patients. Being a disciplined, obedient soldier, however, requires nurse educators and students to be submissive rather than assertive (Section 3.2.4.1.2).
• Leadership	Autocratic leadership style	vs	Democratic leadership style	Participants often experience conflict when different leadership styles are applied. Whereas the Defence Force is generally seen as an autocratic organisation, the nursing profession is seen as being more democratic (Section 3.2.4.1.2)
• Authority	Fearing authority	vs	Respecting authority	The participants agreed that the absence of military influence in the civilian facilities made it easier for them to be both assertive and to communicate since there they were not expected to follow channels of command. There were moreover no military ranks to fear (Section 4.2.3.2.7). According to participants, in the Defence Force, authority however tends to instil fear rather than respect (Section 3.2.4.1.2).
• Ethical principles	Being a soldier first	vs	Being a nurse first	The participants feel especially strongly about non-nursing duties taking precedence over nursing training (Section 3.2.2.2.1). The participants had mixed opinions about the withdrawal of students from the classroom to participate in these operations (Section 3.2.2.2.2). Participants claim that military expectations often outweigh professional expectations (Section 3.2.4.1.2). When it comes to military discipline and conduct, the broader military community tends to emphasise that military healthcare professionals are soldiers first and foremost (Section 3.2.4.1.2).
	Inflicting harm	vs	Beneficence and non-maleficence	Participants are concerned regarding the principles of beneficence and non-maleficence as taught to students, as opposed to what they are taught during Basic Military Training in terms of musketry and warfare (Section 3.2.4.1.2).
	The rights of soldiers	vs	The rights of nurses and patients	Furthermore, the controversial issue of the rights of soldiers – or rather their lack of such rights – is contrasted with the rights of nurses and of patients (Section 3.2.4.1.2).
	Military instructions	vs	Patients' rights	participants debated the ethical conflict that students often experience when confronted with a military order or instruction from a higher-ranking officer, one which may be in contravention of the patient's right to privacy and confidentially (Section 3.2.4.1.2).
	Patient's rank	vs	Patient's needs	The participants acknowledge that nurse educators have a role to play in teaching students that patients have to be treated according to their needs and not their rank (Section 3.2.3.1.2).

Olsthoorn, Bollen and Beeres (2013:82-84) indicate that scrutiny of the various versions of ethical codes related to healthcare professionals reveals one commonality: they have only the interests of the patient at heart and not those of a third party, for example a hospital or a government. Military ethical codes or codes of conduct usually emphasise loyalty to a head of state, a constitution, a republic, a king or to laws. Whereas a soldier's client is either the state or the people, a civilian healthcare professional's client is only the patient. If one, for example, studies the Code of conduct for uniformed members of the South African National Defence Force (SANDF 2016) in Box 5.1, one discovers that it clearly states that the soldier pledges to "serve and defend his country and its people in accordance with the Constitution and the law".

BOX 5.1: CODE OF CONDUCT FOR UNIFORMED MEMBERS OF THE SOUTH AFRICAN NATION DEFENCE FORCE (SANDF 2016)

I pledge to serve and defend my country and its people in accordance with the Constitution and the law and with honour, dignity, courage and integrity.

I serve in the SANDF with loyalty and pride, as a citizen and a volunteer.

I respect the democratic political process and civil control of the SANDF.

I will not advance or harm the interests of any political party or organisation.

I accept personal responsibility for my actions.

I will obey all lawful commands and respect all superiors.

I will refuse to obey an obviously illegal order.

I will carry out my mission with courage and assist my comrades-in-arms, even at the risk of my own life.

I will treat all people fairly and respect their rights and dignity at all times, regardless of race, ethnicity, gender, culture, language or sexual orientation.

I will respect and support subordinates and treat them fairly.

I will not abuse my authority, position or public funds for personal gain, political motive or any other reason.

I will report criminal activity, corruption and misconduct to the appropriate authority.

I will strive to improve the capabilities of the SANDF by maintaining discipline, safeguarding property, developing skills and knowledge, and performing my duties diligently and professionally.

In the Code of conduct for uniformed members of the South African National Defence Force (Box 5.1), it further states that members will obey all lawful commands and respect all superiors. This could explain not only many higher-ranking officers' attitude towards nurses in terms of treatment priorities and the imperative of having to protect patients' rights – as described by nurse educators and students during the course of this study (Sections 3.2.1.3.2, 3.2.3.1.2, 3.2.4.1.2 and 4.2.3.1.2) – but also nurse educators and professional nurses' attitude towards students (Sections 4.2.3.1.4 and 4.2.3.1.5).

In The Nurses Pledge of Service (SANC 2016) in Box 5.2, all nurses promise their service to "humanity", the "profession" and their "patients" and that that "the health of their patients will be their first consideration". It is thus understandable that the nurse educators (Sections 3.2.2.2.1, 3.2.2.2.2 and 3.2.4.1.2) and students (Section 4.2.2.6.6).in this study expressed their dissatisfaction at being expected, in line with the argument that they are soldiers first, to participate in military activities.

BOX 5.2:   NURSES PLEDGE OF SERVICE (SANC 2016)

> *I solemnly pledge myself to the service of humanity and will endeavour to*
> *practise my profession with conscience and with dignity.*
> *I will maintain, by all the means in my power, the honour and noble tradition of*
> *my profession.*
> *The total health of my patients will be my first consideration.*
> *I will hold in confidence all personal matters coming to my knowledge.*
> *I will not permit consideration of religion, nationality, race or social standing to*
> *intervene between my duty and my patient.*
> *I will maintain the utmost respect for human life.*
> *I make these promises solemnly, freely and upon my honour.*

Given the content of the two respective pledges that military nurses are required to take and also the references to the findings of this study that have served to illustrate the confusing interpretations of these pledges, it is clear that nurses in the military serve a different client in their healthcare capacity than they do in their capacity as members of the Defence Force.

Military codes are often aimed at safeguarding military personnel against harassment, sexual intimidation or discrimination and rather involve regulating how soldiers behave

towards one another than about regulating their conduct towards those they have to protect. The codes of conduct for healthcare professionals, on the other hand, emphasise the interests of the patients (Olsthoorn et al 2013:85-87). Attempts to adhere to two different ethical codes are thus likely to cause conflicting loyalties among military healthcare professionals. In this connection, the military students reported that they were not adequately trained to put them in a position to deal with two professional roles at the same time. They also indicated that they were experiencing conflict and confusion as a result of the difference between how they were treated as soldiers and how they were treated as nurses, and also how they were expected to behave. It was also mentioned that switching between roles was difficult (Section 4.2.4.1). The nurse educators on the other hand maintained that although it had initially been difficult to assume both roles, they had managed to incorporate both and also to distinguish when the situation required them to assume which particular role (Section 3.2.4.1).

Griffiths and Jasper (2008:92) highlight the irony of the history of nursing, namely that is intrinsically linked to war, a phenomenon that itself destroys health and contravenes the very ethos of nursing. They assume that military nurses will be able to reconcile the dichotomy existing between, on the one hand, their caring role and, on the other, being a member of an organisation associated with conflict. Their assumption is based on a study conducted among military nurses with the dual aim of exploring the nature of military nursing in an environment of war, and also identifying the actual or potential effect that this had on the nursing role in this unique environment. They found that participants acknowledged their duality in terms of roles, authority, responsibility and accountability. These findings of Griffiths and Jasper (2008:92) are in line with the acknowledgement by the nurse educators in the current study that they had chosen to become military nurses, and that they had accepted the military requirements and had assumed the additional role (Section 3.2.4.1.1). The fact that the military students indicated that they were finding it (more) difficult (than the nurse educators) to switch between the roles of soldier and nurse (Section 4.2.4.1), is ascribable to a lack of experience on the part of the students.

It was mentioned at the beginning of this section on professional role conflict that most of the professional contradictions experienced by nurse educators and students refer not to the moral and ethical dilemmas that one would expect to find in a combat zone, but mostly to day-to-day issues during times of peace (Section 3.2.4.1.2). The study by

Griffiths and Jasper (2008:92) revealed that the highly contrasting roles of nurse and warrior allow the nurses to cross these boundaries with relative ease, each being clearly defined in terms of responsibility and authority. They further found that external pressures – such as a direct threat – are fundamental to the transformation from nurse to warrior: the individual switches from the expected behaviour of the nursing profession to behaviour associated with the role of warrior. The highly contrasting roles of nurse and warrior allow the degree of compartmentalisation of identities or mental fences that separates each role to be negotiated and overcome. The current absence of direct threats in the working lives of nurse educators and students at the SAMHS Nursing College may explain why they find it difficult to assume both roles (Section 3.2.4.1) or to switch between the roles (Section 4.2.4.1).

5.3 SUMMARY OF THE HIDDEN ELEMENTS IN A MILITARY TEACHING AND LEARNING ENVIRONMENT AND THEIR INFLUENCE ON THE PROFESSIONAL SOCIALISATION OF STUDENTS

The first objective of Phase 1 of this study as explained in Chapter 1 was to identify the elements of the hidden curriculum present in a military teaching and learning environment. Chapters 3 and 4 have already alluded to the numerous hidden elements identified by means of mind maps and the discussions of the findings. As a result of the large number of hidden elements identified, the researcher further used inductive reasoning to extrapolate these elements to broader conceptual categories. The researcher concluded that the hidden elements may be ascribed to processes, people and places to which the students are exposed during the course of their training. The most prominent hidden elements were then linked to each of these categories. It is important to bear in mind that each of the processes takes place in one or more of the learning environments and that each of the categories of people are present in one or more of the environments. This implies that there are overlaps of hidden elements between processes, people and places. The issue of dual roles (a process), for example, is present both in the theoretical teaching and learning environment, and in the military clinical learning environment (places), while patient interaction (people) takes place in both the military and the clinical learning environments (places).

The second objective of Phase 1 of the study was to determine how the identified hidden elements influence students' professional socialisation. The influences identified

during the data-analysis process were dealt with in Chapters 3 and 4. The researcher used the same process followed in respect of the hidden elements to reduce the large number of identified influences by grouping them together in categories that were more descriptive. Two main categories were identified. The first category comprised influences that develop or enhance professional socialisation, while the second included the influences that inhibit or impede professional socialisation. Each category of influences can be linked to one or more hidden element(s) and since there is an overlap between the hidden elements, an overlap likewise exists between the influences. It was also apparent that some hidden elements could either enhance or impede professional socialisation. This, for example, implies that both military training (a process) and an unconducive learning environment (a place) can impede learning (a negative influence) or that military socialisation (a process) can either enhance or impede the development of communication and interaction skills. The lists of elements and influences as extracted from the raw data are available in Annexure I.

Table 5.9 provides a summary of the hidden elements in terms of the people, processes, and places and their influences.

TABLE 5.9:   THE HIDDEN ELEMENTS IN TERMS OF THE PEOPLE, PROCESSES AND PLACES AND THEIR INFLUENCES

	Elements	Influences
People	Military instructor Nurse educator Professional nurse Patient Other healthcare professionals Peers	Academic achievement Clinical skills Communication skills Dignity Functional skills Interaction skills Learning skills Life skills Morale Patient care Personal autonomy Personal identity Professional conduct Professional dedication Professional development Professional practice Relationships Self-confidence Self-esteem
Processes	Career choice Military acculturation Professional knowledge acquisition Clinical skills acquisition Dual roles	
Places	Military environment Military learning environment Theoretical learning environment Clinical learning environment	

5.4   SUMMARY

This chapter provided a discussion of the integrated findings from Samples A and B and, where possible, integration with and contextualisation in terms of current literature. The hidden elements were extracted from the findings and linked to potential influences on the professional socialisation of students in a military teaching and learning environment.

The findings of Phase 2 suggested the components for the substantive model that is to be discussed in Chapter 6.

CHAPTER 6

PHASE 3: MODEL DEVELOPMENT, EVALUATION AND REFINEMENT

6.1   INTRODUCTION

Chapter 5 laid the foundation for the substantive model by discussing the four themes that had emerged during data analysis. Each of the four themes – with their categories and subcategories – was discussed and contextualised by means of the relevant existing literature. Utilising inductive reasoning, the hidden elements identified as being present in a military teaching and learning environment, and also their influence on students' professional socialisation were incorporated into the themes.

This chapter focuses on the development, evaluation and refinement of the model and concludes with a description of the structure, the process and guidelines for implementation.

6.2   DEVELOPMENT OF THE MODEL

Chinn and Kramer's (2014:178-185) approach to structuring and contextualising theory was adapted to develop and describe the substantive model. The description of the model includes the following:

- Background to the model
- Purpose of the model
- Rationale for developing a substantive model
- Components of the model
- Assumptions of the model
- Evaluation of the model
- Description of the model
- Context of the model
- Structural description of the model
- Relationships between concepts
- Implementation of the model

6.2.1 Background to the model

The need for a model with which to address the hidden curriculum in a military teaching and learning environment arose from the researcher's personal experiences as a military nurse educator. She had also witnessed interactions among nurse educators and between nurse educators and students, and had moreover experienced the effect of the military environment on the day-to-day activities of nursing education and students' reactions to it.

The findings of this study described in Chapters 3 and 4 served to confirm the assumption that the military teaching and learning environment is extremely complex and although it contains many overt elements, it also comprises a multitude of covert elements. The latter play an unintentional role in the professional socialisation of students.

6.2.2 Purpose of the model

The objective of Phase 3 of this study – as an outcome of the theory-generation process used in the grounded theory methodology – was to develop a substantive model to provide nurse educators and professional nurses with a frame of reference that would create an awareness of the existence of a hidden curriculum. The model further serves to guide nurse educators and professional nurses through the impact of the hidden curriculum on students' professional socialisation and to help them to understand how their contribution could improve the outcome of the professional socialisation process of students.

By creating an awareness of the hidden elements discovered in the course of this study and by making recommendations on how this model should be implemented, nurse educators in particular, but also all other healthcare professionals dealing with students, will be enabled to identify the hidden curriculum prevalent in a particular situation, realise the impact of the hidden curriculum on students' professional socialisation and help them to understand how their contribution could improve the outcome of the professional socialisation process of students.

6.2.3 Rationale for developing a substantive model

The grounded theory research method was used to study the presence of the hidden curriculum in the military teaching and learning environment and also to determine the influence of elements of the hidden curriculum on students' professional socialisation. Grounded theory research usually results in the generation of a theory that explains a phenomenon from the perspective and in the context of those who experience it (Birks & Mills 2011:16).

Theories may however be presented in more than one way. Walker and Avant (2014:147) contend that when the relationships within and among concepts and statements derived from the data are depicted diagrammatically, this representation constitutes a model of the phenomenon. While Walker and Avant (2014:147) use the terms *theory* and *theoretical model* interchangeably, Birks and Mills (2011:175) define a *model* as an abstract representation of reality or a visual summary of the findings. A significant difference between a theory and a model is that a model explains a phenomenon by identifying its causes and the relationship between the theory and the phenomenon in a much more specific way than the relationship between a model and the phenomenon to which the model relates (Mouton & Maree 1996:138-144).

According to Cohen, Manion and Morrison (2013:11), both a theory and a model can be seen as explanatory schemes that have broad conceptual frameworks. Models, however, tend to be characterised by the use of analogies or metaphors, which result in a more visual or diagrammatic representation. Models aim to simplify a phenomenon by means of explanation and conceptualisation, which gives rise to the notion that models operate at a more general level. A substantive theory is described as the interpretation or explanation of a defined phenomenon in a particular area (Charmaz 2014:344).

The product of the present study is thus a substantive model, since the findings, which consist of the perceptions and experiences of nurse educators and students in a military context, are diagrammatically represented.

6.2.4 Components of the substantive model

Components are the elements that convey the focus and meaning of a model (Chinn & Kramer 2014:178-179). The components of the substantive model were shaped during discussions of the research findings in Chapter 5.

6.2.4.1 Career choice

According to Parsons's theory, career choice is the selection of a particular occupation or profession by analysing skills, values, interests and personality and then matching these to a career (Parsons 1909:5). For the purpose of this study, career choice refers to the initial decisions made by the recruits to apply for a career in the Defence Force and to embark on a career in nursing. Career choice was identified as a component of the model based on the emphasis placed on the various reasons given by students for choosing the military and/or nursing as a career (Section 5.2.1.1). This choice and the rationale behind it played a significant role in students' subsequent experiences (Sections 5.2.1.1 and 5.2.2.1).

Figure 6.1 depicts career choice as a component of the model.

Figure 6.1: Career choice

6.2.4.2 Military Skills Development System (MSDS) recruit

The Military Skills Development System (MSDS) is a voluntary service system that was incorporated into the Defence Strategy in 2003 (DOD 2003:2). In terms of MSDS, recruits receive basic military training and enablement skills over a period of two years. Selected nursing students complete the first year of the MSDS programme prior to commencing with the nursing programme. For the purpose of this study, selected students are referred to as *recruits* while they are still undergoing military training. As soon as they commence with nursing training, they are referred to as *students*.

The students' experiences as MSDS recruits laid the foundation both for their integration into the Defence Force and for their military professional socialisation. This was the stage of their careers during which the students were subjected to military training (Section 5.2.1.2) and to military socialisation (Section 5.2.1.3), and were inducted into the military culture.

Figure 6.2 depicts the MSDS recruit as a component of the model.

Figure 6.2: The MSDS recruit

6.2.4.3 Student nurse

A student nurse is a person who has successfully completed 12 years of schooling and meets the entrance requirements of an approved nursing school (Kotzé 2008:187). For the purpose of this study, a student nurse is a person who is registered as a student at the SANC for the four-year Diploma in Nursing Science (General, Community and Psychiatry) and Midwifery as stipulated by Regulation 425 (SANC 1985) and who studies at the SAMHS Nursing College. The term *student* was used throughout this study. The student is the main role player in this study as the primary recipient of the implicit and tacit messages of the hidden curriculum in the military teaching and learning environment throughout the processes of military acculturation, and the acquisition of professional knowledge and clinical skills. The student has thus been included as a component of the model within the military, theoretical and clinical learning environments. Figure 6.3 depicts the student as a component of the model.

Figure 6.3: Student nurse

6.2.4.4 The military environment

For the purpose of this study, the military environment encompasses the entire military-unique context in which the students live, study and work. The highly regulated and structured nature of this environment, of which hierarchy, and military rules and regulations are the main focus, provides the primary context in which the hidden curriculum comes into play. As such, it forms an important component of the model (Section 5.2.1.4).

Figure 6.4 depicts the military environment as a component of the model.
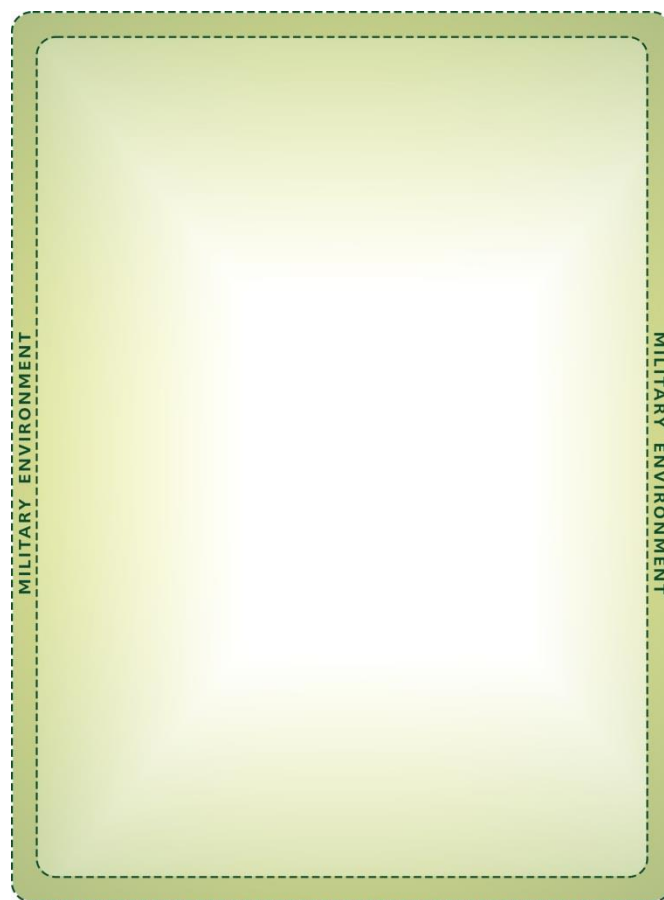
Figure 6.4: The military environment

6.2.4.5 You're in the army now

You're in the army now represents the process of military acculturation. This is the process of being introduced to military life, of learning the traditional content of the military culture and of assimilating its practices and values (Global Perspectives Consulting 2013). Military acculturation encompasses the experiences of both the

MSDS recruit and the student within the military environment and, as such, was identified as one of the themes of the study. Figure 6.5 depicts military acculturation as a component of the model.

Figure 6.5: Military acculturation

6.2.4.6   Military instructor

For the purpose of this study, a military instructor is a person commissioned to induct all new military recruits into the military culture through military training. The military instructor was included as a component of the model due to the important role that he/she plays during military acculturation. Figure 6.6 depicts military acculturation as a component of the model.

Figure 6.6: Military instructor

6.2.4.7   Off to boot camp

Off to boot camp represents the process of professional knowledge acquisition. In this study, professional knowledge acquisition denotes the process by which the theory of nursing is taught and learned.

