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COMMENTARY

STOWAWAY SOLDIER, CAMOUFLAGE IN A KHAKI WORLD CREATING A SINGLE CULTURE OF TRUST FROM DISTINCT SERVICE CULTURES

Charles W. Callahan

After three decades of wearing Army green and camouflage, I finally went to sea. My first "ship," however, was miles from any ocean. In the summer of 2010 I became the executive officer / deputy commander of National Naval Medical Center in Bethesda, Maryland (NNMC). I was the first Army officer to ever hold the job. My Army career had begun in the infantry, back when we were still training to fight "Ivan" in the Fulda Gap in Germany. After spending my entire adult life in the Army, I was struck during my first year at NNMC with how differently the Army and Navy operate. It became clear that these differences were underappreciated in 2005 when the BRAC, Base Closure and Realignment Commission, drafters directed that the two medical centers realign to form the new medical center by September 2011.

Culture is a set of repeated behaviors motivated by thoughts and feelings based in belief that is developed over a long period and reinforced as an individual matures in a given culture. The uniformed services each have well-defined, discernible cultures, as Carl Builder discusses in *The Masks of War.* He discusses the different services' primary cultural foundations: for the Navy, independent command at sea; for the Air Force, devotion to technology; and for the Army, service to the country as a citizen-soldier.[1] Cultural differences between the services were among the

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primary challenges in the medical center merger, and in many ways they posed the greatest risk for its failure.

Much of the work to integrate the different cultures was superficial, such as discussion of the differing enlisted ranks and ratings, as well as vocabularies unique to each of the services. Additional layers added complexity. The Army Medical Department and Navy Bureau of Medicine and Surgery had distinctly different organizational cultures, each representing several centuries of their respective unique histories. The two hospitals themselves had institutional cultures dramatically different from other medical treatment facilities. These institutions not only were significantly different from one another and from other facilities but had been in competition with each other to be considered the "nation's medical center" and the center of gravity for the care of the nation's wounded, ill, and injured service members.

Several Navy flag officers who took the time to help me prepare for my job at NNMC told me that I would not understand the Navy culture without appreciating the significance of isolated command at sea. One admiral told me, "When the ship disappears over the horizon it is a world unto itself, and the captain's word is law." When mutiny and anarchy are the biggest threats to a ship far from the safety of home port, obedience to the captain and to the chain of command becomes paramount. In the words of Admiral R. A. Hopwood of the Royal Navy, "Now these are the laws of the Navy, and many and mighty are they, but the hull and the deck and the keel and the truck of the law is obey."[2] Obedience to and utilization of the chain of command are a clear Navy strength.

The Army has a different view of anarchy. Where anarchy is the greatest threat at sea, command on the ground almost requires a state of controlled anarchy. Subordinate Army commanders are given their commander's intent and some general guidance and are then expected to improvise and adapt operations to meet the challenges of the battle. This expectation affects and shapes the perception of the chain of command in a way that is different from that of the Navy.

Sociologist Geert Hofstede has researched a system of codifying cultural differences and has described several key dimensions that provide insight into the differences between Army and Navy cultures. The "power distance index" (PDI) is the degree to which those with the least power in a cultural system are comfortable with the distance between themselves and those who hold the greatest power. For example, Asian, Latin, African, and some Arab countries have large PDIs—there is a great degree of comfort with the differences in social strata. Northern European countries, as well as the United States, have considerably lower indexes.[3] While I am not aware of its having been measured, I suspect the Navy culture that has evolved from the traditional command at sea would indicate a very large PDI, especially when compared to Army culture.

My commander at Bethesda taught me that Naval Academy plebes are taught five acceptable answers to a question: *Yes, sir!, No, sir!, No excuse, sir!, I'll find out, sir!,* and *Aye, aye, sir!*—the latter acknowledging the senior's statement as a legally binding order. Soldiers, however, sometimes answer a superior officer with the word *Roger,* the old phonetic-alphabet designator for the letter *R,* which implies that a message has been received. More commonly of late, a soldier will answer with a *Hooah!* The derivation of this response is controversial, but some suggest that it should be spelled *HUA*—heard, understood, acknowledged. In this case, rather than accepting a legally binding order, the soldier who replies, "Hooah!" has in essence told the superior officer that he understands and will respond to the request when he is able. The difference in meaning between the responses *Aye, aye!* and *Hooah!* is emblematic of the cultural difference in the idea of command.

