

DEVELOPMENT OF A THEORY OF ORGANIZATIONAL MICROCULTURE
THROUGH AN EXPLORATORY INVESTIGATION OF THE
UNITED STATES ARMY MEDICAL CORPS

A thesis presented to the Faculty of the U.S. Army
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fulfillment of the requirements for the
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General Studies

by

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The opinions and conclusions expressed herein are those of the student author and do not necessarily represent the views of the U.S. Army Command and General Staff College or any other governmental agency. (References to this study should include the foregoing statement.)

ABSTRACT

DEVELOPMENT OF A THEORY OF ORGANIZATIONAL MICROCULTURE
THROUGH AN EXPLORATORY INVESTIGATION OF THE UNITED STATES
ARMY MEDICAL CORPS, by Kimberley A. Maxwell, 147 pages.

Microcultures develop within organizations when groups express thoughts and behaviors, or are responsible for actions, that are distinct from the dominant macroculture. Often the existence of these microcultures is essential to the optimal performance of the organization. When developing policy and applying regulations, it is likely that the impact will differ among members of these groups. This research uses an exploratory, qualitative, grounded theory approach and examines available published data on social media, personal narrative, and scholarly journal sources.

A theory of organizational microculture explores how these groups experience power, rules, and norms while considering the role of the individual and group dynamics. The application of this framework to the United States Army Medical Corps demonstrates the need for focused attention on Graduate Medical Education as a source of professional identity and microculture development early in the Medical Corps officer's career. Additionally, understanding how Medical Corps officers experience different aspects of their service can help to refine and prioritize future research and senior leader emphasis.

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TABLE OF CONTENTS

	Page
MASTER OF MILITARY ART AND SCIENCE THESIS APPROVAL PAGE	iii
ABSTRACT.....	iv
ACKNOWLEDGMENTS	v
TABLE OF CONTENTS.....	vi
ACRONYMS.....	ix
ILLUSTRATIONS	xi
TABLES	xii
CHAPTER 1 INTRODUCTION	1
Background	1
Problem Statement.....	6
Purpose of the Study	6
Research Questions.....	7
Assumptions.....	7
Definition of Terms	8
Scope.....	9
Scope.....	9
Limitations and Delimitations	10
Significance of the Study	11
Summary	11
CHAPTER 2 LITERATURE REVIEW	13
Purpose of the Study	13
Research Questions.....	13
Introduction.....	14
Culture: General Definitions and Research	14
Models of Culture by Author	17
Cross-Cultural Analysis	32
History of the AMEDD, MC, and GME Specific Research Trends	35
Summary	48
CHAPTER 3 RESEARCH METHODOLOGY	50
Purpose of the Study	50

Research Questions	50
Rationale	51
Research Methodology, Data Collection, and Analysis	52
Ethical Considerations	53
Summary	55
CHAPTER 4 ANALYSIS	56
Initial Framework Development	56
Application of Initial Critical Framework	60
Social Media Content.....	60
Narrative Journal.....	61
Academic Journal.....	62
Development of the Final Framework	64
Power	64
Rules	67
Groups.....	69
Individuals.....	71
Norms.....	73
The Final Critical Framework.....	76
CHAPTER 5 CONCLUSIONS AND RECOMMENDATIONS	77
Summary of Research Questions.....	77
Secondary Research Question 1.....	77
Secondary Research Question 2.....	79
Power	79
Rules	80
Groups.....	82
Individuals.....	84
Norms.....	87
Primary Research Question.....	89
Conclusion	91
Recommendations.....	92
Future Research	93
Closing Thoughts.....	94
APPENDIX A EXAMINATION OF THEORIES FOR KEY THEMES	95
APPENDIX B ITERATIVE KEY THEME DATA	97
APPENDIX C SOCIAL MEDIA DATA	107
APPENDIX D NARRATIVE JOURNAL DATA	114
APPENDIX E ACADEMIC JOURNAL DATA.....	122

APPENDIX F FINAL CRITICAL FRAMEWORK	127
BIBLIOGRAPHY	128

ACRONYMS

ACGME	Accreditation Council for Graduate Medical Education
ADSO	Active-Duty Service Obligation
AMEDD	Army Medical Department
AMSUS	Association of Military Surgeons of the United States
BOLC	Basic Officer Leader Course
CCC	Captain's Career Course
DHA	Defense Health Agency
DOTMLPFP	Doctrine, Organization, Training, Materiel, Leadership And Education, Personnel, Facilities, and Policy
FORSCOM	United States Army Forces Command
GLOBE	Global Leadership and Organizational Behavior Effectiveness
GME	Graduate Medical Education
HCPDS	Health Care Personnel Delivery System
HPSP	Health Professions Scholarship Program
IDV	Individualism Value
ILE	Intermediate Level Education
IVR	Indulgence Versus Restraint Index
LTO	Long-Term Orientation Index
MC	Medical Corps
MEDCOM	United States Army Medical Command
MHS	Military Health System
MI	Masculinity Index
MTF	Military Treatment Facility

MUC	Military Unique Curriculum
OBC	Officer Basic Course
OBLC	Officer Basic Leader Course
PAM	Department of the Army Pamphlets
PDI	Power Distance Index
PME	Professional Military Education
UAI	Uncertainty Avoidance Index
USUHS	Uniformed Services University of the Health Sciences

ILLUSTRATIONS

	Page
Figure 1. Initial Critical Framework Word Cloud.....	58
Figure 2. Initial Critical Framework	59
Figure 3. Power Dimension, Comparison of Initial and Final Frameworks	64
Figure 4. Rules Dimension, Comparison of Initial and Final Frameworks	67
Figure 5. Group Dimension, Comparison of Initial and Final Frameworks	69
Figure 6. Individualism Dimension, Comparison of Initial and Final Frameworks	71
Figure 7. Norms Dimension, Comparison of Initial and Final Frameworks.....	73
Figure 8. Final Critical Framework.....	76
Figure 9. Word Map and Nesting Exercise Part 1.....	95
Figure 10. Word Map and Nesting Exercise Part 2.....	96
Figure 11. Word Cloud from Initial Key Themes Data, 391 Items.....	100
Figure 12. Word Cloud from Revised Key Themes Data, 391 Items, Alphabetized, Consolidated Root Word	104
Figure 13. Word Cloud from Final Key Themes Data, 82 Items, Alphabetized, Consolidated Root Word, Single Entries Removed.....	106

TABLES

	Page
Table 1. Medical Corps Army Regulations and Department of the Army Pamphlets	44
Table 2. Initial Critical Framework Key Word Iterative Table	57
Table 3. Initial Key Theme Data, 391 Items, Alphabetized	97
Table 4. Revised Key Theme Data, 391 Items, Alphabetized, Consolidated Root Word	101
Table 5. Final Key Theme Data, 82 items, Alphabetized, Consolidated Root, Solitary Entries Removed	105
Table 6. Social Media Content from January 2022	107

CHAPTER 1

INTRODUCTION

Background

Organizational culture has been examined in the corporate world and applied broadly to both leadership and change in the military. Edgar Schein's three-part model of organizational culture is commonly used to describe the superficial and deep aspects that define the "patterns of basic assumptions—invented, discovered, or developed by a given group as it learns to cope with its problems of adaptation and internal integration—that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems."¹ A subculture is defined as a "subset of an organization's members that identify themselves as a distinct group within the organization and routinely take action on the basis of their unique collective understanding."² Dutch psychologist and a leading theorist on national culture Geert Hofstede, also created an approach to organizational culture, a derivative of the concept that organizations are subcultures of larger cultural constructs.³

¹ Edgar H. Schein, *Organizational Culture and Leadership*, 5th ed (Hoboken, NJ: Wiley, 2017), 176.

² Mary Jo Hatch and Ann L Cunliffe, *Organization Theory: Modern, Symbolic, and Postmodern Perspectives* (Oxford: Oxford University Press, 2006), 176.

³ Ibid.

Culture involves a complicated interplay between human beings, behavior, ecology, and society.⁴ Investigation of culture examines societies, nations, and the similarities and synchronicities that individuals share, helping to generalize and define an area or group using dynamic measurement tools.⁵ Because culture is a social construct and exists only as a set of meanings within the group it applies to, it is not universal and cannot be assessed by a single measurable variable.⁶ Culture is instead represented by the behaviors and expressions of individuals, taking into consideration differing epistemologies and motivations for defining and comparing these aspects.⁷

Identifying cultural components and patterns help to determine correlations, cause and effect relationships, and deeper connections to explain and predict experiences in a meaningful way.⁸ The current “culture theory jungle,” with many overlapping models and theories, provides a robust theoretical foundation to build upon while attempting a

⁴ John W. Berry, *Human Ecology and Cognitive Style: Comparative Studies in Cultural and Psychological Adaptation* (Beverly Hills: Sage Publications, 1976).

⁵ Gert Jan Hofstede, Geert Hofstede, and Paul B. Pedersen, *Exploring Culture: Exercises, Stories and Synthetic Cultures* (Boston: Intercultural Press, 2012).

⁶ Ronald P. Rohner, “Toward a Conception of Culture for Cross-Cultural Psychology,” *Journal of Cross-Cultural Psychology* 15, no. 2 (1984): 111-38, <https://doi.org/10.1177/0022002184015002002>.

⁷ Teresa Levitin, “Values,” in *Measures of Social Psychological Attitudes*, ed. J. P. Robinson and P. R. Shaver, (Ann Arbor: University of Michigan, Institute of Social Research, Survey Research Center, 1973), 489-502.

⁸ Michael Minkov and Geert Hofstede, *Cross-Cultural Analysis: The Science and Art of Comparing the World’s Modern Societies and Their Cultures* (Thousand Oaks, CA: Sage Publications, 2013); Theodore M. Singelis, Michael H. Bond, William F. Sharkey, and Chris Siu Yiu Lai, “Unpackaging Culture’s Influence on Self-Esteem and Embarrassability,” *Journal of Cross-Cultural Psychology* 30, no. 3 (1999): 315-41, <https://doi.org/10.1177/0022022199030003003>.

novel application.⁹ This is seen when examining business relationships, communication, and organizational leadership based on the foundational work of national culture models.¹⁰ Modern foundational theories of national culture demonstrate many areas of convergence and can be traced back to the primary works of Hofstede, who created a model of cultural differences in application to national cultural identity. Hofstede compares six dimensions of culture: power distance, uncertainty avoidance, individualism, masculinity, time orientation, and indulgence.¹¹ Alfons Trompenaars, inspired by the individualism-collectivism aspect of Hofstede's model, based his model on values and personal relationships across cultures in seven aspects: individualism-collectivism, universalism-particularism, specific-diffuse (individual's role), neutral-affective (emotional expression), achievement-ascription, time, and the relationship with the environment.¹² Shalom Schwartz continued this work by identifying ten universal human values: conformity, tradition, security, power, achievement, hedonism, stimulation, self-direction, universalism, and benevolence. Using these he created a model of culture to measure and compare groups relative to conservatism-autonomy,

⁹ Rabit S. Bhagat and Richard M. Steers, *Cambridge Handbook of Culture, Organizations, and Work* (Cambridge, UK: Cambridge University Press, 2009), 3.

¹⁰ Ibid.

¹¹ Geert Hofstede, *Culture's Consequences: Comparing Values, Behaviors, Institutions, and Organizations across Nations*, 2nd ed. (Thousand Oaks, CA: Sage Publications, 2001); Geert Hofstede, Gert Jan Hofstede, and Michael Minkov, *Cultures and Organizations: Software of the Mind: Intercultural Cooperation and Its Importance for Survival* (Maidenhead: McGraw-Hill, 2010).

¹² Alfons Trompenaars, *Riding the Waves of Culture: Understanding Cultural Diversity in Global Business* (New York: McGraw-Hill, 1993).

hierarchy-egalitarianism, and mastery-harmony.¹³ Robert House helped create the Global Leadership and Organizational Behavior Effectiveness (GLOBE) model which has been applied directly to both organizational culture and leadership. The GLOBE model evaluates power distance, uncertainty avoidance, humane orientation, institutional collectivism, in-group collectivism, assertiveness, gender egalitarianism, future orientation, and performance orientation.¹⁴ Schein's theory of organizational culture differs from the other models in that it is not rooted in national culture and applies only to organizational culture by examining the basic assumptions, values, norms, and artifacts of a group.¹⁵

As a distinct group, the military comprises less than 0.5 percent of the population and displays characteristics that separate it from the larger macroculture of the United States.¹⁶ The military is also an organization with a structure that allows for collaboration in conducting business to achieve a collective goal. Within the broad construct of organizational culture, there are focal groups within the military that represent further, organizational microcultures. These microcultures are small collections of divergent thought, purpose, and practice, where members do not operate or exist in the same way

¹³ Shalom H. Schwartz, "Beyond Individualism/Collectivism: New Cultural Dimensions of Values," in *Individualism and Collectivism*, ed. U. Kim, H. C. Triandis, and G. Yoon (London: Sage Publications, 1994).

¹⁴ Robert J. House, *Culture, Leadership, and Organizations: The GLOBE Study of 62 Societies* (Thousand Oaks, CA: Sage Publications, 2004).

¹⁵ Schein, *Organizational Culture and Leadership*

¹⁶ CFR.org Editors, "Demographics of the U.S. Military," Council on Foreign Relations, last updated July 13, 2020, <https://www.cfr.org/backgrounder/demographics-us-military>.

the rest of the culture does, yet are integral to its existence. Within the United States Army, the most obvious microcultures are the Medical and Dental Corps, Judge Advocate General's Corps, and Chaplain Corps. Despite the recognition that these organizational microcultures exist, there is no recognized theoretical framework to describe and examine them.

Diversity is an assumed positive characteristic within an organization. A more diverse group of individuals are better able to address a problem from different perspectives.¹⁷ In application to microcultures, this becomes even more important, as differing perspectives can represent fundamentally different purposes within an organization. In this way, the existence of microcultures is not a spontaneous manifestation, but instead a necessary intentional construct, which ensures the continued existence of the organization. Subjecting these microcultures to the same treatment as the larger organizational culture threatens to diminish their distinct roles and reduce their overall effectiveness within the organization. A theoretical framework will help to examine these microcultures more holistically. In the research presented, the developed theory of microculture is applied to the United States Army's Medical Corps, to determine themes and trends that will better inform decisions regarding these unique members.

¹⁷ Isis H. Settles, Sheila T. Brassel, Patricia A. Soranno, Kendra S. Cheruvilil, Georgina M. Montgomery, Kevin C. Elliott, "Team Climate Mediates the Effect of Diversity on Environmental Science Team Satisfaction and Data Sharing," *PLoS One* 14, no. 7 (2019), <https://doi.org/10.1371/journal.pone.0219196>.

Problem Statement

The United States Army Medical Corps is comprised of a uniquely trained group of officers who represent an organizational microculture. Understanding the impact and implications of this microculture is necessary to optimize the recruiting, training, employment, and retention of these officers. These actions serve to shape the future of the Medical Corps, as the United States Army works to standardize training and development in search of efficiencies. The existence of a microculture indicates the need to look more critically at decisions made impacting these officers, to ensure the desired outcomes are achieved. What framework can assist in examining the microcultures within the United States Army to identify themes and trends for further analysis?

Purpose of the Study

Building from the foundational concepts of national culture and assimilating dimensions of Hofstede, Trompenaars, Schwartz, and House, a theory of microculture will nest within Schein's theory of organizational culture. This theoretical framework developed through application to the United States Army Medical Corps assesses the convergent and divergent aspects of microculture and develops initial themes for further investigation. Defining and explaining this microculture is the necessary initial step in examining the relationships between the microculture and the United States Army. These themes help to inform decisions regarding recruitment, training, employment and retention of members of the organizational microculture. When applied to learning environments, specifically Graduate Medical Education (GME) and Professional Military Education (PME), a better understanding of the microculture will assist in shaping these

environments to reduce negative, maladaptive aspects while optimizing the positive characteristics that contribute to developing functional medical leaders.

Research Questions

Primary: What relationships exist between the microculture of the United States Army Medical Corps and learning environments?

Secondary: (1) What dimensions are most useful in examining and describing organizational microculture? (2) How is the United States Army Medical Corps an organizational microculture?

Assumptions

1. Culture, as a construct, exists and can be bounded by a discrete definition.
2. Existing definitions of national culture and subculture apply to organizational culture and microculture as defined and bounded by the population studied.
3. No model can assess all intricacies of culture and the framework developed presents a single perspective, rather than a discrete or finite product.
4. The Medical Corps is in a period of transition, motivated to develop officers.
5. The number of directly commissioned officers who enter service at a grade higher than O-3 is a relatively small population within the Medical Corps.
6. Further division of the Medical Corps into subgroups was not conducted, general dimensions of culture will represent the convergence of these groups.
7. Published and written accounts are factual and represent real cases and events.

Definition of Terms

Physician: Historically physicians and surgeons represented distinct professions with different training requirements and scopes of practice. Standardization of medical education and residency training has changed the definition and the term physician now means all medical doctors of any specialty.¹⁸

Graduate Medical Education: (GME) includes the period a physician spends in initial training for a medical specialty before becoming board certified. Typically, this time is also known as an internship (usually the first year of training) and a residency (training focused on a chosen specialty). Each medical specialty has different requirements and based on the Accreditation Counsel for Graduate Medical Education (ACGME).¹⁹

Professional Military Education: (PME) for the purpose of this research PME includes the standardized and required military education anticipated for officers based on rank and grade. For Medical Corps officers this includes a Basic Officer Leader Course (BOLC), the Captains Career Course (CCC) and Intermediate Level Education (ILE).

Learning Environment: used within this research when referring to GME and PME experiences collectively.

¹⁸ Christopher Booth, “Physician, Apothecary, or Surgeon? The Medieval Roots of Professional Boundaries in Later Medical Practice” in *Midlands Historical Review* 2, (2018), <https://tinyurl.com/ycxakc86>.

¹⁹ Robert A. De Lorenzo, “Accreditation Status of U.S. Military Graduate Medical Education Programs,” *Military Medicine* 173, no. 7 (2008): 635-40, <https://doi.org/10.7205/milmed.173.7.635>.

Medical Corps: (MC) refers to the United States Army's Medical Corps – a branch that includes only commissioned officers who have completed medical school.

Microculture: is derived from the construct of culture and represents a small, niche group of individuals with a shared collective experience, within a larger culture. A subculture is similarly defined and can be used interchangeably throughout this paper. A microculture is not automatically a counter-culture, which stands in opposition to the culture at large.²⁰

Scope

This exploratory inquiry takes the initial steps into identifying and understanding a complex topic. Creating a framework and identifying themes and trends prevalent within the microculture orients and promotes investigation into meaningful aspects of the MC through additional, subsequent research. Focusing on published and available data identifies areas in which to concentrate more comprehensive, in-depth approaches and aspects of the microculture that shape how data can be collected. The use of a grounded theory approach gave the flexibility to follow the data in developing a more complete theory of organizational microculture through application to the MC.

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²⁰ Hatch and Cunliffe, *Organization Theory*.

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Limitations and Delimitations

Limitations affecting this research include the relatively short duration of time available to collect and analyze data, given the breadth and nature of the topic studied. Data collection methods in general represent a limitation, as access to some media was as readily available based on geographic location and method of search. Access to potentially sensitive data presented an additional external constraint, as organizations further limit access to general data due to its potentially sensitive nature, requiring more specified inquiries and full Institutional Review Board (IRB) approval before release. Due to the initial exploratory nature of this study, this data represents a topic to research further, in-depth.

Related to the limitation of time, the decision to use grounded theory provides the benefit of flexibility but requires robust data collection and an iterative, analytical approach. This delimitation potentially challenges the legitimacy of the study as there is no clear test to ensure enough data is collected. The decision to not include human subjects research was also an intentional delimitation, related to time as the development of a protocol for survey, interview or focused narrative inquiry on this topic would be too great, to then also complete the data collection, coding, and analysis in a meaningful way. Recognizing that the examination of only existing published case reports, documents, and

narratives limits the quality and quantity of the data collected, it is important to recognize that this exploratory study is the first, necessary step in developing research in this area.

Significance of the Study

This study will serve as the foundation upon which more focused research can continue to understand specific aspects of the MC. Doing so will help to optimize effectiveness during a time of significant change and transition for the Army Medical Department (AMEDD). By understanding the MC and how these officers differ from their non-medical peers more holistically, senior leaders can determine more effective ways to right-size and refocus PME and GME, to create more effective officers who are ready to serve and lead in the demanding environments anticipated in the future.

Summary

Culture exists as a construct and differentiates groups from each other in specific, meaningful ways. There are a variety of valid models used to compare national cultures and aspects of each model can be helpful in application to specific microcultures. Several theorists have focused specifically on organizational culture; however, the foundation of these theories is in the development of models for national culture. History demonstrates continued friction between the MC and other, non-medical Army officers, particularly in times of peace and immediately post-conflict. The United States Army is an organizational culture, and the MC is a small distinct group, known as a microculture. The role of GME has been outsized in developing and initiating junior doctors as military officers. The existence of a microculture helps to explain the unique structure and delivery of training for MC officers, but it is also likely that these learning environments

continue to reinforce and shape this microculture reciprocally. Understanding this microculture is critical to understanding how to best recruit, train, employ, and retain the right MC Officers, a timely question as the National Defense Authorization Act (NDAA) calls for efficiency and economy, and the future is unclear regarding what it means to serve in the MC.

CHAPTER 2

LITERATURE REVIEW

Purpose of the Study

Building from the foundational concepts of national culture and assimilating dimensions of Hofstede, Trompenaars, Schwartz, and House, a theory of microculture will nest within Schein's theory of organizational culture. This theoretical framework developed through application to the United States Army Medical Corps assesses the convergent and divergent aspects of microculture and develops initial themes for further investigation. Defining and explaining this microculture is the necessary initial step in examining the relationships between the microculture and the United States Army. These themes help to inform decisions regarding recruitment, training, employment, and retention of members of the organizational microculture. When applied to learning environments, specifically Graduate Medical Education (GME) and Professional Military Education (PME), a better understanding of the microculture will assist in shaping these environments to reduce negative, maladaptive aspects while optimizing the positive characteristics that contribute to developing functional medical leaders.

Research Questions

Primary: What relationships exist between the microculture of the United States Army Medical Corps and learning environments? Secondary: (1) What dimensions are most useful in examining and describing organizational microculture? (2) How is the United States Army Medical Corps an organizational microculture?