In that it takes place in a military environment, the process of professional knowledge acquisition also emerged as a dominant theme because of (1) the multiple references made to adverse conditions in the course of the study (Section 5.2.2.4.1); (2) the fact that it was regarded as regulated, structured, restrictive (Section 5.2.2.4.2), punitive (Section 5.2.2.4.3) and prejudiced (Section 5.2.2.4.4); and (3) the fact that military

activities had been found to interfere with nursing training (Section 5.2.2.4.5). Figure 6.7 depicts professional knowledge acquisition as a component of the model.

Figure 6.7: Professional knowledge acquisition

6.2.4.8   Nurse educator

A nurse educator is a professional nurse who has undergone a programme of education at an approved education institution and is registered for an additional qualification in nursing education (SANC 1987). The nurse educators referred to in this study were those involved in the four-year Diploma in Nursing Science (General, Community and Psychiatry) and Midwifery as stipulated by Regulation 425 (SANC 1985) at the SAMHS Nursing College. In this study, students referred to nurse educators as *lecturers*.

The findings of the study reveal that nurse educators indisputably have a role to play in students' professional socialisation. Especially during the process of professional knowledge acquisition, nurse educators are an important component of the model, not only because of their role-model function in terms of interaction between them and students, but also their teaching ethos and their many competencies (Section 5.2.2.3). Figure 6.8 depicts the nurse educator as a component of the model.

Figure 6.8: Nurse educator

6.2.4.9   Off to the battlefield

Off to the battlefield represents the process of clinical skills acquisition. For the purpose of this study, clinical skills acquisition refers to the process of placing nursing students in a variety of healthcare facilities in order to expose them to clinical learning opportunities

and to the process of practising the clinical skills required to become proficient professional nurses.

What students generally experienced in the clinical learning environment (Section 5.2.5.1) and particularly in respect of actual learning experiences (Section 5.2.3.2), reflected the critical influence of this process on their professional socialisation. For this reason, clinical skills acquisition was thus included as a component in the model. Figure 6.9 depicts clinical skills acquisition as a component of the model.

Figure 6.9: Clinical skills acquisition

6.2.4.10   Professional nurse

Professional nurses are qualified nurse practitioners and registered in terms of section 16 of the Nursing Act, no. 50 of 1978 (South Africa 1978:s16) in order to practise nursing or midwifery. In this study, professional nurses refer to those nurses working at the selected Military Hospital and at other public health facilities at which students are placed, and who are also jointly, with the nurse educator, responsible for students' acquisition of clinical skills.

In general, professional nurses as professional role models (Section 5.2.3.4) and their attitude in terms of their teaching role (Section 5.2.3.2), led to their inclusion as a component of the model because they undeniably contribute to students' professional socialisation in the clinical learning environment. Figure 6.10 depicts the professional nurse as a component of the model.

Figure 6.10: Professional nurse

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6.2.4.11 Patient

The Merriam-Webster's Learner's Dictionary (2016: sv "patient") defines a patient as "a person who receives medical care or treatment". In this study, a patient denotes any person making use of the military or a public clinical facility at which students are placed for clinical exposure.

The interactions between students and patients, ranging from positive to negative, were found to have affected students' clinical experience (Section 5.2.3.3). For this reason, patients were also identified as role players in students' professional socialisation and included as a component of the model. Figure 6.11 depicts the patient as a component of the model.

Figure 6.11: Patient

6.2.4.12 Peers

A peer is defined as "a person who belongs to the same age group or social group as someone else" (Merriam-Webster's Learner's Dictionary 2016:sv "peer"). In the context of this study, peers refer both to other students of the SAMHS Nursing College and to students from other colleges with whom they work in the civilian clinical learning environment. Peers were included as a component of the model because of their continuous interaction from the onset of their careers, the references made by students to teamwork and support during military training, and also the sharing and constant comparing during clinical skills acquisition. Figure 6.12 depicts peers as a component of the model.

Figure 6.12: Peers

6.2.4.13 Healthcare professional

A healthcare professional is "any person registered in terms of the applicable Act which governs the functioning of any of the Councils that form part of the Forum of Statutory Health Councils" (HPCSA 2008:2). For the purpose of this study, the term denotes doctors and ancillary healthcare professionals registered with the Health Professions Council of South Africa and working in both the military and the public clinical facilities at which students are placed.

Healthcare professionals were included as a component of the model due to the importance of interprofessional collaboration in delivering safe and quality healthcare, the perception that nurses do not enjoy recognition among other members of the multidisciplinary team and the influence of these factors on students' professional socialisation (Section 5.2.3.1.8). Figure 6.13 depicts healthcare professionals as a component of the model.

Figure 6.13: Healthcare professional

6.2.4.14 Fighting a dichotomy

Fighting a dichotomy represents the issue of duality. Duality is defined as "the quality or state of having two parts" (Merriam-Webster's Learner's Dictionary 2016). In this study, it refers to the dual professional roles that military nurse educators and military students

have to assume, namely a professional nurse and a professional soldier. Figure 6.14 depicts Theme 4: *Fighting a dichotomy* as a component of the model.

Figure 6.14: Fighting a dichotomy

Duality can be said to be the core component of the model. Duality accounts for the numerous contradictions and the conflicting messages experienced by students throughout the processes of military acculturation, professional knowledge acquisition and clinical skills acquisition and attributed to most of the identified hidden elements in this study (Section 5.2.4).

Figure 6.15 depicts duality as a component of the model.

Figure 6.15: Duality

6.2.4.15 Elements of the hidden curriculum

The hidden curriculum is "a set of influences that functions at the level of organisational structure and culture". It refers to the unwritten, unofficial, and often unintended lessons, values, perspectives, attitudes and principles that may be implicitly conveyed to students (Hafferty 1998:404). The elements of the hidden curriculum, in the context of this model, refer to all the salient aspects present in the military teaching and learning environment that were identified in the course of this study, that have been summarised as four themes and which could potentially have an influence on the students' professional socialisation.

To make sense of the vast number of hidden elements identified in the study, the researcher divided them into three categories, namely people, processes and places (Section 5.3) that are all represented in the model (Sections 6.2.4.1–6.2.4.13). Figure 6.16 depicts the hidden elements as a component of the model.

Figure 6.16: Elements of the hidden curriculum

6.2.4.16 Influences of the hidden curriculum

Throughout the study, references made by participants to how they had been affected by certain experiences, were regarded as possible influences of the hidden curriculum (Section 5.3). These influences were included as a component of the model because they represented the aspects mainly influenced by the hidden curriculum in the military teaching and learning environment. Figure 6.17 depicts the influences of the hidden curriculum as a component of the model.

Professional development
Academic achievement
Professional dedication
Professional conduct
Communication skills
Personal autonomy
Personal identity

Interaction skills
Self-confidence
Functional skills
Learning skills
Relationships
Clinical skills
Patient care

Self-esteem
Life skills
Morale
Dignity
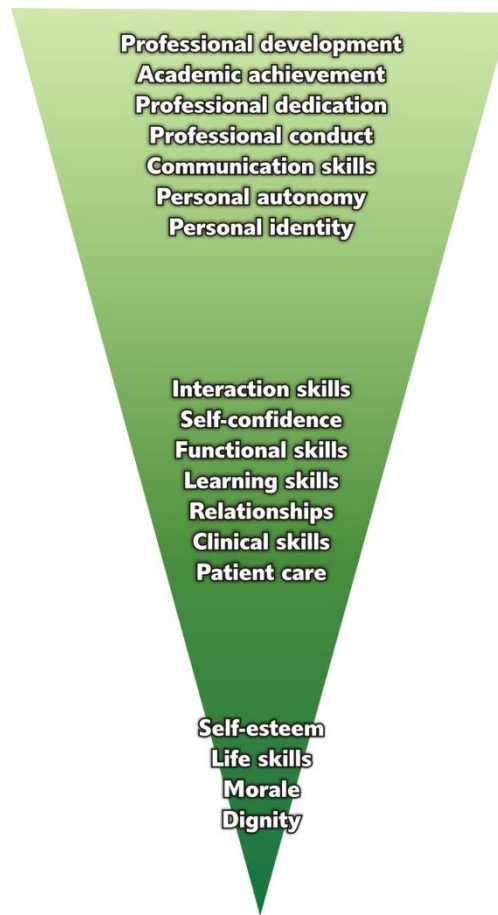
Figure 6.17: Influences of the hidden curriculum

6.2.4.17   Professionally socialised military nurse

The professionally socialised military nurse will be the qualified nurse who has internalised the necessary norms and values, and acquired the requisite attitudes, behaviours, skills and roles to mould a professional identity (Chitty & Black 2011:131). She/he will have done so by moving through the processes of military acculturation, professional knowledge acquisition and clinical skills acquisition without having been impeded by the elements of the hidden curriculum. Figure 6.18 depicts the professionally socialised military nurse as a component of the model.

PROFESSIONALLY SOCIALISED MILITARY NURSE

Figure 6.18: Professionally socialised military nurse

6.2.5 Assumptions of the model

Assumptions are the basic underlying premises from which and within which theoretical reasoning proceeds (Chinn & Kramer 2014:180-181). The theoretical reasoning behind this model was based on the assumptions of symbolic interactionism as embraced by the constructivist grounded theory method used in this study.

Symbolic interactionism is defined as "... a process of interaction that leads to the formation of meanings for individuals" (Blumer 1969:12) and "... a theory which focuses on the manner in which people make sense of social interactions and the interpretations they attach to social symbols such as language" (Blumer 1969:16). Symbolic interactionism thus focuses on the social actions and interactions of humans, their shared symbols and their understanding of one another and it serves as a framework for viewing the social world (Oktay 2012:10-11, Polit & Beck 2014:7).

Meaning of the social world is derived from how people define and interpret what is happening. This perspective implies that interaction, be it with other human beings, objects, symbols or environmental factors, the interpretation of these interactions and the meaning attached to them, determine how people react or respond to them.

In this study, the context of nursing education in a unique military environment was identified as the social world of the participants. Both the interaction of students within this environment and the influence of the hidden elements emanating from the military structure and culture, and how students interpret and make meaning of these elements, resulted in a specific reaction that determined how they were professionally socialised.

The following assumptions were derived from Charmaz's (2014:262-273) interpretation of symbolic interactionism and applied to the key concepts of this model.

The key relationships between symbolic interactionism and the model are diagrammatically represented in Figure 6.19.
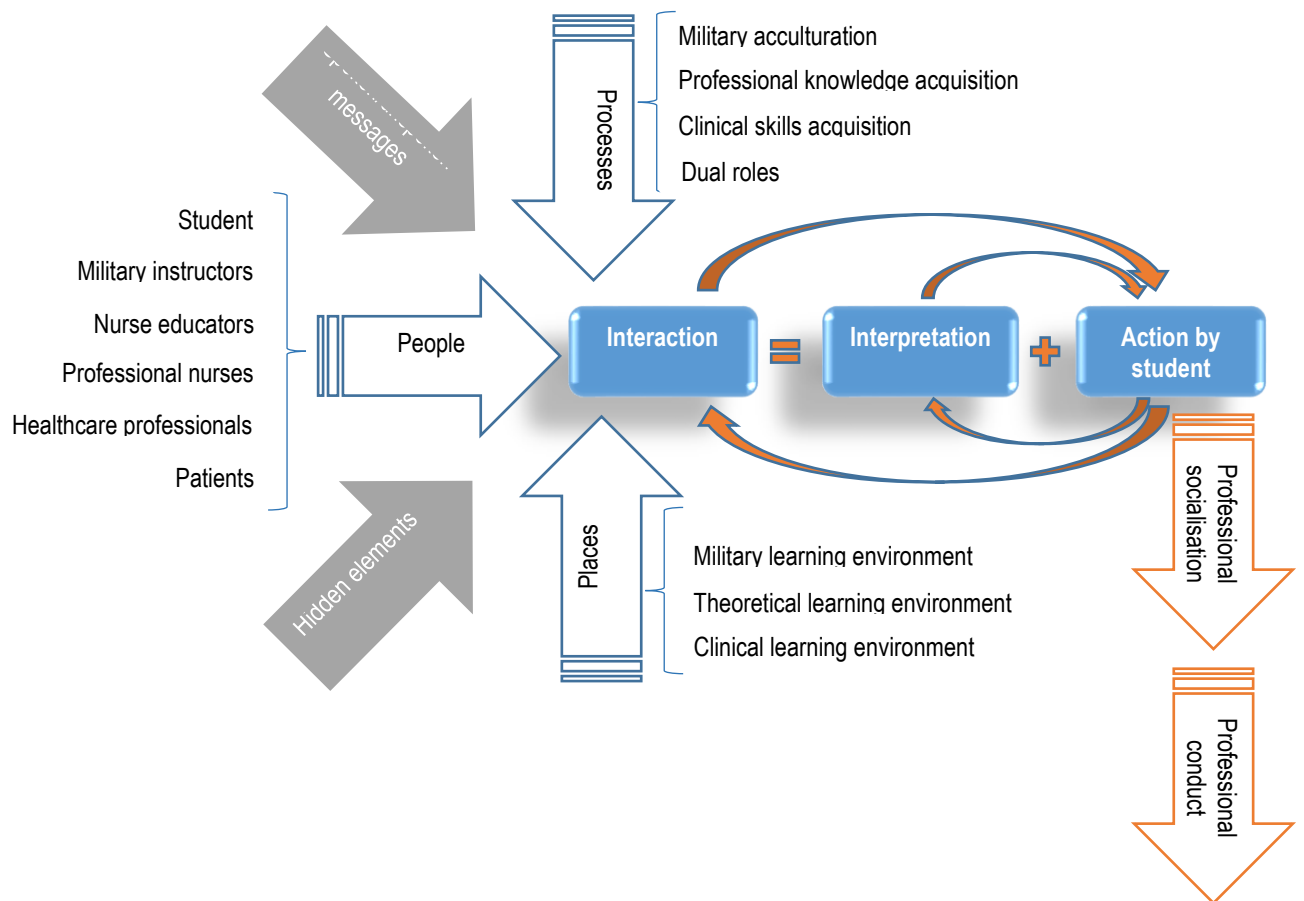
Figure 6.19: Applying symbolic interactionism

6.3 EVALUATION OF THE MODEL

The model was evaluated by expert reviewers with a view to securing expert validation in respect of applicability and usefulness of the model and to determine how well it relates to theory, research and practice. A combination of a framework comprising five reflective questions proposed by Chinn and Kramer (2011:197-205) and the evaluative criteria described by Pearson, Vaughan and Fitzgerald (2005:226-228) were used in developing a tool to evaluate the model. The evaluation tool was in the format of a four-point Likert scale that included the following criteria: acceptable, acceptable with minimum changes, not acceptable and not applicable. The reviewers were also provided with an option for comments. The expert reviewer package is available in Annexure J.

Table 6.1 provides a biographical profile of the expert reviewers.

TABLE 6.1: BIOGRAPHICAL PROFILE OF THE EXPERT REVIEWERS

Reviewer	Area of employment	Specific area of expertise	Years' experience in field of expertise	Highest academic qualification
Reviewer 1	SAMHS	Industrial psychology and training	26	DPhil Leadership in Performance and Change
Reviewer 2	University	Education	20+	PhD
Reviewer 3	DOD	Research design and development of education, training and development	35	DEd
Reviewer 4	SAMHS	Strategy, demography, epidemiology, scenarios, organisational development	26	MPhil Futures Studies
Reviewer 5	Private sector	Nursing education and management	15	PhD
Reviewer 6	University	Higher education student counselling, educational psychology	43	DPhil Psychology
Reviewer 7	SANDF Military Operations	Strategic posture of SANDF military operations	35	MA Clinical Psychology
Reviewer 8	SAMHS	Health management, epidemiology and prevention	36	MChD Community Dentistry
Reviewer 9	University	Nursing education and quality assurance	34	DCur
Reviewer 10	University	Research and public health	40	DLitt et Phil
Reviewer 11	Independant	Research Nursing Education	32	DEd

Where deemed applicable, feedback and suggestions received from the expert reviewers have been considered and incorporated into the final model. Some of the feedback has been included in the discussions that follow.

6.3.1. Clarity of the model

Clarity simply refers to whether or not the model is easy to understand (Pearson et al. 2005:226). Semantic clarity implies that the meanings of concepts contained in the model are clear and understandable. Concepts should be relatable to common meanings and defined in a short and simple manner (Chinn & Kramer 2011:198-199). In order to ensure semantic clarity, the researcher described the concepts by making use of subject literature and commonly accepted operational definitions and terms that make sense. Structural clarity refers to how understandable the connections and the reasoning within the model are, in other words, that the diagram is well presented and clear to follow. The researcher aimed to maintain structural clarity by making use of simple structures to represent concepts, by making use of a variety of colours to

distinguish between the different concepts and by making use of arrows to direct the logical flow of the diagram.

With regard to semantic clarity, the evaluation revealed the model to be easy to understand and to make sense. The description and visualisation were considered to be good. It was also indicated that the meanings of concepts contained in the model were clear and understandable. It was further reported that the relationships between main concepts of the model were clearly described. It was however observed that the model consisted of a large number of concepts and that the hidden curriculum and the effects thereof were not clearly reflected. These comments posed a challenge in terms of limiting the number of concepts while nevertheless including the elements of the hidden curriculum and its influences. Instead of simply symbolically depicting the hidden elements by means of the dashed concentric circles in the explanation of the adapted version of the model, the hidden curriculum was rather referred to in terms of the deduced categories, namely people, processes and places.

6.3.2 Consistency of the model

Consistency refers to whether words and concepts were used in the same way throughout the model description (Pearson et al. 2005:226). Semantic consistency means that concepts are used consistently with their definitions. Structural consistency implies that the concepts fit within the model and that a relationship exists between the diagrammatic representation and the written description of the model. The researcher consistently transferred the concepts to the model as they emerged from the data analysis. The definitions of the concepts in this model are consistent with common meanings in both the nursing and the military environment.

The reviewers found the model to be well presented and clear to follow, that the choice of colours was good and well explained, but commented on the fact that the themes were not well presented in the model. All of the four themes were subsequently incorporated into the final model. It was also noted that the model incorrectly indicates a unidirectional flow. In the original model, green arrows were used to show that the processes of military acculturation, professional knowledge acquisition and clinical skills acquisition takes place in a non-linear fashion. In the adapted final model this was also indicated by the use of arrows between the various processes. The direction of training

however remains unidirectional since the student must exit the training environment at some stage, whether through completion or termination of the course.

6.3.3 Simplicity of the model

According to Chinn and Kramer (2011:201-202), a model meets the criterion of simplicity if there are not too many theoretical relationships between or among many complex structural components. In this model, the relationships between the concepts were organised into a logical, easily understandable sequence of events. Simplicity was once more ensured by making use of simple structures.

The reviewers found the relationships between the concepts to have been organised into a logical sequence and that the simplicity made it practical without however oversimplifying the model.

6.3.4 Generalisability of the model

Chinn and Kramer (2011:202) emphasise that a model should be both broad and wide in scope and thus applicable to an array of situations and contexts. Pearson et al. (2005:226) refer to these criteria as the adequacy of the model. The origin of this model is the experiences of nurse educators and students in a military teaching and learning environment and the model itself is thus intended to guide nurse educators towards recognising the hidden curriculum in this unique military context. The purpose of this model was not to address a general phenomenon but the concept of the hidden curriculum in a specific setting. There are however many generic components in this model that can be applied to other healthcare professionals and to other contexts, be it military or civilian.

The reviewers agreed that the model was broad and wide in scope but not so broad as to become vague. Some of the reviewers indicated that they could identify with the model and its relevance to and necessity for SAMHS and for the broader SANDF. It was also indicated that the generic components of the model would be applicable to other healthcare professionals and to other contexts, both military and civilian. They however observed that the organisational culture of that particular profession would be a critical factor. Though it is not denied that some of the feedback alluded to the additional

influence of the students' homes and communities on their socialisation, this however falls beyond the specific context of the present study.

6.3.5 Accessibility of the model

Accessibility refers to the extent to which each of the concepts can be empirically identified and how attainable the projected outcomes of the model are after it has been operationalised (Chinn & Kramer 2011:203-204). Although not quantitatively measurable, the concepts of this model were clearly described. It was called in question whether the purpose of this model would be achieved after implementation. The researcher subsequently adapted the guidelines for implementing the model to be both clearer and indeed implementable.

6.3.6 Importance of the model

Chinn and Kramer (2011:204) maintain that an important model is usable in practice, education and research, and valuable in terms of creating a desired future. This model provides nurse educators with a framework for identifying the hidden curriculum in a military teaching and learning environment. Being in a position to do so will result in the positive professional socialisation of students, which, in turn, will enhance patient care and professional practice. The fact that the model will also be applicable to settings other than nursing education and the military environment increases its level of importance.

The reviewers considered the model to be usable in practice, in education and in research, and that it definitely gave and understanding of the context in which military nurses are required to function.