In practical terms in a joint environment this difference manifests itself when Army personnel jump or ignore the chain of command, following a matrix approach to communication, demonstrating improvisation and initiative as they reach out directly to individuals in other divisions to accomplish a task. The presumed differences in the PDI between Army and Navy cultures are manifested in Navy personnel as an aversion to anarchy and an emphasis on using the chain of command. For example, Navy personnel will often react to interference in the chain of command with *indignation,* while Army personnel, more comfortable with command ambiguity, respond with *indifference*.

There are also cultural differences between the Army and Navy that have their basis in the characteristics inherent to Army operations on the battlefield in contrast to those of Navy operations at sea—the battlefield versus the battleship. The Army approach to solving a problem or challenge in battle is to reach for more people or "stuff." During World War II, as the U.S. Army broke out of the Normandy beachhead following D-Day in the summer of 1944, its forces rapidly exhausted the supply of replacement soldiers and supplies needed to keep fighting. The solution was the "Red Ball Express," a continuous convoy of more than six thousand trucks moving forty-five tons of supplies a day to the front. There is always room on the battlefield for more people and more stuff.[4]

In contrast, a challenge or problem at sea cannot be solved by adding more people or supplies. There is no room, but even if there were, the means to resupply do not always exist. Navy culture has developed a highly refined ability to develop and modify processes and procedures as an approach to solving problems and mitigating risk. The classic example of the critical importance of procedure in Navy culture is the often-cited disaster on board the aircraft carrier USS *Forrestal* in the summer of 1967. That morning one of the two key processes developed to avoid accidental launch of a fighter-jet rocket pod was bypassed for expediency. The resulting accidental missile launch, detonation of ordnance, and

fuel fire led to the deaths of 134 sailors, injuries to 161, and a fire that blazed for twenty hours.

In the Navy operating environment, bypassing established process and procedure can have devastating, even deadly effects. A screw that has dropped off the tread of an Army tank in the field is consequential only if the tank stops moving, but the same-size screw on the deck of an aircraft carrier can be sucked into a jet engine and destroy a multimillion-dollar aircraft at launch. In the Navy, process matters; it is the primary means for solving problems and reducing risk.

During the national capital health-care mergers, there were many times when Navy and Army staffs working together encountered lines drawn on the basis of these differences. Navy personnel, who were sometimes invested in successful processes and procedures long established at NNMC for the administration and care of patients, presumed that those same procedures would define the way the new medical center would operate. That expectation proved frustrating for incoming Army personnel when these decisions about existing policy seemed to have been made with little discussion.

Army leaders designing future clinical operations for patient care at Walter Reed National Military Medical Center (WRNMMC) often included in their plans all the personnel and equipment that they had had at Walter Reed Army Medical Center (WRAMC), as well as new equipment ordered as part of the BRAC relocation. That presumption contributed to nearly a fifth more military and civilian staff in the new medical center than originally anticipated and a continuous stream of "reuse" equipment brought over from the closed center for the first year after the merger.

There were also nuances that had to be resolved regarding the hospitals' governance and the way that health-care business is run. Army command teams turned over frequently, so that the historical center of gravity at WRAMC comprised the clinical department chiefs who handled medicine, surgery, orthopedics, obstetrics/gynecology, pediatrics, etc. These leaders had longevity that was consistent with the traditional structure of nineteenth-century academic medical centers like Johns Hopkins. Further aggravating hospital governance challenges, the command structure of Army hospitals has developed in a way similar to that of an Army division.

In large Army medical treatment facilities, the commander fills a role equivalent to that of the division commander, the deputy commander of clinical services that of assistant division commander for maneuver or operations, the deputy commander for administration, and the assistant division commander for support. The deputy commander for nursing and other members of the hospital executive committee joined the Army hospital governance team relatively

recently. For example, the chief nurse at WRAMC moved into an office in the command suite in 2006, ninety-three years after the hospital opened its doors.

In contrast, NNMC, as is typical of Navy medical facilities, was governed like a ship. Senior leadership included the commanding officer, executive officer, command master chief (the senior enlisted member), and then heads of the hospital directorates, departments, and divisions. Like the ship's executive officer, the hospital deputy functions as chief operating officer. In addition to the responsibility for the mission and the crew, the commander's job is specifically to train the deputy to become a commanding officer. Both new joint hospitals in the Washington, D.C., area—WRNMMC and the Fort Belvoir Community Hospital—include this leadership position, designated as the chief of staff. Army hospitals have no equivalent.