Introduction

Evaluating this topic requires a baseline understanding of how culture is defined and compared. Because this study is exploratory, a standard model of organizational microculture does not exist for direct application to a military population. Models based on the foundations of national culture were reviewed to determine convergence and initial focus. Large-scale cross-cultural analysis was also examined to understand the existing framework for the study and comparison of cultures using qualitative and quantitative approaches. The history of the AMEDD and the MC was reviewed to understand the origin and foundation of the subject population. Specific emphasis was placed on the structure and purpose of GME within the AMEDD. Education strategies and adult learning principles applied to existing GME models, both within the military and civilian environments, were reviewed to understand the environment as it exists. The foundation of grounded theory was also examined as the proposed methodology for this exploratory study. The literature reviewed and examined in this chapter includes:

1. Culture: General Definitions and Research
2. Models of Culture by Author:
Hofstede, Trompenaars, Schwarz, House, and Schein.
3. Cross-Cultural Analysis.
4. History of the AMEDD, MC, and GME-specific research trends.

Culture: General Definitions and Research

Culture, defined as the features that distinguish one group of people from another, is a social construct and takes place within a dynamic context, creating challenges in measurement, validity, and reliability particularly when trying to determine specific

characteristics for comparison.²¹ It is important to consider the role of ecology - the impact of the environment on both the individual and their behavior as well as broader society - on the development of culture.²² A clear definition is important and necessary for the examination and comparison of specific cultures and aspects of culture, as different epistemologies and motivations will lead to differing definitions.²³

Teresa Levitin explained that “culture is not directly accessible to observation but inferable from verbal statements and other behaviors.”²⁴ Behaviors exhibited by individuals are manifestations of their values and beliefs. These values are part of what comprises the culture.²⁵ A construct is a model, created to organize and convey an idea to others in a way that helps to gain collective understanding.²⁶ Defining culture as a construct is possible because it only exists as a set of meanings within the group it applies to and is not universal.²⁷ Culture relates directly to how individuals within a group may think or behave. Understanding this helps to evaluate culture and recognize themes and patterns in a more meaningful way. This is a starting place to understand the meaning,

²¹ Hofstede, Hofstede, and Pedersen, *Exploring Culture*.

²² Berry, *Human Ecology and Cognitive Style*.

²³ Minkov and Hofstede, *Cross-Cultural Analysis*.

²⁴ Levitin, “Values,” 492.

²⁵ Ronald Fischer and Shalom Schwartz, “Whence Differences in Value Priorities?” *Journal of Cross-Cultural Psychology* 42, no. 7 (2010): 1127-44, <https://doi.org/10.1177/0022022110381429>.

²⁶ Minkov and Hofstede, *Cross-Cultural Analysis*.

²⁷ Rohner, “Toward a Conception of Culture for Cross-Cultural Psychology.”

and attempt to “make sense of the observed phenomenon,” and only by understanding the culture and meanings held by a group can change be affected.²⁸ By defining it and assessing the individual components, more meaningful comparisons, themes, and patterns can be explored, than by simply assessing the broader culture alone.²⁹

Examining the same concept through different lenses, allows multiple theories of culture to persist and creates what Rabi S. Bhagat and Richard M. Steers describe in the *Cambridge Handbook of Culture, Organizations, and Work* as a “culture theory jungle.”³⁰ Rather than trying to determine which model is most correct, it is more helpful to view each model as valid, providing a unique piece of the complicated culture puzzle. Most theories of culture have origins in describing or defining the aspects of national culture; there are some challenges in direct application to other distinct groups, such as in the study of organizational culture. Bhagat and Steer suggest, “the advancement of cross-cultural organizational research lies not in developing new models of national culture or in debating the validity of the various existent models, but rather in seeking commonalities or convergence among existing ones.”³¹

²⁸ Minkov and Hofstede, *Cross-Cultural Analysis*, 15.

²⁹ Singelis et al., “Unpackaging Culture’s Influence.”

³⁰ Bhagat and Steers, *Cambridge Handbook of Culture, Organizations, and Work*, 3.

³¹ Ibid., 9.

Models of Culture by Author

Geert Hofstede's model of cultural differences is one of the primary theories in application to national cultural identity. His work has also been applied to organizational literature and inspired the work of other theorists in the field. Hofstede compares six dimensions of culture: power distance, uncertainty avoidance, individualism (v. collectivism), masculinity (v. femininity), time orientation (long-term v. short-term), and indulgence (v. restraint).³² Within each of these dimensions, he establishes an index for comparison of countries. These indices, derived from observed phenomena and data from within a society, were coded and examined statistically for correlation. It is important to recognize while discussing his theory that he does not create an absolute score, but instead an index used only in comparison. While this index is considered relatively stable it can fluctuate over time, however, the difference between countries does not typically fluctuate.

Power distance was first described in the 1960s through field experiments related to differences in interpersonal power.³³ Hofstede used this early work to develop and apply a theory of power distance as a dimension in evaluating and comparing nations, defining it as the "extent to which the less powerful members of institutions and

³² Hofstede, *Culture's Consequences*; Hofstede, Hofstede, and Minkov, *Cultures and Organizations*.

³³ Murk Mulder, "Power Equalization Through Participation?" *Administrative Science Quarterly* 16, no. 1 (1971): 31-38, <https://doi.org/10.2307/2391284>.

organizations expect and accept that power is distributed unequally.”³⁴ In a society with a large power distance, inequality is considered normal and expected and power is what determines what is good or evil. In a society with a small power distance, inequality is considered fundamentally wrong and should be reduced when possible. Hierarchies exist in these societies as an unfortunate necessity; however, roles are considered interchangeable and in striving for equality the individual holding a title or role is not considered a distinctly different or superior entity. Rules and order are to be upheld by those in legitimate power to enforce a greater good that is established with all members of society, not just those in power. Centralization is a key aspect of large power distance societies, while small power distance societies value decentralization.³⁵ The Power Distance Index (PDI) is used to quantify this relationship.

Uncertainty avoidance was first discussed related to economics in the greater concept known as “the theory of the firm.”³⁶ Richard Cyvert and James March applied the theory to organizations and developed a behavioral theory, which Hofstede used as a framework for application in comparing national societies.³⁷ Uncertainty avoidance is “the extent to which the members of a culture or national society feel threatened by

³⁴ Geert Hofstede, “10 Minutes with Geert Hofstede on Power Distance,” November 18, 2014, Smit Film, Siegmund Audiovisuale Production, video, <https://youtu.be/DqAJclwfyCw>.

³⁵ Hofstede, *Culture’s Consequences*.

³⁶ Daniel Spulber, *The Theory of the Firm: Microeconomics with Endogenous Entrepreneurs, Firms, Markets, and Organizations* (Cambridge, UK: Cambridge University Press, 2009).

³⁷ Richard Michael Cyvert and James G. March, *A Behavioral Theory of the Firm*, (Cambridge, MA: Blackwell Business, 1992).

ambiguous and unknown situations.”³⁸ Uncertainty avoidant societies see ambiguity as a threat that must be fought against, creating stress that does not exist in uncertainty accepting societies where ambiguity is considered an expected, normal part of life. The uncertainty avoidance index (UAI) was developed to measure the difference in this dimension between countries. The UAI fluctuates, for example during periods of war and economic crisis, but in these fluctuations, the indexed difference between countries is typically stable.³⁹

Individualism was first described concerning political ideologies in the 19th century. In the 1960s it was used as a descriptor for personality in the behavioral and psychological communities.⁴⁰ The use of the term was imprecise but allowed a scaffolding for Hofstede to construct a framework for comparing individualism and collectivism as a spectrum in societies. “Individualism is a society in which the ties between individuals are loose, everyone is expected to look after her or himself and the immediate family (father, mother, and children). Collectivism is a society in which individuals, from birth onwards, are part of strong in-groups.”⁴¹ Collectivism is

³⁸ Geert Hofstede, “10 Minutes with Geert Hofstede on Uncertainty Avoidance,” March 7, 2015, Smit Film, Siegmund Audiovisuale Production, video, <https://youtu.be/fZF6LyGne7Q>.

³⁹ Hofstede, *Culture’s Consequences*.

⁴⁰ Anu Realo, Kati Koido, Eva Ceulemans, and Juri Alli, “Three Components of Individualism,” *European Journal of Personality* 16, no. 3 (2002): 163-84, <https://doi.org/10.1002/per.437>.

⁴¹ Geert Hofstede, “10 Minutes with Geert Hofstede on Individualisme versus Collectivisme,” November 18, 2014, Smit Film, Siegmund Audiovisuale Production, video, <https://youtu.be/zQj1VPNPHII>.

associated with in-groups and out-groups and is exclusionary, but focused on harmony and “we” within the in-group. Individualism is focused on universalism where others are accepted as individuals. Conflict is an expected and managed aspect and the focus is on “I” rather than “we.” Collectivist societies are also high context, with many shared assumptions to facilitate faster communication. Individualist societies are low context and more clarification is required, prompting slower communication. Hofstede uses the individualism value (IDV) as the tool to compare countries for individualism and collectivism.

Masculinity and femininity are descriptive words that do not equate to male and female. Instead, men and women both have masculine and feminine traits. Hofstede defines masculinity as “a society in which emotional gender roles are distinct... what you should *feel* being born as a boy or being born as a girl. Boys should be assertive and tough and focused on material success,” while women are expected to be “modest and tender and focused on the quality of life.”⁴² A feminine society as Hofstede describes is when this role differentiation is weaker or not present. This dimension is the most difficult to reproduce in data collection as it is limited by the gender of the person providing and receiving the data. In addition, the use of the words feminine and masculine are easily misconstrued. Feminine societies tend to see a better balance between family and work obligations and are envious of those who stand out as exceptional. Masculine societies value work over family and admire the strong or

⁴² Geert Hofstede, “10 Minutes with Geert Hofstede on Masculinity versus Femininity,” November 18, 2021, Smit Film, Siegmund Audiovisuale Production, video, <https://youtu.be/Pyr-XKQG2CM>.

successful individual.⁴³ In general, the term masculine could be replaced with “role rigid” as the characteristics of masculine societies tend to rely on gender normalized role expectations, while feminine could be replaced with “role fluid,” to reveal a more collective way of managing expectations and obligations. Masculinity and femininity are measured relative to other societies using a Masculinity Index (MI).

Long-term versus short-term orientation was added to Hofstede’s model in 1991, based on the research of Michael Bond who worked with Chinese research scientists to develop a survey that identified new themes not examined before in the previous four dimension model.⁴⁴ “Long-term orientation stands for the fostering in a society of pragmatic virtues oriented to future rewards,” explains Hofstede who also uses perseverance, persistence, thrift, saving, and adapting to change as hallmark characteristics.⁴⁵ Short-term orientation by contrast is related to “fostering in a society, virtues related to the past and the present such as national pride, respect for tradition, preservation of face, and fulfilling social obligations.”⁴⁶ Long-term oriented societies tend to have a more relative consideration of what is normal and adaptability is a desirable trait. Humility and desire to learn from other nations are more common and traditions change over time. Short-term oriented societies tend to have fixed norms that

⁴³ Hofstede, *Culture’s Consequences*.

⁴⁴ Hofstede, Hofstede, and Minkov, *Cultures and Organizations*.

⁴⁵ Geert Hofstede, “10 Minutes with Geert Hofstede on Long versus Short-Term Orientation,” March 7, 2015, Smit Film, Siegmund Audiovisuale Production, video, <https://youtu.be/H8ygYIGsIQ4>

⁴⁶ Ibid.

always apply and consistency is valued more. Nostalgia and positive affirmation are sought; pride and tradition are intrinsically important. The long-term orientation index (LTO) measures the differences between countries with these time-related orientations.

The final dimension of Hofstede's model was added in 2010 in collaboration with Michael Minkov, based on patterns in data that emerged and were inadequately described by the other dimensions.⁴⁷ Related generally to a subjective feeling of happiness or unhappiness and control over one's own life, "indulgent societies allow relatively free gratification of basic and natural human desires, leading to enjoying life and having fun... while restraint societies suppress gratification of needs and are regulated by strict social norms."⁴⁸ While objective measures may be equal, individuals in an indulgent society will subjectively feel happier and healthier, promoting a leisure ethic while individuals in a restraint society will feel less happy and less healthy and promote a work ethic. Indulgent societies are more optimistic and associated with a sense of control over one's own life. In a restraint society, things are out of the control of the individual and generally more pessimistic. Freedom of speech tends to be valued over maintaining order in the nation in an indulgent society, while the opposite is true in a restraint society. This dimension is measured using the indulgence versus restraint index (IVR).

Alfons Trompenaars created a model based on Hofstede's work with a foundation in the dimension of individualism and collectivism. His model focuses on values and

⁴⁷ Hofstede, Hofstede, and Minkov, *Cultures and Organizations*.

⁴⁸ Geert Hofstede, "10 Minutes with Geert Hofstede on Indulgence versus Restraint," March 7, 2015, Smit Film, Siegmund Audiovisuale Production, video, <https://youtu.be/V0YgGdzmFtA>.

personal relationships across cultures. In addition to individualism-communitarianism, Trompenaars' cultural dimensions model evaluates nations based on assessments of universalism-particularism, specific-diffuse, neutral-affective, achievement-ascription, time, and the relationship with the environment.⁴⁹ The primary application of this model has been in business management and communication.

Individualism and communitarianism represented the initial overlap with Hofstede's model and denote a nuanced application to relationships and communication between people.⁵⁰ In this dimension, Trompenaars assesses the need for individual recognition versus commitment to a team, with individualism tending to manifest as those in control of their destiny, empowered to make decisions, and thus being responsible for ensuring happiness and fulfillment. Communitarianism in application to personal relationships is based more on the fundamental belief that the quality of decisions is greater with a group consensus and shared decision making. This can slow down processes as all members are ideally considered or consulted to reach a conclusion. Group success and accolades are shared and celebrated rather than the individual contributions and achievements of one group member.⁵¹

⁴⁹ Trompenaars, *Riding the Waves of Culture*.

⁵⁰ Geert Hofstede, "Riding the Waves of Commerce: A Test of Trompenaars' 'Model' of National Culture Differences," *International Journal of Intercultural Relations* 20, no. 2 (1996): 189-98.

⁵¹ Trompenaars, *Riding the Waves of Culture*.

Universalism and particularism examine the application of standards or rules across members and the degree to which exceptions are made.⁵² Universalism is associated with a more rigid view of the rules and a single, idealistic view of how business should be conducted. Particularism applies less rigid rules and accepts a degree of flexibility in business and communication. Rules are relative, and exceptions are expected and accepted. Relationships are valued more than rules in particularism, while formal rules are often valued over the relationships in an organization or society that has a high degree of universalism.⁵³

Specific and diffuse refers to the roles an individual has and the expectation for compartmentalization of these roles in different settings.⁵⁴ An individual in a highly specific society would interact with those around them in different ways based on the degree of familiarity, formal expectations, or surroundings in each distinct space. A highly diffuse society blends environments and creates a more consistent presentation of the individual in all settings. For example, a professor in a highly specific country may work in a formal environment with students who will use their formal title and observe standard customs and courtesies. That same professor, however, would likely not object to a salesperson calling them by their first name as there is no expectation that their status would transfer automatically from one space to another. The same professor in a more diffuse society may be known as a professor and referred to more formally by sales-

⁵² Bhagat and Steers, *Cambridge Handbook of Culture, Organizations, and Work*.

⁵³ Trompenaars, *Riding the Waves of Culture*.

⁵⁴ Bhagat and Steers, *Cambridge Handbook of Culture, Organizations, and Work*.

people or casual colleagues, as well as their students, as their title, status, and expectations related to their societal role permeate into multiple settings.⁵⁵

The degree to which individuals can express emotions openly is assessed when comparing neutral and affective dimensions.⁵⁶ A neutral society is less likely to display emotions, excitement, or affection publicly. An affective society is more likely to respond emotionally and openly. Reason is often combined with emotion and emotional response is used to help determine if communication has successfully imparted the necessary information. Both neutral and affective communication seeks a response through different means, which is important to recognize when reconciling cross-cultural communication.⁵⁷

Achievement and ascription examine how respect and social status are obtained within a society or organization.⁵⁸ An achievement culture promotes accomplishment, knowledge, and skill and any member can present a logical challenge to a decision. In an ascription culture, status is assigned based on an unrelated demographic and respect is earned with commitment, not performance. A person with less status would not be welcome to challenge someone in a position of authority.⁵⁹

⁵⁵ Fred Luthans and Jonathan P. Doh, *International Management: Culture, Strategy, and Behavior*, 8th ed (New York: McGraw-Hill, 2012).

⁵⁶ Bhagat and Steers, *Cambridge Handbook of Culture, Organizations, and Work*.

⁵⁷ Alfons Trompenaars, "Resolving International Conflict: Culture and Business Strategy," *Business Strategy Review* 7, no. 3 (1996), 51-68, <https://doi.org/10.1111/j.1467-8616.1996.tb00132.x>.

⁵⁸ Bhagat and Steers, *Cambridge Handbook of Culture, Organizations, and Work*.

⁵⁹ Trompenaars, *Riding the Waves of Culture*.

Time, as it relates to Trompenaars' model, examines sequential and synchronic relationships. Sequential cultures view time as a finite concrete measurement, valuable and structured. In sequential cultures, schedules and deadlines are strict and timeliness is expected as members of the team move in an anticipated order from one project to the next. A synchronic culture allows projects to progress at their own pace, occurring in parallel rather than in series. Synchronous cultures risk potential missed deadlines to allow for synergy and spontaneity in completing tasks.⁶⁰

The final dimension in Trompenaars' Model of Culture deals with the relationship an individual has with the environment. Also described as internal direction versus outer or external direction, it compares the degree to which an individual feels they can control their environment, or conversely how much the environment controls them. Cultures with a high degree of internal direction believe they can control outcomes and are more dominant. By contrast, cultures with an external control predisposition tend to be more flexible and allow things to take their natural course, focusing less on trying to control the outcome.⁶¹

Shalom Schwartz developed a model of culture in the late 1990s using the same philosophy as Hofstede and Trompenaars, but slightly shifting the dimensions examined. His methods involved surveying individuals to determine the level of importance they placed on different values. This scale was created by coding and weighting these survey responses to derive statistical inference. Schwartz's culture model identifies seven

⁶⁰ Trompenaars, *Riding the Waves of Culture*.

⁶¹ Bhagat and Steers, *Cambridge Handbook of Culture, Organizations, and Work*.

clusters: embeddedness, harmony, egalitarian commitment, intellectual autonomy, affective autonomy, mastery, and hierarchy.⁶² Embeddedness assesses the likelihood of maintaining the status quo, observing traditions, or embracing change. In contrast, affective autonomy is the degree to which excitement, new experiences, and stimulation are sought. Intellectual autonomy evaluations the desire for creativity and curiosity, and harmony refers to the desire to protect the environment and see the world at peace. Contrary to that, mastery is the focused pursuit of a skill or task to outperform others and the degree to which one will modify their environment to their needs. Egalitarianism includes altruistic pursuits, helpfulness, equality, and transcendence beyond the self. Hierarchy refers to the relationship of roles, who is recognized as having legitimate power, and how resources are allocated.⁶³

From this early model, Schwartz refined his theory to delineate ten broad values within four competing dimensions. The ten values are interrelated, dynamic, and address the three universal existentialist requirements of biological needs, requisite social interaction, and survival of the group.⁶⁴ Four major dimensions capture these ten basic values.⁶⁵ Conservation relates to how individuals find meaning and purpose as either members of a group or as unique individuals. This dimension incorporates the values of

⁶² Shalom H. Schwartz, *Universals in the Content and Structure of Values: Theoretical Advances and Empirical Tests in 20 Countries* (San Diego: Academic Press, 1992).

⁶³ Schwartz, *Universals in the Content and Structure of Values*.

⁶⁴ Schwartz, "Beyond Individualism/Collectivism."

⁶⁵ Shalom Schwartz, "An Overview of the Schwartz Theory of Basic Values," *Psychology and Culture Article 2*, no. 1 (2012): 12-13.

security, conformity, and tradition. These values define aspects of stability and harmony, restraint, impulse, respect, commitment, and customs in relationships and concerning the individual. In contrast to conservation, openness to change includes the values of self-direction, stimulation, and hedonism. These aspects emphasize independent thought, actions, and feelings. Hedonism is also a component of self-enhancement, along with power and achievement. Self-enhancement contrasts with self-transcendence, which includes the values of universalism and benevolence.⁶⁶

Robert House is credited with leading a large team of (over 170) researchers from sixty different countries to develop the GLOBE project. This model compares cultural differences in the context of leadership processes and interactions.⁶⁷ GLOBE's model also draws a connection to the early cultural dimensions of Hofstede. This is apparent in several overlapping dimensions when comparing the two models. GLOBE evaluates power distance, uncertainty avoidance, humane orientation, institutional collectivism, in-group collectivism, assertiveness, global egalitarianism, future orientation, and performance orientation.

Aligning with Hofstede's theory, power distance in the GLOBE model refers to the expectation of an equal distribution of power. The active GLOBE project manual defines this dimension as the "extent to which the community accepts and endorses

⁶⁶ Schwartz, "An Overview of the Schwartz Theory of Basic Values."

⁶⁷ House, *Culture, Leadership, and Organizations*.

power difference, and status privileges.”⁶⁸ The GLOBE model also similarly explains uncertainty avoidance—how much a society relies on norms, rules, and regulations to avoid unexpected events. The original survey definition includes that “the greater the desire to avoid uncertainty, the more people seek orderliness, consistency, structure, formal procedures and laws to cover situations in their daily lives.”⁶⁹ GLOBE evaluates collectivism by looking at both institutional and in-group collectivism. Institutional collectivism is defined as the extent to which institutions encourage and reward group effort, through a “collective distribution of resources.”⁷⁰ In-group collectivism is distinct in measuring the extent individuals are expected to express “pride, loyalty, and cohesiveness in their organizations or families.”⁷¹ GLOBE’s explanation of gender egalitarianism attempts to clarify Hofstede’s masculine-feminine index, but differs slightly in that it is focused on “the degree to which a collective minimizes (and should minimize) gender inequality.”⁷² The GLOBE model did not attempt to assess the gender norms or roles as distinctly as Hofstede’s model, which likely represents social norms at the time of the research (the 1990s versus 1960s). Future orientation in the GLOBE model mirrors the long-term versus short-term measurement in Hofstede’s model,

⁶⁸ Global Leadership and Organizational Behavior Effectiveness (GLOBE), “GLOBE Culture Dimensions, Definitions, and Scale Items,” GLOBE Project, 2014, 7, <https://globeproject.com/data/GLOBE-Dimensions-Definitions-and-Scale-Items.pdf>.

⁶⁹ GLOBE, “GLOBE Culture Dimensions, Definitions, and Scale Items,” 1.

⁷⁰ *Ibid.*, 6.

⁷¹ *Ibid.*, 5.