6.4 DESCRIPTION OF THE MODEL ON THE INFLUENCES OF THE HIDDEN CURRICULUM IN THE MILITARY TEACHING AND LEARNING ENVIRONMENT DURING STUDENTS' PROFESSIONAL SOCIALISATION

Figure 6.20 is a diagrammatic representation of the revised model subsequent to consideration of the expert reviewers' input.
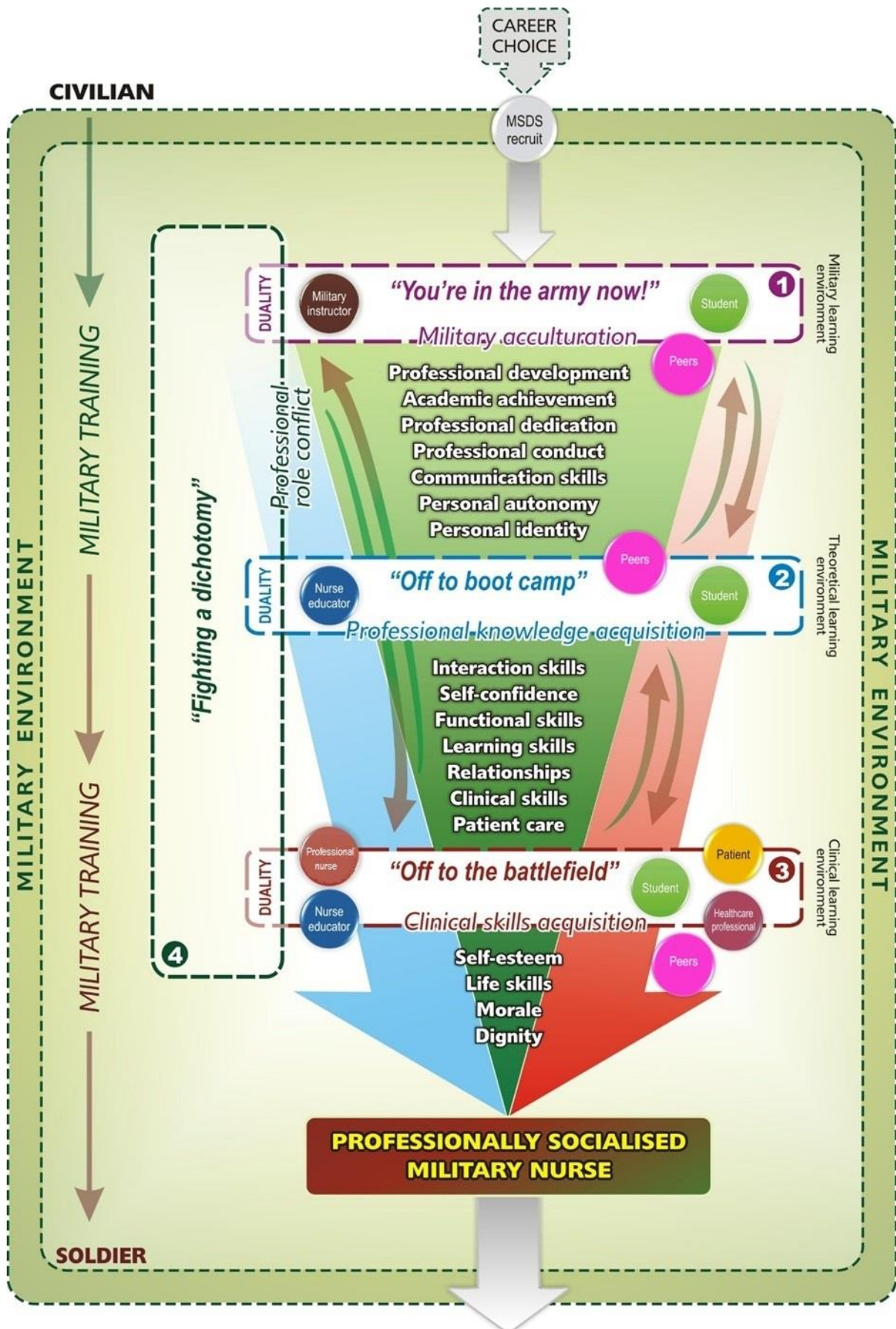
Figure 6.20: Substantive model on the influences of the hidden curriculum in the military teaching and learning environment during students' professional socialisation

6.4.1 Context of the model

The context describes the circumstances or situations in which the theoretical relationships of the model are expected to be empirically relevant and important in terms of implementing the model (Chinn & Kramer 2014:181-182). The context of this model is the SAMHS Nursing College and the respective theoretical and clinical learning environments in which nurse educators, students, professional nurses, patients and other healthcare professionals daily interact with one another. Although the students are also exposed to civilian clinical learning environments, the main context is military specific.

The use of the model is not restricted to the context in which the study was conducted. The model is applicable to all uniformed healthcare professionals within the South African Military Health Service and not only to nurses. It is further applicable to uniformed healthcare professionals in defence forces globally. There are generic elements of the hidden curriculum that could also be applicable to civilian healthcare professionals and non-healthcare professionals alike. This model is thus transferrable to a wide range of contexts.

6.4.2 Structural description of the model

The model consists of the main categories identified during inductive reasoning to identify and categorise the hidden elements in the military teaching and learning environment, namely people, processes and places. The people in the model are represented by circles and include the student, the military instructor, the nurse educator, the professional nurse, the patient and other healthcare professionals. The processes include making a career choice, military acculturation, professional knowledge acquisition, clinical knowledge acquisition and duality. The places are the military environment, the military learning environment, the theoretical learning environment and the clinical learning environment. Each of the role players (people) happens to be situated either in the process or in the place in which they play the most prominent roles.

The colours or the shapes of components of the model are referred to only when these are considered to be significant.

The starting point of the model is the boxed arrow at the top of the diagram. The shape of the arrow has dual symbolism. It firstly symbolises the process of decision making in terms of a career, and secondly it symbolises the direction in which that choice will take the student. The choice made by the SAMHS Nursing College students brought them from the civilian world into the military environment. The grey colour of the boxed arrow indicates that this choice is neither black nor white, reflecting the contradicting preconceptions and uncertainty that students experience when they are called on to make a choice of this nature.

The outer box represents the military environment. It is characterised by the colours of the field wear or camouflage uniform worn by members of the SANDF. The box is enclosed, symbolising both the unique culture of the organisation and the exclusive nature of the military. The square shape of the box is indicative of the structured nature and the rigidity of the military.

The military teaching and learning environment is situated within the military environment and also represented by the light camouflage colours. The military teaching and learning environment includes the military learning environment, the theoretical learning environment and the clinical learning environment.

The moment the civilian enters the military environment, he or she becomes a military recruit – indicated by the white circle. The fact that the circle is white symbolises that the recruit is still pure, that is, unaffected by the hidden elements. The arrow extending downwards from the white circle points to the process of military acculturation. This process refers not only to military training but also to the process of military professionalisation throughout the student's nursing training within the military teaching and learning environment.

The military instructor (brown circle) is the first person whom the recruit encounters during military training. The military instructor plays a part in the recruit's military acculturation, in the process of adopting the military culture and the process of acquiring a professional military identity. Although the military instructor continues to be a presence throughout the students' training, the main focus of her/his role and impact is on basic military training and officer's formative training.

The large downward-pointing arrow represents the entire process of professional socialisation and how the recruit is shaped from a novice student into a professional nurse by the processes of military acculturation, professional knowledge acquisition and clinical skills acquisition. The green inner part of the arrow symbolises the personal and professional growth that occurs.

The four themes that emerged from the data and that represent the experiences of the nurse educators and students form part of the arrow since these experiences have a vital part to play in the professional socialisation process.

The orange-green arrows connecting the themes are an indication that these processes occur simultaneously and that they influence one another. Sections of Theme 4 overlap with themes 1, 2 and 3 to signify that professional role conflict or duality is experienced by students throughout the three processes.

The blue and red sections on the outer parts of the arrows symbolise the elements of the hidden curriculum. They are evident during military acculturation, professional knowledge acquisition and clinical skills acquisition. The blue section signifies the elements that were identified as having a positive contributory influence, while the red section signifies the elements identified as having an impeding influence on professional socialisation. The contributory and impeding influences were identified during data analysis and presented as part of the findings in chapters 3 and 4. This was done by means of mind maps with, respectively, blue and red flags.

The concepts in the middle of the arrow are the main aspects identified in this study as being influenced by the hidden curriculum in the military teaching and learning environment. They were placed neutrally since they could either be enhanced or impeded.

The last component of the model, which is also the optimal outcome of all the processes, is the formation of a professionally socialised military nurse. The ruby colour of the box is representative of both military health services globally and the ruby distinguishing devices worn by a professional nurse in the South African context.

The arrow that pierces and then extends beyond the boundary of the military environment indicates that the professional nurse may leave the Defence Force to practise in another healthcare environment.

Except for the cyclical processes of military acculturation, professional knowledge acquisition and clinical skills acquisition, the model has been designed as unidirectional from the time the recruit enters the Defence Force until the newly qualified military nurse exits from the military teaching and learning environment or the Defence Force. The unidirectionality indicates that the student will, at some stage, exit from the military teaching and learning environment, whether through completion or termination of studies.

6.4.3 Relationship statements

Relationship statements are used to describe the nature of the interactions between two or more concepts of the model (Chinn & Kramer 2014:182; Walker & Avant 2011:183). The relationships already started forming as the concepts emerged during data analysis. Relationships between concepts are usually directional, implying that one concept precedes another or that one or more concepts give rise to another.

In order to become a professionally socialised military nurse, the student must make a double career choice, namely to become a soldier and a nurse. The student then enters the Defence Force and thus the military environment through the MSD System.

Within the military teaching and learning environment, the student receives military training that will lead to military acculturation. The military instructor is responsible for socialising the student into the military culture.

Subsequent to military acculturation, the student commences with nursing training. The nurse educator, while being primarily responsible for professional knowledge acquisition in the theoretical learning environment, however continues to instil military culture into the student.

The student is simultaneously exposed to the acquisition of clinical skills. Although the nurse educator and the professional nurse are the main role players during this process,

other healthcare professionals and the patients also influence the student's experiences.

The processes of military acculturation, professional knowledge acquisition and clinical skills acquisition are cyclical and overlapping. The student experiences contradictions due to simultaneously having to play two professional roles, namely that of a nurse and that of a soldier, which results in the concept of duality to be evident throughout all of the three processes. There are elements of the hidden curriculum present during the processes of military acculturation, professional knowledge acquisition and clinical skills acquisition and all the role players moreover send implicit messages to the student that form part of the hidden curriculum.

The elements of the hidden curriculum can either contribute to or impede the student's professional socialisation.

6.5   IMPLEMENTATION OF THE MODEL

To achieve the purpose of the model, it needs to be implemented in practice. The implementation of any new idea or approach is synonymous with change. According to The Institute for Health Improvement (2016), all changes lead to improvement, all improvement requires change. Initially the researcher planned to use Kotter's (2012) 8-step process for leading change to guide the implementation of the newly developed model. However, after reconsideration and discussion with the supervisor of the study the researcher adopted the Deming Cycle – also known as the Plan-Do-Check-Act (PDCA) Cycle (The Deming Institute 2016) – as implementation guide for this model. This change was made to ensure a cyclic process of implementation rather than a linear process.

Any suggestion of implementing change is however often met with resistance, which prevents lasting transformation of practice (Kotter 2012). To counteract this, the steps outlined in the Deming Cycle could support transformation through an organised and methodical process of behavioural change. By embracing this approach, role players should develop an understanding of lasting modifications to their behaviour, and change their mental and emotional perspective on how they are used to working and gain a new perspective.

Implementing this cycle requires a systematic and holistic approach that focuses on creating an awareness of the existence of a hidden curriculum, guiding role players through the impact of the hidden curriculum on students' professional socialisation and helping them understand how their contribution could improve the outcome of the professional socialisation process.

The Deming Institute (2016) describes the PDCA Cycle as a systematic series of steps for gaining valuable knowledge for the continual improvement of a product or process. When applied to this model, it thus refers to the improvement of the professional socialisation process of students by optimising the contributory influences of the hidden curriculum and minimising the impeding factors identified in this study (Section 5.3).

The framework of the cycle includes three key questions and a process for testing change ideas.
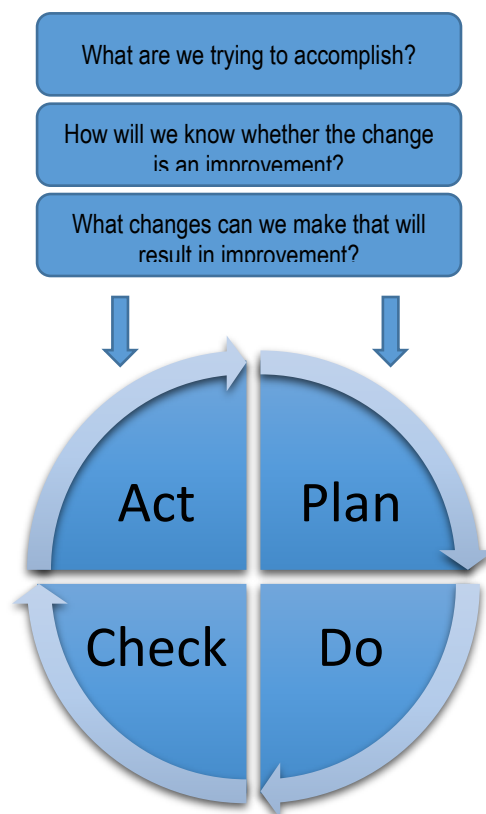
Figure 6.21: The Deming Cycle

(The Deming Institute 2016)

What are we trying to accomplish?

With a view to determining the goal of the improvement or change process, all role players should firstly be identified and secondly be made aware of the existence of the hidden elements and how they could influence the outcome of the professional socialisation process. Role players should further be made aware of the changes they could make either in terms of optimising the contributory factors or of minimising the impeding factors as discussed in Section 5.3.

How will we know whether the change is an improvement?

Implementing the model should, over time, demonstrate whether the implemented changes have led to sustainable improvement relating to the elements of the hidden curriculum and their subsequent influence on students nurses' professional socialisation. Follow-up interviews or focus groups with students and nurse educators could be used to determine the outcomes of the change process.

What changes can we make that will result in improvement?

This question leads to the first step of the cycle

- Step 1: Plan

The first step requires that leadership and management buy into and support the proposed change (in this case, the implementation of the model). This implies that the leadership of the SAMHS Nursing College and military clinical facilities be made aware of the existence of the hidden curriculum and how it influences students' professional socialisation. This could be done by means of workshops or presentations at which the findings of this study are disseminated and the model explained.

Task teams could be formed to actively lead the change process. This strategy requires the expertise, influence and buy-in of a few people to convince others that certain changes are necessary. One could start by identifying a few key role players from both the Nursing College and the military clinical facilities to agree on a number of strategies to enhance or limit the impact of the identified elements.

- Step 2: Do

Through engagement and constant communication with other nurse educators and healthcare professionals, the task team could better educate other role players regarding the hidden curriculum and how it influences students' professional socialisation. The students themselves could be engaged at this stage so that they are also made aware of the existence of the hidden curriculum and its influence on their own professional socialisation.

- Step 3: Check

Once the first two steps have been implemented, the effectiveness of the implementation process could then be assessed. Follow-up interviews with students and nurse educators could be used to determine whether a positive change is evident or not. The task team could also meet to address concerns and remove obstacles to help move the change process forward.

Step 3 could also entail that positive change and successes are communicated and celebrated while momentum and motivation are maintained.

Early successes are the beginning of successful, sustainable change. The identified achievements offer the opportunity either to build on what succeeded or improve on what did not succeed altogether.

- Step 4: Act

The last step, acting, implies that the changes become part of the organisational culture and vision and moreover that leadership continues to support the change. To ensure that new behaviours are repeated in the long term, it is important that the connections between these behaviours and the successes be both defined and communicated. This last step thus entails that those actions and strategies that have a positive influence on students' professional socialisation be continuously reinforced and communicated.

These four steps are repeated as part of a never-ending cycle of continuous improvement and lasting change.

6.6   SUMMARY

This chapter mainly focused on the development of the substantive model that was developed by applying the theory-generating process characteristic of the grounded theory method by connecting the various components that evolved from the study. The substantive model was based on the assumptions of symbolic interactionism and the theoretical underpinnings of constructivist grounded theory. In order to ensure validity and trustworthiness, the tentative model was subjected to an evaluation process by presenting it to various experts. The valuable feedback – based on the combined evaluation criteria of Chinn and Kramer (2011:197-205) and those of Pearson et al. (2005:226-228) – was then incorporated into the revised model. The chapter concluded with a description of the model that comprised the context, structure and relationship statements with a view to providing clarity and enhance understanding. Guidelines for implementing the model – based on Deming's PDCA Cycle – were provided.

Chapter 7 is devoted to a discussion of the conclusions and limitations of the study, and it offers recommendations in respect of nursing education in general, military nursing education, nursing practice and further research.

CHAPTER 7

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

7.1   INTRODUCTION

This chapter concludes the study by providing a brief overview of the methodology, the conclusions based on the main findings, the limitations of the study and the recommendations for nursing education in general, military nursing education, nursing practice and for further research.

7.2   PURPOSE OF THE STUDY

The overall purpose of this study was to explore the nature of the hidden curriculum in a military teaching and learning environment and to determine its significance and influence on students' professional socialisation. Concepts derived from the qualitative data were used to develop a substantive model to create an awareness of the existence of a hidden curriculum, to guide role players through the impact of the hidden curriculum on students' professional socialisation and to help them to understand how their contribution could improve the outcome of the professional socialisation process.

7.3   RESEARCH DESIGN AND METHODS

Based on the general premises of the constructivist paradigm – which best suited the researcher's philosophical assumptions – a qualitative, constructivist grounded theory method was used to answer the research question, *What is the nature and significance of the hidden curriculum in a military teaching and learning environment and how does it influence the professional socialisation of students?*

Three research objectives were formulated to achieve the purpose of the study:

- To establish the existing knowledge, attitudes and perceptions of nurse educators and students with regard to military and nursing professionalism

- To explore and describe the nature and significance of the hidden curriculum in a military teaching and learning environment and its influence on students' professional socialisation

- To develop a substantive model to provide nurse educators and professional nurses with a frame of reference that would create an awareness of the existence of a hidden curriculum, to guide them through the impact of the hidden curriculum on students' professional socialisation and to help them to understand how their contribution could improve the outcome of the professional socialisation process of students

The study evolved in three phases:

Phase 1 addressed the first two objectives of the study simultaneously. During Phase 1, non-probability sampling was used to select the participants. Data were collected from a purposive sample consisting of 15 nurse educators (Sample A) and a volunteer sample of 12 students (Sample B).

The researcher used focus-group interviews to collect data from Samples A and B. Critical-incident narratives provided further data from Sample B. By applying constant comparative analysis, data saturation was reached after the researcher had conducted four focus-group interviews, two with each sample. The critical-incident narratives were analysed after the focus-group interviews had been conducted but confirmed what had already been found during the focus-group interviews. In keeping with the constructivist paradigm adopted for this study, Charmaz's (2014) data-analysis approach was followed, which included open coding, focused coding, theoretical sorting, diagramming, theoretical integration and theoretical coding. The researcher further used theoretical sensitivity, intuiting, memoing, reflexivity, constant comparison and theoretical sampling to ensure data quality. After data analysis, Sample A yielded four themes and nine categories and Sample B, four themes and 12 categories. The hidden elements and their influence were identified and reflected in mind maps in Chapters 3 and 4.

The objective of Phase 2 was to integrate the findings of Samples A and B obtained during Phase 1. From the integration of the data, four themes and 17 categories emerged. A summary of the four themes with their categories and subcategories was presented in Table 5.1 in Chapter 5. During the integration of the findings and an

extensive literature control, the large number of hidden elements in the military teaching and learning environment – and how these might influence students' professional socialisation – were extrapolated by means of further inductive reasoning, to more collective and descriptive categories. These were reflected in Table 5.9 in Chapter 5.

Phase 3 of the study set out to address the third objective of the study, namely to develop a substantive model.

As alluded to in Chapters 2 and 6, grounded theory research usually results in the generation of a theory that explains the phenomenon from the perspective and in the context of those who experience it (Birks & Mills 2011:16). The method also entails the identification of theoretical connections among concepts with the aim of developing a theory that is grounded in the data and relevant to the substantive area (Streubert & Carpenter 2011:128). Charmaz (2014:228) however acknowledges that the term *theory* is ambiguous and Walker and Avant (2014:147) use the terms *theory* and *theoretical model* interchangeably. Walker and Avant (2014:147) further maintain that when the relationships within and among concepts and statements derived from the data are diagrammatically depicted, this diagram constitutes a model of the phenomenon. The inductive approach used in grounded theory facilitated the researcher's decision to develop a substantive model as the outcome of this study.

Symbolic interactionism served as a broad framework during this study, especially from the viewpoint of exploring students' interactions and behaviours in a unique military teaching and learning environment. The major constructs of symbolic interactionism as proposed by Charmaz (2014:262), namely interaction, interpretation, meaning and reaction were considered during the development of the model (Sections 2.5.3 and 6.2.5). The researcher's reflections on the influence of the hidden curriculum on students' professional socialisation in a military teaching and learning environment were grounded in symbolic interactionism. According to this theoretical perspective, meaning of the social world is derived from how people define and interpret what is happening. This perspective implies that interaction (be it with other human beings, objects, symbols or environmental factors), the interpretation of these interactions and the meaning attached to them, determine how people will react or respond to them (Charmaz 2014:262-273). One can thus conclude that the social world of the participants constituted the context of nursing education in a unique military

environment. How students were professionally socialised resulted not only from their interactions within this environment but also from the influence of the hidden elements emanating from the military structure and culture, and from how students ultimately interpreted and made meaning of these.

