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Military Habitus vs. Medical Habitus:

The Complicated Relation between Military and Medical Officers in the Medical Corps of the Dutch Army



Master thesis

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Abstract

Background: In the Medical Corps of the Dutch Army, two categories of officers exist. These are medical officers and military officers. Experience has shown the relation between these two types of officers is complex, for example because lower-ranked military officers can be in the command of a higher-ranked medical officer. Furthermore, the military assignment to only take care of military casualties can conflict with the medical officer's duty to provide good care for any patient. The main question of this thesis is: *How can the complexities in the occupational relation between medical and military officers in the medical corps of the Dutch army be explained and to what extent can these complexities affect the decision-making process in medical units?*

Methods: A qualitative research was performed to get insight in the relation between military and medical officers. For this research, first a literature study was performed and a theoretical framework was created. The theoretical framework focusses on managing professionals in general, the concept of habitus, the military habitus and the medical habitus. Using the found insight from literature, a topic list was created and interviews were held with a total of 12 officers; working in different levels of the Medical Corps. On the basis of encoding, the transcribed interviews were converted to useful data and with help of a data matrix, the results were presented.

Results: The relation between military and medical officers is complex and this research shows there are four possible causes for friction in the relation between medical and military officers: conflicting interests, culture, organizational aspects and hierarchy. To give insight in this complex relation the habitus of the two types of officers were looked into and it was found that the two habitus differ in most of the aspects that were looked into. The habitus differ among others in the area of their goals with regard to patient care, hierarchy and discipline; but especially in the area of culture. However, their habitus also slightly differ from the general military habitus and the civilian medical habitus, as described in the theoretical framework. It appears that military officers and medical officers working for the medical corps have their own specific habitus.

Conclusions: The complexities in the relation between medical and military officers (conflicting interest, culture, organizational aspects and hierarchy) can be understood by their opposing habitus and the extent to which medical officers are embedded in the military organization. The complex relation can affect the decision-making process; a bad relation may result in an inferior decision. What is remarkable is that the two different types of officers have found a way to balance their conflicting habitus and work together; they do this by means of 'tinkering'. This shows, however different, in the end the two occupational groups go together and there does not seem to be a bad relation that negatively affects the decision-making process.

Key words: Habitus, medical habitus, military habitus, embeddesness, tinkering.

Acknowledgements

In August 2007, I started my career in the Dutch army at the Royal Netherlands Military Academy (NLDA) in Breda. As a compulsory part of the bachelor military sciences with a minor in management military healthcare; in 2009, I followed a premaster program at the Erasmus University in Rotterdam with subjects from both the ZoMa and the HEPL Masters. Early 2010, I was told some students from the NLDA would be given the opportunity to follow a Master's program of choice after graduation. After months of selections, in October 2010, I received the good news that I was one of the lucky few. I started the master HEPL on September 5, 2011.

Now, it is July 2012 and I am about to graduate from the Erasmus university. After graduation, I will start the last part of my military training, before actually becoming the commanding officer of a medical platoon. Managing medical professionals is now only but a small step away and to be honest; this makes me a little nervous. Therefore, this research concerning the relation between military and medical officers is more than just a tool to get my Master's degree and to make a contribution to literature. This research is also of personal interest and I sincerely hope the outcomes will help me in my future career

The completion of this Master Thesis was made possible by the support of several persons. First of all, I would like to express my gratitude towards the NLDA for giving me the opportunity, time and means to follow a Master study. I am grateful for this. Second, I would like to thank my supervisor drs. I. Wallenburg. Thank you for your time, support and ideas regarding this thesis. Third, I would like to thank my two co-evaluators prof. dr. P.L. Meurs and J. Postma, MScBA for their criticism that kept me motivated through the final stages of the process. Fourth, I would like to thank prof. dr. J.M.M.L. Soeters and drs. J.J.D. Heeren-Bogers from the faculty of military sciences for their support in finding literature. Above all, I would like to thank all 12 officers who were so kind to help me with my research by allowing me to ask them about the ins and out on their relation with the other category of officers. You were very helpful in creating a clear overview of the complex relation between medical and military officers. You did not just provide in information for writing this master thesis; you also were my teachers in preparing me for my future job. Thank you all so much for your time and your honest and open answers.

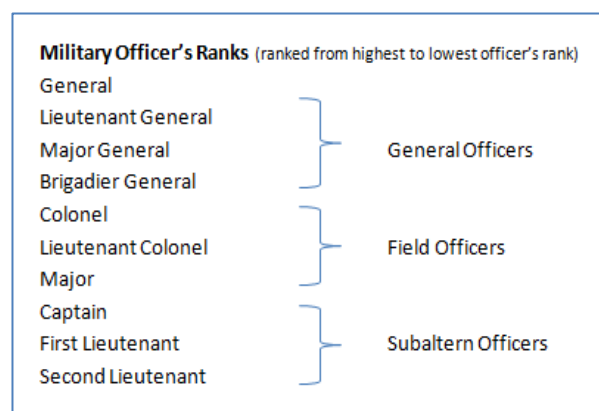
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1. Introduction

In august 2007 I started my officers' training at the Royal Netherlands Military Academy (NLDA) in Breda. As I was recruited for the medical corps; I was predestined to once be in the command of a medical platoon. I soon realized this was going to be tougher than I imagined before. Already in my first year at the academy, I became aware of the difficulties of working with medical professionals. A military officer told me about a situation in Afghanistan. A big military campaign was about to start and the hospital commander, whom I spoke, was ordered by a superior officer to assure enough available beds in case of military casualties. The problem was that almost all beds were occupied; some by military patients, others by civilian patients. The hospital commander ordered to discharge some of the civilian patients. The doctors did not agree to this. They knew discharging those patients would probably mean a death sentence. The doctors did not want to let them die, just to assure capacity for possible military casualties. The commander brought forward that the hospital was employed to help military casualties first. The commander did not want to risk the lives of soldiers. This example clearly illustrates conflicting interests between the hospital commander and the doctors. In my thesis, I will examine the complex relation between these two occupational groups.

In the medical corps of the Dutch Army, there exist two categories of officers. On the one hand there are the managers or military commanders. In this research I will refer to them as military officers¹. They went to the Military Academy for their officers' training and they usually are commanding officers of a military medical facility unit; they manage a medical facility². On the other hand there are the medical professionals; I will refer to them as medical officers³. They enjoyed a medical training at a civil university and practice their medical occupation within the army. Although they do have an officer's rank, this rank often exclusively represents an indication for their salary scale. These officers usually are not in the *command* of a unit. In fact, often they *serve* in a unit. The latter means that, in terms of hierarchy, medical officers often serve under the command of a military officer. Within the group of medical officers, a distinction can be made between professional medical officers who work for the military full-time (i.e. the military GPs) and reserve medical officers who work part-time and sometimes participate in an exercise. Besides that, the Dutch military has a contract with several Dutch hospitals which allows the military to obtain medical specialist (i.e. surgeons and anesthetists) for a certain amount of time per year⁴. These specialists are also medical officers. As was illustrated above, there can be tension between military and medical officers and I expect this tension to be twofold: it can be caused by differences in rank and it can be caused by differences in habitus. I will explain these expected causes for tension in this introduction.