⁷² *Ibid.*, 2.

examining “the extent to which individuals engage (and should engage) in future-oriented behaviors such as planning, investing in the future, and delaying gratification.”⁷³ Humane orientation, the extent to which an institution would or should reward fairness, altruism, generosity, and caring for others, compares but does not compete with performance orientation, which evaluates the tendencies to reward and value performance and excellence.⁷⁴

Edgar Schein is a leading authority in organizational culture and differs from other theorists in that he has focused on this aspect exclusively. While Hofstede studied national culture and deductively defines organizational culture as “derivative of the idea that organizations are subcultures of larger, cultural systems,”⁷⁵ Schein focuses exclusively on cultures within organizations and does not dwell on the larger ecology of national identity with his models. Schein defines organizational culture as “the pattern of basic assumptions that a given group has invested, discovered, or developed in learning to cope with its problems of external adaptation and internal integration, and that have worked well enough to be considered valid, and therefore to be taught to new members as the correct way to perceive, think, and feel in relation to those problems.”⁷⁶ Schein’s

⁷³ Ibid., 8.

⁷⁴ Bhagat and Steers, *Cambridge Handbook of Culture, Organizations, and Work*.

⁷⁵ Hatch and Cunliffe, *Organization Theory*, 187.

⁷⁶ Ibid., 177.

theory posits that organizational culture can be assessed by evaluating three distinct aspects: basic assumptions, espoused values and norms, and artifacts.⁷⁷

Basic assumptions are also known as underlying beliefs which represent the deepest and most accurate indicators of culture. These are also the hardest to discover, as they may conflict with other, more superficial aspects that are easier to observe. These basic assumptions underwrite what behaviors or attitudes are considered acceptable and will lead to success. These deeper beliefs will drive the actions of the organization and guide the decisions of individuals. While they may overlap with espoused values, the incongruity in these two levels will typically lead to friction within an organization.

Espoused values are the published or stated beliefs an organization presents to others. These manifest in the day-to-day operations and how business is conducted publicly. This level of culture is more superficial and easier to access by observation. Espoused beliefs are seen in organizational visions or mission statements, both internal and external focused branding campaigns, and the outward-facing edge that an organization wants the world to see. Norms are the observable manifestations of the organization's values and may be as simple as how individuals provide feedback or request assistance, or as pervasive as how individuals communicate with each other, hiring or promotion policies, and compensation strategies.⁷⁸

Artifacts are even more superficial and provide the shallowest way in which an organization's values can be assessed. These include the direct, visible indications of a

⁷⁷ Schein, *Organizational Culture and Leadership*.

⁷⁸ Schein, *Organizational Culture and Leadership*.

culture. Artifacts can include dress codes and physical appearance standards, the physical layout and appearance of a building or workspace. They also include more tangential displays of what is important to an organization, including ceremonies, slogans, rituals, and printed media. Artifacts can provide interesting information about an organization's culture, but often do not provide significant insight, as artifacts may be more related to historical precedence than current values or beliefs.⁷⁹

Evaluating organizational culture through Schein's model is unique from the application of national cultural models to organizations and offers the benefit of examining the superficial and deep aspects of both observable and non-observable behavior. Because of this, the application of Schein's model is more qualitative and does not include indices with which to compare one organization to another. This is likely because the value of comparison in drawing meaning and conclusions is less useful between organizations than it is between nations. The examination of an organization in depth offers more value concerning organizational change, which is the primary focus of Schein in his work to understand organizational culture.

Cross-Cultural Analysis

Minkov and Hofstede write that "there is no perfect model leading to the ultimate cultural model for the explanation of cultural differences."⁸⁰ Cross-cultural analysis is a challenging process that can be undertaken inductively or deductively but requires a significant contextual understanding of the populations studied. Donald Brown

⁷⁹ Ibid.

⁸⁰ Minkov and Hofstede, *Cross-Cultural Analysis*, 3.

recognized the “conventional patterns of thought, activity, and artifact,” as a starting place to discern meaning, with the caution that the same behaviors when viewed from the outside may appear similar across cultures, but have distinct meanings within each, that can be difficult to discern superficially.⁸¹ Minkov and Hofstede present an overview of cross-cultural analysis using a positivist philosophy that is predictive, nomothetic, etic, and empiric. While their approach does not employ an interpretivist or qualitative approach, they do recognize the benefit of these methods in developing new ideas and hypotheses that can be tested through “rigorous quantitative etic or nomothetic methods.”⁸²

This positivist belief that qualitative research is not rigorous is common, but not widely accepted. The qualitative field of cross-cultural analysis is more diverse in methods and interpretations. “Qualitative methods can shed light on the specific ways culture shapes psychological variables,” which makes it particularly valuable when examining smaller subcultures, organizations, and microcultures.⁸³ Ultimately, the quantitative measures must at some juncture be interpreted, and that “inevitably opens the door to subjectivism,” and the reality that both qualitative and quantitative approaches to cross-cultural analysis are necessary.⁸⁴

⁸¹ Donald E. Brown, *Human Universals* (New York: McGraw-Hill, 1991), 40.

⁸² Minkov and Hofstede, *Cross-Cultural Analysis*, 5.

⁸³ Alison Karasz and Theodore M. Singelis, “Qualitative and Mixed Methods Research in Cross-Cultural Psychology,” *Journal of Cross-Cultural Psychology* 40, no. 6 (2009), 909-16, <https://doi.org/10.1177/0022022109349172>.

⁸⁴ Minkov and Hofstede, *Cross-Cultural Analysis*, 63.

The study of a culture at any level should be conducted from first-hand experience which allows the researcher to achieve a deeper, “more accurate understanding of the interplay of culture and behavior.”⁸⁵ To compare cultures exclusively from the outside (etic) by establishing a set of boundaries and principles and then applying them as a means of comparison, might cause a researcher to “cut their feet to fit the shoe.”⁸⁶ An inside approach (emic) involves instead investigating one culture at a time and evaluating and interpreting the observed behaviors.⁸⁷ Being too close to a subject is also potentially disadvantageous for research, however, as studying a group that the researcher belongs to or identifies with may lead to a distorted or prejudiced view of experiences.⁸⁸

There are likely differences between cultures that will not allow for meaningful comparison and the derivation of complex behaviors into simple statistical indices is problematic if too many inferences are made without considering the weight and context of the operationalized data.⁸⁹ Both uniform and nonuniform biases must be considered when interpreting data as the very data collected may speak to a bias. If items selected to

⁸⁵ Amado M. Padilla, “Hispanic Psychology: A 25-Year Retrospective Look,” *Online Readings in Psychology and Culture* 3, no. 1 (2002), <https://doi.org/10.9707/2307-0919.1025>.

⁸⁶ The Chinese Culture Connection, “Chinese Values and the Search for Culture-Free Dimensions of Culture,” *Journal of Cross-Cultural Psychology* 18, no. 2 (1987): 145.

⁸⁷ Minkov and Hofstede, *Cross-Cultural Analysis*, 85.

⁸⁸ William A. Haviland, *Cultural Anthropology* (New York: Holt, Rinehart & Winston, 1990), 17.

⁸⁹ Minkov and Hofstede, *Cross-Cultural Analysis*, 86.

study do not exist or are not recorded in one culture, the item is not a reliable source of comparison between those cultures.⁹⁰ The sampling of populations for cultural study should also be carefully considered to ensure the most representative group is selected. “Different dimensions may emerge in culture level analyses of different samples” within a single nation, and this possibility should be considered.⁹¹ Convenience samples are a reality that must be accepted, with the understanding that findings may not be generalizable across the entire population. The likelihood of missing data that excludes aspects of a culture entirely even if unintentionally, and the existence of unmeasurable but important aspects of a culture, is also worth considering.⁹²

History of the AMEDD, MC, and GME Specific Research Trends

The MC is comprised exclusively of physician officers. The modern use of the term physician includes all medical school graduates who practice in a composite of surgical and medical specialties. Historically, physicians and surgeons were trained separately and considered to be separate professions. The standardization of training for both surgeons and physicians ran parallel with the colonization of America and following the Revolutionary War, surgeons were expected to be trained in medical schools, rather than through barber-style apprenticeships.⁹³ The birthday of the AMEDD is credited as

⁹⁰ Ronald P. Fischer, “Where Is Culture in Cross Cultural Research?” *International Journal of Cross Cultural Management* 9, no. 1 (2009): 25-49, <https://doi.org/10.1177/1470595808101154>.

⁹¹ Schwartz, “Beyond Individualism/Collectivism,” 90.

⁹² Minkov and Hofstede, *Cross-Cultural Analysis*.

⁹³ Booth, “Physician, Apothecary, or Surgeon?”

July 27, 1775, when the Continental Congress authorized medical services during times of war or emergency.⁹⁴ Described as “creation followed by chaos, then adjustment, and finally, the evolution of a reasonably effective organization,” early activities within the AMEDD were noted to be marked by conflict, bickering, investigations, and censures from congress.⁹⁵ The structure of the department fluctuated initially, but ultimately followed the familiar example of the British Military Medical Department.

Physicians and surgeons were both employed in the care of soldiers in the Continental Army.⁹⁶ Internal friction within the AMEDD mirrored the tensions between medical officers and regular Army officers, as it was not until 1779 when parity was established between the two regarding rank structure. Retirement pay (equivalent) was normalized for medical officers in 1781. Just as the medical officers were achieving equality, congressional discontent regarding the cost of the AMEDD led to limitations on the total number of medical appointments.⁹⁷ While politicians and military leaders alike could see the utility of medical officers, they struggled with the size, structure, and authorizations afforded in the infancy of the AMEDD.

The AMEDD was not permanent until 1818, with the intervening years foreshadowing what would become common practice, in the routine rapid downsizing

⁹⁴ Library of Congress, *Journals of the Continental Congress, 1774-1789*, vol. 2, 1775, May 10-September 20 (Washington, DC: Government Printing Office, 1905).

⁹⁵ James A. Tobey, *The Medical Department of the Army; Its History, Activities and Organization* (New York: AMS Press, 1974), 6.

⁹⁶ Brown, *The Medical Department of United States Army from 1775 to 1873*.

⁹⁷ Tobey, *The Medical Department of the Army*.

following periods of conflict. This mirrored the larger existential questions about the need, role, and structure of a standing Army. Following each major conflict, military senior leaders and politicians would extoll the virtues of the work, and value of the service of the AMEDD, only to then summarily dismantle it when faced with fiscal constraints.⁹⁸

Convention additionally maintained the medical officers as separate, evidenced by Army regulations in 1840 preventing medical officers from being saluted “as was [otherwise] prescribed for majors,” as they were not considered field grade officers.⁹⁹ More importantly, medical officers could not preside over administrative counsels, showing early preference to the medical officer as advisor and consultant, but not the commander. These “early difficulties of adequate military recognition,” as Major James Tobey described them, were worse in times of peace and reorganization and resolved in times of war.¹⁰⁰ During the Civil War, the role of medical officers as leaders was highlighted when the Secretary of War placed hospitals under the control of medical officers only.¹⁰¹ Following the Civil War, however, patterns repeated with the medical structure succumbing as the first casualty of the Defense Authorization and Appropriations mechanisms, capping personnel numbers and decreasing leadership roles within the AMEDD. Unfortunately, this ignored the reality that in a time of need the

⁹⁸ Tobey, *The Medical Department of the Army*.

⁹⁹ Ibid., 13.

¹⁰⁰ Ibid.

¹⁰¹ Ibid., 17.

Army cannot ramp up the production of medical leaders, processes, and facilities as quickly or efficiently as necessary.¹⁰²

This is at least partially due to the unique way in which the military medical departments are interconnected with the community and civilian medical infrastructure. The first medical textbook published in America was a work of *Military Surgery* in 1775, which speaks to the role and magnitude of military medicine in the greater medical community.¹⁰³ Early advances in immunization, preventive medicine, and communicable disease can all be attributed to military medicine, through the combination of large numbers of patients and resources in a wartime environment.¹⁰⁴ There has been a synergy between the civilian and military medical establishments since WWI to generate and advance new research and medical knowledge. There was a tie to the community, where physicians were largely called to service from the civilian sector to supplement the war effort.¹⁰⁵

Throughout the twentieth century, physicians and surgeons served as MC Officers as a patriotic duty, but also through compulsion. WWI and WWII saw compulsory

¹⁰² Ibid., 17, 31, 48; Office of Commission Appointed by the President to Investigate the Conduct of the War Department in the War with Spain, *Report of the Commission Appointed by the President to Investigate the Conduct of the War Department in the War with Spain*, 56th Cong., 1st sess. (Washington, DC: Government Printing Office, 1900), <https://archive.org/details/conductwardept05dodgrich>.

¹⁰³ Tobey, *The Medical Department of the Army*, 9.

¹⁰⁴ William H. Crosby, "The Golden Age of the Army Medical Corps: A Perspective from 1901," *Military Medicine* 148, no. 9 (1983): 707-11, <https://doi.org/10.1093/milmed/148.9.707>.

¹⁰⁵ Richard A. Gabriel and Karen S. Metz, *A History of Military Medicine*, vol. s, *From the Renaissance through Modern Times* (New York: Greenwood Press, 1992).

military service by physicians and surgeons, and the hardships of this service on their subsequent civilian life and practice are evidenced in a letter to the editor related to the Berry Plan from 1954. Here, a physician having served in WWII felt he was professionally delayed compared to his peers who had been able to avoid military service and were potentially exempt from service again in the Korean War.¹⁰⁶ The Berry Plan—also known as “The Doctor Draft” allowed junior doctors in training to defer military service until they had completed their training, before ultimately completing their term of service as a MC officer.¹⁰⁷ More recently (1987) the Health Care Personnel Delivery System (HCPDS) was approved by congress and like selective service, grants the power to draft civilian physicians into military service in a time of war.¹⁰⁸

During WWI there was a significant expansion of the medical department, with the total medical officer strength growing from 589 to more than 31,000, accounting for both regular and temporary appointments.¹⁰⁹ The interwar period, however, saw difficulty with recruiting and maintaining qualified medical officers. The training of medical

¹⁰⁶ C. M. Guest, “Letter to the Editor: DOCTOR DRAFT,” *The Journal of the American Medical Association*, 156, no. 9 (1954): 909, <https://tinyurl.com/4xv425ur>.

¹⁰⁷ F. B. Berry, “The Story of ‘The Berry Plan’,” *Bulletin of the New York Academy of Medicine* 52, no. 3 (1976): 278-82; “The Doctor Draft Law,” *The New England Journal of Medicine*, 248 (1953): 702-703, <https://tinyurl.com/29c7yswf>.

¹⁰⁸ United States Government, “Return to the Draft,” Selective Service System, accessed April 17, 2022, <https://www.sss.gov/about/return-to-draft/>.

¹⁰⁹ P. M. Ashburn, *A History of the Medical Department of the United States Army* (Boston; New York: Houghton Mifflin Company, 1929), 215; *Annual Report of the Surgeon General of the Public Health Service of the United States for the Fiscal Year 1919*, 66th Cong., 2nd sess. (Washington, DC: Government Printing Office, 1919), <https://tinyurl.com/4hnp8m27>.

officers included (in addition to their medical education), a basic course, advanced course, and participation in activities like the Command and General Staff College and Army War College, but was not standardized.¹¹⁰ A large number of military medical officers went on to lead medical colleges following their military service.¹¹¹

Military medicine continued to advance and improve civilian standards of care as surgical management far forward in conflict, gave surgeons access to injuries that otherwise had been considered not survivable.¹¹² Management of these complicated traumatic wounds changed how trauma is managed from evacuation, bleeding control, use of resuscitative fluids, and countless other small but revolutionary practices adopted by wartime military medical officers, as “medicine has become fully integrated into the web of general scientific exploration and progress.”¹¹³

Historically, advancements in military medicine also reflect the change in a society where military service is valued, rather than considered an occupation of the lower class. “A change in values investing the common soldier with both social and military value,” led to the need to care for soldiers and attend to casualties in an attempt to salvage those who may survive regardless of the effort or cost, and alleviate the

¹¹⁰ *Annual Report of the Surgeon General of the Public Health Service of the United States for the Fiscal Year 1925* (Washington, DC: Government Printing Office, 1925), <https://tinyurl.com/yjpu3z7d>.

¹¹¹ Tobey, *The Medical Department of the Army*, 68-72.

¹¹² Peter A. Aldea and William W. Shaw, “The Evolution of the Surgical Management of Severe Lower Extremity Trauma,” *Clinics in Plastic Surgery* 13, no. 4 (1986): 549-69, [https://doi.org/10.1016/s0094-1298\(20\)31536-4](https://doi.org/10.1016/s0094-1298(20)31536-4).

¹¹³ Gabriel and Metz, *A History of Military Medicine*, 215, 259.

suffering of those who would not.¹¹⁴ In their work *History of Military Medicine*, vol. 2, *From the Renaissance through Modern Times*, Richard A. Gabriel and Karen S. Metz summarize that “armies after all, are but reflections of their societies, and the level of organizational articulation of the military machine is no less a reflection of the general levels of organizational development and sophistication of the larger societies which they serve.”¹¹⁵

Military medicine as a social institution has developed as a distinct component of both the military and the civilian medical communities. Military medicine and the MC are more than an accumulated body of knowledge, however, as the lessons applied by MC officers have been accepted practice for centuries (hygiene, general health, and wellbeing practices.)¹¹⁶ The function of the MC officer “is still to rescue from the carnage as many salvageable bodies as possible, treat them quickly, and return them to the field of battle so that the carnage may continue until finally, the enemy’s will gives way.”¹¹⁷ This bleak picture of selfless, seemingly futile service, is found more neatly in Army Regulation from 1924, which stated, “The functions of the Medical Department are to conserve man power and preserve the strength of the military forces, a duty which is accomplished by advice as to the proper selection of the personnel of the Army, the

¹¹⁴ Ibid., 271.

¹¹⁵ Gabriel and Metz, *A History of Military Medicine*, 272.

¹¹⁶ Ibid., 270.

¹¹⁷ Ibid., 274.

maintenance of health, and by the furnishing of adequate medical and hospital facilities to those who become disabled.”¹¹⁸

The single largest enticement for MC officers, as the United States moved towards standardized medical education and professional, specialty-focused care, has been the placement and training in medical specialties. Recruitment and retention from the 1950s through current were largely related to the financial burden of medical school, through scholarships and placement at the military’s joint medical school. Post-graduate medical training is also required to obtain a medical license and practice as a physician within the United States. The AMEDD has provided these training opportunities, as specialties have progressed, to entice physicians to join the Army.¹¹⁹

This ran parallel to initiatives within the broader Army to recruit a different kind of soldier within the all-volunteer force. An emphasis on education and financial incentives toward tuition catered to those who had academic interests and goals, facilitating the belief that individuals who had academic aspirations and potential, would help to make the organizational changes needed in the Army at that time possible. Army GME now encompasses sixty-eight specialties and accounts for more than 1,500 physicians annually. The Army Medical School was established in 1893 and exists now as the Uniformed Services University of the Health Sciences (USUHS), in Bethesda,

¹¹⁸ Headquarters, Department of the Army (HQDA), Army Regulations No. 40-5, *Army Public Health Programs* (Washington, DC: U.S. Government Printing Office, December 31, 1924).

¹¹⁹ U.S. Army, “Army Graduate Medical Education,” RPI 576 FS, May 2011, https://www.goarmy.com/content/dam/goarmy/downloaded_assets/amedd_rpis/gme.pdf.

Maryland (officially chartered in 1972).¹²⁰ The surgeon general has described the Military Medical School as the “The soul of the Medical Corps.”¹²¹ It has also been described historically as the “vivifying, energizing influence of much human sympathy, inciting to professional improvement, stimulating esprit de corps, developing character, and inculcating that devotion to service which is the end and aim of the Medical Department.”¹²²

Table 1 Shows Army Regulations (AR) and Department of the Army Pamphlets (PAM) that apply uniquely to the MC. While this table is not exhaustive, it was derived after reviewing all published Army Regulations and DA Pamphlets subjects.

¹²⁰ “About,” Uniformed Services University of the Health Sciences (USUHS), accessed December 13, 2021, <https://www.usuhs.edu/about/>.

¹²¹ Tobey, *The Medical Department of the Army*, 70.

¹²² H. C. Fischer, “The Objects of the Army Medical School,” *Military Surgeon* 58 (January 1926): 54.

Table 1. Medical Corps Army Regulations and Department of the Army Pamphlets

AR 40-1	Composition, Mission, and Functions of The Army Medical Department	24 May 2019
AR 40-3	Medical, Dental, and Veterinary Care	23 April 2013
AR 40-5	Army Public Health Programs	12 May 2020
AR 40-66	Medical Record Administration and Health Care Documentation	16 June 2008
AR 40-68	Clinical Quality Management	26 February 2004
AR 40-501	Standards of Medical Fitness	27 June 2019
AR 40-502	Medical Readiness	27 June 2019
AR 351-3	Professional Education and Training Programs of The Army Medical Department	15 October 2007
AR 600-63	Army Health Promotion	14 April 2015
AR 601-141	US Army Health Professions Scholarship, Financial Assistance, and Active Duty Health Professions Loan Repayment Programs	19 September 2006
AR 601-142	Army Medical Department Professional Filler System	22 October 2015
AR 615-110	Selection, Training, Utilization and Career Guidance for Army Medical Corps Officers as Flight Surgeons	25 April 2018
PAM 40-11	Army Public Health Program	18 May 2020
PAM 40-502	Medical Readiness Procedures	27 June 2019
PAM 600-4	Army Medical Department Officer Professional Development and Career Management	30 March 2020

Source: United States Government, Army Publishing Directorate, accessed April 17, 2022, <https://armypubs.army.mil/>.

MC officers have unique regulations related to composition, mission, functions, accession and recruitment, professional education and training, deployment support, special missions, and professional development. Routine published AR also applies to MC officers and is at times contradictory to more branch-specific guidance.

International humanitarian law holds physicians in conflicts to both military and technical obligations, as Medical Inspector General Jean Mine delivered in a lecture to the National Association of the Reserve Officers of the technical and administrative Corps of the French Armed Forces Medical Services in 1986. Military obligations require medical personnel to be identified through conventional means (Red Cross or Red Crescent markings) and use such identification to carry out only medical functions, nor

commit harmful actions toward the enemy.¹²³ This distinction allows for special protection for those individuals regardless of party affiliation in conflict, nationality, or status.¹²⁴ Technical obligations require physicians to provide humanitarian assistance, impartially with prioritization based on medical urgency, and commit to patient care by not abandoning sick or wounded personnel.¹²⁵ The protections provided to medical personnel for these humanitarian purposes are for the benefit of the infirm and not the physician specifically. This protects the potential the physician holds to alleviate the suffering of others.¹²⁶

Military GME has evolved to meet the same requirements and standards of comparable civilian GME programs in the United States. Army GME is regulated by the

¹²³ The Geneva Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field, Geneva, August 12, 1949, Articles 19 and 21; The Geneva Convention (II) for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea, Geneva, August 12, 1949, Articles 22 and 34; Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts (Protocol I), Geneva, June 8, 1977, Articles 12 and 13; Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II), Geneva, June 8, 1977, Article 11.