7.4 CONCLUSIONS OF THE STUDY

The conclusions are discussed according to the phases of the study.

7.4.1 Phase 1

Phase 1 explored the existing knowledge, attitudes and perceptions of nurse educators and students with regard to military and nursing professionalism and the nature and significance of the hidden curriculum in a military teaching and learning environment. It moreover sought to determine the influence of the hidden curriculum on students' professional socialisation by means of focus-group interviews and critical-incident narratives. The findings of Phase 1 were discussed in Chapter 3 (nurse educators) and Chapter 4 (students).

By sharing their stories, the nurse educators and students were not simply relating their experiences. They divulged many hidden messages throughout the course of data collection. These were captured during the data-analysis process of the study. Although the objectives of the study were aimed at determining specifically how the hidden curriculum in a military teaching and learning environment influences students' professional socialisation, it was concluded that the valuable data that came from the nurse educators tended to include reflections on their own experiences rather than only their experiences with students. Analysis of the critical-incident narratives led the researcher to conclude that students are not generally well developed in terms of reflective practices. In relating an incident, students merely gave the facts in terms of time, place and person but were however unable to interpret the experience, to relate how the incident had affected them or to describe how they had felt about what had happened.

7.4.2 Phase 2

After further theoretical sorting and coding, the integrated findings of Phase 1 led to the formulation of four themes during Phase 2, as discussed in Chapter 5, namely:

Theme 1: You're in the army now!

Theme 1, *You're in the army now,* refers to the process of military acculturation during which the student undergoes a transition from civilian life to military life and being introduced to military culture. This theme highlights the influence that choosing the military as career, military training, military professional socialisation and the military environment has on students' professional socialisation.

Theme 2: Off to boot camp

This theme points to the processes taking place in the theoretical learning environment, whereby students are taught the knowledge and skills that enable them to execute their roles as nurses. This theme highlights the following as influences on professional socialisation: reasons for choosing nursing as a career; the fact of the presence of multiple generations and the resultant generation gap between nurse educators and students; the role played by nurse educators, specifically their role-model function; their interaction with students; their teaching ethos and their abuse of power and authority; and, finally, the military teaching and learning environment.

Theme 3: Off to the battle field

This theme is symbolic of the clinical learning environment in which students are placed to apply the knowledge and skills they have acquired in the theoretical learning environment. Here professional socialisation was found to have been influenced by the distinction between the military clinical learning environment and the civilian clinical learning environment, by learning experiences, by the attitudes of patients and by role models in the military clinical learning environment.

Theme 4: Fighting a dichotomy

Theme 4 focuses on the professional role conflict experienced by nurse educators and students alike. Being a military nurse leads to professional incongruity between having to be a nurse and a soldier simultaneously, which is experienced as being conflicting and confusing. This theme highlights the influence of duality on command and control, and the need for both nurse educators and students to be adequately prepared to deal with their dual roles. It can be concluded that duality represents the most important hidden element in that it is present throughout the entire process of professional socialisation, from the moment the student commences military training and will be present for as long as the professional military nurse practices within a military environment.

Conclusions arrived at regarding the elements of the hidden curriculum present in a military teaching and learning environment and their influence on students' professional socialisation were based on the process of extrapolation described in Section 5.3 of Chapter 5. The hidden curriculum was found to be present in the people, the processes and the places to which the students are exposed in the course of their training. Most of the elements could be related to a consequence, which could, in turn, influence professional socialisation. This was specifically highlighted by means of the mind maps in Chapters 3 and 4. An important conclusion in this regard, is that although nurse educators and students alike tended rather to focus on their negative experiences, the hidden curriculum does not always exert a negative influence. To end this section, the researcher reflects on how the hidden curriculum is taught and also what the hidden curriculum has taught students.

- People

People who significantly influence students' professional socialisation are the military instructors, the nurse educators, the professional nurses, patients, peers and other healthcare professionals.

The **military instructors** play a role during military training. The demeaning and offensive tone of the communication style used by the military instructors during military training and that serves the purpose of training soldiers to take appropriate action when

experiencing stress or fear, is unprofessional when applied in the nursing environment. The habit is however transferred to nurse educators who transfer it to students who then adopt an inappropriate communication style as the norm.

The main conclusions regarding the **nurse educators**, relate to them as role models, the nature of their interaction with students, their teaching ethos and the abuse of power and authority. Students are very critical about the conduct of nurse educators and are not hesitant to express their dissatisfaction with how nurse educators are fulfilling their roles. Nurse educators are generally considered to be poor role models and students imitate their inappropriate professional behaviour. Nurse educators' generally negative approach in dealing with students is, among others, reflected in the inappropriately negative communication style they use, their indifference, their judgemental attitude, their indiscriminate use of rank, and the fact that they tyrannise students. They moreover treat students unjustly and with a condescension that borders on incivility. Nurse educators often neglect to maintain ethical teaching standards by, for example, not always being fair and honest, not valuing confidentiality in educator-student relationships, not treating students equally and by failing to demonstrate respect for students. Such behaviour seems to stem from the power differential between nurse educators and students, a situation referred to as rankism, and one that is not unique to the military. The abuse of rank and authority by nurse educators is however demeaning and it disempowers students, which results in feelings of inferiority and not being respected. These behaviours and attitudes of nurse educators definitely send implicit messages to students that they are not important and that nurse educators do not care about them. These behaviours and attitudes also affect students' professional socialisation. They give rise to diminished confidence, interfere with learning and discourage academic inquiry, and ultimately engender a sense of powerlessness, feelings of dehumanisation, distress and desperation. Nurse educators' negative attitudes towards students likewise negatively affect the students' experiences in the clinical teaching and learning environment.

The role of the **professional nurse** in students' professional socialisation is beyond measure. Unfortunately, professional nurses do not seem to realise the impact they have on students. The negative fashion in which students are generally treated by professional nurses influences the students' attitude towards these nurses. Students are told that they are stupid and when they are disrespectfully addressed in front of patients,

they rather withdraw from the ward, which has a negative effect on learning. Professional nurses leave students largely unsupervised, with little guidance, which leads to incompetence, frustration and loss of interest in the nursing profession. Students often leave a ward without having learnt anything. Professional nurses also demonstrate a generally negative inclination towards teaching. Not only do they show no interest in students, but they also fail to demonstrate a caring attitude towards students. Professional nurses are mostly 'too busy' to answer students' questions and, instead of correcting their mistakes, they shout at them. There are however some professional nurses who are more favourably disposed towards teaching, who are more patient with students, who are more approachable and who give them more freedom to use their own initiative. Professional nurses have been found to be poor role models. They do not assist students with patient care, they display favouritism, their appearance is untidy, they administer poor patient care, and their treatment of and communication with patients is unacceptable. The overall experience of students in the clinical learning environment ultimately prevents them from realising their full potential as nurses; it leaves them unmotivated, unconfident, unassertive and, ultimately, with little knowledge or few skills. Modelling their behaviour in the nurse-patient relationship on that of the professional nurses could have an extremely negative result in that students would distance themselves from patients and so lose a key professional skill, namely empathy.

Positive experiences involving **patients** who demonstrate trust and gratitude make students feel respected, appreciated and trusted. It also leads to their being more motivated and committed. When patients however refuse to be treated by students, make unreasonable demands, expect preferential treatment and fail to express any appreciation, students find it difficult to deal with the situation. In the military clinical facilities, rank also has an important part to play in respect of how students are approached by patients. These negative experiences have a considerable effect on students' professional socialisation. They are denied learning opportunities, are scared to enter patients' rooms and their confidence is affected.

Peers are valuable sources of support who contribute to one another's learning. Students not only rely on one another during military training – during which teamwork and camaraderie are essential for survival – but also during the process of clinical skills acquisition in the course of which they share their experiences with one another. The

differences between the military and civilian students, too, do not prevent them from sharing experiences and learning from one another.

Other healthcare professionals mostly make students feel inferior because they do not acknowledge students to be part of the multidisciplinary team. Yet, some doctors do contribute to the students' training by respecting their opinions and by discussing patients with them. Students' relationship dynamics with other healthcare professionals influence both their identity as nurses and their attitudes and behaviours.

Thus, as regards the hidden curriculum conveyed by people, it can be concluded that students fail to be taught the value of humaneness and healthy relationships, which renders communication, empathy and patient-centeredness virtually impossible.

- Processes

The processes that proved to influence students are those of making a career choice, military acculturation, professional knowledge acquisition, clinical skills acquisition and fulfilling dual roles.

The respective motives for **choosing the military and nursing as a career** are implicit factors that could potentially influence professional socialisation. Examples are a lack of other/better opportunities; a lack of finances to pursue tertiary studies at another institution; a lack of prior knowledge or specific preconceived ideas about the military and nursing; and career prospects. While students who choose either career for the wrong reasons or who have erroneous preconceptions are not motivated to learn, those who have identified potentially positive career prospects are motivated to do so. Very few students see nursing as a calling, which ultimately affects their commitment, professionalism and professional socialisation.

Military acculturation, which includes military training, military socialisation and developing a military professional identity, on the one hand provides students with valuable experiences and skills such as group cohesion and teamwork, self-motivation, obedience, respect, personal grooming, endurance, confidence, independence and self-reliance, resilience, determination, patience and discipline. These skills could positively contribute to the development of many functional attributes that a professionally

socialised nurse is expected to have. On the other hand, military indoctrination, as a strategy of military training to induce duty, loyalty, integrity, courage, discipline and solidarity, could lead to cognitive and behavioural conditioning. Cognitive and behavioural conditioning could, in turn, adversely affect students' critical-thinking skills, decision-making skills, ability to think independently, and their creative and innovative ability. Other adverse effects of military indoctrination include depersonalisation, dehumanisation and de-emotionalisation, and a resultant loss of identity and individuality. Military socialisation and internalisation of military culture contribute to students' disciplined behaviour, which distinguishes them from their civilian counterparts. Military socialisation also contributes to characteristics like commitment, appreciation, passion, pride, love, while a sense of belonging and feelings of camaraderie are further experienced.

The lack of exposure to a variety of clinical learning opportunities, which is attributable to the smaller patient population and low bed-occupancy rates at military clinical facilities influences students' **clinical skills acquisition.** This influences learning. The fact that students are allocated outside their scope of learning or not according to their learning objectives also influences clinical knowledge acquisition in that opportunities to learn and practise clinical skills are lost.

As regards **duality**, nurse educators and students are not sufficiently prepared to deal with simultaneously being a nurse and a soldier. They experience conflict in terms of the many contradictions related to governance, leadership style, military command and functional control, military rank and professional rank, disciplining and caring, disciplining and teaching, patients' ranks versus their needs, and being emotionally undemonstrative as a soldier but empathetic as a nurse. The military tends to treat people as objects instead of human beings and authority has the tendency to instil fear, rather than respect. Military expectations often take precedence over professional expectations and the rights of soldiers take precedence over the rights of nurses and patients. Students find themselves confronted with military orders or instructions from higher-ranking officers, which may be in contravention of the patient's right to privacy and confidentially. Although these contradictions are addressed by the ethical guidelines in accordance with which each professional is expected to practise, the broader military community still tends to emphasise that military healthcare professionals are soldiers first, which adds to the confusion.

- Places

The places or environments found to play a part in the professional socialisation process include the military environment, the theoretical learning environment and the clinical learning environment.

Resulting from the stringent rules and regulations, the regulated and restricted nature of the **military environment** denies students a sense of freedom, which leaves them feeling disempowered and frustrated. It further encroaches on their personal autonomy and dignity. The military hierarchy also renders the environment highly authoritarian with clearly delineated ranks, responsibilities and chain of command, which, in turn, regulate professional and personal relationships. These elements of the hidden curriculum influence the students' professional socialisation in terms their own communication and interaction skills. Students are unable to argue and debate or freely express their thoughts. They are reluctant to ask questions and they become unassertive. Also not conducive to professional socialisation is the fact that disregard for professional and personal boundaries is interpreted as a display of familiarity. Nurse educators or professional nurses also tend to demonstrate favouritism in that they favour certain students at the expense of others.

The **military teaching and learning environment** is, itself, not conducive to professional knowledge acquisition and thus also to professional socialisation. Besides having generally poor infrastructure and state of facilities, the military teaching and learning environment is also much more regulated, structured and restrictive than those of civilian colleges or universities. Military activities often take precedence over teaching and learning activities. Classes are thus often cancelled or rescheduled to attend to military activities, a circumstance that leaves nurse educators and students feeling unsafe and demotivated. Having to adhere to military routine leaves students feeling that they are being controlled, that their private lives are being invaded and interfered with and that their freedom is being inhibited. Having to abide by military rules and regulations moreover renders the military teaching and learning environment punitive, since non-adherence to these rules and regulations usually results in some form of punishment. The nature of the military teaching and learning environment can be said to militate against both the use of an adult-learning approach and the implementation of self-directed learning by nurse educators.

Although by no means unique to the military, male nursing students experience the military teaching and learning environment as extremely prejudiced. They are called names and belittled by other male soldiers. In terms of professional socialisation, this makes them doubt themselves and their career choice, which results in their being ashamed to acknowledge that they are nurses. Female students who fall pregnant during their training are forced to take four months' maternity leave, which automatically serves to extend the duration of their training. This arrangement is implicitly perceived as discrimination and a denial of their right to fall pregnant. The resultant feelings of guilt and frustration and the perception that they are being punished, influence their professional socialisation in the sense that they feel alienated, lonely and moreover that they are not being supported by the College.

In both the military and the civilian **clinical teaching and learning environments** students experience a prevalence of general negativity towards them. Professional nurses with a negative attitude, and who further do not seem to enjoy nursing, transfer this negativity to students. The negative attitude adopted towards students in the civilian clinical learning environment is ascribable to ignorance regarding the military. The military uniform worn by student nurses could serve to intimidate civilian personnel.

Like the military teaching and learning environment, the military clinical learning environment is rigid and constrained. This makes for little autonomy in that students' opinions are disregarded and they are not allowed to speak up or use their own initiative. Lack of autonomy hampers the development of decision-making skills and of innovative thinking. Students are not allowed to make mistakes in the clinical learning environment. If they do, they are demeaned and shouted at. This inhibits development of self-confidence. Positive feedback and acknowledgement, on the other hand, would boost students' confidence and increase their job satisfaction.

The fact that rank permeates the military clinical learning environment poses an additional challenge to students. They are often confronted with having to obey an order from a higher-ranking person rather than remaining true to the ethical principles of nursing care and the patient's rights to privacy and confidentiality. Related to this is the exploitation of power in the military clinical learning environment, which inhibits assertiveness and communication.

The foregoing could lead one to conclude that the various processes to which military nursing students are exposed, the military environment in which they primarily operate and their interactions with various role players during their training contain a hidden curriculum. This hidden curriculum in one way or another impacts on academic achievement, clinical skills, communication skills, dignity, functional skills, interaction skills, learning skills, life skills, morale, patient care, personal autonomy, personal identity, professional conduct, professional dedication, professional development, professional practice, relationships, self-confidence and self-esteem.

7.4.3 Phase 3

The findings of Phase 2 served to generate the components of the model that was developed. The purpose of the model is to provide nurse educators and professional nurses with a frame of reference that would create an awareness of the existence of a hidden curriculum, to guide them through the impact of the hidden curriculum on students' professional socialisation and to help them to understand how their contribution could improve the outcome of the professional socialisation process of students. The rationale for including each of the components is discussed in Section 6.2 of Chapter 6.

The model was submitted to expert reviewers for evaluation. Their inputs were considered and the model accordingly modified. This process is discussed in Section 6.3 of Chapter 6.

The use of the Deming Cycle (The Deming Institute 2016) was recommended as implementation guide for this model and its application is discussed in Section 6.5 of Chapter 6.

The model focuses on the ideal outcome of having a student exit as a professionally socialised military nurse. Unfortunately, some students will obviously terminate training prior to completion of the course, whether as a result of personal choice, academic failure or disciplinary misconduct. Failure to complete the course successfully may however also be ascribable to the impeding influences of the hidden curriculum. If one isolates the influences of the hidden curriculum in a military teaching and learning

environment that enhance the professional socialisation of students – as derived from the data in this study – the product should be a professional military nurse who

- possesses the necessary communication and interaction skills to communicate and interact effectively with his/her patients and colleagues and to embrace teamwork, and to write coherently and scientifically.
- possesses the necessary functional skills to execute his/her nursing duties and activities competently in terms of being an effective leader and manager with adequate planning and decision-making skills, and who moreover displays excellent clinical skills and promotes patient care.
- possesses the necessary life skills to cope with the demands and challenges of a professional work life and still be able to maintain a healthy balance, is confident, is able to function independently, manages stress appropriately, shows determination and endurance, is resilient, adaptable and patient, and pays attention to personal appearance and hygiene.
- shows dedication to the nursing profession by being motivated, by taking ownership of the nursing profession and by displaying love and passion for and pride in the nursing profession.
- pursues academic excellence by being inquisitive and seeking learning opportunities for continuous professional development.
- conducts himself/herself professionally by displaying maturity, discipline, assertiveness, trustworthiness, respect and responsibility.

This model is transferable to other contexts with their own unique characteristics. Each context will have its own hidden curriculum, and can as such be adapted by addressing for example, organisational acculturation instead of military acculturation or by referring to the dichotomy between organisational culture and professional culture.

7.5   LIMITATIONS OF THE STUDY

The researcher's position at the College, although not as an educator, may have encouraged socially desirable responses from participants. The researcher attempted to minimise this risk by making use of an independent co-facilitator and by allowing the researcher and the participants to wear civilian clothes during the focus-group interviews. Participants were also encouraged to use pseudo names and not to refer to

rank during the focus-group interviews. This assisted in de-rolling the researcher in terms of position and rank.

As the focus of the study was on the teaching and learning environment, the participants in this study comprised nurse educators and students of the SAMHS Nursing College. In terms of the focus of the study, data saturation was reached. However, the inclusion of professional nurses and other healthcare professionals from the military clinical learning environment could have yielded additional information on aspects related to the hidden curriculum, although it was beyond the scope of this study. A recommendation was therefore made for further research to include professional nurses and other healthcare professionals in a similar study.

7.6   RECOMMENDATIONS

Based on the findings of the study, the following recommendations can be made.

7.6.1 Recommendations for military nursing education and nursing education in general

The findings of this study suggest that, from the students' perceptions, nurse educators have many competency-related shortcomings. These could be brought to nurse educators' attention at workshops during which the findings of the study are disseminated and the core competencies of nurse educators are reinforced.

Nurse educators need to be made aware of the unique hidden elements present in the military teaching and learning environment to enable them consciously to optimise the positive aspects and eliminate the negative aspects. Using scenarios and simulation exercises that uncover the ways in which the hidden curriculum manifests itself in the learning environment could help nurse educators to deal with the issues in this regard.

Students likewise need to be made aware of the unique hidden elements present in the military teaching and learning environment. This may also be achieved through scenarios and simulation exercises, role play, critical incidents and reflective activities that help students to learn to identify not only the hidden curriculum, but also how they are influenced by it.

The positive consequences of military training for students need to be cherished with a view to augmenting nursing training and professional socialisation and further empowering students. Aspects such as camaraderie and teamwork could be applied in the learning environment to enhance peer support by making use of group assignments or projects and by implementing peer-support strategies such as study groups or peer mentoring.

The study revealed that military nurses need to be adaptable and flexible to be able to operate in a dynamic military environment and to reconcile the conflicting identities of nurse and soldier. This could be achieved by role clarification and by reinforcing the ethical principles of the nursing profession.

Reflection on the impeding aspects of the hidden curriculum could have a positive impact on nurse educators and students. Thus, to counteract the influences of the hidden curriculum, students should be encouraged to engage in reflective writing and feedback on their clinical experiences. Nurse educators should therefore make provision for reflective activities in the formal curriculum.

7.6.2 Recommendations for nursing practice

The findings of this study also suggested that students perceive professional nurses to have many competency-related shortcomings. Professional nurses could be alerted to these during in-service training and in reflective activities that explore their own values and beliefs regarding professional nursing practice.

With a view to eliminating the conflict between military rank and patient needs, professional nurses need to learn the art of de-rolling and then model this to nursing students. This could be done by facilitating workshops that reinforce ethical conduct in patient care. These could also include role play enacting various scenarios in which these incongruities are simulated and appropriate conduct rehearsed.

Although the ideal of nursing training is to develop a professionally socialised nurse, professional socialisation is an ongoing process even after successful completion of training and should thus be augmented by continuous professional development.

7.6.3 Recommendations for further research

Though this study mainly focused on nurse educators and students of the SAMHS Nursing College, numerous references were made to the roles and influences of professional nurses and other healthcare professionals. A similar study could be conducted in which the inclusion of participants is extended to professional nurses and other healthcare professionals from the military clinical learning environment.

Although some of the data revealed that the hidden curriculum in a military teaching and learning environment does indeed also exert influence on the professional socialisation of nurse educators, this was not the specific aim of this study. A future study can thus be conducted to address the influence of the hidden curriculum on nurse educators.

During discussions with colleagues and various other people, they shared instances from their own experiences either as healthcare professionals or as patients in which they could identify with aspects of the hidden curriculum identified in this study. It is thus proposed that individual case studies be conducted with a view to further exploring the hidden curriculum in healthcare settings.