The Dutch army is organized in a hierarchic way and ranks make this hierarchy visible. Soldiers often wear their ranks with pride and show respect towards higher ranked colleagues. Medical officers usually are field officers. This means they are officers holding the rank of major, lieutenant colonel or colonel. However, as I explained above, their ranks often only represent an indication for their salary scale. Military officers, on the other hand, can be field



¹ In the Afghanistan example explained above; the hospital commander is a military officer.

² Military officers can also perform tasks in administrative staffs or in policy functions etc. The military therefore has more officers than one would expect on the basis of the amount of units, not all military officers are military commanders but this research focusses on commanding officers.

³ In the Afghanistan example; the doctors are medical officers.

⁴ This collaboration between the military and civilian Dutch hospitals is coordinated by the Instituut samenwerking Defensie en Relatieziekenhuizen (IDR).

officers as well as subaltern officers. Subaltern officers hold the rank of lieutenant or captain. Lower-ranked military officers can thus be in the command of higher-ranked medical officers and within a hierarchic organization such as the military, this is a unique and almost unthinkable situation. This situation was the daily practice in Afghanistan, where the Dutch Army ran a hospital in the period between summer 2006 and fall 2010. The hospital was under the command of a subaltern officer. This officer was in the command of 54 persons, among who were a general practitioner (GP), a surgeon and an anesthetist. These specialists were field officers. This unique situation created difficulties, especially for young and inexperienced hospital commanders (military officers); they were sometimes run over by higher-ranked medical officers. These difficulties caused by differences in ranks are one reason for the complex relation between the two categories of officers.

Besides the explained 'rank difficulties', the different officers also seem to have their own beliefs about good and bad. They have their own way of thinking and acting and their own goals which was already clearly demonstrated in the example presented above. This idea led to the assumption that the way of thinking and acting is an important factor in explaining the difficult relation between the two types of officers. Within the sociological literature this very own way of thinking and acting is described as 'the habitus'. I will draw on literature from the famous French sociologist Pierre Bourdieu. He explains the habitus as a set of socially learnt dispositions, skills and ways of acting, that are often taken for granted, and which are acquired through the activities and experiences of everyday life (Witman, 2007:37). However both occupational groups are soldiers, military and medical officers have their own habitus and this is another reason for their complex relation.

I expect the complex relation between military and medical officers can also be explained using the more general information about the difficulties of managing professionals; since in the relation between the two types of officers the medical officers are the professionals who are managed by the military officers. I will use this literature to familiarize myself with the general difficulties of managing professionals. On the one hand, managers want regulations and guidelines to guarantee quality or a certain output (Raelin, 1985). These managers do not have specific professional knowledge, but they are interested in arranging a framework in which professionals can perform their tasks (Vogd, 2006). Professionals, on the other hand, want to do what they are trained for; which is patient care. They have specific medical knowledge and they are convinced only the professional can make the right decisions. They feel the manager's framework of preconditions limits their professional autonomy (Freidson, 2001).

According to literature, relations between managers and professionals are often complex. However, for the above explained reasons, I believe this relation can be even more complex between managers and professionals within the medical corps of the Dutch army. The difference in habitus and the hierarchic position in combination with the more general difficulties of managing professionals make the relation between managers and professionals, or military and medical officers in the Dutch Army very interesting. In this thesis, I will explore the complexities of the relationship between the two types of officers. I will do this by first thoroughly exploring the military and medical habitus and consequently comparing the two habitus. With the found insights, I hope to determine to what extent the concept of habitus can be used to explain the complexities in the relation between military and medical officers. Finally, I hope to answer whether the complex occupational relation influences the decision-making process in a medical unit.

The main question of this research is:

How can the complexities in the occupational relation between medical and military officers in the medical corps of the Dutch army be explained and to what extent can these complexities affect the decision-making process in medical units?

In order to be able to answer this question, the following sub questions were formulated:

1. Which complexities are encountered in the relationship between military and medical officers and how are these complexities perceived by both groups?
2. How can we understand the habitus of military officers in the medical corps of the Dutch army?
3. How can we understand the habitus of medical officers in the Dutch army?
4. What are the differences and similarities between the military and the medical habitus and to what extent do these outcomes affect the complexities between military and medical officers in the Dutch army?
5. How does the complex occupational relation between the medical and military officers affect the decision-making process in medical units?

The second chapter of this research comprises the theoretical framework; the theoretical framework is a theory that serves as a basis for conducting research. It discusses several theories concerning managing professionals; it explains the concept of habitus and presents the military and the medical habitus. In chapter 3, the research methods of this thesis are presented. Chapter 4 contains the core of this research: the results. The first paragraph explains the complexities in the relation between military and medical officers. The second paragraph starts with a description of the habitus of military officers working for the medical corps; their habitus slightly deviates from the 'regular' military habitus. After that, a description of the habitus of medical officers follows. Moreover, in this paragraph the two habitus are compared. In the third and final paragraph results are presented about how the complex occupational relation influences the decision-making process in medical units. Also in this paragraph it is explained how the two types of officers manage to work together, despite their vast differences. In chapter 5, the final conclusions are presented as well as a discussion and some recommendations.

2. Theoretical framework

In this thesis, the questions introduced in chapter 1 will be answered. The literature that will be used to do so is explained in this chapter. This literature is structured in five subjects. First, a general description of the relation between managers and professionals is presented. Second, an explanation of the habitus; a concept extensively examined by Bourdieu, is provided. In the third paragraph, a description of the military habitus will be given; followed by a description of the medical habitus in paragraph four. Finally, the theoretical framework concludes with a short comparison of the military and the medical habitus.

2.1 Managing professionals

In the introductory chapter, the difficulties of managing professionals were shortly described. In the following paragraph, these difficulties will be explained more thoroughly, focusing on the medical world. It is expected that this explanation of the complex relation between healthcare professionals and managers will help understand the complex relation between military and medical officers. This is expected since medical officers are healthcare professionals; they are GP's, anesthetists or surgeons and they got the same education as civilian healthcare professionals and sometimes they even also work or have worked as a healthcare professional outside the military. The military officers are managers; most of them have a degree in management with a specialization in healthcare management and they manage a military medical unit both in times of peace and war. Just like the managers of a civil hospital; they are responsible for the quality of care and the availability of good quality personnel and equipment. They have to make sure the medical facility is prepared for possible future events. Furthermore, like civilian hospital managers, they have to balance different interests. Civilian hospital managers usually have to find a balance between quality and costs and military managers or military officers are responsible for balancing for example the safety of the facility, the quality of care and the responding time after an incident takes place. Healthcare managers and healthcare professionals are often displeased about their mutual relation (Davies et al. 2003-1; 2003-2). Their mutual relation is complex and literature gives several explanations for this complex relation.