¹²⁴ The Geneva Convention (I), Article 18; Protocol Additional to the Geneva Conventions (I), Articles 16(1) and 17(1); Protocol Additional to the Geneva Conventions (II), Article 10(1).

¹²⁵ The Geneva Convention (I), Article 12; The Geneva Convention (II), Article 12; Protocol Additional to the Geneva Conventions (I), Article 10; Protocol Additional to the Geneva Conventions (II), Article 7.

¹²⁶ Jean Mine, “Review of *The Geneva Conventions and Medical Personnel in the Field*,” (Lecture Presented at the “National Instruction Days” of the National Association of the Reserve Officers of the technical and administrative Corps of the French Armed Forces Medical Services, Paris, February 1986), <https://international-review.icrc.org/sites/default/files/S0020860400025316a.pdf>.

internal requirements in AR 351-3 but also meets the standards required by the Accreditation Council for Graduate Medical Education (ACGME).¹²⁷

The Brandt Committee, a Senate-directed panel in the 1980s, resulted in the development of the “Military Unique Curriculum” (MUC) after identifying a need for military-specific training to prepare physicians in GME to manage unique aspects of military medicine.¹²⁸ A survey performed in 1988 reviewed the MUC by surveying 464 family medicine residents from military residencies, evaluating to what extent the MUC had been implemented, as well as attitudes and opinions related to experiences with this program. Responses from the survey revealed a wide range of opinions on the topic of relevance and importance of implementation, as well as significant variation in the depth and breadth of their experiences with operational medicine. This survey has been a foundational baseline for the establishment of military-specific curriculums in family medicine residencies, as well as others over the past thirty years.¹²⁹

¹²⁷ De Lorenzo, “Accreditation Status of U.S. Military Graduate Medical Education Programs,” 635-40.

¹²⁸ Uniformed Services University of The Health Sciences (USUHS), *Military Unique Curricula: Instructional Objectives for Military Physicians and Graduate Medical Education Programs* (Bethesda, MD: USUHS, 1989).

¹²⁹ Howard Suls, Karen Karnei, John W. Gardner, John P. Fogarty, and Craig H. Llewellyn, “The Extent of Military Medicine Topics Taught in Military Family Practice Residency Programs: Part I. A Survey of Current Military Family Practice Residency Directors,” *Military Medicine* 162, no. 6 (1997): 422-27, <https://doi.org/10.1093/milmed/162.6.422>; Howard Suls, Karen Karnei, John W. Gardner, John P. Fogarty, and Craig H. Llewellyn, “The Extent of Military Medicine Topics Taught in Military Family Practice Residency Programs: Part II. A Survey of Residency Graduates from 1987-1990,” *Military Medicine* 162, no. 6 (1997): 428-34, <https://doi.org/10.1093/milmed/162.6.428>.

Operational medicine is defined as the “medical care provided in an austere environment with limited resources and possibly under hostile condition.”¹³⁰ Curriculums related to operational medicine are fragmented and there is a lack of universal implementation across military GME programs likely due to the lack of specificity in how and where to implement operational medical training when the initial need was established and mandated by Congress.¹³¹ GME serves as a means of developing a professional military identity, leadership skills, and practical applicable tools military physicians will use in their service as MC officers.¹³² Multiple sources have evaluated the cost of military GME and found it to be a cost-effective investment for satisfying critical positions, retaining physicians, and ensuring adequate filling of leadership billets.¹³³

¹³⁰ Roselyn Fuentes, “Operational Curriculum and Research Initiatives: Shaping the Future of Military Medicine,” *Federal Practitioner*, 10, no. 38 (October 2021): 474, <https://doi.org/10.12788/fp.0192>.

¹³¹ Stuart A. Roop, Clinton K. Murray, Alice M. Pugh, Yancy Y. Phillips, and Charles D. Bolan, “Operational Medicine Experience Integrated into a Military Internal Medicine Residency Curriculum,” *Military Medicine* 166, no. 1 (2001): 34-39, <https://doi.org/10.1093/milmed/166.1.34>.

¹³² Joanna J. Sharpless, Nell Baldwin, Robert L. Cook, Aaron D. Kofman, Alessio Morley-Fletcher, Rebecca Slotkin, and Hedy S Wald, “The Becoming: Students’ Reflections on the Process of Professional Identity Formation in Medical Education,” *Academic Medicine* 90 (2015): 713-17; Richard L. Cruess, Sylvia R. Cruess, Joseph Donald Boudreau, Linda S Snell, and Yvonne Steinert, “Reframing Medical Education to Support Professional Identity Formation,” *Academic Medicine: Journal of the Association of American Medical Colleges* 89, no. 11 (2014): 1146-51, [doi:10.1097/ACM.0000000000000427](https://doi.org/10.1097/ACM.0000000000000427).

¹³³ Fuentes, “Operational Curriculum and Research Initiatives.”

Summary

Understanding culture relies on a clear and binding definition. This is important when attempting to compare or construct meaning and interpretation of behaviors, as different philosophical approaches to culture can lead to unique explanations. Many researchers have studied culture at the national level and developed theories and tools to compare societies in cross-cultural analysis. Geert Hofstede is the preeminent authority on national culture and developed a model comparing initially four dimensions. His work expanded to ultimately six dimensions and inspired many other researchers to develop operationalized, quantitative tools to compare aspects of culture among nations. Alfons Trompenaars used his model comparing seven dimensions to explore business relationships and communication. Shalom Schwartz similarly developed a model that identified seven clusters of thought for comparison. In subsequent refinement, his model ultimately evolved into ten broad values encompassing four major dimensions. The collaborative efforts of the GLOBE project reproduced the work of previous psychologists at a larger scale and with more diversity, to develop a slightly different six-dimension model. Hofstede defined organizational culture as a subset of national culture, while Edgar Schein has focused extensively on the study of organizational culture as a distinct phenomenon. Schein's model of organizational culture is distinct from those previously discussed—establishing three aspects of culture when examining an organization rather than specific indices. Schein's theory did benefit from the work of previous psychologists in philosophical underpinnings but also benefited from the focused nature of its application. The best practice of culture theory and analysis is not to compare theories to adjudicate which may be the best, however, but instead to establish

where they complement or corroborate each other, as well as what areas are missed in analysis based on existing gaps in the research.

The study of microcultures has been more specifically applied to those within national cultures as it relates to ethnic and gender-based trends. Microculture and subculture are used synonymously to discuss a further subset of a specific cultural population. There is precedent in the study of the impact of microcultures in academic environments, however, no consistent model or theory has emerged to examine microcultures within organizations including the United States Army and the microcultures that exist within it.

The United States Army employs physicians as MC officers, who have unique insignia, branch, and history. The history of the Army Medical Corps is as long as the history of the United States Army and the AMEDD has functioned in some capacity since the Revolutionary War. The establishment of the AMEDD and the MC has seen significant friction within the Army at large as well as within congress, as it has been a costly endeavor to train and maintain medical professionals. Medical professionals have always been considered separate or distinct from other, regular Army officers. There is extensive documentation and regulation regarding the accession, training, employment, and retention of the MC within the United States Army. GME has been a consistent theme within the existence of the MC and emphasized as a vital and value-added program.

CHAPTER 3

RESEARCH METHODOLOGY

Purpose of the Study

Building from the foundational concepts of national culture and assimilating dimensions of Hofstede, Trompenaars, Schwartz, and House, a theory of microculture will nest within Schein's theory of organizational culture. This theoretical framework developed through application to the United States Army Medical Corps assesses the convergent and divergent aspects of microculture and develops initial themes for further investigation. Defining and explaining this microculture is the necessary initial step in examining the relationships between the microculture and the United States Army. These themes help to inform decisions regarding recruitment, training, employment, and retention of members of the organizational microculture. When applied to learning environments, specifically Graduate Medical Education (GME) and Professional Military Education (PME), a better understanding of the microculture will assist in shaping these environments to reduce negative, maladaptive aspects while optimizing the positive characteristics that contribute to developing functional medical leaders.

Research Questions

Primary: What relationships exist between the microculture of the United States Army Medical Corps and learning environments? Secondary: (1) What dimensions are most useful in examining and describing organizational microculture? (2) How is the United States Army Medical Corps an organizational microculture?

Rationale

The research conducted in this exploratory study is qualitative. With minimal research about the application of microcultures to the United States military, there is no accepted framework to describe or discuss organizational microcultures in this population. Recent initiatives Army-wide have focused on norming the force and standardizing policies and activities to include previously exempt or separate microcultures such as the MC. An initial inquiry into this topic will help to establish the definition and characteristics of organizational microculture and examine convergent and divergent aspects in application to the United States Army. From the perspective of a member of this microculture, the researcher used insights from lived experience to focus efforts and set boundaries on the inquiry, while being conscious of the limitations of personal involvement and taking in a wide variety of data to move beyond the personal, to understand the more universal cultural dimensions. Epistemologically, this inquiry is constructivist and attempts to make meaning from the established, identifiable dimensions. This type of inquiry will help to describe and explain a concept, creating a foundation for further, focused research to continue to understand, shape, and advance the MC.

Grounded theory facilitated this inquiry by incorporating a large quantity of data collected and analyzed in an iterative process. The lack of a step-by-step framework for analysis allowed for flexibility as themes and clusters emerged from the early data. This exploration was necessary to move from the anecdotal limited understanding of this microculture to meaningful and purposeful data that can help inform and shape further study. This methodology requires not just the assessment of the proposed population, but

also the determination of the best assessment criteria to examine and report those observations. Constraining data collection to available, published records limited the full capability a more robust qualitative study could have had; however, this was necessary before conducting focused research on human subjects. This initial exploratory study will ensure the right questions are asked and the correct approach is taken, for future inquiries within the organization.

This methodology provides the broadest aperture to approach a unique and difficult-to-describe problem set. Because this data is qualitative, very little has been written about it in a meaningful way. Many assumptions exist about motivations, attitudes, beliefs, and behaviors, but establishing a framework to define and describe an organizational microculture within the United States Army has not previously been done. The biggest strength of grounded theory is the flexibility to pursue and examine multiple threads of data as they are, rather than limiting the examination to one type of data. By its nature, grounded theory can be adapted to the problem set addressed.

Research Methodology, Data Collection, and Analysis

This research conducted using constructivist grounded theory demonstrates themes and trends that define the culture of the MC while reinforcing the aspects of a theoretical framework with which to examine organizational microculture. The existence of this microculture will help to understand how the MC functions within the Army and how to best optimize learning environments to shape and develop MC officers more effectively.

Theoretical frameworks examining national and organizational culture were reviewed for areas of convergence and divergence. The areas of greatest convergence

were weighted highest and used as the scaffold for an initial theoretical framework. All themes were included and nested within this scaffold, creating a critical questionnaire. Data collection included reviewing statements of MC officers on both social media forums and a personal narrative, as well as published material in the *Military Medicine* academic journal. Research related to the history and regulations specific to the AMEDD and MC were also reviewed to ensure adequate context for the interpretation of data.

Following initial data collection from each source, reflection, and use of the initial framework's critical questionnaire, the initial framework was interrogated to determine if the data collected was adequately captured with the dimensions included or if any areas were not well represented, aspects that may require additional inquiry or dimensions that do not seem applicable or approachable with this study. The results of this exercise informed the data collected in subsequent iterations. Any aspects identified by a later source were applied to previous sources to ensure adequate analysis. Data saturation was achieved in each source when no new themes emerged with an additional review of similar content.

A final review of the framework was performed to ensure all data was represented holistically. This revealed the original scaffolding was essentially unchanged but the critically reflective questions were adjusted based on the refinement of each source's data. The final framework identified the most critical aspects of the organizational microculture and was then applied to the MC and a narrative summary was recorded.

Ethical Considerations

There is substantial potential for observer effect in this research, as the act of studying attitudes and behaviors will impact them. By avoiding direct contact with the

population studied, the risk of direct physical harm is eliminated however, any unflattering, contradictory, or negative attitudes, beliefs, or behaviors uncovered by this research may reflect poorly on those officers if their recollections are taken out of context. For this reason, all data was anonymized and direct quotations and content were replaced with coded themes. Specifically, when using currently published opinions, social media content, or internal documents that although public, were not intended for wide distribution, all inclusions were completely anonymous and only general trends, themes, and reflections were recorded. No direct quotes, examples, or anecdotes were included due to the small size of the population and the likelihood that specific inclusions could be traced back to their source. By researching as a member of the population studied, the researcher acknowledges the potential for bias in both the data collection and analysis or interpretation of that data. To address and mitigate the potential negative impact, a research journal was maintained throughout all aspects of data collection and analysis to identify early subjectivities, motivations, and desires.

Obliging the exploratory nature of this study, the researcher committed to reporting the data as it exists intending to analyze it without the intent to change or modify it. As a result, specific emphasis was placed on identifying and acknowledging when data was unexpected or contradictory to the researcher's opinions, beliefs, or experiences. Throughout the research process, the researcher reiterated the goal of developing a framework to begin the process of affecting change rather than addressing specific aspects that arose in data collection.

Summary

Grounded theory is flexible by design and offers the widest aperture to conduct an initial exploratory investigation on the subject. Because culture and microculture are broad topics that while familiar, are poorly differentiated, this research will help to establish a framework with which to describe and increase shared understanding of the existence of organizational microcultures. Data collection and analysis occurred continuously in an iterative process using mapping and critical reflection to help identify patterns in a large volume of qualitative, published, narrative data. The use of the MC as a data source helped to refine the critical framework of organizational microculture while beginning the initial exploration into aspects of this microculture that will benefit from additional, focused inquiry.

CHAPTER 4

ANALYSIS

Initial Framework Development

Initial data collection and iterative analysis began with an examination of the existing theoretical frameworks used to describe national and organizational culture. Using the models of Hofstede, Trompenaars, Schwartz, House, and Schein, word mapping revealed areas of convergence and divergence. This exercise also demonstrated that Schein's model of organizational culture did not address the question of culture in the same manner as the other models, describing levels rather than specific characteristics. This was noted and the process was continued, revealing several key areas of overlap that required a deeper understanding of the models rather than just a comparison of terms or aspects as listed in each theory.¹³⁴

Narrative summary descriptions included in the literature review for each explanation of culture were analyzed to determine key words. Syncategorematic words were removed and the sentence was examined for descriptive, categorical words. The key descriptive words were transcribed on a spreadsheet and repetitive descriptive words were included as they occurred. All descriptions were reviewed yielding 391 total items which were then sorted alphabetically and reviewed for clarity. Words derived from a common root were combined under one root which allowed repetitive themes to emerge to identify which concepts were most convergent throughout the descriptions of all theories. Items included only once were removed from the list and the root-based list was

¹³⁴ See Appendix A for the complete word mapping and nesting exercise, 94.

reduced to eighty-two items occurring in iterations of two to six occurrences. Raw data from this process was recorded in a table of items during each review step to ensure reproducibility.¹³⁵ The final table of items, displayed as groups of iterative occurrences, was used to create a visual representation of the initial key themes in a word cloud using open-source software.¹³⁶ The iterative data in table form and word cloud are included in Table 2 and Figure 1.

Table 2. Initial Critical Framework Key Word Iterative Table

(6) Instances	(4) Instances	(3) Instances	
Change Individual Norms Power Rules	Achievement Assumption Control Equal Performance Relationship Respect Reward Status Tradition	Adapt Affective Autonomy Avoid Consistency Decision Distribute Egalitarianism Environment Future	Happiness Harmony Open Order Pride Self Share Uncertainty Universalism
(5) Instances			
Expectation Group Role			

(2) Instances			
Allocate Altruism Artifact Ascription Assertiveness Collectivism Commitment Communication Desire Different Direction Display	Distinct Emotion Enhancement Exceptions Express Flexible Friction Gratification Hierarchy Humane Inequality Investing	Legitimate Life Neutral Obligations Orientation Perseverance Reason Resources Response Responsibility Restraint Rigid	Skill Society Specific Stimulation Strict Structure Term Transcendence Values

Source: Created by author using Appendix B, 96.

¹³⁵ See Appendix B for tables reporting all raw iterative data described, 96.

¹³⁶ WordClouds.com, accessed April 17, 2022, <https://www.wordclouds.com/>.

<u>Initial Critical Framework (Focus Questions to Consider):</u> 1. POWER: explore the role of power, authority, and hierarchy. a. What does power look like? b. How do individuals obtain and maintain power? c. How can power be lost? d. What reverence or respect is granted to those in power? e. What reverence or respect is granted by those in power to those who are not? f. Is power abused, revered, scoffed, or avoided (etc)? g. Explore the dynamic of CONTROL as it related to power. 2. RULES: explore the role of rules, regulations, and requirements. a. How are rules decided, disseminated, and enforced? b. Is it fair, how is it perceived, and do people respect rules? c. What is the consensus about rules? (Are they made to be broke, are they to be followed, etc) d. Are there different rules for different people or groups? e. Explore the dynamic of control as it relates to rules. 3. GROUP: explore the nature of groups. a. How are individuals placed into groups, and how is this decided? b. What types of groups, distinctions, or classifications exist? c. What is the role and purpose of these groups? d. Explore the nature of equality within these groups and between these groups e. Explore the nature of respect within these groups and between these groups f. What type of relationships exist within, and because of these groups? 4. INDIVIDUAL: explore the role and nature of the individual (versus group). a. What is considered Success / Good / Positive b. What performance is rewarded? c. Do individuals strive to achieve? What does this look like? d. What is considered Failure / Bad / Negative e. What performance is punished or admonished? f. Do individuals endeavor to avoid failure or punishment? g. Explore the nature of respect, control, autonomy, and equality as experienced by individuals. 5. NORMS (v CHANGE): examine what is considered “normal” versus “abnormal” a. What are existing expectations, and how are expectations experienced. b. What assumptions are made, and what is not safe to assume. c. What does the “status quo” look like, and is there a desire to maintain the status quo or more desire to change. d. What are the norms related to achievement, equality, respect, rewards, and punishments? e. What traditions exist? How are traditions regarded? f. How is change regarded?	
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Figure 2. Initial Critical Framework

Source: Created by author using Data in Appendix B, 96.

Application of Initial Critical Framework

Social Media Content

The initial critical framework was used to examine social media content from a closed, online group of approximately 2,000 MC officers. There is no comprehensive demographic information available for this group. Members are vetted, however, and must be Army MC officers to join, although participants may no longer be serving on active duty. Participation in the group is primarily through message board posts that arise from moderators or group members. Over one month, forty-five discrete posts were reviewed for the topic, intent, engagement, and themes occurring in both the original post and subsequent comments. Posts were not transcribed or reproduced due to community rules and the sensitive nature of direct quotations in a small population. Each post was annotated on a spreadsheet where the motivation, engagement, and themes were recorded. For example, a post made by a member asking for help regarding a clinic or hospital-related process, with forty “likes,” and twenty comments would be recorded as (example): *“Inquiring, Assistance - 40, 20 - Processes, Complaints, Lack of familiarity with systems.”* The reply comments were also evaluated for themes, potentially like the initial, but often revealing new themes (example): *“direct assistance, mentorship, advice, venting, processes, regulations, appeals to authority.”* The complete review of social media posts is included in table format in Appendix C.¹³⁷

The table of data was reviewed and the researcher applied each post to the critical outline previously developed. Ensuring this process was completed shortly after

¹³⁷ See Appendix C for data obtained from social media content, 106.

reviewing the data was critical, as the researcher served as the instrument and was responsible for ensuring the complete inclusion of all themes reviewed. This was accomplished by utilizing a reflective process in response to each of the focal areas of the critical framework in a brief description. All posts were analyzed in this manner leading to a comprehensive narrative explanation of the key themes expressed in the social media content. No novel dimensions emerged during the examination of the social media content. The researcher noted that after reviewing approximately twenty-five of the forty-five posts, no new themes emerged, indicating adequate data saturation for this source.¹³⁸

Narrative Journal

A first-person narrative journal from an Army family medicine intern (2012-2013) was reviewed for content and examined for themes and trends with the initial review of sixty entries encompassing sixty-nine pages in three months. The stated purpose of the journal was to record events and reflect on experiences during residency. Most of the content was related to the individual emotional state of the author and day-to-day events and interactions with colleagues in a hospital setting. The primary focus of this journal was on patient care, acquiring knowledge as a junior physician, and acclimating to the new roles of house staff and primary care physician. These reflections provided a robust discussion of power, rules, group dynamics, individual aspects, and attitudes toward change, facilitating continued use of the previously developed initial critical framework. After reviewing approximately fifty entries no new themes emerged

¹³⁸ See Appendix C for summarized content and themes after application of the initial critical framework to social media content, 109.

from the reflective process and an additional ten entries were reviewed which confirmed data saturation had been reached for this data source. Because of the nature of journaling, an additional thirty-one entries covering thirty-seven pages and approximately two and a half months were examined from the end of the journal to ensure consistency in themes recorded earlier. While the entries at the end of the journal were generally shorter and included more personal information, the themes relating to residency and culture were consistent with the earlier entries and did not reveal a significant change over one year. This data was recorded in a narrative reflective process, similar to the social media content previously discussed.¹³⁹

Academic Journal

The Association of Military Surgeons of the United States (AMSUS), referred to as The Society of Federal Health Professionals, encompasses medical professionals within the Department of Defense, Department of Veterans Affairs, Department of Health and Human Services, and Department of Homeland Security.¹⁴⁰ AMSUS publishes *Military Medicine*, a journal including peer-reviewed scientific papers, case reports, editorials, and letters to the editor. The journal is published every two months and is open to society members for free, otherwise requiring a paid subscription to access all content. After obtaining unrestricted access, the journal was reviewed in reverse chronological order, starting with the most recent published issues. Several limitations of

¹³⁹ See Appendix D for data obtained after application of the initial critical framework to narrative journal content, 113.

¹⁴⁰ The Society of Federal Health Professionals, “Our Mission,” AMSUS, accessed April 17, 2022, <https://www.amsus.org/mission-vision-values/>.

this data source were noted including, a large number of international submissions from military professionals outside of the United States, as well as content from the United States Navy and Air Force. Most content was focused on reporting medical research and case reports and did not include a significant amount of personal narrative description.