7.7   CONTRIBUTION OF THE STUDY

This study makes a unique contribution specifically to the body of knowledge on military nursing education but also to that on nursing education in general in that it not only alluded to the hidden curriculum present in the military teaching and learning environment but also to how it influences students' professional socialisation.

The contradictions present in terms of nurse educators and students being simultaneously required to fulfil the roles of nurse and of soldier substantiate the dilemma of duality in military nursing education. No literature could be found that either supported or described this specific instance of duality. This reaffirms the value of this study in having elicited these contradictions as part of the hidden curriculum.

The substantive model on the influences of the hidden curriculum in the military teaching and learning environment during students' professional socialisation could help to reveal and clarify the hidden curriculum. Implementation of the model could moreover provide nurse educators and professional nurses with a frame of reference with which to identify and acknowledge the existence of a hidden curriculum in the military teaching and learning environment in the spirit of improving students' professional socialisation.

By creating an awareness of the existence of the hidden curriculum, nurse educators in particular, but also all other healthcare professionals who deal with students will be enabled to identify the elements of the hidden curriculum that come into play and to use them to the benefit of both the student and the health profession.

7.8   CONCLUDING REMARKS

This study not only revealed the complexity of the military teaching and learning environment but also exposed the many forms and facets of the hidden curriculum and its power and influences. It was found that the hidden curriculum in the military teaching and learning environment could function either as a positive force or as a negative one. By its very nature, the military environment can cause the hidden curriculum within to stand in opposition to the otherwise sanctioned domains of nursing education and nursing practice. The mere fact that the hidden curriculum in the military teaching and learning environment could be identified, implies that the negative aspects can potentially be overcome or be countered and that the positive aspects can be embraced as a viable alternative with which to facilitate the process of professional socialisation.

Hafferty and O'Donnell (2014:13) aptly conclude that the hidden curriculum is everywhere and that it touches everything. It is important to remember that even when certain elements of the hidden curriculum are revealed, some may remain hidden and other, new elements may emerge as a result of an ever-changing environment. Whatever is done to close the gap between what is supposed to be learned and what is actually learned will have a huge impact on nursing education, nursing practice and, ultimately, patient care.

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ANNEXURES

Annexure A

Ethical clearance certificate from the University of South Africa

UNISA | university of south africa

UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

REC-012714-039

HSHDC/335/2014

Date:	8 October 2014	Student No:	3182-293-2

Project Title: The nature and significance of the hidden curriculum in a military teaching and learning environment and its influence on the professional socialization of student nurses.

Researcher: Karen Zagenhagen

Degree: D Litt et Phil   Code: DPCHS04

Supervisor: Prof GH van Rensburg
Qualification: D Litt et Phil
Joint Supervisor: Prof MJ Oosthuizen

DECISION OF COMMITTEE

Approved   [√]   **Conditionally Approved**   [   ]

Prof L Roets
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

Prof MM Moleki
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

Annexure B

Request for permission and approval to conduct research at the SAMHS Nursing College

NURSCOL/R/91002675PE

Telephone:	(012) 674 6302	SAMHS Nursing College
Facsimile:	(012) 674 6046	Private Bag X1022
Enquiries:	Lt Col K. Zägenhagen	Thaba Tshwane

0143

14 October 2014

Lt Col S.C. Coetzee
Acting Officer Commanding SAMHS Nursing College

Colonel

REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT THE SAMHS NURSING COLLEGE

1.   The abovementioned refers.

2.   I, 91002675PE Lt Col K. Zägenhagen am currently registered for the degree D Litt et Phil at the Department of Health Studies, University of South Africa and hereby wish to request your permission to conduct research among the students and staff of the SAMHS Nursing College.

3.   The study will be conducted under the supervision of Prof G.H. van Rensburg and Prof M.J. Oosthuizen.

4.   The study titled "The influence of the hidden curriculum on professional socialisation of student nurses in a military nursing context" The aim of the study is to develop a model to provide nurse educators and registered nurses with a frame of reference in order to sensitise them to the existence of a hidden curriculum in the military teaching and learning environment and to alert them to the effect that the elements of the hidden curriculum have on the professional socialisation of students.

5.   A qualitative grounded theory method will be used to gather the necessary data through means of focus groups and critical incident narratives.

6.   Upon completion of the study, a full research report will be made available to all interested stakeholders and role players.

7.   A copy of the proposal is enclosed for your perusal and consideration.

Sincerely

(K. ZÄGENHAGEN)
REGISTRAR SAMHS NURSING COLLEGE: LT COL

Enclosure 1:   Research Proposal
           2:     UNISA Ethical Clearance Certificate

REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT THE SAMHS NURSING COLLEGE

Approved / Not Approved

Remarks: *Ensure that proper military processes are adhered to*

SL Coetzee (Lt Col)

(S.C. COETZEE)
ACTING OFFICER COMMANDING SAMHS NURSING COLLEGE: LT COL

DISTR

For Info

D NURS
GOC MHTF

Internal

File: NURSCOL/R/91002675PE

Annexure C

Request for permission to conduct research in the Department of Defence to Defence Intelligence

NURSCOL/R/91002675PE

Telephone:	(012) 674 6302	SAMHS Nursing College
Facsimile:	(012) 674 6046	Private Bag X1022
Enquiries:	Lt Col K. Zägenhagen	Thaba Tshwane
		0143
		17 October 2014

Chief of Defence Intelligence
Private Bag x367
Pretoria
0001

General

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN THE DEPARTMENT OF DEFENCE

1.   The abovementioned refers.

2.   I, 91002675PE Lt Col K. Zägenhagen am currently registered for the degree D Litt et Phil at the Department of Health Studies, University of South Africa and hereby wish to request your permission to conduct research among the students and staff of the SAMHS Nursing College.

3.   The study will be conducted under the supervision of Prof G.H. van Rensburg and Prof M.J. Oosthuizen.

4.   The study titled "The influence of the hidden curriculum on professional socialisation of student nurses in a military nursing context" The aim of the study is to develop a model to provide nurse educators and registered nurses with a frame of reference in order to sensitise them to the existence of a hidden curriculum in the military teaching and learning environment and to alert them to the effect that the elements of the hidden curriculum have on the professional socialisation of students.

5.   A qualitative grounded theory method will be used to gather the necessary data through means of focus groups, participant observation and critical incident narratives.

6.   Upon completion of the study, a full research report will be made available to all interested stakeholders and role players.

7.   A copy of the proposal is enclosed for your perusal and consideration.

Sincerely

(K. ZÄGENHAGEN)
REGISTRAR SAMHS NURSING COLLEGE: LT COL

Enclosure	1:	UNISA Ethical Clearance Certificate
	2:	Research Proposal
	3:	Letters of consent

Annexure D

Approval to conduct research in the Department of Defence from Defence Intelligence

defence intelligence

Department:
Defence
REPUBLIC OF SOUTH AFRICA

DI/SDCI/DDS/R/202/3/7

Telephone: (012) 315-0216
Fax: (012) 326-3246
Enquiries: Brig Gen M. Sizani

Defence Intelligence
Private Bag X367
Pretoria
0001
30 October 2014

AUTHORITY TO CONDUCT RESEARCH IN THE DOD: LT COL K. ZAGENHAGEN

1.   Your letter NURSCOL/R/91002675PE dd 28 October 2014 as well as the attached research proposal has reference.

2.   Permission is hereby granted from a security perspective to Lt Col K. Zagenhagen to conduct the research on the topic "**The nature and significance of the hidden curriculum in a Military teaching and learning environment and its influence on professional socialisation of student nurses**" as requested.

3.   On completion the final research product must be submitted to Defence Intelligence (DI) Sub-Division Counter Intelligence (SDCI) for security scrutiny before it is released to any entity outside the DOD.

4.   For your attention.

(G.S. SIZANI)
CHIEF DIRECTOR COUNTER INTELLIGENCE: MAJ GEN
VWM/VWM (Lt Col K. Zagenhagen)

DISTR

For Action

General Officer Commanding 1 Military Hospital   (Attention: Lt Col K. Zagenhagen)

Internal

File: DI/SDCI/DDS/R/202/3/7

Lefapha la Boiphemelo Umnyango wezokuVikela Kgoro ja Tshireletso Sebe lezoKhuselo . Department of Defence Muiraisho wa Turidedzo
UmNyango WezokuVikela Ndzawulo ya swa Vusirheleri Lehlaha la Tshireletso . Departement van Verdediging L-Tiko le Tekuvikela

Annexure E

Request for permission to conduct research in the Department of Defence to 1 Military Hospital Research Ethics Committee

NURSCOL/R/91002675PE

Telephone:	(012) 674 6302
Facsimile:	(012) 674 6046
Enquiries:	Lt Col K. Zägenhagen

SAMHS Nursing College
Private Bag X1022
Thaba Tshwane
0143
29 October 2014

The Chairperson
1 Military Hospital Research Ethics Committee

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN THE DEPARTMENT OF DEFENCE

1. The abovementioned refers.

2. I, 91002675PE Lt Col K. Zägenhagen am currently registered for the degree D Litt et Phil at the Department of Health Studies, University of South Africa and hereby wish to request your permission to conduct research among the students and staff of the SAMHS Nursing College.

3. The study will be conducted under the supervision of Prof G.H. van Rensburg and Prof M.J. Oosthuizen.

4. The study titled "The influence of the hidden curriculum on professional socialisation of student nurses in a military nursing context" The aim of the study is to develop a model to provide nurse educators and registered nurses with a frame of reference in order to sensitise them to the existence of a hidden curriculum in the military teaching and learning environment and to alert them to the effect that the elements of the hidden curriculum have on the professional socialisation of students.

5. A qualitative grounded theory method will be used to gather the necessary data through means of focus groups, participant observation and critical incident narratives. The researcher will make use of unstructured data collection guides only. These have been approved by the UNISA Health Studies Higher Degrees Committee for use.

6. Upon completion of the study, a full research report will be made available to all interested stakeholders and role players.

7. A copy of the proposal is enclosed for your perusal and consideration.

Sincerely

(K. ZÄGENHAGEN)
REGISTRAR SAMHS NURSING COLLEGE: LT COL

Enclosure	1:	UNISA Ethical Clearance Certificate
	2:	Research Proposal
	3:	Permission from 1 Military Hospital
	4:	Permission from SAMHS Nursing College
	5:	Letter to Defence Intelligence
	6:	CVs
	7:	Proof of Indemnity
	8:	South African Nursing Council Annual Practicing Certificate

Annexure F

Approval to conduct research in the Department of Defence from 1 Military Hospital Research Ethics Committee

1MH/302/6/01.11.2014

Tel: 012 314 0487
Facsimile: 012 314 0623
Enquiries: Prof / Lt Col
M.K. Baker

1 Military Hospital
Private Bag X1026
Thaba Tshwane
0143
           December 2014

CLINICAL TRIAL APPROVAL: "THE NATURE AND SIGNIFICANCE OF THE HIDDEN CURRICULUM IN A MILITARY TEACHING AND LEARNING ENVIRONMENT AND ITS INFLUENCE ON THE PROFESSIONAL SOCIALIZATION OF STUDENT NURSES"

1.   The 1 Military Hospital Research Ethics Committee (1MHREC) registered in South Africa with the National Health Research Ethics Council (NHREC) (REC-111208-019-RA) adhering to GCP/ICH and SA Clinical Trial guidelines, evaluated the above-mentioned protocol and additional documents.

2.   The following members approved the study:

    a.   Lt Col M.K. Baker: Neurologist, male, chairman 1 MHREC.
    b.   Lt Col C.S.J. Duvenage: Specialist physician, female, member 1 MHREC.
    c.   Lt Col D. Mahapa: Dermatologist, female, member 1 MHREC.
    d.   Lt Col A.D. Moselane: Urologist, male, member 1 MHREC.
    e.   Lt Col E.J. Venter: Periodontist, male, member 1 MHREC.
    f.   Maj M.L. Kekana: Specialist physician, female, member 1 MHREC.
    g.   DR T.J. Marè: Advocate, independent of the organization, male, member 1 MHREC.
    h.   Mrs. C. Jackson: Layperson, independent of the organization, female, member 1 MHREC.

3.   The following documents were evaluated:

    a.   Study proposal submitted 31 October 2014
    b.   UNISA Ethical Clearance Certificate dated 8 October 2014
    c.   Permission from 1 Military Hospital dated 14 October 2014
    d.   Permission form SAMHS Nursing College dated 14 October 2014
    e.   Letter to Defence Intelligence dated 14 October 2014
    f.   Curriculum Vitae Lt Col K Zagenhagen
    g.   Curriculum Vitae Prof GH van Rensburg
    h.   Curriculum Vitae Prof MJ Oosthuizen
    i.   Proof of indemnity
    j.   South African Nursing Council Annual Practicing Certificate

4.   The recommendations are: The study was ethically approved on 12 December 2014. The principal investigator, Lt Col K Zagenhagen, will be supervised by Prof GH van Rensburg and Prof MJ Oosthuizen. Report backs are to be made to the 1MHREC six monthly, in the event of any serious adverse events and on completion or termination of the study. Should publications result from the study the relevant manuscripts will also need to be approved by Military Counter Intelligence.

5.   The 1 MHREC wishes you success with the study.

(M.K BAKER)
CHAIRMAN 1 MILITARY HOSPITAL RESEARCH ETHICS COMMITTEE:
LT COL / PROF

DIST

For Action

Lt Col K Zagenhagen

Annexure G

Letter for obtaining consent from nurse educators

Dear Colleague

INVITATION TO PARTICIPATE IN A RESEARCH STUDY AT THE SAMHS NURSING COLLEGE

1.   The abovementioned refers.

2.   I am currently registered for the degree D Litt et Phil at the Department of Health Studies, University of South Africa (UNISA).

3.   You are hereby invited to participate in a study titled "The influence of the hidden curriculum on professional socialisation of student nurses in a military nursing context". The study will aim to develop a model to provide nurse educators and registered nurses with a frame of reference in order to sensitise them to the existence of a hidden curriculum in the military teaching and learning environment and to alert them to the effect that the elements of the hidden curriculum have on the professional socialisation of students. It is my hope that your experience will assist me in reaching this aim.

4.   The study will be conducted under the supervision of Prof G.H. van Rensburg and Prof M.J. Oosthuizen.

5.   The following information should help you make an informed decision on whether to take part in the study or not:

   a.   <u>Your involvement in the study</u>. As a nurse educator, you will be required to participate in a focus group with other nurse educators. Certain probing questions will be posed to initiate and stimulate the discussion. The discussion will be recorded digitally to enable me to transcribe it at a later stage. The researcher may also need to make a few field notes during the discussion. The focus group will take place at a venue and time convenient for you and may last approximately 2 hours. It may be necessary to schedule a follow-up interview to clarify some aspects.

   b.   <u>Risks and discomfort</u>. Besides requiring some of your time and effort, it is not foreseen that you will be exposed to any risks. Should anything during the course of the study cause you any physical, psychological or emotional discomfort, you should feel free to communicate this to the researcher. You are not required to do anything or answer any questions that you are not completely comfortable with.

   c.   <u>Benefits</u>. There may be no direct benefits for you for participating in this study; however, the knowledge gained through the study may be of future value to nurse educators and students.

   d.   <u>Anonymity and confidentiality</u>. Your identity will be protected at all times and all personal information will be treated as confidential. Throughout the study codes will be utilised to identify a participant. All digital recordings, field notes and other documents will be locked away and be accessible to the researcher only. Other participants, the independent transcriber and external reviewers will sign a confidentiality oath. Nothing that may identify any participant will be included in the research report, presentations or subsequent publications. Computerised data will be password protected.

   e.   <u>Participation and termination</u>. Your participation in this study is entirely voluntary. If you agree to participate you may choose to withdraw from this study at any time and for any reason. If you choose to withdraw from the study, all your research records will be destroyed and you will not be penalised in any way.

   f.   <u>Compensation</u>. You will not receive any form of payment or reward for participating in this study. Participation is strictly voluntary. There will also be no costs to you for

participating in this research.

g. <u>Ethical approval and authority</u>. The researcher obtained ethical clearance from the UNISA Departmental Higher Degrees Committee and the 1 Military Hospital Research Ethics Committee as well as permission from the SAMHS Nursing College and Defence Intelligence.

h. <u>Additional information</u>. If you have any questions about the study you are welcome to contact the researcher at the contact number provided above. Alternatively you may contact one of the supervisors at UNISA at 012 429 6514.

6. Upon completion of the study, a full research report will be made available to all stakeholders and role players. You are welcome to request a copy from the researcher if you are interested.

7. Your willingness to participate will be highly appreciated.

Sincerely

Zägenhagen

(K. ZÄGENHAGEN)

CONSENT TO PARTICIPATE IN THIS STUDY: NURSING EDUCATOR

1. I hereby confirm that

    - I have read and understand the information provided in the participant information letter.

    - I was provided with an opportunity to ask questions related to the study and all uncertainties have been cleared.

    - I have no objections to participate in the study.

    - I agree to participate in the study out of my own free will.

2. I undertake to refrain from providing the researcher with any misleading information.

3. I further undertake to refrain from disclosing any personal identifiable information that may come to my knowledge with regard to my co-participants during the course of the study.

4. I understand that the following information will be used for statistical purposes only:

    - Age

≤20	21-30	31-40	41-50	51-60

    - Gender

Male	Female

    - Race

African	White	Asian	Coloured

    - Years educational experience

≤5	6-10	11-15	16-20	>20

    - Area of speciality

5. I understand that I will receive a signed and dated copy of this participant information and consent form.

PARTICIPANT

Name in print	
Signature	
Date	

RESEARCHER

Name in print	
Signature	
Date	

Annexure H

Letter for obtaining consent from students

Dear Student

INVITATION TO PARTICIPATE IN A RESEARCH STUDY AT THE SAMHS NURSING COLLEGE

1.   The abovementioned refers.

2.   I am currently registered for the degree D Litt et Phil at the Department of Health Studies, University of South Africa (UNISA).

3.   You are hereby invited to participate in a study titled "The influence of the hidden curriculum on professional socialisation of student nurses in a military nursing context". The study will aim to develop a model to provide nurse educators and registered nurses with a frame of reference in order to sensitise them to the existence of a hidden curriculum in the military teaching and learning environment and to alert them to the effect that the elements of the hidden curriculum have on the professional socialisation of students. It is my hope that your experience will assist me in reaching this aim.

4.   The study will be conducted under the supervision of Prof G.H. van Rensburg and Prof M.J. Oosthuizen.

5.   The following information should help you make an informed decision on whether to take part in the study or not:

  a. <u>Your involvement in the study</u>. As a nursing student, you will be required to participate in a focus group with other students. Certain probing questions will be posed to initiate and stimulate the discussion. The discussion will be recorded digitally to enable me to transcribe it at a later stage. I may also need to make a few field notes during the discussion. The focus group will take place at a venue and time convenient for you and may last approximately 2 hours. It may be necessary to schedule a follow-up interview to clarify some aspects. You will also be requested to keep a journal about any incidents or aspects, at the college or the hospital, which is either in line with or contradictory to your perception of a professional nurse.

  b. Reflect on your thoughts and feelings provoked by the incident and discuss how the incident may have influenced you professionally

  c.   <u>Risks and discomfort</u>. Besides requiring some of your time and effort, it is not foreseen that you will be exposed to any risks. Should anything during the course of the study cause you any physical, psychological or emotional discomfort, you should feel free to communicate this to the researcher. You are not required to do anything or answer any questions that you are not completely comfortable with.

  d.   <u>Benefits</u>. There may be no direct benefits for you for participating in this study; however, the knowledge gained through the study may be of future value to nurse educators and students.

  e.   <u>Anonymity and confidentiality</u>. Your identity will be protected at all times and all personal information will be treated as confidential. Throughout the study codes will be utilised to identify a participant. All digital recordings, field notes and other documents will be locked away and be accessible to the researcher only. Co-participants, the independent transcriber and external reviewers will sign a confidentiality oath. Nothing that may identify any participant will be included in the research report, presentations or subsequent publications. Computerised data will be password protected.

  f.   <u>Participation and termination</u>. Your participation in this study is entirely voluntary. If you agree to participate you may choose to withdraw from this study at any time and for

any reason. If you choose to withdraw from the study, all your research records will be destroyed and you will not be penalised in any way.

g. <u>Compensation</u>. You will not receive any form of payment or reward for participating in this study. Participation is strictly voluntary. There will also be no costs to you for participating in this research.

h. <u>Ethical approval and authority</u>. The researcher obtained ethical clearance from the UNISA Departmental Higher Degrees Committee and the 1 Military Hospital Research Ethics Committee as well as permission from the SAMHS Nursing College, 1 Military Hospital and Defence Intelligence.

i. <u>Additional information</u>. If you have any questions about the study you are welcome to contact the researcher at the contact number provided above. Alternatively you may contact one of the supervisors at UNISA at 012 429 6514.

6. Upon completion of the study, a full research report will be made available to all stakeholders and role players. You are welcome to request a copy from the researcher if you are interested.

7. Your willingness to participate will be highly appreciated.

Sincerely

(K. ZÄGENHAGEN)

CONSENT TO PARTICIPATE IN THIS STUDY: STUDENT NURSE

1.   I hereby confirm that

- I have read and understand the information provided in the participant information letter.