The medical occupation is characterized by the specific knowledge owned by the medical professional. A professional has knowledge lay people do not possess. This means lays cannot verify the professionals' work and this gives a professional power or professional autonomy. Professional autonomy is the quality or state of being independent and self-directing in making decisions, deciding on a code of conduct and on review criteria as well as the freedom to decide on training criteria (Hulst, 1999). This autonomy is embedded in the professions' culture and originates from many years of controlling their own work (Light, 2000). The professionals' sense of power and authority is not only coming from their special knowledge, but also from the control over interpersonal situations (Larson, 1979). Professionals are typically concerned with the problems of individuals and not so much with society as a whole (Ibid.). Professionals want to do what they are trained for; which is patient care, and they feel limited in their freedom because of the managers.

Managers can thus be seen as third parties trying to influence the primary process of healthcare. Managers in healthcare focus on the entire process around patient care. They are interested in arranging a framework in which professionals can perform their tasks (Vogd, 2006). Over the past decades, non-medical managers have gradually taken over the management positions in hospital boards. These managers typically have no medical knowledge; they make their decisions using statistical information and they think in a bureaucratic and economic manner (Vogd, 2006). The difficulties between managers and professionals can derive from fundamental differences between the two occupational groups. To put it simple, a manager focusses on cost containment whereas a professional is focused on patient care (Kaissi, 2005). Managers focus on the population, public responsibility and rationing and professionals focus on their professional autonomy, individual

patients and self-regulation (Davies et al., 2003-1). Another explanation of the difference between managers and professionals is presented by Berg et al., they believe:

At heart, the deepest dividing line runs between the professionals 'owning' and improving the content of health care work and the manager 'owning' and improving the organization of that work (Berg et al., 2005).

Maason and Cappolse (2005) argue that, because managers and professionals speak a different language, it might seem as if they have a conflict of interests. Atun (2003) also believes this; according to him difficulties in communication are the main cause for the complex relation between managers and professionals. Managers and professionals have different values, goals and working methods, therefore it is not surprising their relation is tense (Kaissi, 2005) (Davies et al., 2003-1) (Berg et al., 2005) According to Edwards et al. (2003) this tension is not only inevitable but also necessary. They argue a patient benefits from a professional who focusses on healthcare and a manager who focusses on finances; a patient thus benefits from the tension between managers and professionals. However, mutual respect is required to control the tension (Edwards et al., 2003).

Whereas others try to explain the difference between managers and professionals; Noordergraaf (2008) argues it is important to critically assess the contradiction between managers and professionals. He discusses the described gap between managers and professionals and questions whether the gap actually exists or whether it was created in theory. In other recent literature, Ackroyd & Muzio also question this described gap. They argue there is "little evidence of the development of an autonomous managerial cadre... (Ackroyd & Muzio, 2004:21)." According to them, the number of professionals is growing and they argue professionals work in every part of the organization. Managers also are professionals and therefore "...the elite of the profession continues to retain ultimate control over its own work and division of labor within professional firms (Ibid.)." According to Ackroyd & Muzio, there is no distinct gap between managers and professionals; they argue the professional occupation is embedded in the organization.

In her PhD research, Witman also examined the difficulties of managing professionals. She looks into the concept of medical professionals in the lead and she assumes the process of socialization is very important for their style of leadership (Witman, 2007:46). In this thesis, it is expected that this process of socialization is also decisive for the relation between military and medical officers. The concept of habitus refers to this process.

2.2 The habitus

Habitus means 'appearance'. The term habitus is used in many different fields of study. In the medical world for example, the habitus of a human being is explained as its physical appearance; its physique (American Heritage Dictionary, 2003). The term habitus is also used in sociology and throughout history; many philosophers and sociologists used the term in their work. According to Loïc Wacquant, the roots of habitus can be found in the notion of hexis by Aristotle. Hexis is an ancient Greek word. It stems from a verb related to 'possession' or 'having' and in modern texts it is translated as a 'state'. The term was translated into the Latin term habitus in the thirteenth century⁵ (Wacquant, 2003). In the twentieth century, Mauss defined habitus as:

Those aspects of culture that are anchored in the body or daily practices of individuals, groups, societies, and nations. It includes the totality of learned habits, bodily skills, styles, tastes, and other non-discursive knowledge that might be said to "go without saying" for a specific group (Mauss, 1934).

⁵ Habitus stems from the past participle of the verb 'habere'; which means to have or to hold (Wacquant, 2003).

The term habitus was re-elaborated by the French sociologist and anthropologist Pierre Bourdieu in the 1960s. Bourdieu's writings are often complex and even ambiguous, therefore Richard Jenkins wrote a 'translation', without changing the contents (Jenkins, 1992:10). According to Jenkins, Bourdieu is interested in very diverse subjects but his theories on social practice are often considered the heart of his work (Jenkins, 1992:21). Throughout his entire work, Bourdieu is concerned with subjectivism and objectivism and consciousness and unconsciousness. Bourdieu thinks about what people do in their daily lives and what determines social life (Jenkins, 1992:74). He is sure social life cannot be understood as simply a consequence of objective, conscious or rational acting. He does not believe individuals are capable of making rational, isolated decisions. However, nor does he believe social life is merely a result of subjectivism or unconsciousness. The concept of habitus provides the bridging answer between these two extremes; habitus answers the question of what determines social life (Ibid.).

The concept of habitus can be explained as a set of socially learnt dispositions, skills and ways of acting and thinking and feeling, that are often taken for granted, and which are acquired through the activities and experiences of everyday life (Witman, 2007:38). A habitus is a product of in the past received dispositions; and through common circumstances a common habitus can originate within a group of persons (Ibid.). Bourdieu describes the habitus as a durable and subconscious way of observing, thinking and acting, with which people can hang on in a social field. The habitus disposes people to do certain things (Jenkins, 1992:78). In Bourdieu's definition, two ideas in particular need further explanation; these are 'subconscious' and 'durable'.

The first important aspect of Bourdieu's definition is 'subconscious'. Bourdieu emphasizes that the way of thinking and acting is not a conscious, rational choice. Bourdieu believes people can act in an objective or rational manner, but he explains this rationality is based on the habitus; which is something people have not chosen for themselves and is thus subjective. Bourdieu says rational choices can happen "but, and this is a crucial proviso, it is habitus itself that commands this option. We can always say that individuals make choices, as long as we do not forget that they do not choose the principals of these choices (Bourdieu, 1992 cited by Jenkins, 1992:77)." In the end, this means that the unconscious dispositions of the habitus produce practices (Jenkins, 1992:77); the way in which people act and think are thus based on subjectivism.