The most useful sections for obtaining the personal narrative and subjective content were: “Columns,” “Commentary,” “Letters,” and in select “Case Reports,” which focused on experiences and perceptions. A review of this data source was focused only on those sections, and limited to US cases involving Army medical professionals only. The USUHS was referenced frequently and although USUHS reports often included Navy and Air Force students, the combined nature of the training program indicated the content was appropriate to include.

Six months of issues were reviewed for content, after which no new themes emerged and data saturation was achieved for this source. The researcher used a process of reviewing the article for general themes and content, scraping excerpts and references as applicable, and finally reflecting on the aspects of the initially developed critical framework. Initial use of the critical framework proved cumbersome for this data source, and a revised generalized framework was used instead, seeking open-ended feedback and reflection on power, rules, group, individual, and norms (versus change) based on the general understanding of these concepts from earlier reflection.

All content was recorded on a single outline to easily review for repetitive content. This reflective framework worksheet incorporated all the notes from the articles and in review ensured that the themes collected from the academic journal source fit within the originally established critical framework. There were no new dimensions,

however, some new perspectives of the previously developed framework aspects were explored.¹⁴¹ The researcher refined the initial critical framework using the products from each source of data and a final framework was proposed and applied again, to each of the data sources to ensure validity with an additional review of content. The final proposed framework included below is shown in comparison to the initial critical framework, with a discussion of the data supporting the revised critical framework in each aspect.

Development of the Final Framework

Power

<u>Power: Initial critical framework- (explore the role of power, authority, and hierarchy).</u> - What does power look like? - How do individuals obtain and maintain power? - How can power be lost? - What reverence or respect is granted to those in power? - What reverence or respect is granted by those in power to those who are not? - Is power abused, revered, scoffed, or avoided (etc)? - Explore the dynamic of CONTROL as it related to power.
<u>Power: Revised Critical Framework- (examine power and influence through questioning).</u> - How does the microculture experience the concept of power – both internally and externally? (IE how is it obtained, maintained, or lost, how is it demonstrated or abused) - What exerts power over or on the microculture? - How does power relate to control and autonomy within the microculture?

Figure 3. Power Dimension, Comparison of Initial and Final Frameworks

Source: Created by author using Appendix B, 96; Appendix F, 125.

¹⁴¹ See Appendix E for data obtained after application of the initial critical framework to academic journal content, 121.

The revised portion of the framework examining power is compared to the initial proposed framework in Figure 3, showing the evolution of the critical framework. Three groups of observations yielded information about the external and internal experience of power experienced within the microculture. In response to the question: “what kind of power is exerted over the microculture?” the data collected showed that power is represented by outside entities and agencies. The military as an organization is perceived to wield power in the world through its ability to assess and affect situations. The military also wields power over physicians through the processes, procedures, and regulations. Those who are less knowledgeable about these systems are less powerful. For the MC—the Defense Health Agency (DHA) and MHS as organizations exert power. Healthcare administrators also have a significant amount of power over physicians in their ability to change rules and processes.

In response to the question: “what kind of power do members of the microculture have?” the most common theme revealed that knowledge and experience serve as the largest factors in the power held by MC officers. The power of MC officers rests in their ability to impact both individuals and operations through medical readiness and direct access to commanders to influence decisions. This power differs from the power of other branch officers, as it is not directly tied to rank and instead experience, knowledge, and position. There is some power associated with rank and time in service, as older physicians tend to be more knowledgeable and competent, however, there is a limit to this as many very senior physicians are seen as out of touch and no longer competent due to perceived skill atrophy or lack of clinical practice. There is also power through proximity as those who associate or work with these older physicians are extended more

positional power than they would otherwise have within the MC community. Members of the microculture can also exert power and influence by mentoring and sponsoring those junior to them. Direct mentorship as a one-on-one relationship is preferred and is often selected top-down, as senior MC officers initiate a mentoring relationship. Because of this arrangement, information is often passed between individuals who serve as gatekeepers rather than conduits, where all members could experience the benefit of such information.

Additional power dynamic themes were also explored from the data, including the existence of a rich internal MC hierarchy separate from the rank structure of the Army. This hierarchy includes training status, position in a program, years of practice on a service, and the service itself, as well as other less concrete characteristics such as time at a facility or in a position, reputation, and relationships within the organization. While not as clearly documented in all instances this is a commonly experienced dynamic in both the hospital and operational medical settings. Because power and influence so significantly rely on expertise and competence, only hollow respect is given to rank alone and those in positions of power are expected to demonstrate and prove themselves and validate the worthiness of their position of power. Power over patients, however, is sacred and treated differently than power over peers or other professional colleagues. This complicates scenarios where the lines between patients and colleagues blur. A loss of power on behalf of the physician is experienced when their autonomy and control are limited by the organization. This is a common perception among MC officers who often feel responsible for outcomes, but unable to influence decisions resulting in a sense of powerlessness within the larger system.

Rules

<u>Rules: Initial critical framework- (explore the role of rules, regulations, and requirements).</u> - How are rules decided, disseminated, and enforced? - Is it fair, how is it perceived, and do people respect rules? - What is the consensus about rules? (Are they made to be broke, are they to be followed, etc) - Are there different rules for different people or groups? - Explore the dynamic of control as it relates to rules.
<u>Rules: Revised critical framework- (explore rules, regulations, and obligations).</u> - How does the microculture experience the concept of rules? (Where do rules originate from, and how are they perceived in general.) - How do the rules in the microculture differ from those in the larger macroculture? - How do rules impact power and control?

Figure 4. Rules Dimension, Comparison of Initial and Final Frameworks

Source: Created by author using Appendix B, 96; Appendix F, 125.

The revised portion of the framework examining rules is compared to the initial proposed framework in Figure 4, showing the evolution of the critical framework. There is an overarching structure in which all MC officers function, that relies on compliance with existing procedures for patient safety and effectiveness. The practice of medicine follows many written and unwritten rules and from the perspective of the MC officer, rules exist for a reason. Rules and regulations are directly associated with power, as the perception is that those who are in power can write or influence the enforcement of rules. It is however acceptable to question rules and regulations if it results in practice improvement. Rules from external sources are regarded as suspicious, particularly if they do not fully align with the priorities of those who must follow them. Changes are not well received, particularly if a rule or regulation is considered valid or acceptable. Rules as

simple as standard operating procedures at the unit level and as complex as congressional mandates are openly discussed and critiqued by MC officers. This exchange is often negative but occurs all while complying with the rule in question. MC officers frequently feel powerless to change or influence rules because they do not understand them or know they exist and improved comprehension is more appropriate than radical change. In this way, rules that do not make sense are complained about and worked around rather than revised or clarified.

Rules that exist within the operational world differ significantly from the rules that exist within the military treatment facilities and the clinical world, despite both being based on the same regulations. MC officers are often handicapped in these environments because they are not as familiar with the rules and regulations that are more common knowledge among other branch officers. The MC appears to have an unwritten rule about maintaining an outwardly positive affect, despite consistently expressed internal dissatisfaction and in-fighting. MC officers are expected to support and reinforce each other, particularly when in conflict with other branch officers, regulations, or processes. Rules and requirements are very specific concerning time, likely related to the rigid schedule expected in clinical practice, and for this reason, schedules are seen as the biggest rule encountered each day, creating a tension as the individual who must complete the scheduled tasks is not in control of creating the schedule. MC officers accept that rules differ between individuals and this inequality is accepted and rarely challenged as eventually, individuals hope to reach the more desirable, advantageous position. Rules are seen as the tool to exert power and control over a subordinate and with enough power, rules do not need to be followed.

Groups

<u>Group: Initial critical framework- (explore the nature of groups).</u> 1. How are individuals placed into groups, and how is this decided? 2. What types of groups, distinctions, or classifications exist? 3. What is the role and purpose of these groups? 4. Explore the nature of equality within these groups and between these groups 5. Explore the nature of respect within these groups and between these groups 6. What type of relationships exists within, and because of these groups?
<u>Group: Revised critical framework- (explore the role and nature of groups).</u> 1. What makes the microculture a distinct group and what other groups are related? 2. What groups exist within the microculture? 3. What perpetuates these groups and what does their existence cause?

Figure 5. Group Dimension, Comparison of Initial and Final Frameworks

Source: Created by author using Appendix B, 96; Appendix F, 125.

The revised portion of the framework examining groups is compared to the initial proposed framework in Figure 5, showing the evolution of the critical framework. MC officers are a distinct, separate group because of how they have chosen to serve and for that reason should be given special consideration. Not only are they distinct from other Army professionals they are also distinct from their civilian medical counterparts because of the austere, atypical environments in which they serve. For this reason, they require specialized training, distinct from other branch officers and civilian medical professionals. MC officers are seen as different even from other Army Medical Professionals to include nurses and administrators. Due to their small relative size within the Army, MC officers are expected to support each other and work together to accomplish difficult tasks in difficult situations. For real change to be effective MC

officers must mobilize together which is against their general inclination to work alone or in isolation on projects. This orientation (against collectivism) is likely related to the isolated nature of their employment, serving often as the only subject matter expert in a sizeable formation, separated from professional peers.

Within the MC, there is a clear “us versus them” mentality between physicians who practice daily and those who are not clinically active. There is also a divide between those who are operationally experienced and those who have only practiced within larger, fixed facilities. MC officers are more likely to engage in activities to which they have already been exposed, which perpetuates these differences over time. Medical specialties also serve as important subgroups, with MC officers having professional identities rooted within their scope of practice. The perception of unequal respect and treatment for different medical specialties perpetuates the subgroup narrative, which is disruptive to the collective movement of the MC toward effective change. There is also a subtle subgroup related to medical school affiliation, specifically with those who graduate from USUHS, who statistically tend to serve longer than those who matriculate from the Health Professions Scholarship Program (HPSP) and disproportionately hold key leadership roles within the MC as a result.

Individuals

Individualism: Initial critical framework- (explore the nature of the individual (versus group)).

1. What is considered Success / Good / Positive
2. What performance is rewarded?
3. Do individuals strive to achieve? What does this look like?
4. What is considered Failure / Bad / Negative
5. What performance is punished or admonished?
6. Do individuals endeavor to avoid failure or punishment?
7. Explore the nature of respect, control, autonomy, and equality as experienced by individuals.

Individualism: Revised critical framework- (explore the role and nature of the individual).

1. How are individuals regraded concerning the group, within the microculture and outside of the microculture?
2. What motivates and inhibits individuals?
3. How do individuals succeed, fail and distinguish themselves from the group?
4. How does the individual experience power, control, and autonomy?

Figure 6. Individualism Dimension, Comparison of Initial and Final Frameworks

Source: Created by author using Appendix B, 96; Appendix F, 125.

The revised portion of the framework examining groups is compared to the initial proposed framework in Figure 6, showing the evolution of the critical framework. The MC officer often works in professional isolation as the only expert in their direct sphere of influence and as a result, feels a strong sense of individualism. The individual officer is considered significant to the patient and mission in the operational setting. Working hard, sacrifice and selflessness are considered positive attributes. Laziness and incompetence are seen as negative attributes that should be avoided. MC officers are responsible for continually developing themselves to ensure they can perform their role when needed. It is considered the individual's responsibility to maintain their unique

skillset, often with little institutional support. The needs of the individual are considered valid necessitating a unique approach for each officer. Lack of individual consideration is considered a slight. Often, the role of the MC officer is to stand in opposition to the larger organization to advocate for the individual as a form of balancing needs. There is a limit to individualism, however, as when the goals or beliefs of the individual are too different from the group, they are not typically supported by the MC community.

Success is rewarded by selection for promotion, awards, and recognition and reinforced with positive feedback. There is little motivation to provide critical feedback about negative performance until it reaches a significant level of dysfunction. There is substantial motivation to maintain and protect one's professional reputation through appearing confident, correct, and not making mistakes. Perfect performance is rewarded, deviations from perfect are tolerated but not rewarded. The ideal MC officer "makes it look easy," and is efficient, effective, and timely. The unattainability of this standard often leads to an attitude where MC officers strive to avoid negative consequences or perceptions of failure. There is a strong sense of responsibility and a heavy burden attached to patient care that transfers to other aspects of professional life. Because failure in this respect is related to potentially harming a patient, failure is avoided at all costs. Lack of control and autonomy creates the most significant psychosocial stress for MC officers as they are unable to change their macro-environment and thus seek to regulate their micro-environments, while also trying not to make waves or create tension within the organization, as this historically has limited effectiveness.

Norms

<u>Norms (v Change): Initial critical framework- (examine “normal” versus “abnormal”).</u> 1. What are existing expectations, and how are expectations experienced. 2. What assumptions are made, and what is not safe to assume. 3. What does the “status quo” look like, and is there a desire to maintain the status quo or more desire to change. 4. What are the norms related to achievement, equality, respect, rewards, and punishments? 5. What traditions exist? How are traditions regarded? 6. How is change regarded?
<u>Norms (v Change): Revised critical framework- (examine “normal” versus “abnormal”).</u> 1. How is change considered and experienced within the microculture? 2. What is the experience related to the status quo within the microculture? 3. How are diversity and divergence experienced within the microculture? 4. Where do norms and expectations arise from, and can they be traced back to a root?

Figure 7. Norms Dimension, Comparison of Initial and Final Frameworks

Source: Created by author using Appendix B, 96; Appendix F, 125.

The revised portion of the framework examines norms as compared to the initial proposed framework in Figure 7, showing the evolution of the critical framework. The practice of medicine is always evolving and for that reason, there is a strong belief that the status quo should be challenged to take the best care of patients. MC officers look to the past for experiences but often take novel approaches. If the greater good is the goal, changes are acceptable and there is an expectation that MC officers will adapt to new practices. Even with this, change is slow and considered more along the lines of evolution versus revolution for military medicine. There are some “enduring truths,” which seem impossible to change particularly related to mindsets and metrics of performance. A division within the MC sees some excited to embrace change and others who seek to

avoid it at all costs. This is often based on the level of experience and success in the system that is being challenged. Additionally, there is a lack of self-efficacy related to the ability to change the norms of the organization. Many MC officers expressed discontent without motivation or intention to make progress in the areas of frustration.

Norms give a benchmark against which measurements can be made, however, they must always be questioned and refined to ensure that the rules and norms adopted aren't inhibiting the work that MC officers aim to accomplish. Overall, there is a sentiment that the MC must seek its own changes and cannot expect the Army to adapt itself to the microculture. The unwritten rules and norms within the MC are often passed down through the one-on-one mentoring and sponsoring relationships that develop between members. This creates an in-group who follows the unwritten rules and is rewarded and an out-group who unknowingly breaks these rules and has more difficulty finding success. The out-group often feels a general sense of disorder and lack of clarity, identifying there is something they do not know and cannot find it.

Fitting in is important and not being too divergent is valued within the MC. While diversity is an espoused valued quality, being too different will lead an individual to be ostracized and ultimately less successful. This does not manifest in physical characteristics as much as in personality and mannerisms. Assumptions, often inaccurate, are made about professional competence based on the individual's ability to fit in concerning personality and mannerisms. Within the MC there is a strong desire to continue along the more stable chartered course for the organization, however, there is a growing sentiment that the MC holds onto toxic and broken systems because they represent at least some order in what is otherwise chaos. Residency training (GME) is an

example of a tradition-steeped period, where junior MC officers know and anticipate a highly regimented “rite of passage” that changes little from year to year. Norms that derive from the GME environment center around the ideals of self-sacrifice, hard work—often to excess and burnout, expecting thanklessness, and creating a personal identity that is centered around being an Army physician. The further physicians are from this period the more likely they are to have critically reflected on these norms; however, the rank structure of the MC ensures that the majority of MC Officers are junior physicians within five years of GME.¹⁴²

¹⁴² Benjamin F. Mundell, “Retention of Military Physicians: The Differential Effects of Practice Opportunities Across the Three Services,” (PhD diss., Pardee Rand Graduate School, 2010), https://www.rand.org/content/dam/rand/pubs/rgs_dissertations/2010/RAND_RGSD275.pdf.

The Final Critical Framework

Final Critical Framework.

Power: (examine power and influence through questioning).

1. How does the microculture experience the concept of power – both internally and externally? (IE how is it obtained, maintained, or lost, how is it demonstrated or abused)
2. What exerts power over or on the microculture?
3. How does power relate to control and autonomy within the microculture?

Rules: (explore rules, regulations, and obligations).

1. How does the microculture experience the concept of rules?
(Where do rules originate from, and how are they perceived in general.)
2. How do the rules in the microculture differ from those in the larger macroculture?
3. How do rules impact power and control?

Group: (explore the role and nature of groups).

1. What makes the microculture a distinct group and what other groups are related?
2. What groups exist within the microculture?
3. What perpetuates these groups and what does their existence cause?

Individualism: (explore the role and nature of the individual).

1. How are individuals regarded concerning the group, within the microculture and outside of the microculture?
2. What motivates and inhibits individuals?
3. How do individuals succeed, fail and distinguish themselves from the group?
4. How does the individual experience power, control, and autonomy?

Norms (v Change): (examine “normal” versus “abnormal”).

1. How is change considered and experienced within the microculture?
2. What is the experience related to the status quo within the microculture?
3. How are diversity and divergence experienced within the microculture?
4. Where do norms and expectations arise from, can they be traced back to a root?

Figure 8. Final Critical Framework

Source: Created by author using Appendix F, 125.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

The development and subsequent application of the theoretical framework examining organizational microcultures uncovers specific aspects of the United States Army Medical Corps that would benefit from additional focused research. Reviewing the secondary research questions addresses the primary research question and the role of learning environments in the development and influence of organizational microcultures.

Summary of Research Questions

Secondary Research Question 1

What dimensions are most useful in examining and describing organizational microculture?

The novel framework developed to examine organizational microculture rests soundly on the concepts of national culture and organizational culture examined for this purpose. The similarities in characteristics of nations and organizations assisted in the transformation of one concept to the next. While Hofstede felt that organizational cultures were likely only a subset of nations, there are many instances where an organization holds very different values and espoused beliefs from its nation of origin. Organizational cultures offer a unique aspect of national culture, and further still, the microcultures that exist within organizations help to better understand the organization as a whole. The framework established includes an examination of power, rules, groups, individuals, and norms.

Understanding how a microculture views and experiences power includes examining how power is gained, demonstrated, regarded, and lost, both internally within the microculture and externally within the macroculture. Power specifically relates to control and autonomy and exploring this connection can help to establish how the microculture differs in this experience. Rules relate to regulations, obligations, and contracts. Investigating how rules originate and how they are regarded helps to understand the impact that rules have on power, control, and autonomy. Additionally, examining objective differences in rules applied to the microculture as well as unwritten or unenforced subjective rules provides depth in this aspect. The group dimension relates to group dynamics and the role and nature of groups within the microculture.

Understanding ways in which a microculture is a distinct group is a starting place, however fully understanding this dimension also examines groups that form within the microculture, how they are perpetuated and their impact on the microculture.

Individualism and the examination of the individual v. collective dichotomy are well informed from all models of culture as the role and experience of the individual reveal a significant amount of insight into a culture. Understanding how individuals are regarded and respected, motivated or inhibited, and how individuals succeed, fail, and distinguish themselves within a group helps to understand the role that the individual experience plays within the microculture. Examination of norms encompasses aspects of power, rules, and groups and looks primarily at how the microculture experiences change and distinguishes normal from abnormal. Investigating where the norms develop from and how expectations and norms are established helps to understand the microculture's regard for the status quo, diversity, and divergent thought.

Secondary Research Question 2

How is the United States Army Medical Corps an organizational microculture?

Power

Beginning with separate recruiting and commissioning efforts MC officers are required to have a higher level of education than their combat arms peers, typically twice the length. As a result, MC officers commission directly at the grade of O-3 while combat arms officers must enter as O-1 regardless of any prior experiences. The MC only includes physicians, and the initial environment in which they serve does not involve as many collaborative relationships with soldiers or noncommissioned officers. Many interactions in this setting occur with higher-ranking non-medical officers who have less expertise, and the experience of power is thus different. The initial environment in which a combat arms officer serves establishes clear roles and expectations based on rank and position. These clear delineations are not always present in the MC, evidenced by the data suggesting that knowledge, skill, and expertise create a stronger personal power than position or rank alone. This disparity is perpetuated in units outside of the Military Treatment Facility (MTF) where Forces Command (FORSCOM) surgeons will often be included in decision making that their rank-based peers will not, because of their specific skill set alone. A unit surgeon yields a significant amount of power because of their direct access to vulnerable populations and the related inherent responsibilities, as well as their relationship with the commander which creates a proxy positional power.

This experience of power creates conflict when officers are treated uniformly based on rank alone, as the rank of the MC officer does not always denote their role or potential to impact the organization. Because there is no role for a physician below the

battalion level, MC officers benefit more significantly from mentoring and feedback early in an assignment as they are likely less familiar with organizational structures, customs, and roles than their combat arms peers who have served at increasing levels of visibility and responsibility within the same organizations for the five years preceding. The lack of hierarchy and positional rank-based power in a hospital setting does not translate into the expected deference in a FORSCOM environment. Additionally, because MC officers experience power as a concept directly related to competence, there is often an expectation for those in positions of power to validate or prove themselves before being respected as legitimate leaders.

MC officers also experience power as the body it is exerted on, often from disparate entities that lack a coordinated focus or goal. The requirements of the overarching medical structure do not often nest well with the requirement of the operational unit and the MC officer from their first assignment, feels the difficulty of receiving disparate guidance and instruction from multiple superiors. While this experience occurs in the combat arms branches, it is not typically experienced at the grade of O-3, where most combat arms officers work again, within a clearly defined organizational structure that is delineated by rater and senior-rater relationships. MC officers often have more complex relationships that are not established formally by rating chains, but are important to maintaining the resources, prioritization, and wellbeing of the organization.

Rules

The MC is reverent to rules, but often does not understand or believe they are valid unless there is a direct impact or correlation to safety or performance. The medical

community is focused constantly on process and performance improvement, efficiency, and safety. There is an expectation that processes that inhibit these areas should be changed. This often ignores the larger context of why rules came to be and continue to exist. The focus on evidence-based inquiry can sometimes ignore historical precedence that creates cycles of change where a policy is made, reversed, returned, and reversed again as individuals join and leave organizations. Because of the flexibility within the medical community, the rigidity experienced with Army regulations and the slow time for changes is often cited as a frustration. When rules are seen as unnecessary, they are often complained about but followed. Those who choose not to follow are not ostracized by the MC group so long as their violation does not otherwise violate tenants of morality, safety, or efficiency. They are also not supported, however, should they experience conflict by breaking a rule or regulation that they knew to exist. Because regulations are so often separate for the MC community there is a disconnect with their combat arms peers and a deferral to the MC officer to determine if what they are doing is correct. This perpetuates errors, as lived experiences then often directly contradict with what the standard states and the evidence then does not support the regulation. Because there is not a collaborative and open way in which these often-embarrassing lessons are learned, many officers make the same mistakes in private and do not share their solutions. Evidenced by the propensity of individuals to offer direct advice and guidance in a one-to-one relationship, the MC is reliant on mentorship or sponsorship for success as there are fewer opportunities for those who do not have a senior MC officer directly assisting them in obtaining feedback.