- I was provided with an opportunity to ask questions related to the study and all uncertainties have been cleared.

- I have no objections to participate in the study.

- I agree to participate in the study out of my own free will.

3.   I further undertake to refrain from disclosing any personal identifiable information that may come to my knowledge with regard to my co-participants during the course of the study.

4.   I understand that the following information will be used for statistical purposes only:

- Age

≤20	21-30	31-40	41-50	51-60

- Gender

Male	Female

- Race

African	White	Asian	Coloured

- Year of study

1st	2nd	3rd	4th

5.   I understand that I will receive a signed and dated copy of this participant information and consent form.

PARTICIPANT

Name in print	
Signature	
Date	

RESEARCHER

Name in print	
Signature	
Date	

Annexure I

Lists of hidden elements and influences

- 2nd nature if socialised
- Able to apply clinical judgement
- Absenting themselves
- Abuse
- Acceptance of requirements of military
- Accepting the military culture
- Accused as rude
- Accusing military students being of incompetent, irresponsible
- Adapting
- Address negative behaviour rather than recognise positive
- Addressed in harsh militaristic way, feel offended
- Addressing students disrespectfully in front of patients
- Adopt autocratic style, overlook individual patient needs
- Affecting patient care
- Affecting profession
- Also become rude to patients
- Appear less professional, knowledgeable
- Appearance and military conduct make them look more senior than they are
- Appearing more professional
- Appearing uninformed and ignorant re military
- Appearing un-neat
- Apply mil in civ life
- Approaching all students the same, generalising negative behaviour
- Approaching students negatively
- Are being commended for discipline, punctuality, hard work, respectfulness
- Are being loved by patients
- Are being loved by staff
- Are being mean to students
- Are being respected by patients
- Are progressing academically
- Are rather keeping quiet
- Are using initiative
- Are using opportunities optimally
- Asking - easier adjustment
- Assertive vs submissive
- Assuming both roles over a period of time
- Attitude
- Autocratic culture
- Autocratic vs democratic leadership
- Avoid being in the ward
- Avoiding patients

- Becoming committed
- Becoming de-emotionalised
- Becoming demotivated to study
- Becoming demotivated, demoralised, disinterested
- Becoming difficult to attend to other patients
- Becoming difficult to execute nursing duties
- Becoming difficult to prioritise patients according to their needs
- Becoming difficult to remain professional
- Becoming difficult to treat patients equally and fair
- Becoming disciplined
- Becoming discouraged to approach for help
- Becoming focussed
- Becoming goal directed
- Becoming more passionate
- Becoming motivated
- Becoming motivated to learn harder
- Becoming negative
- Becoming protective of profession
- Behaving poorly towards patients
- Behaviour of more senior students change negatively, attributed to exposure to civilian students
- Behaviour outside military
- Behavioural conditioning
- Behavioural expectations of profession
- Being able to give better care
- Being able to identify patient problems and help them
- Being accused of lying
- Being afraid to act naturally, feeling inhibited
- Being afraid to ask questions
- Being amongst professionals
- Being as good a nurse as can be
- Being bound by accommodation rules
- Being bound by the military disciplinary code
- Being bound to military norms and values
- Being discouraged by negative experiences
- Being enabled to apply course content
- Being enabled to guide family
- Being impatient
- Being inaccessible
- Being inducted into military norms and values

- Being influenced to join
- Being inhibited from communicating
- Being insensitive towards patients
- Being labelled as having a certain mentality
- Being less patient with patients
- Being less professional than civilian lecturers
- Being motivated to give the best care
- Being motivated to work hard
- Being neat is part of professional image
- Being negative towards patients
- Being prevented from developing
- Being prevented from reaching full potential
- Being reprimanded - anger
- Being rude
- Being rude to patients
- Being shocked by the manner of communication
- Being stimulated more
- Being submissive as result of rank
- Being taught the art of talking
- Being too busy to answer questions
- Being too militaristic
- Being trusted by patients
- Being two different persons in one body
- Being unable to advocate for patient
- Being unapproachable
- Being unavailable
- Being uncaring
- Being uninformed
- Being unprepared
- Being unsympathetic
- Better working conditions
- Blinded by complexities
- Brainwashing
- Breaching of personal confidentiality
- Building resistance
- Burnout
- Can't advocate for patient
- Can't challenge, question decisions
- Can't refuse an order
- Can't separate mil from home
- Cannot be assertive due to ranks
- Cannot teach assertiveness if educator, RNs cannot be assertive themselves
- Caring not taught
- Challenge of re-conditioning into a caring nurse
- Change - discipline

- Changing as a person
- Changing from being a hard person
- Channels of command
- Channels of communication, grievance procedures, time consuming, not user friendly, effective
- Choice to adapt
- Choosing nursing for financial reasons
- Civilian career management
- Civilian Registered Nurses not fulfilling teaching role
- Civilian students not being respectful towards superiors
- Civilian students taking advantage of lack of disciplinary measures
- Civilians are changing their attitude
- Clinical accompaniment
- Cognitive conditioning
- Command and control - military rank takes precedence over professional rank, professional experience, professional qualification and academic qualification
- Communicate in demeaning way
- Communication is being Inhibited
- Communication skills
- Compare conduct of soldier vs nurse
- Compare mil & civ students behaviour
- Compare worse ito cognitive abilities i.e. Debating
- Comparing hospital with heaven, there are no ranks, everyone is equal
- Comparing military students to civilian students
- Comparing well with civilian students ito knowledge
- Comparing with university
- Complexity of mil
- Complying and accepting
- Compromising military discipline
- Compromising Professional development
- Conducting self more professional
- Conflict
- Conflicting
- Conforming
- Confusing
- Contradicting causing confusion
- Contrasting culture and mind-set
- Contribute to decision making skills
- Conveying discouraging messages
- Conveying negative, degrading messages, Said to be stupid

- Cooperate
- Create conflict
- Create negative emotions
- Critical thinking skills, decision making skills suppressed
- Cultural barriers
- Cultural incompatibility
- Culture deteriorating
- Culture plays role ito favouritism
- Demanding treatment according to rank
- Denied learning opportunities
- Denying students to be assertive
- De-roling, see and treat a person as a patient and not a rank
- Detrimental to nursing profession
- Develop critical thinking skills
- Develop decision making skills
- Develop negativity towards certain areas of nursing
- Develop planning skills
- Develop resistance
- Develop skill to work with limited resources
- Developing a caring attitude
- Developing a conscience
- Developing a negative attitude towards higher ranks
- Developing as a professional
- Developing assertiveness
- Developing concentration
- Developing determination
- Developing devotion
- Developing into soldier
- Developing love and passion for nursing
- Developing love for nursing
- Developing nursing skills
- Developing physical abilities
- Developing self-discipline
- Developing self-doubt
- Developmental opportunities
- Developmental problems
- Difference in behaviour between x and y
- Different cultures, races
- Different curriculums
- Difficult to adapt
- Difficult to adjust
- Difficult to be assertive
- Difficult to find balance
- Difficult to fulfil two diverse roles
- Difficult to separate military mind-set at work from home environment

- Difficult to understand culture, processes
- Difficult transition
- Difficulty to adapt from civilian environment into military environment
- Diluting military culture
- Disciplinarian vs carer
- Disciplinary action
- Disciplinary actions are making things worse
- Disciplinary measures
- Disciplinary processes
- Discipline
- Discipline not taught
- Discouraging Military behaviour
- Discriminating against military students when working with civilian students
- Discriminating management of poor performers
- Discriminatory treatment due to ranks
- Discussing students with other lecturers
- Displaying familiarity
- Displaying favouritism
- Disregarding student input
- Do not add value to professional development
- Don't care anymore
- Don't like to work there
- Dress regulations
- Drs discussing patients with them
- Drs respecting their opinion
- Earning a salary and incentives
- Earning respect
- Easier to be assertive
- Education friendly institute
- Effect visible
- Effect wearing off
- Effects cognitive development
- Emphasis on rank
- Emphasising caring as essence of nursing
- Endurance
- Enhancing caring
- Enhancing interaction with other professionals
- Ensures continuous professional development
- Entering military as student, adjustments easier
- Entering the military as a student makes adjustments to the military culture easier
- Even if related to high ranking officer, demand preferential treatment
- Exclude the influence of rank

- Existing in two different worlds but primary in the military
- Existing in two different worlds but primary in the military
- Expectations operationally vs non-operational deployment
- Experience role conflict
- Experiencing initial confusion
- Experiencing no sense of belonging
- Exposure influence confidence
- Factors determining ability to adapt
- Fading of initial passion and excitement for nursing with time
- Faith
- Familiar with expectations
- Family support
- Favouritism between Registered Nurses and students
- Fear for authority vs respect for authority
- Fear of asking questions not inquisitive
- Fear of disappointing family
- Fear of failure
- Fear to communicate
- Fearing higher ranks
- Fearing lecturers
- Feel left out
- Feel oppressed
- Feeling a sense of belonging
- Feeling aggressive towards seniors
- Feeling appreciative
- Feeling awkward
- Feeling belittled
- Feeling betrayed by those supposed to be role model
- Feeling degraded
- Feeling depressed
- Feeling detached from patients
- Feeling disappointed
- Feeling disappointed in unprofessional behaviour of Registered Nurses
- Feeling embarrassed, looking like a fool
- Feeling frustrated
- Feeling grateful
- Feeling grateful for additional opportunities
- Feeling gratitude
- Feeling guilty when making mistakes
- Feeling happy and blessed
- Feeling held back because of other's personal issues
- Feeling intimidated

- Feeling intimidated by the military uniform
- Feeling like a hero
- Feeling like a real soldier
- Feeling like knowing nothing
- Feeling like quitting
- Feeling negative
- Feeling offended
- Feeling offended
- Feeling oppressed
- Feeling overworked
- Feeling passion
- Feeling pride
- Feeling proud
- Feeling pushed aside by seniors not wanting to be nursed by them
- Feeling sad
- Feeling special to assist patient
- Feeling stressed
- Feeling targeted by other units, always getting blame
- Feeling there's no point in trying
- Feeling threatened
- Feeling unable to interact
- Feeling unappreciated
- Feeling unpopular by other units
- Feeling unrecognised
- Feeling worthless
- Finding it easy to balance things in life as a result of nursing training
- Finding the balance between military culture nursing culture
- Focussing more on soldering than nursing
- Focussing on less important things than nursing training
- Follow orders without questioning them
- Following military orders affect role as patient advocate
- Forming a person
- Freedom being Inhibit
- Freedom limited
- Further studies
- Gaining a positive attitude
- Gaining confidence
- Gaining knowledge and experience
- Gaining professional exposure and interaction
- Gender stereotyping discrimination
- General knowledge
- General still "commanding" ward even as patient
- Generalisation for mistakes

- Generalised punishment
- Get burnout
- Getting abused
- Getting acknowledgement
- Getting positive feedback
- Getting recognition from patients
- Giving better patient care
- Giving sarcastic responses
- Good patient care
- Good service delivery
- Good things not recognised
- Governance
- Governance
- Grievances not readily, easily voiced
- Group cohesion
- Growing up in military
- Growing, maturing professionally
- Hampers ability to argue and debate
- Hampers ability to express thoughts
- Hampers development of self-esteem hampers development of confidence
- Have to wait for an instruction
- Having a range of career possibilities
- Having a solid ethical background
- Having career development opportunities
- Having Deployment opportunities
- Having Employment opportunities
- Having less patients
- Having negative perceptions of students
- Having negative preconceived ideas
- Having networking opportunities
- Having no self-confidence
- Having previous negative experiences
- Having Promotional opportunities
- Having self-doubt
- Having status
- Having the perception that civilian students are more knowledgeable than military students
- Having Travel opportunities
- Having unrealistic expectations of military students
- Health professionals place norms, ethical principles above rank
- Held in high esteem in civilian sector because of their discipline, conduct, timeless, neatness
- Hierarchical structure
- Hierarchical structure, rank
- High ranking patient abusing students, order them around

- High turnover
- High turnover
- Higher behavioural expectations
- Higher ranking patients don't want to be treated by students
- Higher ranks demeaning students
- Higher ranks expect special treatment
- Higher ranks private rooms
- Higher ranks threaten students
- Highlighting the need to teach students decision making skills and self-assertiveness
- Highly valued in civilian sector as a result of military discipline
- HODs specialists
- Humiliating management of poor performers
- Identification
- If voicing opinion, seen as ill disciplined
- Ignorance - embarrassment
- Ignoring military students' presence
- Ignoring, not recognising positive feedback
- Importance of disciplining students as part of developing them
- Imposing authority, creates negative attitude, high turnover
- Improving character
- Inability to adjust high turnover rate
- Inability to adjust to military culture leads to high turnover rate
- Inability to integrate wish to leave organisation
- Inability to integrate causing conflict
- Inability to question negative effect on learning
- Inconsistent application of rules
- Incorporating cultures for benefit of the student
- Individual academic problems being overlooked
- Inflicting harm vs do no harm
- Influence ethical decision making
- Influence of civ on students
- Influence patient needs
- Influencing academic performance
- Influencing attitude and approach positively
- Influencing attitude towards patient
- Influencing attitude towards subject
- Influencing clinical performance

- Influencing confidence and self esteem
- Influencing learning
- Influencing patient care
- Inhibit students to think for themselves
- Initially identifying self as nursing professional not as soldier
- Initially identifying self as nursing professional not as soldier
- Inspections
- Instilling confidence
- Instilling discipline
- Instilling knowledge
- Instilling love for nursing
- Instructed to give VIP special treatment
- Insults
- Interfering of Military activities
- Interfering with, having a negative effect on nursing career
- Intimidating students
- Issue if patient is not addressed by rank
- Issue of prioritising patient care ito rank vs patient needs
- Issues remaining unresolved
- Joining military for financial reasons
- Judged by other students' behaviour
- Knowing there will always be hurdles
- Labelling students
- Lack role modes
- Leadership skills
- Learn mil culture by observing
- Learn to adjust, part of professional socialisation
- Learning anger management skills
- Learning communication skills
- Learning cultural tolerance
- Learning emotional skills
- Learning financial management skills
- Learning how to carry yourself
- Learning how to deal with patient needs
- Learning how to react to challenges
- Learning leadership skills
- Learning neatness
- Learning not to work for others' praises
- Learning obedience
- Learning problem solving skills
- Learning punctuality
- Learning social and communication skills
- Learning stress management skills
- Learning teamwork
- Learning to be assertive
- Learning to be humble

- Learning to be inquisitive
- Learning to be patient and tolerant
- Learning to be resilient
- Learning to be responsible
- Learning to be strong
- Learning to be supportive and loving and give nursing care
- Learning to be trustworthy
- Learning to become independent
- Learning to endure
- Learning to give love, to care
- Learning to manage power abuse
- Learning to master new skills
- Learning to prioritise
- Learning to respect
- Learning to see each patient as having a higher rank and treating them with equal respect
- Learning to trust
- Learning to work hard
- Lecturer development
- Lecturer military training
- Lecturers enculturated into the military, to understand the way things are done, to act congruently with the way students were trained
- Lecturers must lead by example, act as role model, must do themselves what we expect from our students
- Lecturers must play role in teaching students critical thinking skills and assertiveness
- Lecturers opinions not considered
- Lecturers portraying passion
- Lecturers transfer negative attitude to clinical area
- Less clinical exposure
- Limited learning opportunities
- Long working hours
- Looking at superiors in different way
- Loosing concentration
- Loosing love for nursing as a result of negative experiences
- Loosing morale
- Loosing respect for seniors
- Losing morale
- Loss of identity, loss of individuality
- Loving the military
- Loyalty
- Making invalid accusations
- Making learning difficult
- Males doubting career choice due to gender stereotyping

- Males feeling ashamed due to gender stereotyping
- Management skills
- Manner in which things are said
- Manner of communication
- Manner of communication not professional
- Manner spoken to
- Meeting other people
- Mil course vs promotion
- Mil discipline vs learning
- Mil experience vs professional qualifications
- Mil influence +/-
- Mil promotion vs educational qualification
- Mil rank vs experience
- Mil rank vs experience and knowledge
- Mil rank vs professional experience
- Mil rank vs professional qualification
- Mil role during humanitarian ops
- Mil role in peace vs war
- Mil students popular
- Mil training - transition from civ
- Mil training, positive influence
- Mil training, rules & regulations
- Militarism drilled in
- Military and civilian students are learning from each other
- Military and nursing profession have shared values
- Military appearance attracting civilians
- Military attitude vs caring personality
- Military command vs functional control
- Military compliance hampers development of assertiveness, hampers inquisitiveness
- Military conduct
- Military conduct vs professional conduct
- Military culture is unique
- Military customs
- Military customs, habitualisation
- Military discipline
- Military duties taking precedence over nursing training
- Military environment to compatible with y
- Military etiquette
- Military expectations same for all
- Military instructions, inhibit sense of autonomy

- Military not meeting technological xxx of y
- Military orders vs ethical principles
- Military patients expects treatment according to rank
- Military rank vs professional rank, influence command and control, influence patient care
- Military ranks, inhibits asking if students don't know something
- Military regulations vs professional regulations
- Military rigidity
- Military roles
- Military routine vs adult learning
- Military rules, disempower SRC
- Military student less assertive, responsible and inquisitive
- Military students behaviour influenced
- Military students being ill-treated, isolated, treated like outsiders, left unsupervised
- Military students being misused by civilian students
- Military students can't do anything right
- Military training prior to nursing training
- Military training to be aligned with new generation
- Mistakes are being recognised and rectified
- Mistreating military students when making mistakes
- Morale being boosted
- More concerned with conforming to military norms and values than with patient care
- More disciplined
- Must be able to adapt to changing circumstances
- Must conform to civilian way of doing things
- Must consider rank before treatment
- Mutual respect
- No obedience in war
- Neater
- Need to combine civilian culture and military culture for benefit of the student
- Need to combine civilian culture and military culture for own satisfaction and fulfilment
- Negative Attitude of lecturer
- Negative effect when certain lecturers visit clinical area

- Negative emotions
- Negative emotions is portrayed as ill-discipline
- Negative experience in class influence clinical experience
- Negative role models
- Negativity transferred to students
- Newcomers' view often expose issues
- No autonomy frustrating
- No channels of command
- No distinction between students ito seniority demoralising
- No rights vs rights of nurses and patients
- Non-caring management style
- Non-continuity ito lecturers due to military courses
- Not 1st choice
- Not accepting military students well
- Not acknowledging students' opinions
- Not all professionals are professional
- Not allowing military students to be in groups
- Not allowing military students to sit
- Not being guided
- Not fearing ranks
- Not feeling confident in front of patients
- Not feeling like a student
- Not gaining knowledge and experience
- Not humanitarian approach
- Not learning anything
- Not learning from own experience
- Not orientating military students
- Not prepared to deal with it
- Not receiving additional academic support
- Not receiving clarity
- Not rectifying military students mistakes
- Not understanding the military processes frustrating
- Not using the official language
- Not wanting to work in certain wards
- Not wanting to work with certain seniors
- Nurses are abused in fulfilling military roles
- Nurses disregarded by other musterings
- Nurses not excluded from military duties
- Nursing is a calling
- Nursing profession is overruled by military

- Nursing profession is overruled by military
- Nursing profession is overruled by military
- Obedience
- Obeying vs advocating
- Offend patient if not addressed according to rank
- Offensive approach
- Okay to ask questions
- Older students less submissive, more respect
- Only mistakes are noticed
- Only noticing mistakes
- Opportunities to explore and learn
- Oppressing vs reprimanding
- Orderliness
- Organisational boundaries - blending of boundaries between military practitioners and health practitioners causes confusion
- Organisational boundaries - other arms of service interferes with work of SAMHS
- Organisational structure - health professionals appointed on strategic level seem to lose touch with their professions and disregard them when making decisions or giving instructions
- Organisational structure - members become stagnant
- Organisational structure - members become super specialised
- Organisational structures - non-health professional is in charge of health facilities and health professionals
- Over enforcement of ranks
- Overlook individual human being under uniform, rank
- Ownership
- Passion
- Patient accused students as being useless for not understanding home language
- Patient expects to be addressed in home language
- Patient showing gratitude
- Patient's right takes precedence over military culture
- Patients acknowledging good care received

- Patients demanding preferential treatment
- Patients don't cooperate
- Patients expects different treatment compared to civilian
- Patients expects personal treatment
- Patients knowing they will receive good care
- Patients looking up to them
- Patients loosing trust in students
- patients preferring to be treated by military students
- Patients refusing to be treated by students
- Patients showing appreciation for good care
- Peer support
- People having doubt in student
- Perceived as knowing nothing
- Perceiving as stumbling block to professional development
- Perceiving military students as being less informed
- Perceiving military students as being superior
- Perceiving military students as getting more money
- Perceiving military students as lazy
- Perceiving nurses as kind, loving, caring
- Perceiving nurses as lazy
- Perceiving nursing as the foundation to every profession in the world
- Perceiving self as more mature than civilian students
- Perceiving soldiers are less learned
- Perceiving students as disrespectful, defensive
- Perception of professionalism
- Personal empowerment
- Poor state of facilities
- Popular due to discipline and respect
- Portraying a negative attitude towards military students
- Portraying intellectual superiority
- Positive influence on behaviour
- Positive influence on discipline
- Positive patient outcome
- Power abuse counter efforts to instil professional values
- Power abuse degrades military culture of discipline and respect
- Power imposed by rank applied negatively