The second important aspect of Bourdieu's definition is 'durable'. Bourdieu says: "the habitus, a product of history, produces individual and collective practices – more history – in accordance with the schemes generated by history (Bourdieu, 1992 cited by Jenkins: 1992:80)." This means the history that people create, the way in which people think and act, is not because of their own choice but because of their habitus. In this way, history can be seen as the foundation of the habitus (Jenkins, 1992:80). As a consequence, history tends to repeat itself and a durable status quo is achieved (Jenkins, 1992:81).

According to Jenkins "in this sense, history is an ongoing set of likely outcomes or probabilities that are the product of what people do (Jenkins, 1992:80)". This means the concept of habitus makes social life regular and predictable and gives it a pattern. Bourdieu explains:

In reality, the dispositions durably inculcated by the possibilities and impossibilities, freedoms and necessities... generate dispositions objectively compatible with these conditions and in a sense pre-adapted to their demand. The most improbable practices are therefore excluded, as unthinkable... (Bourdieu, 1992 cited by Jenkins, 1992:81).

This means that the habitus determines future dispositions and deviating ways of thinking and acting will be excluded and seen as unthinkable. The concept of habitus is interesting for this thesis since it can make social life predictable. This means it gives insight in how people act and think; it makes

their choices predictable. Yet, this also means that complexities or problems in the relation that are caused by the differences in habitus are difficult to solve since a habitus is deep-rooted. Explaining the habitus of military and medical officers and their differences is therefore likely to help explain their complex mutual relation. In the following paragraphs the two habitus will be described and compared on different aspects. These are organizational structure, hierarchy and discipline, perspective of culture, communal life, position within society, financial aspects, how to become a military person and recent developments. These aspects are chosen since it is expected they have a big impact on how people think and act. Financial aspects for example can be a good explanation why people behave in a certain way. When money does not play a big role; in general people will be more likely to spend more and thus focus on other things than cost containment. This shows that financial aspects affect peoples' ways of thinking and acting. A good understanding of all these aspects from both military and medical officers is therefore likely to help understand their complex relation.

2.3 Military habitus

Military people⁶ have a lot in common, as a group they have a specific habitus that distinguishes them from other occupational groups. Military persons are often recognized as soldiers because of their physical appearance and their behavior in its broadest sense. In this paragraph, insight will be given in the military habitus. The military organization is a bureaucracy (Soeters, 2000:468; 2006:241). Mintzberg argues there exist two different forms of bureaucracies: the professional bureaucracy and the machine bureaucracy (Mintzberg, 2006). Machine bureaucracies are highly hierarchic and regulated, have big units on the production level that execute highly standardized work and the power of decision is centralized (Ibid.). The professional bureaucracy, on the other hand, is less hierarchic and regulated. This system relies more upon the specialized knowledge of the operating core. They get some control over their own work and are steered by a small group of leaders (Ibid.). Ouchie also refers to this structure as 'clan' (Ouchie, 1980). The military organization can best be compared with the machine bureaucracy, "The level of power distance, i.e., hierarchy, in military academies is much larger than in the business sector" (Soeters et al., 2006:242). Besides the strong notion of hierarchy, discipline is another characteristic of a military organization. "Discipline is the compliance with rules, the acceptance of orders and authority, and the way the organization deals with disobedience through overt punishment" (Arvey and Jones, 1985). The degree of discipline in the military varies a lot between countries, but in general military organizations have a high degree of discipline (Soeters, 2000:470; 2006:243). This discipline is among others expressed in the appearance of military personal, polished shoes and ironed shirts, and in their punctuality.

Soldiers have more in common than just discipline, they have a common culture. "Culture is the collective programming of the mind, which distinguishes the members of one group or category of people from another" (Hofstede, 1991:5). In his paper about military culture, Soeters defines three perspectives on culture. First, he describes the integration perspective. Within this perspective, a group has a group culture and the group can be seen as a 'little society' (Soeters et al., 2006:239). The second perspective is the differentiation perspective. Within this view, the emphasis is on subcultures. The perspective "...emphasizes the homogeneity within the subcultures but the heterogeneity of the group's organizational culture" (Ibid.). The third and final perspective is the fragmentation perspective. As indicated by the name, the cultural elements in this perspective are only loosely connected (Ibid.). The majority of literature on military culture is based on the integration perspective (Ibid.). This means the military as a whole has their very own culture and the military can be seen as a little society. The latter is also strengthened by the fact that the military often has all the facilities to fully take care of their personnel; they have restaurants, houses for the military families, training centers and even universities, recreation areas and even their own health

⁶ This paragraph applies to all military persons, including officers.

care facilities. Furthermore, they have their own health insurance and pension fund. The military cannot just be seen as a little society, it really is in fact a little society.

It may come as no surprise that the members of the society, the soldiers, value their job as a way of life. According to Soeters, (2000:467; 2006:241) a distinction can be made between the institutional and the occupational orientation towards working in the military. When this institutional orientation dominates, employees are fully committed to the military; their job is a way of life and all that matters is their job. On the contrary, when the occupational orientation dominates, employees believe the military is just another job (Ibid.). Although there are differences between countries; overall military cultures can be seen as institutional cultures. Soeters (2006:241) refers to them as “Greedy organizations”, as they ask much from their employees. In this respect, there seems to be an overarching military culture worldwide (Ibid.).

What is also worldwide is the fact that military organizations have a special position within society. Because of the strong culture but also because of their role as armed forces, they enforce power and respect. The military has the ability to punish and use violence when approved by politics and in that way they can sometimes even decide on life and death (Wilson, 2008). The military is in fact an organization, approved to use force, ran by politics. The military is state-owned and therefore also state-funded. Although the budget for the military is getting smaller and smaller worldwide, money does not seem to matter as much as in the business sector. What matters is safety, sometimes at whatever costs and the military organization does not want to waste time on discussing costs. Cost containment and cost awareness always remain sensitive subjects (Berinski, 2007).

To become part of the military, the military makes use of a specific recruitment tool: endo-recruitment. Military organizations often recruit persons who have relatives with a military background. (Soeters, 2000:477; 2006:249). Endo-recruitment is a form of self-selection that provides the military with personnel that already has a military culture (Soeters et al., 2006:249). Another important tool to become part of a military society is the ‘degreening’ process or Plebe system. Shortly after beginning the military training, the new recruits go through a process of degradation and mortification. This form of socialization deconstructs the civilian status and rebuilds the recruits with a new identity. This means the recruits are taught about the military norms, authority relations and disciplinary codes of the organization (Soeters et al., 2006:250)

It was earlier explained that a military organization is institutional, hierarchical en discipline oriented. This traditional military organization still exists nowadays, especially in the less Western parts of the world. In the Western part of the world, however, it seems the organizational culture is slowly developing into a more businesslike one (Soeters, 2000:479; 2006:244). The military is losing its role as ‘a way of life’; soldiers often go home after work (Soeters et al., 2006:244). The organization is changing towards a professional bureaucracy; thinking soldiers and more occupational oriented. Soldiers are increasingly being seen as professionals and the military is often referred to as a professional organization that values highly skilled and academic trained employers (General Van Uhm, 2009). This development set in after the Cold War ended. Results are among others: smaller, more professional armies, all volunteer forces etc. (Dandeker, 1994) (Moskos et al, 2001) (Segal et al, 1983).