The relationship between power and rules is similar in the MC as well as other branches in that those in positions of power can write, change, and enforce rules and policies that affect others. The MC often feels less in control of this as they are not placed in command positions where they can exert these changes until much more senior in their career. While combat arms officers will serve as platoon leaders and company commanders within their first five years of service, MC officers will not usually take command positions until they are at O-5 grade after twelve years of service.

Groups

Groups and group dynamics are at the core of microcultures. The existence of characteristics that distinguish one group from another has varying degrees of significance and relevance that depend on the question being posed and the information necessary to answer it. Ethnic and gender-based microcultures are discussed more extensively in the literature, particularly in educational environments. While these are also valid aspects to address within the military, the existence of organizational microcultures that are distinct in their stated purpose, goals, and function within an organization are more specifically the focus of this research. Distinct groups exist within the microculture with an unknown impact on the overall experience of the microculture. Women, for example, are a minority but it is not possible from the research conducted to determine if this is a factor in the aspects of microculture examined from the MC. Similarly, because the data was also not examined for race-based demographics it is possible that many demographics were not included and a design to address this should be considered in future research.

Specific groups within the microculture that arose from the research revolved around skills and specialties, experiences, and reputations. Medical specialties often group together in support of their colleagues and see themselves separate still from their MC peers. There is a specific division between surgical and non-surgical specialties continued by the longer training length and thus assured duration of time spent at MTFs, which perpetuates a similar divide between operational and non-operational physicians. Operational physicians serve in FORSCOM units without direct ownership from the MTF. A variety of relationships exist, but the priorities and ratings come from a non-Medical Command (MEDCOM) structure versus MC officers who serve in direct MEDCOM billets. In the past decade, the organization and control of the MEDCOM has changed significantly to give more control to FORSCOM units. Because of the volatility and novelty of some of these changes, many attitudes and expressed opinions set in opposition FORSCOM and MEDCOM in a way that organizationally no longer exists, but is still a pervasive mindset within the MC. This group dynamic evolves differently beyond the initial years of service, however, as the divide is greater in the middle of a MC officer's career, and then normalizes again at the most senior ranks, likely because experience and understanding of FORSCOM are required to reach these ranks. Surgical specialties who do not typically have roles in units at the battalion or brigade level will have had their own experience as surgeons within the FORSCOM structure, as more senior O-4s and O-5s.

A similar group dynamic in combat arms branches is difficult to find, however, this may be because combat arms branch officers who do not want to continue the very linear and focused typical career path of their assigned combat arms branch, explore other

opportunities through voluntary branch transfers, functional areas, and broadening assignments that prevent the formation of similar in and out-groups within the same branch. It is likely that in other branches where technical skill is valued as well as leadership, the tension in groups between those who are good at one, or the other exists, with a small minority excelling at both.

Individuals

The role of the individual is significant when considering the MC. Due largely in part to the power and control a physician has over others, often in vulnerable situations, MC officers recognize the value of their contributions to an organization. Because they are often a novel entity and even while serving on a medically focused team are often the only licensed provider, there is a sense of responsibility that rests on the individual rather than the team for decisions and outcomes. The development and training of physicians is a solitary and isolating experience. High-stakes testing and practical examinations are performed individually and teamwork is not highlighted or emphasized in most medical school curriculums. MC officers are often introduced to their first team, as the leader, having little experience working collaboratively. This can lead to competitive, storming groups that never form truly cooperative, norming, or performing teams.¹⁴³

These high stakes and external pressures can motivate MC officers to avoid failure more than seek success. Because failure often represents a poor clinical outcome, avoiding this at all costs is considered more important than achieving acclaim for other

¹⁴³ Bruce W. Tuckman, "Developmental Sequence in Small Groups," *Psychological Bulletin* 63, no. 6 (1965): 384-99, <https://doi.org/10.1037/h0022100>.

reasons. Tasks that only MC officers can perform are the priority which often leads to a lack of development of other skills that are required for the officer to succeed at higher levels and in other areas of their career. For this reason, there is a perception of a double standard where MC officers are exempt from even basic staff-related responsibilities, and often do not even recognize their existence, because of the time-consuming, unique requirements of the MC role. In organizations that recognize and value the individual, these officers can excel. In organizations where all individuals are subject to rank or unit-related training or requirements, they often fail to perform and become frustrated with the system that does not value the skills they possess instead of staff or soldier-related proficiencies, which are otherwise considered basic in combat arms branches.

Success in the MC is typically experienced in progression and reputation. Because rank and promotion are relatively stable and protected for MC officers these are often not distinguishing features. Until 2021, the promotion from O-3 to O-4 was considered a “qualified” promotion wherein all officers who met the minimum standard were promoted. In 2021 the standard was changed to “most-qualified” and capped at 95 percent, which is still well beyond the promotion rate for most branches. Promotion to O-5 is harder to interpret from data as officers have often self-selected to leave active duty before the board meeting based on initial active-duty service obligation (ADSO) timelines, and others have voluntarily elected to not complete requirements due to other goals (often education-related) and do not opt into the board. MC officers fear being released from active duty due to failure to progress, much less than other branches, and a nonchalant attitude is typically expressed. Based on attrition many are not concerned with promotion rates and being passed over for promotion if it is desired, is unlikely. Awards

are controversial as those in MTFs, directly associated with GME, and with strong sponsorship ties are often awarded and recognized more than equivalent peers who are not as involved in these communities. Research is conducted almost exclusively with GME-supported facilities and the rate of published research by MC Officers not associated with GME is extremely low.

This trend parallels medical staff outside of the military as academic medicine is much more focused on research, publication, and thus recognition and awards, than those who are involved in the full-time delivery of care. Many MC officers maintain ties to the MTF and GME in addition to their other assigned roles and those relationships become distinguishing factors in who is recognized. Reputation thus becomes the biggest distinguishing factor for physicians and is guarded fiercely. More so than rank, a MC Officer is held in high esteem based on how they are perceived, past performance, and word of mouth vouching by others based on work performance in previous assignments. This system rewards specific personalities, work styles, and those with high emotional intelligence but not exclusively as an individual's medical competence is foremost. Being friendly, loyal and a team player are valued but only if the individual is first deemed competent and a "good doctor." This system rewards those who figure out how to do things earlier, as they know systems and help others, are then held in high esteem, and are promoted for follow-up assignments or opportunities. Because the community is small it is difficult to outrun a negative reputation. Having a good reputation is more important than winning awards or publishing as it is an external validation that individuals cannot manipulate as easily. Reputation and esteem provide power and autonomy.

Norms

When examining change within the microculture it is important to consider different reactions are likely when considering different areas of change. Obtaining a more complete sense of how change was regarded required more attention to themes. The MC is more receptive to change, likely because of the precedence and expectation for adaptation and change within the medical field. As MC officers become more senior their motivation to promote change decreases but the scale of the changes, they do make increases. This is like other branches and organizations. MC officers have less control over their environments than their non-military peers and this impacts their response to other changes, sometimes less consequential ones, in unexpected ways. Neurotypically, individuals seek to create routine and patterns and continued novelty is distressing, which explains the desire for orderliness and schedules even in austere locations and unprecedented conflicts. It is possible that the desire to control the direct environment is in direct, inverse proportion to the sense of lack of control they have over their larger environment. The orderliness and routine of MC officers' unique duties are thus often in direct contrast to the perceived chaos in which they perform them. This can make MC officers appear in some sense to be more rigid as defenders of the status quo, while also being likely to advocate for organizational change.

The aperture for what is considered "normal" is wider than other branches, however, as there is less frequently direct comparison between MC officers, than combat arms officers, and individuality is more acceptable. Because MC officers often don't "fit in," they are less concerned about trying to conform and are more likely to be seen as outsiders. There is a strong, although not a specific sense of what is considered normal

and abnormal behavior within the MC, and those who do not comply are ostracized and not provided access to the same opportunities through the mentorship, sponsorship, and reputation-based advantages. In this way, the MC polices its own and recent events have seen more extreme examples where MC officers are shut out from the community for espousing extreme, radical, or unscientific beliefs that serve to bring discredit, distrust, or malign the MC and the Army. A degree of dissension and debate is tolerated within the microculture but there is a pervasive norm that a unified front must be presented for the wellbeing of the organization. Individuals who highlight disagreement within the MC community are not welcome to continue to participate in it.

Norms in the MC arise generally from the early experiences physicians have in GME. In this fundamental period, there is a strong aspect of inculcation and commitment to the community, Army values, and selfless service. Some areas of friction between aspects of the microculture can be traced back to different climates within different residency programs or facilities, however, the data collected in this research did not seek to compare these aspects. In addition to GME, early experiences cement what is considered normal and abnormal for the MC officer, which then is perpetuated in their subsequent roles. This furthers the divides between operational and non-operational and academic and non-academic MC officers, as the experiences an individual has in the first five years of service are the most impactful to their individual developmental pathway. Most of the direct accession, HPSP scholarship MC Officers will leave active-duty service after eight years, having been promoted to O-4 but not remaining to serve in the O-4 billets. Because the MC structurally has a significantly larger number of O-3 than any other rank, this GME-focused normalization persists. Similar inculcation can be seen

in ranger school and special forces selection processes where the training and subsequent graduation also serve to develop the identity of the individual. In the same way, it is always an anchor to return to for comparison or a shared experience to connect with a colleague. MC officers' identity development and determination of what is normal and expected is more attributed to medical school and GME versus PME.

Primary Research Question

What relationships exist between the microculture of the United States Army Medical Corps and learning environments?

The development of professional identity is significant in the development of organizational microculture. This identity helps to bring together the two professions that Army physicians must understand: the medical profession and the profession of arms. Tension within the MC is often experienced when officers are unable to reconcile the dissonance in being a member of both a healing and a destructive vocation. Through examination of this organizational microculture, recurrent reference to both USUHS and GME helped to understand the anchoring phenomenon related to rules and norms. USUHS and GME serve as the initial touchpoint for MC officers as they begin their service in a way that exceeds the comparable experience of basic training as medical students will spend four years at USUHS and new physicians spend between three and five years in a full GME experience. The timing and duration of this training make it the most impactful aspect of developing this microculture and the most meaningful way in which it can be influenced.

The development of expertise and knowledge-related power differentials is developed primarily in GME. The atypical hierarchy, only loosely connected to rank is

perpetuated, and the experience of being an individual with significant power develops, given the individual performance expectations and responsibility of the student and resident. The first introduction to the military often helps to serve as the primary normal experience and a benchmark of what rules are recognized as legitimate and expected. Medical students at USUHS and residents in GME are first introduced to Army regulations and standards but learn quickly that the rules do not always apply to them, and that there are often additional rules that do. The protections and special status of new MC officers in training environments help to develop different expectations for rules and regulations. GME is often the only time in a MC officer's career where they will be surrounded by like-peers in skill level and medical specialty. This experience serves to form discrete and intense in-groups within MTFs. These groups tend to dissipate as MC officers leave the GME environment and must work more collaboratively with other specialties and non-medical officers alike to be successful.

Learning environments also develop and perpetuate the competency and reputation-based in-groups that persist beyond the learning environment. GME and USUHS are individual accomplishments with high-stakes testing and unique requirements focused on the competency of the individual. Residents must work collaboratively for patient care, but are graded and evaluated individually, ranked and compared to their peers, and compete for positions and assignments, creating a strong sense of individualism. This is perpetuated throughout the MC officer's career when they are placed in professional isolation in most FORSCOM assignments, or locations, outside of learning environments when they are often a solitary novel subject matter expert. The MC officer experiences power in their ability to individually impact decisions and

outcomes in operations. More than anything, however, the early and persistent experiences of any officer are likely to prepare for them what will be normal and expected for their careers. As most MC officers' first experiences are in GME, this period is the most impactful in developing that sense. While these norms change over time and with experience, the rank structure and composition of the MC assumes that most officers will be junior and within five years of their GME training. This helps to perpetuate the learning environment-related norms to the entire MC, despite the distance in time that the more senior members have from it.

Conclusion

The examination of microcultures allows for a deeper, more holistic understanding of populations that exist distinctly, within larger organizational cultures. Organizational microcultures that exist in what appears to be a direct conflict with the larger macroculture, yet in doing so are essential to the continued existence and success of the organization, require nuanced understanding when attempting to normalize or regulate the individuals within. Beyond the creative advantages diversity brings to a team, organizational microcultures fill a role that may be overlooked in an organization that seeks efficiency and conformity. Norming those in these organizational microcultures is to their detriment and the detriment of the organization as a whole.

Examples within the United States Army include the Medical Corps, wherein Army physicians are focused on preserving the fighting force rather than engaging enemy combatants, and as a result are provided special protection by international humanitarian law and subject to unique regulations that ensure competence and resources to adequately perform their unique role. In developing a tool to assist in the evaluation of

organizational microcultures, a common understanding and language can be used to describe this phenomenon and consider the consequences of changes to the doctrine, organizational, training, materiel, leadership and education, personnel, facilities, and policy. The existence of the organizational microcultures indicates that the impact of changes will not be uniform across the organization.

Recommendations

The importance of learning environments on the development of professional identity and organizational microculture supports the continued existence of military GME should the military medical profession continue to exist. The role of the MC officer is unique and the function of the MC often stands what appears to be, in direct opposition to the combat arms goals. Their existence, however, is fundamental to maintaining the status and effectiveness of the military in its missions today and in the future. Public regard for military service and the existence of an all-volunteer force requires a MC that cares and advocates for the individual as well as the group, plainly translating the cost of training and war into the risk to the force as well as risk to the mission. A MC officer who has not embraced their role in either aspect of the military or medical professions will not be able to accomplish this task.

Unless all military physicians are to matriculate from USUHS, which is not a likely or feasible option for multiple reasons, the point of entrance and most important area to impact is the time spent in GME. As this is the most important period for developing the sense of professional identity and individualism, a specific focus on this time would yield the most benefit in trying to instill new norms, understanding of rules and regulations, and an increased appreciation for teams and collaborative efforts.

Outside of GME, MC senior leaders and policymakers should understand the microcultures that exist in the Army and the impact decisions might have on these microcultures, separate from the macroculture. Continued efforts to standardize experiences create either an additional burden on the MC officer to maintain their identity, or a loss of this identity, which is contrary to their purpose and function. As we consider what are “fundamental soldier skills,” we should holistically consider that what is fundamental in one branch may be abstract in another. Time spent on the abstract at the cost of the fundamental may prove deleterious overall when it relates to long-term effectiveness and motivation to continue service. Continued erosions into the identity of the MC impact recruiting and retention, leading to the real concern of who in an all-volunteer Army, will be left to perform those essential tasks that only the MC can do.

Future Research

Continued research into understanding the MC and the experiences of MC officers should be conducted, including direct interaction with individuals through interviews, surveys, and focused discussion groups. The framework developed can assist in the initial focus, as well as continued refinement based on these more direct sources of experience. A focused comparison of different experiences and attitudes related to rank and experience level, gender, race, and geographic location would also help to validate the tool developed and ensure that the limited data used for its initial construction does not perpetuate objective or subjective bias within the MC or the Army.

Additional, specific evaluation of course material, content and learning objectives, principles, and techniques used in the PME courses for MC officers would improve the understanding of current professional development efforts. This was limited intentionally

in this study, as the courses offered currently are very different from those experienced by many MC officers reflected in the data collected.

Continued comparison and evaluation of the MUC offered at different GME locations would help to update the understanding from previous assessments that have been performed, and a focused examination of the leadership development and professional identity development aspects would yield an additional understanding of how this MC is developing, uniquely in each location.

Application of this novel framework to other, discrete microcultures within the United States Army would also help to refine and validate its use.

Closing Thoughts

Moving beyond anecdote and personal knowledge requires a focused, reflective process to make meaning out of experiences we can relate to and those that are vastly different from what we may have considered universal. Recognizing the existence of a microculture is the first step in examining, understanding, and optimizing the impact of this microculture. For those that exist as guard rails or hand breaks to institutions, it is so important that we do this, lest we risk preventable self-destruction. This framework does not offer an answer but rather a tool with which answers can be found.

APPENDIX A

EXAMINATION OF THEORIES FOR KEY THEMES

Word Mapping and Nesting Exercise Products

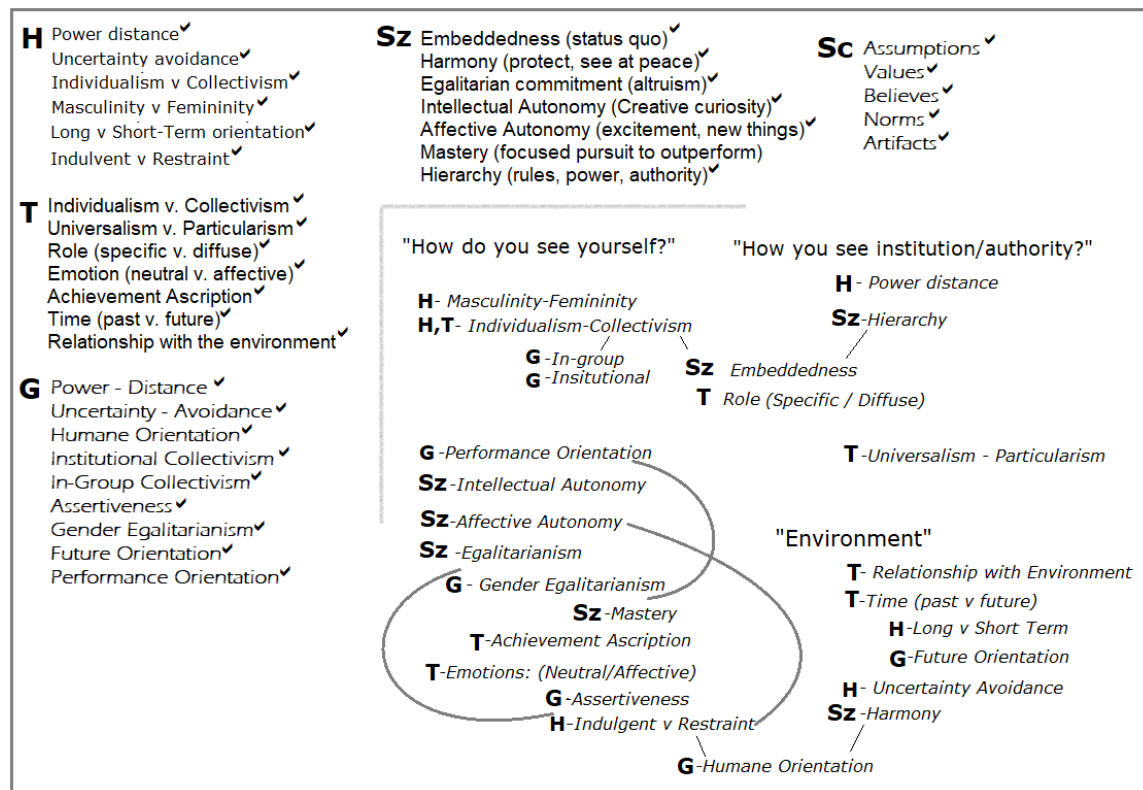


Figure 9. Word Map and Nesting Exercise Part 1

Source: Created by author using Data from Chapter 2, "Literature Review," 13-48.

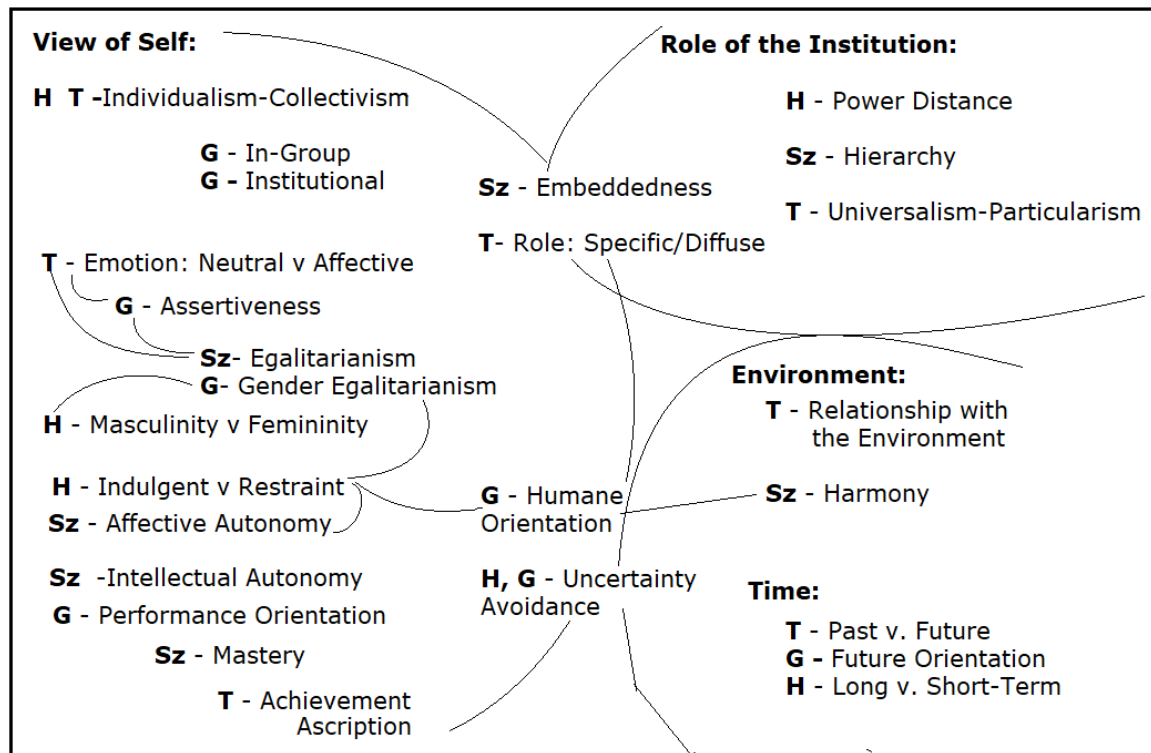


Figure 10. Word Map and Nesting Exercise Part 2

Source: Created by author using Data from Chapter 2, "Literature Review," 13-48.