- Preferential treatment
- Preferring lecturers not to visit clinical area
- Prepare to adapt and function in military environment
- Prepare to function under stressful situations
- Prepare to provide medical support to combat forces
- Privacy being Invaded
- Professional development of lecturers
- Professional growth influenced negatively
- Professional nurses and managers also finding it difficult to deal with higher ranks
- Promotion vs experience and knowledge not years of service
- Protect military professional status
- Protect self against harshness of the military environment
- Punctuality
- Punishment for mistakes
- Punishment for transgressing rules
- Questioning military students' knowledge
- Questioning students' integrity
- Rank - fear
- Rank abuse
- Rank abuse - compensate for incompetence
- Rank abuse - compensate for knowledge deficit
- Rank abuse - protect personal space
- Rank system hampers professional development
- Rank system leads to submissiveness
- Rank system leads to submissiveness
- Rank system, inhibits decision making, being overruled by higher ranks
- Rank system, inhibits development of managerial skills inhibits development of leadership skills
- Rank, authority demeaning nurses
- Ranks, inhibit creativity and innovation
- Rationale for leadership style in peace/war
- Rationale for military way
- Rationale for recording everything
- Re-affirming passion for nursing
- Realising no place is perfect

- Realising that own morals will determine how good a military nurse you will be
- Receiving advice
- Receiving Bursaries
- Receiving compliments for ability to apply clinical skill
- Receiving more clinical exposure
- Receiving positive assurance
- Receiving praise for critical intervention
- Receiving support
- Recognised for being disciplined
- Regarding self as better than civilian students
- Registered Nurses are being too prescriptive
- Registered Nurses being more approachable
- Registered Nurses being more patient
- Registered Nurses doing nothing all day
- Registered Nurses don't enjoy nursing
- Registered Nurses not caring about students
- Registered Nurses not involving students in nursing activities
- Registered Nurses not protecting students against abuse of higher ranks
- Registered Nurses not showing interest in students
- Registered Nurses not willing to teach students
- Registered Nurses relax when students are working
- Registered Nurses take advantage of students, not assisting with patient care
- Registered Nurses treating students based on preconceived ideas
- Registered Nurses use friendships with lecturers to threaten students
- Rejuvenation of nurse educator
- Resist change
- Respect for authority not earned
- Respecting age, irrespective of rank
- Restrictive
- Role depends on situation
- Role during peace
- Role of lecturers in professional development of students
- Role of lecturers to act as role models, examples
- Role of lecturers to develop military nurses
- Role of lecturers to socialise students as military nurses

- Role of lecturers to teach students to be assertive
- Role of the educator to teach assertiveness, critical thinking, confidence
- Roles vs rank
- Rounding them of, contribute to patient care
- Routine interfere in private life
- Routine orientated
- Rules and regulations
- Rules vs profession
- Saluting and complementing
- SAMHS high regard by other arms
- SANC regulations
- Scared to address Registered Nurses
- Scared to ask questions
- Seeing questioning as ill discipline
- Self-motivation
- Self-reliance
- Seniors are prejudiced against students
- Seniors more confident
- Seniors not practice what they preach
- Separate health professions from military
- Sharing
- Sharing accommodation
- Shouting at military students
- Shouting at patients
- Shouting at students
- Showing lack of interest
- Showing lack of knowledge
- Showing less respect for patients
- Socialising with students
- Some conform
- Some default
- Speaking to patients in unacceptable manner
- Staffing
- Stereotyping soldiers as not being learned
- Strict military attitude helps to control students better
- Student body (SRC) less power due to military rules
- Student ranks
- Students accused of staying away for no reason
- Students accused of taking advantage
- Students accused of taking chances
- Students are being restricted
- Students are not being allowed to make mistakes

- Students are not being allowed to speak
- Students are not being allowed to use own initiative
- Students becoming more dependant again
- Students being assigned duties outside their level of training
- Students competing for limited learning opportunities
- Students expected to pay complements while busy with nursing duties
- Students feeling their opinions are not required
- Students involved in humanitarian operations, provide learning opportunities and experience
- Students must be taught the correct approach, the way to interact with difficult patients or patients demanding preferential treatment
- Students must be taught to stand up for the rights of the patient
- Students not acknowledged by other members of MDT
- Students not being afforded opportunities to learn
- Students not being task allocated according to clinical objectives
- Students not being taught the right thing when making mistakes
- Students not getting opportunities to practice clinical skills
- Students not given opportunity to manage ward
- Students not meeting clinical objectives
- Students regarded as lazy
- Students scared to stand up for themselves
- Students threated when correcting seniors
- Students unable to express dissatisfaction
- Subjective assessment
- Submissiveness
- Submissiveness seen as sign of respect, discipline
- Suggesting caring management style to curb negativity
- Suppress independent thinking hampers independent functioning
- Taking a long time learn the military customs
- Taking confidentiality more serious

- Task orientated
- Taught about military rules and regulations
- Taught about types of leadership styles
- Taught to listen, not to argue, students don't open up
- Teach independence
- Teaching a student decision making skills in a complex military environment will enable him to also make decisions under normal situations
- Teaching military etiquette, culture and discipline in the classroom
- Teaching respect
- Teaching students that patients are treated according to need and not rank
- Teamwork, interpersonal relations
- The importance of role modelling to teach students the correct ways to handle certain situations
- Theory practice correlation
- Theory-practice contradictions
- Threatening students
- To discipline vs to teach
- Top-down approach
- Tradition
- Training students to be able to do or take decisions is not always easy
- Transference of military rank / role from working environment to home environment
- Transgressing assessment policies
- Transition
- Treated as object vs human
- Treating military students different due to uniform
- Treating patients as if it is one self being nursed.
- Treating patients poorly
- Treating students as being nothing
- Treating students based on preconceived ideas
- Treating students in a demeaning way
- Treating students inconsistent
- Treating students unfairly
- Treatment of x and y
- Unable to give an opinion
- Unconducive learning environment
- Underestimating students' knowledge
- Underestimating what it takes
- Undermining

- Unemotional vs empathy
- Unethical assessment practices
- Uniformity
- Uniqueness
- Unknown - frustration
- Use of concrete everyday scenarios as a teaching strategy to teach students ethical decision making skills will boost their confidence and assertiveness
- Using emotional blackmailing
- Using military as stepping stone - Not 1st choice
- Using military culture to the advantage of lecturers ito discipline instead of caring culture
- Using of reflective performance practice
- Using rank to overrule nurses
- Using superiority making students uncomfortable
- Valuing saving lives and earning respect
- Victimising students
- VIP accuse student of incompetence
- VIP demanding attention
- VIP stress importance
- Wanting to make a difference
- Willingness to teach
- Wishing to remain working in civilian sector
- Withdrawing
- Work life miserable, full of hardships
- Working conditions becoming uncomfortable, making it difficult to work
- Working in other military facilities
- Workload
- Wounded soldiers sharing their experiences
- Wounded soldiers showing trust
- Writing skills
- Wrong expectations
- Y more questioning, less submissive, more free spirited
- Y potential supressed
- Years of service vs promotion

Annexure J

Expert reviewer package

1828/29 Klipkraal Crescent
Candlewoods Country Estate
Centurion
0157

14 July 2016

Dear XXXXXXX

INVITATION TO PARTICIPATE IN THE REVIEW OF A NEWLY DEVELOPED MODEL ON THE INFLUENCES OF THE HIDDEN CURRICULUM IN THE MILITARY TEACHING AND LEARNING ENVIRONMENT DURING STUDENTS' PROFESSIONAL SOCIALISATION

I am currently registered for the degree D Litt et Phil at the Department of Health Studies, University of South Africa (UNISA).

I conducted a study titled "The influence of the hidden curriculum on professional socialisation of student nurses in a military nursing context". The aim of the study was to develop a model that focuses on creating an awareness of the existence of a hidden curriculum, guiding role players through the impact of the hidden curriculum on students' professional socialisation and helping them understand how their contribution could improve the outcome of the professional socialisation process.

Ethical clearance for the study was obtained from the Department of Health Studies Higher Degrees Committee at UNISA (Certificate no HSHDC/335/2014) as well as the 1 Military Hospital Research Ethics Committee. The study was conducted under the supervision of Prof GH van Rensburg.

You are hereby invited to participate in the review of the model. Your professional background and expertise will be of great value to ensure that the model complies with the required criteria. Your participation is voluntary.

Your identity will be protected at all times and all personal information will be treated as confidential. Nothing that may identify you will be included in the research report or subsequent presentations and publications.

Attached is an overview of the study and the model as well as the tool to be utilised for the review.

Your participation will greatly contribute to the finalisation of the model in particular but also to nursing education in general.

Should you need to discuss any aspects related to the study or the model, feel free to contact myself at 012 674 6302 or kzagenhagen@gmail.com or Prof van Rensburg at 012 429 6514 or vrensgh@unisa.ac.za.

Your willingness to participate will be highly appreciated.

Sincerely

(K. ZÄGENHAGEN)
DOCTORAL STUDENT UNISA

1. OVERVIEW OF THE STUDY AND MODEL

1.1 Background to the study

During a National Nursing Summit held in April 2011 issues of central concern to the future of the nursing profession in South Africa were highlighted. Concerns pertaining to professional ethos that were raised and discussed by attendees included the drop in standards of nursing, the decline in the image and status of the profession, the lack of professionalism, an increase in cases of unethical conduct and complaints against nurses, poor nurse-patient relationships characterised by poor communication, bad attitudes and incidents of violence and abuse and moral distress amongst nurses (DOH 2013:22-23).

Similarly, during 2013 the Military Psychological Institute (MPI) conducted a client satisfaction survey with the aim to determine if the South African Military Health Services (SAMHS) clients are satisfied with the health services they receive. A 21-item questionnaire was constructed to measure the key components of client satisfaction in healthcare. The finding of the study indicated that the SAMHS clients had broadly positive experiences at SAMHS service points across the country. Despite this largely positive feedback, it appeared that the respondents encountered some very serious challenges at the various facilities. These issues included inter alia the long waiting times, the attitude of SAMHS personnel towards patient and the perceived lack of professionalism from staff (MPI 2013).

The process through which a person acquires the norms, attitudes, behaviours, skills, roles and values to form a professional identity and that will allow an individual to become a member of a specific group or society is dubbed by Chitty and Black (2011:131) as professional socialisation.

Zarshenas, Sharif, Molazem, Khayyer, Zare and Ebadi (2014:432–438) identify two aspects of socialisation for health professionals. The process of organisational socialisation entails fitting into the structure of the organisation, learning the organisational culture, learning the formal and informal rules of the organisation and maintaining relationships with colleagues. Professional socialisation refers to the internalisation of the values and the culture of the profession.

By integrating the definitions of Chitty and Black (2011:131) and Zarshenas et al (2014:438), professional socialisation can thus be described as the process whereby a lay person is influenced to assimilate, internalise and reflect the norms, values, beliefs, attitudes, behaviours, skills, knowledge and roles of a profession into his own behaviour and self-concept in order to acquire the professional identity characteristic of that profession.

Cruess and Cruess (2009:112-113) identify two distinct approaches to the teaching of professionalism. The first contemporary formal didactic approach underlines the need for professionalism to be taught explicitly to ensure that the student understands the nature, characteristics, reasons and obligations of professionalism. The second approach regards professionalism as fundamental to the process of socialisation during which the values, attitudes, interests, skills and knowledge associated with the profession are acquired through experiential learning in an authentic context. Stern and Papadakis (2006:1794) propose, in line with the second approach, that professionalism is "caught rather than taught", and as an outcome, it is implicit rather than explicit. Numerous studies (Karimi, Ashktorab, Mohammadi & Abedi 2014:53-57; Chuang, Nuthalapaty, Casey, Kaczmarczyk, Cullimore, Dalrymple, Dugof, Espey, Hammoud, Hueppchen, Katz & Peskin 2010:316; Gaufberg, Batalden, Sands & Bell 2010:1709-1716) relate that most of what is learned, takes place not within the formal course curriculum, but by means of interactions and influences intrinsic to the teaching and learning environment.

These perspectives on the teaching of professionalism and the process of professional socialisation within a multi-dimensional teaching and learning environment suggest the existence of different types of curricula.

Educational theorists such as Jackson (1968), Tyler (1969), Snyder (1970), Apple (1980) and Eisner (2002) make distinctions between three layers of curricula namely the formal, the informal and the hidden.

The formal curriculum is seen as the explicit transmission of official knowledge to students. It represents the structure and content of intentional education, designed in accordance with specific objectives. Educators have however long determined that the formal curriculum does not serve as the only means of education within social institutions (Hafferty & Franks 1994:869).

Stern and Papadakis (2006:1794) explain the informal curriculum as an undocumented, predominantly *ad hoc* and highly interpersonal form of teaching and learning that takes place among and between educators and students.

The hidden curriculum is about "those parts of the environment that influence the experience of students but that are either not accounted for or cannot be accounted for in curriculum planning" (Van Veen et al 2012:66). The term was introduced by Jackson (1986) and became especially useful for discovering mechanisms underlying the experiences of students.

Melrose, Park, and Perry (2015:37) use the terms incidental or unintentional learning to refer to unplanned learning where students are only aware that learning has occurred after the experience. It is situated, contextual and social and can happen when watching or interacting with others, from making mistakes, or from being forced to accept or adapt to situations.

Hafferty (1998, 2010, 2011) also makes reference to the fact that some of the learning processes take place in the formal explicit part of the training, but that others operate latently in the sphere of the hidden curriculum. He introduced the concept of the hidden curriculum to the medical education community by highlighting the importance and impact of structural factors on the learning process and challenged medical educators to acknowledge those factors present during training that will define what is 'good' and 'bad' medicine. Hafferty (2000:238) defines the hidden curriculum thus as a set of influences that function at the level of organisational structure and culture, inclusive of commonly held understandings, implicit rules, customs, rituals, and taken for granted aspects. The hidden curriculum thus entails the potential transmission of knowledge, attitudes, behaviours, values, norms, perceptions and skills that were not originally intended by the formal curriculum.

From the above discussion, it is evident that a clear correlation exists between the process of professional socialisation and the potential influence of factors in the teaching and learning environment on this process.

1.2   Statement of the research problem

Due to the unique context, the professional socialisation of student nurses at the SAMHS Nursing College is compounded by simultaneous military socialisation within a teaching and learning environment inundated with military culture. Given the unique teaching and learning environment in which these students find themselves, it is difficult to ascertain whether desirable professional attributes are nourished by the military environment or if its development is inhibited by this same environment. It is thus likely that implicit factors or hidden elements in the military organisational structure, culture and learning environment may influence the professional socialisation of these students.

1.3   The research question

What is the nature and significance of the hidden curriculum in a military teaching and learning environment and how does it influence the professional socialisation of student nurses?

1.4   Purpose of the study

The purpose of this study was to explore the nature of the hidden curriculum in a military teaching and learning environment, and to determine its influence on students' professional socialisation. Concepts derived from the qualitative data were used to develop a substantive model to create an awareness of the existence of a hidden curriculum, to guide role players through the impact of the hidden curriculum on students' professional socialisation and to help them to understand how their contribution could improve the outcome of the professional socialisation process.

1.5   Objectives

In order to achieve the aim of the study the following research objectives were formulated:

- Establish the existing knowledge, attitude and perceptions of nurse educators and student nurses with regard to military and nursing professionalism.

- Explore and describe the nature and significance of the hidden curriculum in a military teaching and learning environment and its influence on the professional socialisation of student nurses.

- To develop a substantive model to provide nurse educators and professional nurses with a frame of reference that would create an awareness of the existence of a hidden curriculum, to guide them through the impact of the hidden curriculum on students' professional socialisation and to help them to understand how their contribution could improve the outcome of the professional socialisation process of students.

1.6   Significance of the study

Examining the hidden curriculum in a military teaching and learning environment will allow nurse educators to acknowledge the subtle or not-so subtle messages that are not part of the intended curriculum and will help them to understand the role of transmitting "tacit messages to students about values, attitudes and principles" (Kentli 2009:6). By determining the nature and elements of the hidden curriculum, and by developing a model for the hidden curriculum in the military teaching and learning environment will assist nurse educators and professional nurses to recognise its presence, enhance their understanding thereof, and its influence on the professional socialisation of student nurses.

1.7   Research methodology

A qualitative constructivist grounded theory research study was conducted based on the researcher's philosophical assumptions. The study was conducted in three phases, where each phase addressed one of the objectives. The first two objectives were addressed simultaneously during Phases 1 and 2. The researcher made use of focus groups and critical incident narratives to gather rich data in order to reach the first two objectives. In keeping with the constructivist paradigm adopted for this study, Charmaz's (2014) data analysis approach was followed which included open coding, focussed coding, theoretical coding, sorting and integration, diagramming, theoretical sensitivity, reflexivity, constant comparison, memoing and theoretical sampling.

After identifying the emerging concepts, grouping them to form sub-categories and then categories, Phase 1 finally lead to the formulation of four themes namely:

- Theme 1: "You're in the army now!" – Military acculturation
- Theme 2: "Off to boot camp" – Professional knowledge acquisition
- Theme 3: "Off to the battle field" – Clinical skills acquisition
- Theme 4: "Fighting a dichotomy" – Professional role conflict

In order to reach the second objective of the study, the researcher scrutinised the findings of Phase

1 to identify all the hidden elements in the military teaching and learning environment as well as the influences these might have on the professional socialisation of student nurses. Through inductive reasoning, the researcher extrapolated the large number of hidden elements to broader conceptual categories. In the same manner, the large number of influences identified were reduced into more collective and descriptive categories. Two broad categories of influences were identified namely either those that enhance or those that impede the professional socialisation of student nurses. The influences were then linked to the hidden elements.

2. THE MODEL

2.1 Overview of the model

The need for a model to address the hidden curriculum in a military teaching and learning environment arose as a result of the researcher's personal experience as a military nurse educator, witnessing the interactions between nurse educators themselves as well as between nurse educators and students and also experiencing the effect of the military environment on the day-to-day activities of nursing education and how students react to it. The findings of the focus groups contributed to the notion that the military teaching and learning environment is extremely complex and contains a myriad of overt, but mostly covert elements that unknowingly play a role in the professional socialisation of student nurses.

2.2 Purpose of the model

The purpose of this model is to provide nurse educators and registered nurses with a frame of reference in order to sensitise them to the existence of a hidden curriculum in the military teaching and learning environment and to allude them to the effect of the elements of the hidden curriculum on the professional socialisation of student nurses.

By creating an awareness of the hidden elements discovered during the course of this study and by making recommendations on how this model should be implemented, nurse educators in particular, but also all other healthcare professionals dealing with students will be enabled to identify the elements of the hidden curriculum at play and use them to the benefit of the student and the health profession.

2.3 Assumptions of the model

Assumptions are the basic underlying premises from which and within which theoretical reasoning proceeds (Chinn & Kramer 2014:180-181). Since grounded theory research was used to study the influence of social interactions between educators and students, the interaction of students with the military and professional environment as well as the influence of 'symbols' emanating from the military structure and culture on the professional socialisation of students nurses, the assumptions of this model are based on the constructivist paradigm (Polit and Beck 2014:7) and symbolic interactionism with its focus on social processes (Oktay 2012:10-11).

The constructivist assumptions are related to the multiple and subjective realities constructed by the participants of the study during data collection, the insight grounded in the participants' experiences that emerged during data analysis and the inductive processes which led to the formulation of the substantive model.

Symbolic interactionism is defined as "... a process of interaction that leads to the formation of meanings for individuals" (Blumer 1969:12) and "... a theory which focuses on the manner in which people make sense of social interactions and the interpretations they attach to social symbols such as language" (Blumer 1969:16). Symbolic interactionism serves as a framework for viewing the social world. The context of nursing education in a military environment was identified as the social world of the participants of this study. The social world comprised the behaviours, actions and responses to the interactive processes between human beings themselves and between human

beings and their environment. The following assumptions were derived from Charmaz's (2014:262-273) interpretation of the symbolic interactionism:

- Interaction occurs within a social, cultural and historical context that shape but do not determine it.

- Interaction depends on the spoken and unspoken shared language and meanings.

- Interpretation and action arise from interaction.

- Interpretation and action are viewed as reciprocal processes, each affecting the other.

- People are active beings engaged in practical activities in their world and how they accomplish these activities.

- Social interaction forms human conduct.

These assumptions are applied to the key concepts of the model as follows:

- Students are actively engaged in learning activities or interactive processes.

- Interaction takes place between students and military instructors, students and nurse educators, students and professional nurses, students and health care professionals and students and patients.

- This interaction takes place within a military environment. The interaction is influenced by symbolic elements in this environment such as the military culture.

- The interaction between the mentioned role-players occurs by means of verbal and non-verbal messages and these messages can be explicit as well as implicit.

- Students interpret or form meaning from these messages and act upon them.

- The social and environmental interaction determine the students' conduct or the manner in which they are professionally socialised.

2.4   Context of the model

The context describes the circumstances or situations in which the theoretic relationships of the model are expected to be empirically relevant and is important for the implementation of the model (Chinn & Kramer 2014:181-182). The context of this model is the SAMHS Nursing College and the respective theoretical and clinical teaching and learning environments in which nurse educators, student nurses, professional nurses, patients and other health care professionals interact with each other on a daily basis. The main context was military specific, although student nurses were also exposed to civilian clinical learning environments.