2.4 Medical habitus

Medical professionals, e.g. doctors, also have a lot in common⁷. They clearly have their own habitus. This medical habitus will be described in this paragraph. In her PhD research, Yolande Witman states the medical world has its own specific culture that is known for its strong hierarchy and is closed for

⁷ In defining the medical habitus, the focus was on medical professionals because the thesis aims at them.

outsiders (Witman, 2007:12). The structure of the world of medical professionals, often a hospital⁸, can be described as a professional bureaucracy (Witman, 2007: 26). A hospital relies upon the specialized knowledge of the operating core; the medical professionals (Mintzberg, 2006).

Comparable to the common culture within the military, medical organizations also have a specific culture; a medical culture. Above, three perspectives on culture by Soeters (2006:239) were introduced. The medical culture fits best to the differentiation perspective. In a hospital there are several groups: nurses, doctors, anesthetists etc. They have their own specific culture, but these specific cultures also fit together. Furthermore, within the doctors' culture, there are also subcultures. These subcultures are mainly driven by seniority and specialization, but they also have a common or overarching culture (Witman, 2007). This common culture is among others caused by the intensive contacts between medical personnel. Medical professionals often have long working weeks; they work irregular shifts and eat and sleep in the hospital. The medical world demands a lot of time and dedication from a professional and this often results in less contact with the world outside of the hospital. Medical professionals often meet most social contacts in the hospital, so their work controls their life (Witman, 2007). Although there obviously are differences between individuals, the average medical professional thinks his work is more than just a job. This can be described as an institutional orientation towards the job (Soeters, 2000:467; 2006:241). This traditional institutional orientation is more and more changing towards a more occupational orientation (McKinlay and Marceau, 2002), this will be explained below.

Like soldiers, medical professionals have a notable position within society. They are on top of society's hierarchy (Schnabel, 1995). They are expected to act in the patients' best interest when they are consulted concerning the patients' health. In fact, they are obliged to do so since they have taken the Hippocratic Oath. The Hippocratic Oath is taken by physicians and other healthcare professionals swearing to practice medicine ethically. Medical professionals have the ability to decide on life and death through their actions and they have specific medical knowledge. Because of the massive information-asymmetry, doctors have power or professional autonomy. In literature, the situation in which one party is superior over the other party because of information-asymmetry is called a principal-agent relation.

Because of the explained information-asymmetry and for other reasons such as solidarity (Soeters, 1999); healthcare cannot be left to the free market. Some form of government intervention is necessary to guarantee healthcare for everybody. Healthcare is therefore partly paid for by the healthcare budget that consists of tax money; and it is collectively funded by insurance premiums. The available money is always a problem. People's demands are infinite whereas the budget is finite. Cost containment thus is always a hot issue within healthcare (Drummond et al. 2005). However, saving lives is often valued higher than saving money, at least among most medical professionals. Professionals want to perform their jobs and guarantee a patients' health and sometimes at all cost, but because of budget restrictions this is not possible and rationing choices have to be made. Rationing choices can put the medical professional offside and in literature this is referred to as the end of the golden age of doctoring (McKinlay and Marceau, 2002). This will be more thoroughly illustrated below.

To become part of the world of medical professionals, young students have a long way to go. First, they have to get their medical degree. During their education, the specific medical culture is already passed on. This is done by a long process of socialization and individualization and through separation from the 'outside world' (Witman, 2007:22). This process is within the medical world referred to as the 'hidden curriculum' (Witman, 2007:23). When they finally start working as a young doctor, they have to prove themselves all the time, so once they actually become medical

⁸ In this thesis, a medical organization is seen as a hospital.

professionals, this does not automatically mean they are 'one of them'. Experience and seniority play a big role in the hierarchy of medical professionals (Ibid.).

In the last decades, literature describes important developments concerning the medical habitus. The traditional medical organization is changing; it is becoming more occupational oriented; the medical occupation is more and more considered as 'just a job' and therefore has less control over the professional's life. McKinlay and Marceau (2002) argue the golden age of doctoring has come to an end. They describe eight interrelated reasons for the decline of de doctor's power; among others the bureaucratization of doctoring and the competitive threat from other health workers (McKinlay and Marceau, 2002). The golden age refers to the years after World War II, when new medical technologies were invented and physicians were "at the pinnacle of the health care field" (Timmermans, 2010). An increasing amount of money was being spent on healthcare. Financial incentives attracted third parties into healthcare which lead to even higher healthcare expenses. The increase in expenses lead to concerns about costs and regulations to limit costs were introduced (Ibid.). Sociologists detected a decline in professional power and wrote about proletarianization⁹, corporatization¹⁰, and 'deprofessionalization'¹¹ within medicine (Ibid.). More information is available for patients for example through the internet, organizations are becoming more transparent, patients themselves are higher educated etc. (Freidson, 2001). Linked to this 'assault on professionalism' there may be an assault on the traditional medical structure. Due to the changes in the management and due to introduction of management tools in the medical organization, there may be a development in structure (Witman, 2007). This is a development from the professional bureaucracy (Mintzberg, 2006) or clan (Ouchie, 1980) to a managed professional business (Witman, 2007). Julia Evetts (2011) also argues professionalism is experiencing some major changes, but she also believes there are continuities. She does not see the changes as an assault on professionalism but she believes in a new professionalism (Evetts, 2011). Evetts agrees with other authors such as Freidson, that there are changes in the structure of professionalism. She mentions the introduction of targets and performance indicators, work standardization and financial control. However, she argues relationship aspects have stayed the same. She points out professionals still have a certain prestige, respect, identity and work culture and the discretion to deal with complex cases (Ibid.). According to Evetts, the occupational value of a professional, which can be explained by a number of aspects such as collegial authority and discretionary judgment¹², is increasingly being used within management functions. "Professionals themselves as managers" is a new form of professionalism (Ibid.).

2.5 Military vs. medical habitus

In this final paragraph of the theoretical framework, the reader will be provided with a short comparison between the two habitus. This is done to provide some insight in the complexity of the relation between military and medical officers. Especially the aspects in which the description of the two habitus differ are expected to help explain the complex relation since deviating ways of thinking and acting will be excluded and seen as unthinkable, as was explained above (Jenkins, 1992:81). Just like the military organization, the medical organization is a bureaucracy. The difference is that the military bureaucracy is a machine one and the medical bureaucracy is a professional one. This means that within the military organization, hierarchy plays a bigger role and decision making is centralized. For the medical organization, this means the system relies more upon the specific knowledge of the professionals.