In a Navy facility, the clinical and administrative functions of the hospital are arrayed like departments on a ship—administration, deck, engineering, navigation, supply, and weapons. The new joint hospitals too are organized consistent with the Navy model, with different directorates (including nursing, dentistry, surgery, medicine, behavioral health) or assistants (public health and medical staff), as well as administrative services (administration, operations, and comptroller) under several more. Each directorate is led by a deputy commander, who reports to the chief of staff.

The traditional Army hospital structure worked well when the scope of work for the deputies was narrower, and it is still relatively effective in smaller facilities. But as missions grew and became more complex, it became a challenge for the traditional structure to provide effective command and control. Hospital governance at WRAMC (having developed at the same time as other historic academic institutions, like Johns Hopkins) reflected this structure, in its organization around the major academic departments. So the center of gravity at WRAMC came to rest with the academic clinical department chiefs. These senior colonels represented the institutional memory of the organization, while deputy commanders and commanders rotated in and out of WRAMC every one or two years.

The practical governance structure and system for the new hospital had to be developed to allow adequate authority to rest with the deputy commanders while still allowing scope for the influence and leadership of the new integrated clinical department chiefs, many of whom had served in these roles for many years at WRAMC. This change in governance was another major cultural divide between organizations, and the operational implications in command and control are still being recognized.

On executive rounds in one of the WRNMMC clinics, I was reminded of the difference between the "chief" at the old WRAMC and the "chief" at NNMC

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when I asked a young sailor to get me her chief. Instead of the service chief, she returned with her chief petty officer, the real center of gravity in any Navy organization. Even after six months as a merged organization, service and institutional cultures still ran deep. The center of gravity for both NNMC and WRAMC was the "chief," but the word implied different people in the two services. On board ship the chief petty officer is imbued with power and authority to represent the commanding officer to the enlisted personnel. This authority is somewhat blunted in the occasionally less formal, more fluid dynamic of the battlefield, where the Army senior enlisted role developed. Also, of course, in Army medicine "chief" has a different meaning that harkens to the academic clinical leaders typical of the older WRAMC structure.

The civilian business world recognizes the significance of the differences between the services and the skill sets that leaders bring to private industry. In a recent *Harvard Business Review* article, Boris Groysberg and his colleagues note that former military officers make up just 3 percent of the U.S. adult male population but represent three times that proportion of the chief executive officers in Standard & Poor's and Fortune 500 firms. Looking more closely at forty-five of these civilian executives with military experience, the authors observed that former Navy and Air Force officers adopted process-driven approaches to management, whereby personnel follow standard procedures without deviation. They were more likely to run highly regulated industries and disciplined innovation sectors. On the other hand, chief executives with Army and Marine Corps experience embrace flexibility and empower people to act on vision with initiative, while working at smaller firms where direct communication and direction are possible.[5] Cultural differences clearly carry over and can be leveraged into advantage in the civilian business world.

The cultural transformation of two storied institutions into a new culture of mutual, shared trust for the Walter Reed National Military Medical Center will likely take decades. The evolution will be made more complex by the replacement of a third of the uniformed staff every year by an influx of Navy and Army personnel who have never operated with a sister service before. Until the recent conflicts in the Middle East, a Navy or Army medical officer could serve an entire career without spending any time working alongside professionals from another service.

Now, however, Navy enlisted personnel and officers routinely deploy on the battlefield with Army units, Army hospitals care for Marines, Air Force professionals care for all services on evacuation missions, and Army medical headquarters manage logistics for Navy medical trauma teams. As key leadership roles at the medical center, including that of the commanding officer, rotate between the

different services, the culture of WRNMMC, as well as Fort Belvoir Community Hospital, will evolve into one that will be formed less by one service and more by the institution's people, patients, and unique missions.

We have learned an invaluable lesson from more than a decade of war together, as we shake the same dust from our identical khaki boots. It is a lesson that will guarantee the eventual success of the merger of WRNMMC and the emergence of a new culture that represents all our unique backgrounds. It is the creation of this new culture that must be the primary task of the medical center leadership. Admiral Vernon E. Clark, the Chief of Naval Operations from 2000 to 2005, observed that "culture is the result of the combined decisions of the leadership of an organization."

The things that our separate services share are far greater than those not shared. What is different about us, in fact, makes us stronger. A single, shared common purpose—*pro cura militis,* the care of the warrior—coupled with the range of different strengths from each service culture results in an unparalleled combination that will benefit our patients in ways that would never be realized by stubborn adherence to any one service culture.

NOTES

The views and opinions expressed in this manuscript are those of the author and do not reflect the official position or policy of the Department of Defense, the Department of the Army, the Department of the Navy, or the U.S. government.

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