The use of the model is not restricted to the context in which the study was conducted. The model is applicable to all uniformed healthcare professionals within the South African Military Health Service, not only nurses, as well as to uniformed healthcare professionals in any Defence Force globally. There are generic elements of the hidden curriculum that are also applicable to civilian health care professionals as well as to non-health care professionals. This model is thus transferrable to a wide range of contexts.

2.5 Conceptual definitions

The concepts are the elements that convey the focus and meaning of the model (Chinn & Kramer 2014:178-179). The model comprises of a variety of concepts which were derived from the data. In order to ensure a comprehensive understanding of the model, all concepts reflected in the model are defined.

- Career choice

  According to Parson's Theory, career choice is the selection of a particular occupation or profession through the analyses of skills, values, interests and personality and matching these to a career (Parson 1909:5). For the purpose of this study, career choice refers to the initial decisions made by the recruits to firstly apply for a career in the Defence Force and secondly to embark on a career in nursing.

- Military Skills Developments System (MSDS) recruit

  The Military Skills Development System (MSDS) is a voluntary service system that was incorporated into the Defence Strategy in 2003 (DOD 2003:2) through which recruits receive Basic Military Training and enablement skills over a period of two years. Selected nursing students complete the first year of the MSDS programme prior to commencing with their nursing programme. For the purpose of this study, selected nursing students are referred to as recruits while they are still busy with military training. As soon as they commence with nursing training, they are referred to nursing students.

- The military environment

  For the purpose of this study, the military environment encompasses the entire military unique context in which the nursing students live, study and work.

- The military teaching and learning environment

  The military teaching and learning environment as applied to this study encompasses the overarching milieu in which health care professionals, nurse educators and students interact, inclusive of the clinical and theoretical learning environments.

- Military acculturation

  Military acculturation is the process of being introduced to military life, of learning the traditional content of the military culture and to assimilate its practices and values (Global Perspectives Consulting, 2013).

- Professional knowledge acquisition

  For the purpose of this study and model, professional knowledge acquisition refers to the process of teaching and learning the theory of nursing.

- Clinical skills acquisition

  For the purpose of this study, clinical skills acquisition refers to the process of placing student nurses in a variety of healthcare facilities in order to expose them to clinical learning opportunities as well as the process of practicing the clinical skills required to become proficient professional nurses.

- Military instructor

   For the purpose of this study, a military instructor is a person commissioned to induce all new military recruits into the military culture through military training.

- Nurse educator

   A nurse educator is a registered nurse who has undergone a programme of education at an approved education institution and is registered for an additional qualification in nursing education (SANC 1987). Nurse educators referred to in this study were those involved in the four year Diploma in Nursing Science (General, Community and Psychiatry) and Midwifery as stipulated by Regulation 425 (SANC 1985) at the SAMHS Nursing College. Student nurses referred to nurse educators as 'lecturers' in this study.

- Student nurse

   A student nurse is a person who has successfully completed 12 years of schooling and meets the entrance requirements of an approved nursing school (Kotzé 2008:187). For the purpose of this study a student nurse is a person who is registered as a student at SANC for the four year Diploma in Nursing Science (General, Community and Psychiatry) and Midwifery as stipulated by Regulation 425 (SANC 1985) and studied at the SAMHS Nursing College.

- Health care professional

   A health care professional is "any person registered in terms of the applicable Act which governs the functioning of any of the Councils that form part of the Forum of Statutory Health Councils" (HPCSA 2008:2). For the purpose of this study, the term was used to refer to health care professionals other than nurses, for example doctors and ancillary healthcare professionals registered by the Health Professions Council of South Africa.

- Registered nurse

   Registered nurses are qualified nurse practitioners and registered under section 31(1) of the Nursing Act (Act 33 of 2005) in order to practise nursing or midwifery. For the purpose of this study registered nurses refer to those working at the selected Military Hospital and who are also responsible for the teaching of student nurses.

- Patient

   For the purpose of this model, a patient refers to any person making use of the military clinical facilities where student nurses are placed for clinical exposure.

- Duality

   Duality refers to the dual professional roles that military nurse educators and military student nurses assume namely a professional nurse as well as a professional soldier.

- Elements of the hidden curriculum

   The hidden curriculum is a set of influences that function at the level of organisational structure and culture. It refers to the unwritten, unofficial, and often unintended lessons, values, perspectives, attitudes and principles which may be implicitly conveyed to students (Hafferty 1998:404). The elements of the hidden curriculum, in the context of this model, refer to all the salient aspects in the military teaching and learning environment, identified during the course of this study, which may have an influence on the professional socialisation of student nurses.

- Contributing influences

  Contributing influences refer to the positive effects of the elements of the hidden curriculum on the professional socialisation of student nurses.

- Impeding influences

  Impeding influences refer to the negative effects of the elements of the hidden curriculum on the professional socialisation of student nurses.

- Professionally socialised military nurse

  The professionally socialised military nurse will be the qualified nurse who acquired the necessary norms, attitudes, behaviours, skills, roles and values to form a professional identity (Chitty & Black 2011:131) by moving through the processes of military acculturation, professional knowledge acquisition and clinical skills acquisition without being impeded by the elements of the hidden curriculum.

2.6 Relationship statements

Relationship statements are used to describe the nature of the interactions between two or more concepts of the model (Walker and Avant 2011:183, Chinn and Kramer 2014:182). The relationships already started to form as the concepts emerged during data analysis. Relationships between concepts are usually directional, implying that one concept precedes another, or that one or more concepts give rise another.

In order to become a professionally socialised military nurse, the recruit must make a double career choice, firstly to become a nurse and secondly to become a military nurse. The recruit then enters the Defence Force and thus the military environment through the MSD system.

Within the military teaching and learning environment, the recruit receives military training which will lead to military acculturation. The military instructor is responsible for the socialisation of the recruit into the military culture.

Following military acculturation, the recruit then commences with nursing training. The nurse educator is primarily responsible for professional knowledge acquisition, but at the same time, continues to instil military culture into the student nurse.

Simultaneously, the student nurse is exposed to the acquisition of clinical skills. Although the nurse educator and the professional nurse are the main role-players during this process, other healthcare professionals and the patients also have an influence on the experience of the student nurse.

The processes of military acculturation, professional knowledge acquisition and clinical skills acquisition is cyclical and overlapping. Due to the dual professional roles of being a nurse as well as a soldier, the concept of duality is evident throughout all three processes as a result of the contradictions experienced by the student nurse.

There are elements of the hidden curriculum present during the processes of military acculturation, professional knowledge acquisition and clinical skills acquisition and all the role-players also send implicit messages to the student nurse which form part of the hidden curriculum. The elements of the hidden curriculum, depending on whether they are positive or negative, can either contribute to, or impede the professional socialisation of the student nurse.

2.7 Structural description of the model

The previous section described the relationships between the concepts forming the model. This section continues to clarify the model in Figure 2 by describing its structure.

The main building blocks or components of the model originated from the discussions of the research findings. The model further consists of the categories identified during inductive reasoning of the hidden elements in the military teaching and learning environment, namely people, processes and places.

The starting point of the model is the grey arrow at the top of the diagram. The shape of the arrow has dual symbolism. It firstly symbolises the choice that a student must make in terms of a career, and secondly it symbolises the direction into which that choice will take the student. The grey colour of the arrow means that this choice is neither black nor white, reflecting the contradicting preconceptions and uncertainty that students experience when making such a choice.

The next component represents the new military recruit after the career choice has been made. The white colour of the box is an indication that the recruit is still 'pure', unaffected by the hidden elements. The square shape of the box signifies the narrowmindedness of the recruit as a result of military indoctrination during military training. The arrow extending from the white box crosses the boundary of the military environment indicating a new direction, the transition from civilian to soldier. The military instructor is the first person that the recruit encounters during military training. The brown colour of the circle representing the military instructor symbolises his military role. The military instructor forms part of the arrow that stretches to the green circle labelled military acculturation to indicate that he plays a part in the process of adopting the military culture and a professional military identity.

The outer box represents the military environment. It is characterised by the colours of the field wear or camouflage uniform of members of the SANDF. The box is enclosed, symbolising the unique culture of the organisation as well as the inclusive nature of the military. The square shape of the box is indicative of the structural nature and rigidity of the military.

The military teaching and learning environment is situated within the military environment. The trough-like shape of the military teaching and learning environment also has a dual meaning. It firstly shows how a person is being shaped from a novice into a professional and secondly, more literally, how a large group of students are reduced to a much smaller group who complete the course successfully. The camouflaged colour of the outside of the trough is an indication that the teaching and learning environment is still a military environment. The pink inside of the military teaching and learning environment symbolises the nurturing and caring environment that should be evident in a nursing education institute but is covered or overshadowed by the military environment.

Within the military teaching and learning environment, the processes of military acculturation, professional knowledge acquisition and clinical skills acquisition are taking place. These processes are represented by green circles to symbolise the personal and professional growth that takes place. The green arrows connecting the circles are indicative that these processes occur simultaneously and that they have an influence on one another. The overlapping sections of the circles signify the professional role conflict or duality experienced by student nurses throughout all three processes. This part of the model represents the four themes of this study.

The student nurse is situated in the middle of these processes as the main recipient of the training as well as influences from the military teaching and learning environment. The student is depicted as a neutral grey coloured circle to indicate that he or she is still in the process of developing a nursing identity. The nurse educator, as a blue coloured circle, is indicated as being a main role-player throughout all the processes. The patients, registered nurses and other healthcare professionals are depicted as circles around the process of clinical skills acquisition to illustrate their role during this process.

The dashed concentric circles symbolise the elements of the hidden curriculum. They are situated within the military teaching and learning environment and are white to illustrate their actual invisibility. They are dashed to give the illusion of a filter, to illustrate that certain elements enhance whilst others

inhibit professional socialisation. This is then demonstrated by the light blue and orange arrows which represent the contributing and impeding influences on professional socialisation respectively.

The last component of the model, which is also the optimal outcome of all the processes, is the formation of a professionally socialised military nurse. The ruby colour of the box is representative of military health services globally as well as the ruby epaulettes of a registered nurse in the South African context. The arrow depicts the exit of the newly qualified nurse from the military teaching and learning environment, into the military environment to practice as a military nurse. The dashed extension of the arrow reaching through the boundary of the military environment, symbolises the possibility of the qualified nurse to exit the Defence Force and continue to practice as a registered nurse in any other context.

2.8   Implementation of the model

To achieve the purpose of the model, it needs to be implemented in practice. The implementation of any new idea or approach is synonymous to change. The researcher thus adopted the Change Management Model of Kotter (2012) as implementation guide for this model.

In order to optimise the contributing influences of the hidden curriculum on the professional socialisation of student nurses and to minimise the impeding factors, all role players must firstly be identified and secondly be made aware of the existence of the hidden elements and how they may influence the outcome of the professional socialisation process. Role players must further be made aware of the changes they can make to either optimise the contributing factors or minimise the impeding factors.

Any suggestion of implementing change is however often met with resistance, preventing lasting transformation of practice. To counteract this, the steps outlined in Kotter's change management approach can support transformation through an organised and methodical behavioural change process. By embracing this approach, role players will develop an understanding of lasting modifications to their behaviour, and change their mental and emotional perspective from the way they are used to working and sustain a new perspective.

Implementing this model requires a systematic and holistic approach which focuses on creating an awareness of the existence of a hidden curriculum, guiding role players through the impact of the hidden curriculum on the professional socialisation process of student nurses and helping them to understand how their contribution can make a difference to the outcome of the professional socialisation process.

- Step 1: Create urgency

  The first step requires that leadership and management buy into and support the proposed change. This implies that the leadership of the SAMHS Nursing College and military clinical facilities are made aware of the existence of the hidden curriculum and the influence thereof on the professional socialisation of student nurses. This can be done by means of workshops or presentations where the findings of this study are made visible and the model is explained.

- Step 2: Form coalitions

  Coalitions or task teams must be formed to actively lead the change process. This strategy involves the expertise, influence and belief of a few people to convince others that certain changes are necessary. This step can start by identifying a few key role players from the Nursing College and the military clinical facilities to collectively agree on some strategies to enhance or limit the impact of the identified elements.

- Step 3: Communicate the vision

  Through engagement and constant communication with other role players, the task team can better educate other role players regarding the hidden curriculum and the influence thereof on the professional socialisation of student nurses. The student nurses themselves will be engaged at this stage so that they can also become aware of the existence of the hidden curriculum and its influences on their own professional socialisation.

- Step 4: Remove obstacles and enable actions

  Having implemented the first three steps, the effectiveness of the implementation process can now be assessed. Follow up interviews with student nurses and nurse educators can be used to determine if a positive change is evident or not. The task team can also meet to address concerns and remove obstacles to help move the change process forward.

- Step 5: Generate wins

  Step 5 will entail that positive change and successes are communicated and celebrated whilst momentum and motivation are maintained.

- Step 6: Hold the gain, build the change

  Early successes are the beginning of successful sustainable change. During step 6 achievements offer the opportunity to build on what went right or improve what didn't work quite as well.

- Step 7: Anchor the change in the culture

  Anchoring the changes implies that it becomes part of the organisational culture and vision as well as that the leadership continues to support the change.

- Step 8. Institute change

  To ensure new behaviours are repeated over the long-term, it is important that the connections between these behaviours and the successes are defined and communicated. This last step thus entails that those actions and strategies which had a positive influence on the professional socialisation of student nurses be reinforced and communicated on a continuous basis.

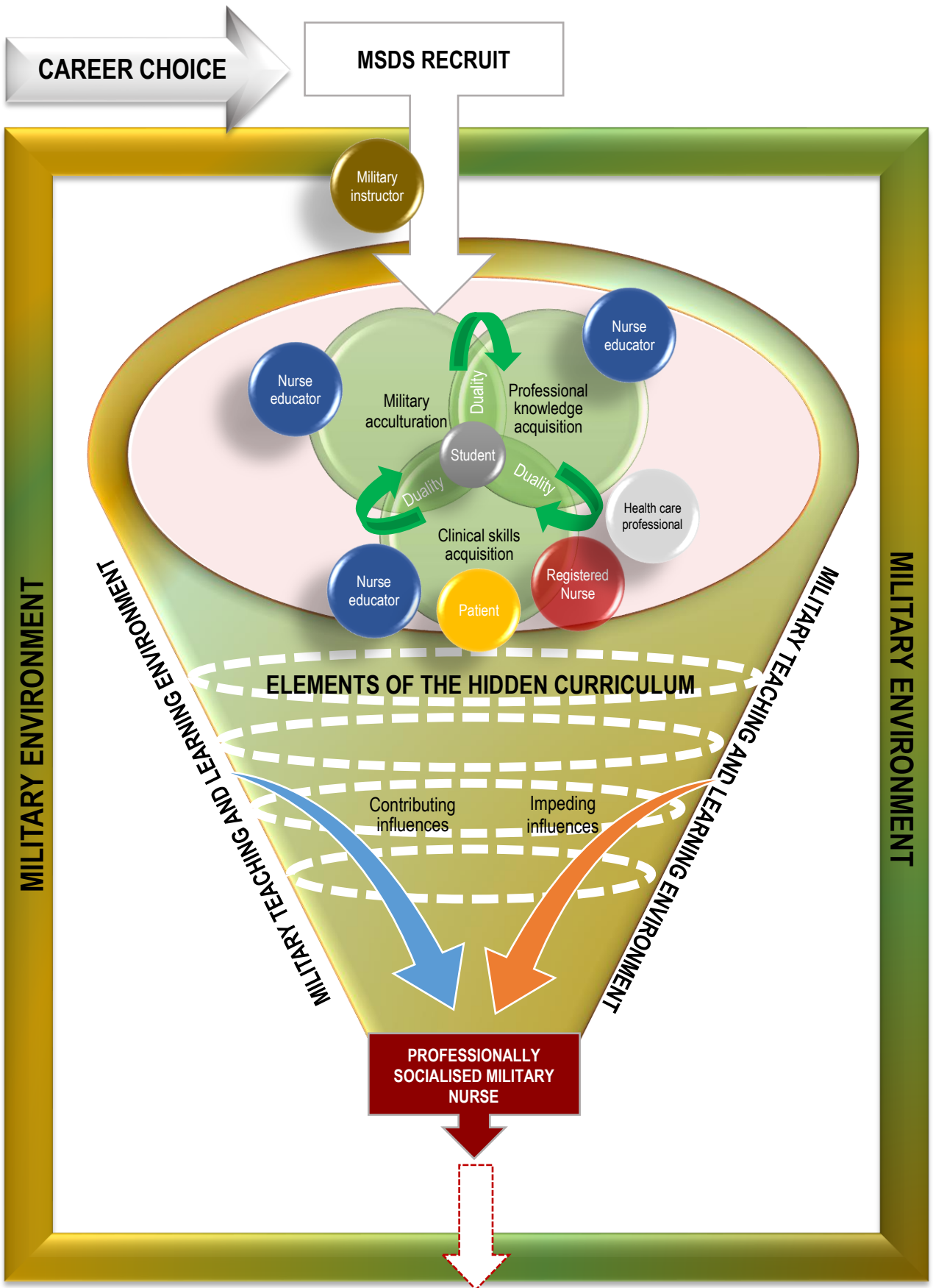**Figure 1: Kotter's 8-step process for leading change (Kotter 2012)**

Figure 2: A model for integrating the influences of the hidden curriculum in a military teaching and learning environment on the professional socialisation of student nurses

TOOL FOR THE REVIEW OF THE MODEL

Biographic data

Area of employment	
Specific area(s) of expertise	
Years of experience in field(s) of expertise	
Highest academic qualification	

Review of the model

Kindly indicate whether you think the model complies with the undermentioned criteria by making a cross in the relevant block. Any additional comments are welcome.

Semantic clarity and consistency

Criteria	Acceptable	Acceptable with minimum changes	Not acceptable	Not applicable	Comments
The model is easy to understand					
The meaning of concepts contained in the model are clear and understandable					
Concepts are relatable to common meanings and defined in a short and simple manner					
Concepts were described by making use of subject literature and commonly accepted operational definitions and terms that are making sense					
Words and concepts were used in the same way throughout the model description					
Concepts are used consistently with their definitions					
The relationships between the main concepts are stated					
The relationship statements are clear					
The definitions of the concepts in the model are consistent with common meanings in the nursing as well as the military environment					

Structural clarity and consistency

Criteria	Acceptable	Acceptable with minimum changes	Not acceptable	Not applicable	Comments
The diagram is well presented and clear to follow					
The connections and reasoning within the model are understandable					
Structural clarity is maintained by making use of simple structures to represent concepts, by making use of a variety of colours to distinguish between the different concepts and by making use of arrows to direct the logic flow of the diagram					
The concepts fit within the model and a correlation exists between the diagrammatic presentation and the written description of the model					
The structures are helpful and meaningful					
The structures are consistent with their definitions					
The structures are compatible and coherent					
There are no gaps in the flow of the model					
There are no ambiguities as a result of the sequence of presentation					
The model accomplish what it set out to do					

Simplicity

Criteria	Acceptable	Acceptable with minimum changes	Not acceptable	Not applicable	Comments
There are not too many theoretical relationships between or among many complex structural components					
Relationships between the concepts are organised into a logical sequence of events that is easy to understand					
The relationships contained within the model are clear, congruous and consistent					
The relationships are organised logically					
The number of concepts contained in the model are sufficient to explain the model					

Criteria	Acceptable	Acceptable with minimum changes	Not acceptable	Not applicable	Comments
The model imparts understanding and creates meaning					
The assumptions underlying the model are explicit					

Generalisability

Criteria	Acceptable	Acceptable with minimum changes	Not acceptable	Not applicable	Comments
The model is broad and wide in scope					
The model is applicable to an array of situations and contexts					
The generic components in the model can be applied to other healthcare professionals as well as other contexts, military as well as civilian					
The purpose of the model is stated specifically					
The purpose of the model applies to other practice/educational areas					

Accessibility

Criteria	Acceptable	Acceptable with minimum changes	Not acceptable	Not applicable	Comments
Empiric indicators for each of the concepts can be identified in reality					
The projected outcomes of the model will be achievable after it has been operationalised					

Importance

Criteria	Acceptable	Acceptable with minimum changes	Not acceptable	Not applicable	Comments
The model is usable in practice, education and research					
The model is valuable in creating a desired future					
The model has the potential to influence the outcome of nursing education					

Criteria	Acceptable	Acceptable with minimum changes	Not acceptable	Not applicable	Comments
The use/application of this model will resolve important issues in nursing					
The model is futuristic and forward-looking					
Research based on the model will answer important questions					

General

Criteria	Acceptable	Acceptable with minimum changes	Not acceptable	Not applicable	Comments
The title of the model is explanatory of and relevant to its purpose					
The model is socially congruent, it meets social expectations					
The model is socially significant, it can lead to actions that could make a difference					
The model is socially useful, it is comprehensive enough to provide guidelines for practice, education, administration and research					
The model can be implemented without any additional cost in material and human resources					
The model can be implemented without additional training of those implementing it					
The model was developed by using appropriate methods					
The model is internally valid and structurally sound					

Any other comments:_____
_____
_____
_____
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Thank you!