APPENDIX B

ITERATIVE KEY THEME DATA

Initial Key Themes

Table 3. Initial Key Theme Data, 391 Items, Alphabetized

acceptance	belief	creativity	environment
accolades	benevolence	curiosity	environment
accomplishment	blend	customs	environment
achievement	caring	decision	equal
achievement	celebrated	decision	equal
achievements	challenge	decisions	equality
actions	change	delaying	equity
adaptation	change	deregulation	evil
adapting	change	desire	excellence
adapting	change	desire	exceptions
affective	change	destiny	exceptions
affective	change	developed	excitement
affective	cohesiveness	difference	exclusion
affirmation	collective	different	expectations
allocation	collectivism	differentiation	expectations
altruism	collectivism	diffuse	expectations
altruism	commitment	direction	expectations
ambiguous	commitment	direction	expectations
artifacts	communication	discovered	express
artifacts	communication	display	express
ascription	communitarianism	display	external
ascription	compartmentalized	distance	fairness
assertive	compete	distinct	familiarity
assertiveness	concrete	distinct	family
assigned	conduct	distribution	feel
assumption	conflict	distribution	femininity
assumptions	conformity	distribution	finite
assumptions	conservation	dominant	fixed
assumptions	consistency	effort	flexibility
attitudes	consistency	egalitarianism	flexible
authority	consistent	egalitarianism	fluid
autonomy	context	egalitarianism	formal
autonomy	contributions	embedded	freedom
autonomy	control	emotion	friction
avoidance	control	emotion	friction
avoidance	control	empowered	fulfillment

avoidance	control	enhancement	fun
balance	correct	enhancement	future
behaviors	course	enjoy	future
future	intellectual	orientation	respect
gender	interact	orientation	respect
generosity	internal	outcome	respect
good	invested	parallel	respect
gratification	investing	particularism	response
gratification	jealous	past	response
group	knowledge	peace	responsibility
group	laws	perceive	responsible
group	Learn	Perform	Restraint
group	legitimate	performance	restraint
group	legitimate	performance	reward
happiness	life	performance	reward
happiness	life	performance	reward
happiness	long	perseverance	reward
harmony	loyalty	persistence	rigid
harmony	maintain	pessimistic	rigid
harmony	manifestation	power	role
healthy	masculinity	power	role
hedonism	material	Power	role
helpful	meaning	power	role
hierarchy	merit	power	roles
hierarchy	mission	power	routine
humane	modest	present	rule
humane	natural	presentation	rule
humility	needs	preservation	rules
idealistic	neutral	pride	rules
imbalance	neutral	pride	rules
impulse	new	pride	rules
inclusion	normal	privilege	saving
incongruity	normalized	procedures	schedule
independent	norms	protect	security
indication	norms	purpose	self
individual	norms	pursuit	self
individual	norms	quality	self
individual	nostalgia	reason	separate
individual	obligations	reason	sequential
individualism	obligations	recognition	series
individualism	open	regulations	share
indulgent	open	relationship	shared
inequality	openness	relationship	shared
inequality	optimistic	relationship	short
inferior	order	relationships	situation

innovation institution integration	order order orderliness	relative resource resources	skill skill social
society specific specific spontaneity stability standards status status status status quo stimulation stimulation stress strict	strict structure structure success superior suppress synchronic synergy taught team tender term term threat	thrift time title tough tradition tradition tradition tradition transcendence transcendence uncertainty uncertainty uncertainty unexpected	unhappy universalism universalism universalism unknown unrelated valid value values values vision weak work ethic

Source: Created by author using Data from Chapter 2, "Literature Review," 13-48.

Initial Key Themes with Consolidated Roots

Table 4. Revised Key Theme Data, 391 Items, Alphabetized, Consolidated Root Word

acceptance	blend	decision	equal
accolades	care	decision	evil
achievement	celebrate	delaying	excellence
achievement	challenge	deregulation	exceptions
achievement	change	desire	exceptions
achievement	change	desire	excitement
action	change	destiny	Exclusion
adapt	change	develop	expectation
adapt	change	difference	expectation
adapt	change	different	expectation
affective	cohesiveness	different	expectation
affective	collectivism	diffuse	expectation
affective	collectivism	direction	express
affirmation	collectivism	direction	express
allocate	commitment	discover	external
altruism	commitment	display	fairness
altruism	communication	display	familiarity
ambiguous	communication	distance	family
artifact	communitarianism	distinct	feel
artifact	compartmentalize	distinct	femininity
ascription	competition	distribute	finite
ascription	concrete	distribute	fixed
assertiveness	conduct	distribute	flexible
assertiveness	conflict	dominant	flexible
allocate	conformity	effort	fluid
assumption	conservation	egalitarianism	formal
assumption	consistency	egalitarianism	freedom
assumption	consistency	egalitarianism	friction
assumption	consistency	embedded	friction
attitudes	context	emotion	fulfillment
authority	contribute	emotion	fun
autonomy	control	empowered	future
autonomy	control	enhancement	future
autonomy	control	enhancement	future
avoid	control	enjoy	gender
avoid	correct	environment	generosity
avoid	course	environment	good
balance	creativity	environment	gratification
behavior	curiosity	equal	gratification
belief	custom	equal	group
benevolence	decision	equal	group

harmony	manifestation	power	role
healthy	masculinity	power	role
hedonism	material	power	role
helpful	meaning	power	role
hierarchy	merit	power	role
hierarchy	mission	power	routine
humane	modest	present	rules
humane	natural	presentation	rules
humility	needs	preservation	rules
idealistic	neutral	pride	rules
imbalance	neutral	pride	rules
impulse	new	pride	rules
inclusion	norms	privilege	saving
incongruity	norms	procedures	schedule
independent	norms	protect	security
indication	norms	purpose	self
individual	norms	pursuit	self
individual	norms	quality	self
individual	nostalgia	reason	separate
individual	obligations	reason	sequential
individual	obligations	recognition	series
individual	open	regulations	share
indulgent	open	relationship	share
inequality	open	relationship	share
inequality	optimistic	relationship	short
inferior	order	relationship	situation
innovation	order	relative	skill
institution	order	resources	skill
integration	orderliness	resources	social
intellectual	orientation	respect	society
interact	orientation	respect	specific
internal	outcome	respect	specific
investing	parallel	respect	spontaneity
investing	particularism	response	stability
jealous	past	response	standards
knowledge	peace	responsibility	status
laws	perceive	responsibility	status
learn	perform	restraint	status
legitimate	performance	restraint	status quo
legitimate	performance	reward	stimulation
life	performance	reward	stimulation
life	performance	reward	stress
long	perseverance	reward	strict
loyalty	persistence	rigid	strict
maintain	pessimistic	rigid	structure

structure	term	transcendence	unknown
success	threat	transcendence	unrelated
superior	thrift	uncertainty	valid
suppress	time	uncertainty	value
synchronic	title	uncertainty	values
synergy	tough	unexpected	values
taught	tradition	unhappy	vision
team	tradition	universalism	weak
tender	tradition	universalism	work ethic
term	tradition	universalism	

Source: Created by author using Data from Chapter 2, “Literature Review,” 13-48.

Final Key Themes

Table 5. Final Key Theme Data, 82 items, Alphabetized,
Consolidated Root, Solitary Entries Removed

(6) Instances	(4) Instances	(3) Instances	
Change Individual Norms Power Rules	Achievement Assumption Control Equal Performance Relationship	Adapt Affective Autonomy Avoid Consistency Decision Distribute Egalitarianism Environment Future	Happiness Harmony Open Order Pride Self Share Uncertainty Universalism
(5) Instances	Respect		
Expectation Group Role	Reward Status Tradition		

(2) Instances			
Allocate Altruism Artifact Ascription Assertiveness Collectivism Commitment Communication Desire Different Direction Display	Distinct Emotion Enhancement Exceptions Express Flexible Friction Gratification Hierarchy Humane Inequality Investing	Legitimate Life Neutral Obligations Orientation Perseverance Reason Resources Response Responsibility Restraint Rigid	Skill Society Specific Stimulation Strict Structure Term Transcendence Values

Source: Created by author using Data from Chapter 2, “Literature Review,” 13-48.

APPENDIX C

SOCIAL MEDIA DATA

Social Medial Content Data

Table 6. Social Media Content from January 2022

	Type/Intent	“Like”	Comments	Key Concepts
1	Inform Congratulate	62	19	Congratulations, Appreciation, Recognition.
2	Inquire Assistance	0	20	Confusion regarding regulation, lack of knowledge of processes and regulations, achievement specific inquiry, entitlement inquiry. Complaint about the system. Complaint about bureaucracy. Unfavorable comparison to other services, discouragement, condolences.
3	Inquire Assistance	0	10	Operational Medicine, Processes, Direct connection to peers (private means).
4	Inform	4	2	Processes, Policies Awareness. Humor, Sarcasm.
5	Inform Appreciation	46	2	Appreciation
6	Inquire Assistance	0	20 *	Regulations, Policy, Tricare and DHA. Citing regulation, direct connection for assistance, Resources, complaint, frustration, processes, systems, clarifications, disagreement, entitlements, Cost, trust, reputation, systems, philosophical debate, dissent, credibility, “bad press.” Reputation, roles, values, legal, const-conscious, blame, frustration, groups – specialty based, comparison to civilian system, morality, fraud, right and wrong, comparisons and judgment.
7	Inquire Assistance	1	1	Appeal to senior leaders. Humor, Sarcasm
8	Inform	21	0	Wellness, support, humor, sarcasm.
9	Inform Promote	36	3	Senior leader engagement, history, legacy, example, leadership, congratulations, appreciation, recognition.
10	Inquire Assistance	6	12	Entitlements, Benefits, Transition, ETS, Procedures, Policies, Processes, Advice, regulations, encouragement, requirements.
11	Inform Discuss	1	2	Suspicion, doubt, whistleblowers, data/evidence.

12	Inquire Assistance	4	17	Regulations, Processes, Entitlements, PCS. Encouragement, regret, direct advice and assistance via personal email, disbelief, sadness, humor, sarcasm, policies.
13	Inform Promote	14	0	Job Posting, Operational Medicine
14	Inform Promote	19	0	Senior Leader engagement, history, legacy, example, leadership.
15	Inquire Assistance	3	13	Regulation, Requirements, Standards, DHA, humor, direct link to answer, challenges of leadership, GENESIS, processes, systems, questioning, punishment, consequences.
16	Inquire Assistance	5	3	Controversial topics, processes, regulations, change. Recommendation to go to civilian for expertise, advice, frustration.
17	Inquire Assistance	6	14	Processes, Finances, advice, encouragement, frustration. personal experiences.
18	Inform Request Nominations	3	0	Senior leader engagement, achievement, recognition, prestige.
19	Inform Congratulate	147	36	Congratulations, awards, promotion, recognition, appreciation.
20	Inquire Assistance	2	6	Regulation, benefits, processes, caution, advice, admonishment, doubt.
21	Inform Assistance	27	3	Regulations, requirements, standards, DHA, gratitude, clarification.
22	Inform Promote	58	1	Senior Leader engagement, history, legacy, example, leadership.
23	Inquire Assistance	1	1	Processes, system, humor, leadership challenge, GENESIS, punishment and consequences.
24	Inform Promote	86	9	Achievement, congratulations, competition, recognition.
25	Inform Promote	5	0	Women's health, operational medicine.
26	Inform Discuss	3	3	Regulation, policy, procedure, dissent, complaint, process, sense of inability to change.
27	Inform	52	41	Loan Repayment, , personal experiences, regret, skepticism, finances, , Information, Congratulations, processes.
28	Inquire Inform Assistance	2	11	Recruiting, personal experiences, collaboration, direct offer for assistance, research, assumptions about perceptions, connections with other, civilians practice comparison.
29	Inform Request Nominations	2	0	Senior Leader Engagement, representation, recognition, promotion, competition.

30	Inform Promote	28	8	Policy, compliance, force health protection, compliance, appreciation, dissent, humor, sarcasm.
31	Inquire Assistance	1	3	Procedures, resources, condolences, similar experiences.
32	Inform	3	0	Medical Journal Link – no engagement.
33	Inquire Assistance	6	9	Medical systems, processes, benefits, resources, assistance, care coordination, direct assistance offer (email), resources.
34	Inform Request Nominations	0	0	Promotion, Achievement, recognition, opportunity leadership.
35	Inquire Assistance	1	0	Processes, procedures, regulations.
36	Inform Discuss	15	5	Benefits, retirement, entitlement, finances, systems, humor, sarcasm, snark, comparison to civilian sector (money).
37	Inquire Assistance	10	9	Connections, individual POC, appeal to personal assistance (email), humor, inside humor.
38	Inform Promote	31	2	History, leadership, legacy, example, gratitude, appreciation, personal connections.
39	Inquire Assistance	7	31	Process, policy, entitlements, retirement, POCs, direct connection for assistance (email), resources, Catharsis, shared hardship, direct appeal to senior leaders.
40	Inform Promote	0	2	Requirements, achievement, competition, direct quote from milper message.
41	Inquire Assistance	0	11	Process, regulation, direct offer for assistance (DM, email), personal experiences.
42	Inform Discuss	3	19	Requirements, Policy, COVID, politics, humor, sarcasm, controversial topics (stem cells), exclusion, dissent, religious beliefs, argument, bias, fallacies, helplessness.
43	Inquire Assistance	2	17	UQR, ETS, procedure, policy, timeline, personal experience, perceptions, accessibility, care from leadership, frustration, catharsis, direct assistance offer (email, phone).
44	Inform Promote	16	2	ACFT, requirements, policy, sarcasm, humor.
45	Inquire Assistance	9	23	Finance, procedure, policy, direct answer, frustration, instructions, frustration, micromanaged.

Source: U.S. Army Medical Corps, January 2022, Facebook, <http://www.facebook.com/groups/2035591226721636/>.

Narrative Reflection for Social Media Data

I. POWER: explore the role of power, authority and hierarchy.

- i. What does power look like?*
- ii. How do individuals obtain and maintain power?*
- iii. How can power be lost?*
- iv. What reverence or respect is granted to those in power?*
- v. What reverence or respect is granted by those in power to those who are not?*
- vi. Is power abused, revered, scoffed, or avoided (etc)?*
- vii. Explore the dynamic of CONTROL as it related to power.*

Power is demonstrated by the individuals who post. Anyone can post on the social media, but those who are senior in rank have an expectation to share congratulatory posts. Those who are identified in these posts are given respect and some power through their recognition and by proxy from the senior leader who posts. (Power through Proximity) Response to these congratulatory posts is all positive. There are no negative responses. Power appears to be an external concept. Poster felt lack of power in being unable to navigate a process. Multiple comments echoed the idea that someone else controlled the ability to change things. General commiseration is experienced for those perceived to not be in power. There is a loss of control sensed throughout the thread and not being in control of entitlements, benefits, or aspects that would otherwise be obtainable in another setting. Power is transferred from the poster, to those in the comments as the OP has a question that needs to be answered. Power is demonstrated by knowledge and direct mentorship. Information is less often to be shared openly, and rather is shared 1 on 1 which controls the narrative and flow of information. Power is outside of the control of the physician who is responsible for everything but unable to make decisions. Power rests in rank and seniority, power is directly related to how high up you are in the system, however there is a cap and those at the highest levels are perceived as “others” being a part of the problem and out of touch with the needs of those below. Abuse of power in making arbitrary rules that don’t make sense to the people they apply to. The real power of day-to-day control is in the hands of the DHA / Timekeepers, GENESIS and administrators. Soldiers who are junior seem to have less power. Power is directly related to experience and influence.

II. RULES: explore the role of rules, regulations, and requirements.

- i. How are rules decided, disseminated, and enforced?*
- ii. Is it fair, how is it perceived, do people respect rules?*
- iii. What is the consensus about rules? (Are they made to be broke, are they to be followed, etc)*
- iv. Are there different rules for different people or groups?*
- v. Explore the dynamic of control as it relates to rules.*

There appears to be an unwritten rule that responses should only be positive. This is not a place for dissent / to point out flaws in those who are being recognized. Rules seem to be unfairly applied across the services. Rules are not followed when the benefit the

individual only when the benefit the service. Posters feel powerless to change the rules. Reverence for regulations is mixed, some know and understand the processes and why things are done the way they are done, but others do not and show contempt / disdain for the rules and systems in place. Rules, regulations and policies are poorly established and understood which creates much of the friction / discontent for individuals. Rules are decided “by someone else,” and the inference that physicians should have a say in those rules is shunned by the group. “Stay in your lane.” Rules are to be complained about and worked around, ignored when possible, despite the OP stating that the rules were unclear. The rules don’t make sense and shouldn’t apply to fight against them – with examples of how they may have done it, versus, those are the rules and you just have to take it. Even still. “Whistleblower” is not perceived to have followed the rules and in this instance has gone against the science-based rule / questioned the group conventions (See norms). General lack of familiarity with policies and procedures that directly impact the individual / group. Learned helplessness as there is a perception that even if they were known they wouldn’t be followed anyway. Rules exist and we are held to them, but they are not clear or clearly documented or disseminated. Systems and processes are complicated and often broken, but we can’t change them. Strong hold onto following the rules and admonishment for those who attempt to skirt around them, sometimes.

III. GROUPS: explore the nature of groups.

- i. How are individuals placed into groups, how is this decided?
- ii. What types of groups, distinctions, or classifications exist?
- iii. What is the role and purpose of these groups?
- iv. Explore the nature of equality within these groups and between these groups
- v. Explore the nature of respect within these groups and between these groups
- vi. What type of relationships exist within, and because of these groups?

This shows the groups of “selected v not selected,” the recognition “haves” and “have nots.” These groups are not clearly demarcated. Us against them mentality with those “in the trenches” who are asking for an entitlement, and the idea that those above us do not see that as reasonable or valuable. Perceived inequality. The group dynamic is split between those who know and have operational experience, and those who do not. Low engagement is a sign of low individual experience in an area. Groups also exist within specialties and like-specialties, some groups feel more disenfranchised than others, or like they have more work / have to pick up the slack. This dissent often takes away from the collective experience against the real issue that creates the environment where these groups exist. There is inferred respect that is unequal for groups, and these groups are not treated equally. Strong group mentality with the MC versus others (administrators and benefits experts). Creating Us v Them groups related to vaccines, covid, etc. Physicians are expected to be squarely in the pro-vaccine, covid is real, do not question the science – group. USU graduates v others.

IV. INDIVIDUALS: explore the role and nature of the individual (versus group).

- i. What is considered Success / Good / Positive
- ii. What performance is rewarded?

- iii. *Do individuals strive to achieve? What does this look like?*
- iv. *What is considered Failure / Bad / Negative*
- v. *What performance is punished or admonished?*
- vi. *Do individuals endeavor to avoid failure or punishment?*
- vii. *Explore the nature of respect, control, autonomy, and equality as experienced by individuals.*

Success is defined by selection, reinforced by positive reinforcement, congratulations and positive feedback only. Performance is rewarded through access and selection for promotion / awards / recognition, etc. Post serve to motivate and inspire those to achieve, and leaders to promote these programs to subordinates. Individual circumstances require individual consideration. The needs of the individual are valid and the individual is valid, necessitating a unique approach to each individual. Lack of this approach is perceived as a slight against the individual and the group. The individual is vulnerable, but is neither reproached for their lack of knowledge, nor rewarded for their willingness to ask for help. Senior leaders are able to show appreciation / recognition through this medium to both individuals and groups. The role of the individual is to stand against “the machine” and make a difference even if it is only in one patient vs. the role of the individual is to do the best they can but recognize it is sometimes futile and they should focus on the patient NOT in fixing the machine. Needs of the individual are valid and important and should be met. Needs of the individual are not being met. Individual does not have control. When the goals or beliefs of the individual are too different from the group they are not supported or encouraged.

- V. *NORMS (v CHANGE): examine that is considered “normal” versus “abnormal.”*
- i. *What are existing expectations, and how are expectations experienced.*
 - ii. *What assumptions are made, and what is not safe to assume about.*
 - iii. *What does the “status quo” look like, and is there desire to maintain the status quo or more desire to change.*
 - iv. *What are the norms related to achievement, equality, respect, rewards, and punishments?*
 - v. *What traditions exist? How are traditions regarded?*
 - vi. *How is change regarded?*

There is a perceived norm that all should be aspiring, but an unwritten expectation demonstrated by numbers that only a small few will be selected. Strong sense of status quo, that is the way it has been. Strong desire to see the status quo be different but little desire to be the person to change it. Change is regarded as too difficult and out of their locus of control. An understanding of how things work appears to be a norm / tradition handed down from one person to another individually as in a mentorship versus an open forum. Dysfunction and confusion, lack of clarity is normal / expected and to seek to change that might upset the current status quo that, despite being chaotic allows more freedom as in the confusion people are more able to do what they want, unchecked. A strong sense of – this is the way the system is, it is known to be unfair but there is no

sense in trying to change it. Strong sense of belief in science, skepticism regarding dubious data and extrapolation. Unwelcome resistance against the mass. The norm is for people to be denied entitlements, to not be given what they are owed / promised or deserve. Norms are "Changing with DHA" but also staying the same. There is a lack of clarity of what is expected. Social changes that are happening in the civilian side are not being considered in the MHS side and we should look to the civ sector as to what we should be doing.

APPENDIX D

NARRATIVE JOURNAL DATA

Narrative Journal Reflection (Initial)

POWER: explore the role of power, authority and hierarchy.

What does power look like?

Power belongs to those who are senior to you, even if they don't deserve it.

Junior = powerless, not in control, having to "take it."

How do individuals obtain and maintain power?

Just by existing longer, seniority, increased medical training (where their power is warranted, but not always wielded appropriately). Opportunity can also give power – being in the right place at the right time and looking smart or doing well.

How can power be lost?

Messing up, making the wrong decision, making people mad – even patients creates a loss of power. Everyone seems in control except you. Those who control the environment can take power away and there is little you can do about it.

Those in power who demonstrate they "don't matter" no longer seem to have power over you.

What reverence or respect is granted to those in power?

A hollow respect for those in charge, unless they demonstrate they are actually worthy of the respect their rank or position gives. Those who demonstrate they deserve your respect are infallible and wonderful.

What reverence/respect is granted by those in power to those not?

There is lacking benevolence and a sense of "it was hard for me and therefore will be hard for you." Those in power do not seem to care about those who do not have any. Those who are truly benevolent and care for those below them are rare and wonderful.

Is power abused, revered, scoffed, or avoided (etc)?

Attendings and senior residents go on "power trips" and abuse juniors because they can, not because it actually accomplishes anything.

Explore the dynamic of CONTROL as it related to power.

Control is everything, and being junior means you are not in control of anything: environment, change, how things are done.

RULES: explore the role of rules, regulations, and requirements.

How are rules decided, disseminated, and enforced?

Rules exist and supersede you and those around you. Schedules are the biggest rule / contract and you are not in control of it. Rules don't always make sense and sometimes should just be ignored when it makes the greater good / intent easier to achieve.