⁹ the idea that people move from self-employment to wage labor.

¹⁰ turning health care into a profit-maximizing corporation.

¹¹ the loss of professional characteristics such as autonomous decision-making.

¹² See appendix 1 for a complete overview of aspects that help to explain the appeal of professionalism as a managerial tool.

The military and the medical organization both have a specific culture, but the perspective on culture is different. The military organization fits best to the integration perspective, whereas the medical culture fits best to the differentiation perspective. This means the military organization has a more homogeneous culture and the medical organization is more based on sub-cultures. This perspective on culture does not seem to matter much for the orientation towards the job, since both military and medical persons seem to value their job as more than just a job. This can be described as an institutional orientation towards the job (Soeters, 2000:467; 2006:241).

A similarity is that, concerning the position within society, both military and medical persons have a notable position. Soldiers enforce power and respect, because they have the ability to punish and use violence and because they risk their lives for others. Doctors on the other hand have power because of their specific knowledge and because of their influence on patients' health. Another similarity is the fact that both within the military culture as well as in the medical culture, money does not play an important role. Soldiers and medical professionals want to perform their tasks at whatever costs; they do not seem to feel limited by budgets. However, there is a budget and it is limited and this means for both groups that containing costs and rationing is inevitable. Another similarity is the path of becoming a soldier or a medical professional. Both paths consist of a long process of socialization and individualization and through separation from the 'outside world'.

Finally, the traditional view on both occupations has changed over the past decades, according to literature. The military culture becomes less institutional, hierarchical and discipline oriented. The organization is changing towards a professional bureaucracy; it is more depending on its skilled, professional employees. Also it is becoming more businesslike (Soeters, 2000:479). The medical culture is also changing; the role of professionals is changing (Evetts, 2011) and the organizational structure is changing from a professional bureaucracy (Mintzberg, 2006) to a managed professional business (Witman, 2007). Both occupations are thus subject to influences from the business-sector; this may result in worries among elder medical professionals and soldiers. They may fear a shiftwork mentality (Szymczak et al, 2010).

After this first description of the habitus on the basis of literature, the military and medical habitus appear to match on the aspects of orientation towards the job, status or position within society, cost awareness, the process of socialization to become part of the occupational group and the recent developments. The habitus mainly differ as a result of a different organizational structure. In the military organization, hierarchy and centrally made decisions play a big role, whereas in the medical organization professionals have a big influence because of their specific knowledge. Furthermore, the habitus differ on the aspect of culture. After this short comparison it is now expected that culture and the different organizational structure play an important role in explaining the complex relation, which corresponds to the expectations that were described in the introduction.

3. Research methods

This thesis answers how the complexities in the occupational relation between medical and military officers can be explained and to what extent these complexities affect the decision-making process. The following chapter comprises how this research was realized. This research is designed as an exploratory research. An exploratory research is characterized as a way of unearthing new theory from constantly searching and comparing empirical data and theoretical concepts, rather than from a predisposed hypothesis (Verschuren et al., 2007: 192). It is a type of research for a problem that has not yet been clearly defined and it should draw conclusions only with extreme caution. The results of exploratory research can provide significant insight into a given situation and this methodology is also referred to as a grounded theory approach to qualitative research or interpretive research. Questions that are asked often start with 'why' and 'how' (Ibid.).

3.1 Data collection

Data collection for this qualitative research (Boeije, 2005) (Wester and Peters, 2004) was done through interviewing. Semi-structured¹³ in-depth face-to-face interviews were held with 12 respondents; among who were seven military officers and five medical officers. In this research they are referred to as military and medical respondents. These respondents were carefully chosen which resulted in a wide variety of officers who are an accurate reflection of the officers within the Dutch Medical Corps. Among the respondents were two officers that are both very familiar with the military as the medical part of the job: one of the military officers has a background as a medical officer and one of the medical officers participated in elite military trainings and exercises. Interviewing these officers was of especially high value for this research, because they were, more than others, able to describe why the relation between the two types of officers is complex. Due to the combination of chosen respondents, information from different perspectives could be collected. A total list of respondents along with details concerning their experiences can be found in appendix 5. Variety among the group of respondents was a criterion. Other criteria were for military officers that they must have recently been in a situation in which they were in command of medical officers; and for medical respondents that they must have recently been in a situation in which they were under the command of a military officer.

On the basis of the theoretical framework and the research questions, a topic list was created that served as a guidance to structure the interviews. Topics that were discussed are:

- Experience with working together with the other category of officers;
- Possible difficulties in relation with other category of officers;
- The theoretical description of the habitus; do they think it is right?
- Differences and similarities between the medical and military habitus;
- The influence of the complex relation between the two categories of officers on decision-making;
- Ways in which working together is made possible.

Because these topics were addressed in all interviews, this study's validity was increased (Boeije, 2005). The topic about the influence of the complex relation on decision-making was insufficiently addressed in the first five interviews. The respondents were asked whether medical respondents can affect the decision-making process instead of whether the quality of the relation between medical and military officers can affect the decision-making process. This means the right question with regard to this topic was not asked in the first five interviews. Therefore, this question was later asked by using e-mail. Because this time, the question was formulated more accurate, answers were more

¹³ All interviews were semi-structured leaving room for interviewees' narration while still being able to focus on topics relevant or the various research questions.

useful. Furthermore, the medical respondents were asked whether they believe they have adapted military characteristics. It was interesting to hear whether they see themselves as purely medical professionals or maybe also as soldiers. Right before the interview, the respondents were asked whether they agree with recording the interview. An advantage of recording is that, during the interview, the researcher can focus on the respondent instead of on making notes. Furthermore, when the interview is recorded, the researcher will have the respondents' complete answers instead of just some notes. This increases the validity of the research.

3.2 Data-analysis

After finishing all 12 interviews, the interviews were transcribed using the recorded interviews. This is done to increase the research's validity. After transcribing, the encoding process started. During this process, the information in the interviews was divided in topics or codes (Boeije, 2008). A code is a short statement that captures the essence of a text fragment (Boeije, 2008: 85). This process of encoding enables the researcher to get a clear view on the data. Moreover, this process makes the data manageable (Boeije, 2008). In order to be able to analyze the data and to draw conclusions from it; the codes were subsequently entered in a data matrix. The codes were entered on the horizontal axes and the 12 respondents on the vertical axes. In this way, it was easy to read off what is remarkable and important. Subsequently, the data matrix was used to write chapter 4.