Is it fair, how is it perceived, do people respect rules?

People follow the rules because the rules keep everything running. When people don't follow the rules it is infuriating and only tolerated because those below do not have the power to change things.

What is the consensus about rules?

(Are they made to be broke, are they to be followed, etc)

Rules are followed but its unclear why other than, doing what everyone else is doing and wanting to conform and NOT stand out. People outside of the situation make rules that don't really make sense.

Are there different rules for different people or groups?

Rules differ for those in different levels of training, but this is knowns and agreed upon. Interns are at the "bottom of the totem pole, but at least they are on it." Standards are not the same for expectations – IE an intern has to be perfect but senior residents do dumb stuff all the time.

Explore the dynamic of control as it relates to rules.

There is no control over the rules, they exist outside of the system and are given to others to follow. Feeling out of control, not being grounded, lonely and dissociative is common.

GROUP: explore the nature of groups.

How are individuals placed into groups, how is this decided?

External classification more than Self Identification.

What types of groups, distinctions, or classifications exist?

Groups exist based on rank / class, specialty, but there is also in / out group in the "spaz" and 'not spaz' designations. Students versus residents. Those who are "good at the army" and those who aren't.

What is the role and purpose of these groups?

Different groups are at different phases of training and their education is cohorted. Different programs have different requirements and objectives (OB v Family)

Explore the nature of equality in these groups and between these groups

There is inequality baked in these groups as they have different roles. In some instances there is unfair inequality in instances where the groups are supposed to be treated equally but are not, and that is not acceptable but occurs.

Explore the nature of respect in these groups and between these groups

Respect is earned and tenuous. It is easier to lose it than gain it in both the in group and among other groups.

What type of relationships exist within, and because of these groups?

Loose bonds as "mandatory friends" from cohort / year groups. Bonding as family versus OB. Identity in your specialty. A collective sense of us together against them, for survival. The group bonds over shared hardship and perceived indignation at insult to one, becomes insult to all.

INDIVIDUAL: explore the role and nature of the individual (versus group).

What is considered Success / Good / Positive

Being prepared, being committed, being invested, not looking stupid or making mistakes. Making a patient happy, being correct, being validated by an attending. Finishing work, being caught up, being efficient.

What performance is rewarded?

Perfect performance is rewarded, other performance is punished. Being efficient, being correct, making things look “easy.” Finishing work, being caught up, being efficient.

Do individuals strive to achieve? What does this look like?

Individuals strive but more so to avoid negative consequences of failure or even just being average. Individuals recognize that failure results in others being hurt so failure is avoided at all costs. There is a strong sense of responsibility and a heavy weight burden attached to patient care.

What is considered Failure / Bad / Negative

The perception you are unprepared, lazy, not pulling your weight, not willing to sacrifice everything. Making the wrong decision about a patient. Hurting a patient or misdiagnosing them. Not knowing what to do with a patient.

What performance is punished or admonished?

Verbal rebuke, group humiliation. Being wrong in a question or making a mistake with a patient. Not knowing an answer, but being prepared. Punishments are not always fair but they cannot be re-evaluated once dealt out.

Do individuals endeavor to avoid failure or punishment?

More so than to receive praise or reward. Punishment avoidance. Avoiding failure is paramount.

Explore the nature of respect, control, autonomy, and equality as experienced by individuals.

Lack of control, lack of respect, feeling powerless as a junior person. Individuals are not treated equally but there is no expectation for this and you are supposed to endure until it is your time to be on the other side. Lack of autonomy and control over environment creates significant psychosocial stress.

NORMS (v CHANGE): examine that is considered “normal” versus “abnormal”

What are existing expectations, and how are expectations experienced?

There is a well developed model of what you are supposed to know and do and follow. Fitting in and being “normal” is values and expected, being too different is something you will be made fun of , ostracized about. Going with the flow and not making waves is expected / necessary. A sense of expectation that you should be able to accomplish everything without burdening others.

What assumptions are made, and what is not safe to assume about?

You can assume that those above you are smarter/ more experienced than you, unless they have demonstrated otherwise. You should not assume they are until you know them, It is not safe to assume that people have good intentions or will help you. It is not safe to assume things will go well / according to plan. It is not safe to be comfortable or rest on your laurels.

What does the “status quo” look like, and is there desire to maintain the status quo or more desire to change?

Strong desire to keep the boat afloat and rowing even if you don't know where you are going or why you are doing what you are doing. The status quo is ok, and you don't know enough to want to change it. Status quo represents routine which is values when other things are chaotic. We hold onto toxic and broken systems because they at least represent a system to make sense of the chaos. "what is wrong with army doctors" – the idea that there is an ideal we should be maintaining but that most do not.

What are the norms related to achievement, equality, respect, rewards, and punishments?

People expect humiliation, punishment and unfair treatment based on their rank / position. Rewards are given in the form of validation and acceptance.

What traditions exist? How are traditions regarded?

Residency is steeped in tradition, morning report, rounding, pimping, interviews and patient interactions are all classic actions that should be honored and not deviated from.

How is change regarded?

There really isn't place or need for change. (As above, lack of understanding what needs to be changed). If things do need to change it seems like an impossible process and it is easier to just "wait things out." (Rotations end, people leave, shifts are over – nothing bad (or good) can last forever).

Narrative Journal Reflection (Subsequent)

I. POWER: explore the role of power, authority and hierarchy.

a. What does power look like?

Attendings are the ones in power over residents, but residents have power as physicians, over patients.

Senior residents also have power over more junior residents.

b. How do individuals obtain and maintain power?

Demonstrating competence and confidence is importance to obtaining and maintaining power. Position. It is often bestowed but must be maintained by how you treat people and how good you are at your job,

c. How can power be lost?

Even those in authority positions will lose power if they are not good doctors. "lack of respect for people in charge of me and leading my organization."

d. What reverence or respect is granted to those in power?

Those in power are good, and while they can be questioned or challenged, they have the advantage of the benefit of doubt.

e. What reverence or respect is granted by those in power to those who are not?

Power over patients comes with great responsibility.

f. Is power abused, revered, scoffed, or avoided (etc)?

Administrators who do not understand the day to day challenges of clinical life aren't really in power even if they seem to be administratively.

Uneven distribution of labor and lack of appreciation for the work that is done.

g. Explore the dynamic of CONTROL as it related to power.

Power generally equals control in how and when you work, in what you do at work, etc. There is a fundamental lack of control for junior doctors that is difficult to manage.

II. RULES: explore the role of rules, regulations, and requirements.

a. How are rules decided, disseminated, and enforced?

Rules are typically decided on in advance. They are agreed upon and everyone should follow them

b. Is it fair, how is it perceived, do people respect rules?

Clearly not everyone follows the rules which is what makes it challenging to be motivated to follow them yourself.

c. What is the consensus about rules?

(Are they made to be broke, are they to be followed, etc)

Typically, rules are to be followed, unless the group decided that the rule is stupid or doesn't apply and then its ok to break it,

d. Are there different rules for different people or groups?

With rank and seniority comes its privileges, however these are agreed on in advance so it seems fair. If you have enough power, you make the rules or you don't have to follow them.

- e. **Explore the dynamic of control as it relates to rules.**
Rules are how those in positions of power exert control over those below them, formally. If you have enough power, you make the rules or you don't have to follow them.

III. GROUP: explore the nature of groups.

- a. **How are individuals placed into groups, how is this decided?**
Positional based on who they are and where they are in their training. Specialties and services are also distinct groups (IM, FM, OBGYN, etc)
- b. **What types of groups, distinctions, or classifications exist?**
Residents, attendings, and patients are all in separate distinct groups. Specialties and services are also distinct groups (IM, FM, OBGYN, etc)
- c. **What is the role and purpose of these groups?**
Roles exist based on their responsibilities and training levels. These groups are supposed to evenly divide the patients into services and distribute work equitably and appropriately.
- d. **Explore the nature of equality within these groups and between these groups**
There is no expectation for equality in these groups. These groups are treated differently and it is accepted that this occurs because of the different dynamics between them,
- e. **Explore the nature of respect within these groups and between these groups**
There is perfunctory and expected respect between these groups as related to roles and responsibilities. There is formal respect but rampant casual disrespect between these two groups.
- f. **What type of relationships exist within, and because of these groups?**
There is a power dynamic between these groups that is both written and unwritten. There is a dynamic of competition and mutual blame for fault between groups.

IV. INDIVIDUAL: explore the role and nature of the individual (versus group).

- a. **What is considered Success / Good / Positive**
*Work until exhaustion. Being appreciated and acknowledged by patients
Being competent.*
- b. **What performance is rewarded?**
Individual recognition and recognition in front of others, being told "you are good." Being good and not making waves. Conforming to other's definitions of what it means to be a good doctor.
- c. **Do individuals strive to achieve? What does this look like?**
Desire to achieve because of how much is invested in the career versus personal life. Everyone wants to win the awards but not everyone wants to put in the work.
- d. **What is considered Failure / Bad / Negative**
Making mistakes is a failure on the individual's part. Making waves, being difficult, not succeeding on your first try. Being perceived as lazy. Not trying as hard as those around you.

- e. **What performance is punished or admonished?**
Being bad at administrative “stuff” which is actually pretty meaningless will get you in trouble. Making mistakes is punished by silencing, ignoring, or ostracizing others. Being lazy, failing rotations, making others look bad.
- f. **Do individuals endeavor to avoid failure or punishment?**
Certainly, some of this, but mostly because the job is so important. Seems like both occur, those at the top end strive to achieve, those at the bottom just want to survive.
- g. **Explore the nature of respect, control, autonomy, and equality as experienced by individuals.**
The individual is respected and important but only in how they serve in the role. The importance of the individual directly relates to service to others. Respect is earned, hard to get and easy to lose. With increased respect comes increased autonomy and control over your life. Equality is only partially expected as it can be good for others it can be good for you; you just must work to be on the ‘have’ side.

V. NORMS (v CHANGE): examine that is considered “normal” versus “abnormal”

- a. **What are existing expectations, and how are expectations experienced.**
There is a perception that change is unwelcome and the way we have always done things exists for a reason and cannot be challenged. Expectations are based on past performance or experiences.
A lot of the things we do in medicine aren’t the best way to do thing.
- b. **What assumptions are made, and what is not safe to assume about.**
There are a lot of assumptions made about intent and motivation based on the intent and motivation of the individual examining it. It is not safe to assume as much about people (nurses, patients) but they continue to.
It is not safe to assume that the best people will be recognized or rewarded. It is not safe to assume you will be appreciated for hard work.
It’s not safe to assume your attending knows what they are doing.
- c. **What does the “status quo” look like, and is there desire to maintain the status quo or more desire to change.**
The system to train doctors and what it means to be a doctor is a norm that shouldn’t be questioned because it can’t be changed.
The status quo is in place for a reason but sometimes needs to be challenged if it doesn’t work anymore.
Making waves and not maintaining the status quo is “dangerous” but likely needs to be done because the system is so broken
- d. **What are the norms related to achievement, equality, respect, rewards, and punishments?**
Being a good doctor is often a thankless job and you should be happy to do it even if you are not receiving recognition or praise.
You should not expect to be recognized for doing extra work,

e. **What traditions exist? How are traditions regarded?**

The crucible of residency is a respected tradition even if some of the issues with it are questionable. The relationship between patients is like a dance.

Traditions are important even if you don't like them. They set bench marks of expectations that come around and help you keep track of time.

Tradition of abuse? Toward junior house staff.

f. **How is change regarded?**

Change isn't really considered. Change is sometimes necessary but it is difficult.

Change isn't necessary most of the time.

The old guard seem to cling to broken and chaotic things because they don't know better or don't want to accept that they are a part of the problem.

APPENDIX E

ACADEMIC JOURNAL DATA

Notes and Reflections for Academic Journal Data

AMSUS Journal Articles, January / February 2022:

Rachel Crispell, MC, USN, Catherine Woodard, MD, MC, USN, Kaitlyn Mullin, MD, MC, USA, Yonatan Moreh, MC,” USA, Eric G Meyer, MD, PhD, USAF, Military Medical Students’ Perspectives on Medical Education in the COVID-19 Era, *Military Medicine*, Volume 187, Issue 1-2, January/February 2022, Pages 9-11, <https://doi.org/10.1093/milmed/usab478>

General Themes:

- a. Perspective of medical students and recent graduates.
- b. Optimism
- c. Improvisation
- d. Professional Identity – medical professionals and military medical professionals.
- e. Role of the Military Medical professional in society
- f. Commitment and dedication to the field.

Review of Framework: (in BLACK)

Paul R Schaettle, MPH, Robert S Kaplan, PhD, Vivian S Lee, MD, PhD, MBA, Michael D Parkinson, MD, MPH, Gregory H Gorman, MD, MHS, USN, Michael-Anne Browne, MD, Mobilizing the U.S. Military’s TRICARE Program for Value-Based Care: A Report From the Defense Health Board, *Military Medicine*, Volume 187, Issue 1-2, January/February 2022, Pages 12–16, <https://doi.org/10.1093/milmed/usab271>

General Themes:

- a. Change is Slow but possible.
- b. Military medicine has a duality.
- c. Balance is difficult and will take some sacrifice in services available.
- d. Focus should be on quality and long term outcomes.

Review of Framework: (in BLUE)

David Shahbodaghi, MD, MPH, Edwin Farnell, MD, COVID-19 Crisis: The Pandemic Highlights the Unique Training and Skills of Military Physicians Afforded by Military-Specific Graduate Medical Education, *Military Medicine*, Volume 186, Issue 11-12, November-December 2021, Pages 292–293, <https://doi.org/10.1093/milmed/usab288>

General Themes

- a. Military physicians accomplish things that civilians would be less able to
- b. Training for military physicians is specifically useful in austere, atypical environments, such as the COVID-19 pandemic.
- c. Training military physicians is critical to being prepared for crisis.
- d. Training involved medical residency and initial assignments, and prepares not just medical practitioners but professional leaders above and beyond the civilian.

Review of Framework (Notes in PURPLE)

Johanna Barron, MC, USN, Virginia F Randall, MD, MPH, MC, USA (Ret.), Charisse Villareal, MD, MC, USN, Valentina Ramirez, MC, USN, Leslie Vojta, MD, USAF, MC, Medical Student Experiences in Operation Bushmaster 2019: “I Now See Myself as Equal Parts Physician and Leader.”, Military Medicine, Volume 186, Issue 11-12, November-December 2021, Pages e1066–e1070, <https://doi.org/10.1093/milmed/usaa432>

General Themes:

- a. Medical School is part of developing professional identity for physicians. Military professional medical identity is shaped significantly by the experience: BUSHMASTER, which serves as a transformative experience.

Review of Framework: (in GREEN)

Philip J Davis, USN, Daniel J Stinner, MC, USA, The Next Step in Maintaining Peacetime Readiness, Military Medicine, Volume 186, Issue 9-10, September-October 2021, Page 263, <https://doi.org/10.1093/milmed/usab145>

General Themes:

- a. Skill Atrophy, ways to measure and ensure readiness of medical professionals during peacetime.

Review of Framework: (in RED)

John A Hodgson, MD, Physicians...Please Silence Your Pagers, Military Medicine, Volume 186, Issue 9-10, September-October 2021, Page 265, <https://doi.org/10.1093/milmed/usab148>

General Themes:

- a. Change is necessary so we should embrace it but smartly.
- b. Ensure you incorporate all members of the team in decisions that will impact the whole team.

Review of Framework: (in MAROON)

John H Armstrong, MD, Lenworth M Jacobs, Jr., MD, MPH, Donald H Jenkins, MD, USAF (Ret.), Low-Volume, High-Risk Surgical Procedures in the Military Health System: Time for a Volume Pledge?, Military Medicine, Volume 186, Issue 7-8, July-August 2021, Pages 190–192, <https://doi.org/10.1093/milmed/usaa576>

General Themes:

- a. The military medical system is complex, and responsible for multiple echelons and types of care that are not similar to the civilian experience.
- b. Current processes and protocols are inadequate to address skill atrophy and competence.
- c. There are workable solutions that should be implemented.

Review of Framework: (in DARK BLUE)

Ariana Ramirez, MC, USA, David Owshalimpur, MC, USA, Cristin Mount, MC, USA, Christina Schofield, MD, Retrospective Review of a Novel Virtual Medical Soldier Readiness Processing Process in Response to the COVID-19 Pandemic, Military Medicine, Volume 186, Issue 7-8, July-August 2021, Pages 651–655, <https://doi.org/10.1093/milmed/usaa580>

General Themes:

- a. The military is adaptable and needs to remain so to be relevant.
- b. SRP can be done differently than it has been.
- c. Physicians can alter the way in which they do things to make them better / more efficient.

Review of Framework: (in light green)

Joseph M Maciuba, MD, MC, USA, Matthew E Griffith, MD, MC, USA, Leadership Lessons for a New Battalion Surgeon, Military Medicine, Volume 186, Issue 5-6, May-June 2021, Pages 121–122, <https://doi.org/10.1093/milmed/usab082>

General Themes:

- a. Military physicians are generally good clinicians but lack some of the basic understanding of military etiquette, culture, and communication.
- b. Military physicians will benefit from understanding their role in the unit and what tools they have at their disposal.

Review of Framework: (in ORANGE)

Adam B Cohen, MD, Michael Davis, MD, USA, Sarah E M Herman, PhD, Prolonged Field Care Research Approach and Its Relevance to Civilian Medicine, Military Medicine, Volume 186, Issue 5-6, May-June 2021, Pages 123–128, <https://doi.org/10.1093/milmed/usaa352>

General Themes:

- a. Military medicine presents challenges due to the austere and resource constrained environments in which we work.

Review of Framework: (in yellow)

POWER: Not discussed in this article. Referenced medical school leadership and national authorities, policy makers. Congress hold power of the MHS. The military was powerful because of its ability to assess and affect a situation. Knowledge and impact are power. Knowledge, and experience are power and lead to competence which is the biggest power factor for physicians. Doctors have the power in on the floor but administrators make decisions and have the real power. Physicians wield power though their ability to impact deployments and operations related to medical readiness. Power in the regular army comes with rank and position, however physicians have some power due to their close personal nature of their relationship with the commander.

RULES: Rules are something to be discussed, but followed. It is acceptable to question a rule or an order, but also ok to ask why and explore alternatives. Rules are congressionally mandated in order to keep order from what is otherwise complicated priorities. Rules are necessary, but can get in the way of what seems like “common sense,” and efficiency in smaller scale decisions. Rules are set by those in power. Regulations exist for a reason and guidelines are in place to keep patients and doctors (et al) safe, however we should look and see when / where rules might actually be inhibiting us and change them. Regulations should be followed but solutions can be found within them, Rules are different in the unit versus what most physicians are familiar with. There are regulations and written rules, but there are also unwritten rules that physicians often don’t realize or recognize.

GROUP: Military medical professionals are seen as a distinct, separate group because of the values, commitment and service they have chosen. Military medical professionals are lauded in this as being more than other professionals and should have special consideration. Military physicians are a separate group and superior to civilian physicians in austere, atypical environments. Military Medical professionals have a unique role and must work together as a team to accomplish difficult tasks in difficult situations. This is something they share with each other and way that that they as a group are distinct from their peers. Military providers require different training than other physicians and than other military service members. Doctors are distinct from nurses, from administrators. Military surgeons need to mobilize together for change and will not be successful on their own, which seems to be the norm for most things.

INDIVIDUAL: The development and impact of the individual is considered important / significant and should be considered. The individual is key to the make-up of the group. Hard work and dedication are seen as positives, Sacrifice and Selflessness should be rewarded with praise and exaltation. Individuals strive to not be seen as lazy or slacking off. Everyone wants to be able to contribute. Those lower in rank / status have less control / autonomy but are still valuable. It is the individual's role to be prepared to step up in unclear environments to affect change and help their community/ nation. The individual has a responsibility to work and transform themselves, develop and grow into the competent physician that are necessary to ensure the care of those in their charge. It is the individual's responsibility to be ready to perform their unique and difficult skills when called upon in wartime. The individual can be given a lot of power and must recognize that when making decisions that impact others. Surgeons are fiercely independent but must work together for solutions that make sense. Physicians are the only one of them, but they are not alone. There are others on their team and they need to recognize their role as individuals.

NORMS (v CHANGE): medicine is always evolving, the status quo should be challenged to take the best care of patients. We should look to the past for experiences but not decide against novel approaches. Military physicians have a tradition of public service and self-sacrifice, if this tenant is held to, other changes are acceptable to adapt to new times. Change is slow but necessary. Think Evolution rather than Revolution. Things around us change but there are some things that remain static, enduring truths. There is a standing expectation that military physicians will be prepared to "answer the call," when necessary, and perform these tasks without difficulty. Change and transformation of the individual is expected. Old metrics may not adequately address things we need to know and measure now. We need to continue to seek out and explore data and ensure we are not stagnant. How we did things before may not be the best way (it probably isn't!). Change is good! We must embrace it. Holding onto old ways of doing things ensure our obsolescence. Regulations exist for a reason and guidelines are in place to keep patients and doctors (et al) safe, however we should look and see when / where rules might actually be inhibiting us and change them. Norms should be challenged and evaluated; do they make sense? Can we do it differently. The mission should come first, and we must be able to adapt and overcome. Norms are norms and we cannot expect the army to change for us, we must learn and adapt to the army's customs and norms.

APPENDIX F

FINAL CRITICAL FRAMEWORK

Power: (examine power and influence through questioning).

1. How does the microculture experience the concept of power – both internally and externally? (IE how is it obtained, maintained, or lost, how is it demonstrated or abused)
2. What exerts power over or on the microculture?
3. How does power relate to control and autonomy within the microculture?

Rules: (explore rules, regulations, and obligations).

1. How does the microculture experience the concept of rules?
(Where do rules originate from, and how are they perceived in general.)
2. How do the rules in the microculture differ from those in the larger macroculture?
3. How do rules impact power and control?

Group: (explore the role and nature of groups).

1. What makes the microculture a distinct group and what other groups are related?
2. What groups exist within the microculture?
3. What perpetuates these groups and what does their existence cause?

Individualism: (explore the role and nature of the individual).

1. How are individuals regarded concerning the group, within the microculture and outside of the microculture?
2. What motivates and inhibits individuals?
3. How do individuals succeed, fail and distinguish themselves from the group?
4. How does the individual experience power, control, and autonomy?

Norms (v Change): (examine “normal” versus “abnormal”).

1. How is change considered and experienced within the microculture?
2. What is the experience related to the status quo within the microculture?
3. How are diversity and divergence experienced within the microculture?
4. Where do norms and expectations arise from, can they be traced back to a root?

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