3.3 Validity

A central issue in qualitative research always is validity or sometimes referred to as credibility or reliability. As qualitative research is aimed at gathering an in-depth understanding of human behavior, smaller but focused sample sizes are often preferred over large sample sizes. Qualitative methods investigate *how* and *why* questions and it is argued that the answers to these questions may differ when answered by a different sample size; critics thus have a problem with the validity of small sample sizes (Wester and Peters, 2004:191).

Validity always remains a discussion point in qualitative research, but several attempts have been made to increase the validity. First of all, triangulation or cross-examination¹⁴ was used. Literature from many different authors was used to create a theoretical framework. Subsequently, interviews were held with different occupational groups, military and medical officers, to increase the validity of the interview outcomes. The respondents were carefully chosen which resulted in an accurate reflection of the officers that work for the medical corps. This positively affects validity. Second, validity was also increased through fully transcribing interviews from tape recordings; because of this no data gets lost or interpreted wrong. This also positively contributes to this study's validity. Third, validity was increased through asking all respondents the same questions in the same way and through using data matrices for the data analysis.

¹⁴ Triangulation is often used to indicate that more than two methods are used in a study with a view to double (or triple) checking results. This is also called "cross examination" (Verschuren et al., 2007).

4. Results

This chapter comprises the results and the analysis of the interviews¹⁵. In the first paragraph the found complexities in the relation between medical and military officers will be thoroughly explained. The following paragraph, 4.2, is focused on the concept of habitus. First, an explanation of the military habitus for officers working in the medical corps is presented, followed by an explanation of the military medical habitus. Moreover, the two habitus are compared. Finally, in paragraph 4.3, results are presented on how military and medical officers manage to work together and on how their relation affects the decision-making in military medical units.

4.1 A complex relation

In the introduction, the complexity of the relation between military and medical officers was already shortly explained. This paragraph presents the results of the complexities or friction points that are encountered; in practice four possible causes for friction were found through interviewing the 12 respondents. These are conflicting interests, culture, organizational aspects and hierarchy; these four causes are very much intertwined. This paragraph will be concluded with some remarks about how the complexity of the relation also depends on the setting.

Conflicting interests

The relationship between medical and military officers is first of all complicated because of conflicting interests. Something can be in the best interest of a patient and at the same time be bad for a military medical facility and vice versa. All respondents explain this conflict of interests is caused by the assignment of a medical unit during a mission which conflicts with medical ethics. On the one hand, it generally is the task of a medical unit to support soldiers. This means the medical unit on a mission, a military medical facility, is often not allowed to treat locals. On the other hand, the medical officers or medical specialists who work in the military medical facility have a duty to help injured people; they have taken the Hippocratic Oath. The Hippocratic Oath is taken by physicians and other healthcare professionals swearing to practice medicine ethically. Obviously, this oath can conflict with the military assignment, making a conflict almost inevitable. One of the military respondents witnessed such a conflict while being the commanding officer of the military medical facility in Tarin Kowt, Afghanistan:

I remember a situation in which a prisoner of war (POW) was treated in the military hospital in Tarin Kowt. This POW was treated in a separate room. Naturally, I did not want the POW to share a room with NATO soldiers. Therefore, the POW was a burden for the hospital and I suggested an early discharge. The doctor, a medical officer, did not agree to this. To him, this POW was a normal patient. The POW stayed for a few more days, but was still discharged early (Military respondent 9).

This quote makes it clear how both groups of officers give a different meaning to the same situation. Because of the Hippocratic Oath, the doctor will do anything to help the patient. This means time and means do not matter. In fact, it would be wrong to account factors such as costs and time etc. This view mainly stems from the professional disposition: the doctor feels responsible for the treatment of the patient. This responsibility conflicts with the responsibilities from the commander. The commander's goal is to use time and means efficiently for the benefit of more patients and to protect the own colleagues. Both groups thus argue on whose responsibility is more important; both try to affect decision making with it.

Besides the above described conflict of the military assignment and medical ethics, the medical officers mention another conflict of interests, which takes place in peace time. The two GPs and the health and safety doctor say it is difficult to combine the treatment of patients with the keeping up

¹⁵ An overview of the 12 respondents who were interviewed can be found in appendix 5.

of military skills and the medical support of a military exercise. Military GPs and health and safety doctors are comparable with their civil consort; they see patients every day on appointment. This makes it difficult for them to do the medical support of a military exercise on short notice, the annual physical test or keeping up with military skills. This conflict of seeing patients or being a doctor on the one hand and being a soldier and thus part of the military on the other hand hinders the relation between medical and military officers. In practice, this situation is very difficult for the doctor's military commander since he or she is always in a struggle to make sure exercises and physical tests do not interfere with the doctor's day to day work. It is thus hard to schedule military activities for the medical officers. The latter affects the embeddesness of medical officers in the military, since they often do not compete in military activities and as a result of that, they are not completely familiar with military proceedings.

Occupational Culture

A second factor that affects the relation between medical and military officers is culture; friction might arise when officers are not aware of or do not take into account the other officer's culture. Chapter 2 has shown military people have a common culture. The military officers say it irritates them when medical officers are not familiar with this military culture, the military proceedings and habits. An important element of the military culture is discipline. Discipline can cause friction when military officers feel discipline is low among medical officers. According to them, this lower discipline shows in physical appearance: medical officers wearing the wrong uniform or wearing the uniform wrong. Military respondents often mention their dissatisfactions about medical officers; a young officer who was commanding the Dutch military medical facility in Kunduz, Afghanistan says:

In Afghanistan, a five feet long medical officer borrowed a coat from a six feet long colleague and wore this far too big coat during a ceremony. I just do not get that, I mean, what was she thinking while doing so!?! (Military respondent 3).

This quote illustrates medical officers are not always embedded in the military culture; this will be explained in more detail now. Medical officers often work alone and they often are the only medical officer around. They describe themselves as individuals in the military and the military officers agree to this. Some military respondents believe the medical officer's individualistic behavior causes irritations among military officers. They believe these officers are individualistic and often self-centered. The military respondents say soldiers, on the other hand, are team players par excellence and individual behavior is not appreciated. A medical respondent confirms medical officers are individuals: "we are individuals and they (military officers) should let us do our jobs individually (Medical respondent 6)." The medical officers believe investing more in becoming part of the culture and the team might make the cooperation easier. However, they say they stay on the side on purpose:

The distance we (medical officers) have is functional. It makes us more objective as doctors; it lets us do our jobs better. It also makes it easier for soldiers to come to us, since we are not really part of the team, they can easily come to us with problems without feeling ashamed (Medical respondent 7).

This quote shows medical officers believe being an outsider positively affects the quality of their work. They are aware of a difference between medical and military officers, but they believe this difference enables them to better perform their tasks as a military doctor. Medical officers more often consciously deviate from their military colleagues in order to perform their medical tasks better. They say they generally try to work according to the military discipline. However, sometimes they believe military discipline is irrelevant and not functional and they then deviate from it. This suggests military discipline is not embodied in their culture; they can step away from it for example when they believe it allows them to better perform their job. A medical respondent illustrates this by

describing a situation during a mission in Afghanistan. During the mission, medical officers sometimes visited Afghan patients in their own houses:

When I see a patient inside their own house, I do not want to wear my bulletproof vest and helmet. I cannot do my job wearing that heavy gear and also I believe such things create a certain distance. When I do not see direct danger, I will decide to take them off. That irritates my military commander (Medical respondent 6).

This quote shows medical officers carefully consider when to follow military discipline. They tend to make their own decision in this and that makes them different from most soldiers. Soldiers are more inclined to follow up orders, whereas doctors are more inclined to critically appraise such an order. This shows a difference in between military and medical officers. Overall, it can be said that medical officers often are not fully embedded in the military culture. They usually do not participate in the 'military life': they do not go on military training etc. and as a result of that, they never really acquire the military culture and they stay the 'odd one out'. The medical respondents all believe there is a difference in discipline between military and medical officers and according to them discipline can be a reason for friction.

Besides this difference in discipline, the interviews show both officers believe the way of approaching each other can cause friction in the relation with the other category of officers. Some military respondents for example believe it is wise to approach the medical officers different than the military officers. They believe the military way of approaching people can be experienced as blunt by medical professionals. They believe this is caused by their nature of being critical and their social status. Therefore typical military behavior, such as the use of military slang and their tough attitude, is unwanted and would cause irritations among the medical officers.

Yet, the medical officers say friction is caused by the fact that military officers do not treat them as full part of the military organization. This might mean the adjusted approach, which was explained above, in fact causes irritations! Medical respondents sometimes feel as if they are not accepted and appreciated as a part of the military organization. The medical respondents state military officers refer to themselves as "the green part" of the organization and to the medical officers as "the white part". These terms refer to the colors of the officers' uniforms and even though nowadays both medical as military officers usually wear green uniforms, medical officers are still referred to as the white part of the organization. The differentiation that is indicated with by these terms implies military officers believe medical officers are not fully part of the military organization, which already shows that there is friction:

We also are part of the military and belong to the green part. We also go on missions but they (military officers) say we are different (Medical respondent 6).

A medical respondent is very upset with this subject. The respondent believes there are differences between medical officers and that some medical officers are well aware of the military habits. It irritates the respondent that military commanders simply assume that medical officers do not have a clue. This example suggests some medical officers are more embedded in the military culture than others, but also that medical respondents do not feel accepted as a part of the organization. In the end, it is clear that there are differences in culture between military and medical officers and that these differences can lead to mutual irritations.

Organizational aspects

The relation between military and medical officers is also thwarted because of organizational aspects. The respondents mention the relation between medical officers and military officers is hindered because they often do not know each other before going on a mission together. The two

categories of officers often get to know each other a few weeks before a mission and only get to train together for a few days. Both medical officers and military officers say this causes irritations because of different working methods and expectations. A medical officer, who was attached as a doctor to a military team that was assigned to go on a mission, said it was difficult to join the team last minute: “they already had plans and established certain working methods and I did not always agree to their methods (Medical respondent 7).”

Besides this, commanders of a medical facility, often get to work with two or more medical teams. This means a medical team with a surgeon and an anesthetist changes after a month or two. This means working with another team with different working methods which can lead to irritations on both sides. The commander of the military medical facility in Kunduz says: “I was in Kunduz (Afghanistan) for quite a while and this new doctor arrives and he has new ideas about the location of the ambulance, that is aggravating (Military respondent 3).” A medical respondent also finds the rotations of personnel irritating. The respondent says it is annoying that the hospital commander in Afghanistan changed every four months: “the hospital teams had to reinvent the wheel every time a new commander arrives (Medical respondent 11).”

The unfamiliarity with team members before going on a mission and the rotation of teams while on a mission is difficult for both military and medical officers. In both situations, the new medical or military officer will be confronted with a team or a commander that is already set and that is used to do things in a certain way. It will therefore be very difficult for the newcomer to make changes, also when those changes would mean an improvement. Furthermore, the newcomer is often not immediately accepted; he or she first has to gain confidence. Added up, these organizational aspects affect the relation between military and medical officers and make it complex.

Hierarchy

Hierarchy is inherent to a military organization and it is also strongly embedded into the culture of the military. Hierarchy is an important and interesting factor to affect the relation between military and medical officers; therefore it is discussed separately now as the fourth factor that contributes to the complexity of the relation between the two types of officers.

The problems with regard to hierarchy were already discussed in the introduction. All respondents mention the complexity of a lower ranked military officer in command of a higher ranked medical officer; they agree this can be a reason for friction. The military officers explain the problem arises because medical officers are given ranks that do not necessarily correspond to their tasks. Normally, in the military, a rank corresponds to a task. A lieutenant usually is the commander of a small unit: a platoon. The higher the officers' rank, the bigger the unit he or she commands¹⁶. This means a higher rank is accompanied by more status and military officers usually have a high regard for higher ranks. As was mentioned above, hierarchy is embedded into the military culture. Addressing a higher-ranked officer in a different way than a private goes without saying; the consequences of the hierarchic organizational structure are strongly embedded into the military behavior.

A high rank raises high expectations with regard to for example military discipline and knowledge, but also with regard to responsibility for a big military unit. This usually does not hold up for medical officers; they often do not behave according to the expectations military officers have with regard to high ranks. Although medical officers are field officers, they are usually not in command of a big military unit. This can be confusing for other soldiers, since there is no visible distinction between military and medical officers. There are many cases in which medical officers were mistaken for an important commanding officer. A military respondent explains an example of such a situation in Tarin Kowt, Afghanistan:

¹⁶ See appendix 2 for an overview of military units and the corresponding ranks of the commanding officers.

A high Dutch commanding officer, a colonel, was discussing a military campaign with another colonel. The commanding officer thought he was talking to the commanding officer of the Dutch hospital in Tarin Kowt, while in fact he was talking to a surgeon (Military respondent 10).

To solve this part of the problem, some military respondents mention they want to make a clear visible distinction between military and medical officers. They say countries that already do this no longer have these problems of confusion. The military respondents also state that a problem arises when medical officers try to derive power from their medical education and high rank, and wear their rank with pride. A respondent explains the Belgians give their medical specialists lower ranks; Belgian medical specialists are therefore said to be more down to earth and consequently the relation with their commanding military officer is less complex. The Belgian example suggests higher ranks affect the Dutch medical specialists' behavior in such a way that they are inclined to use their rank as a means of power. Since medical officers often do not live up to the expectations military officers have with regard to high ranks; this way of dealing with a high rank is not appreciated by the military officers.

The medical officers state that a problem can occur when a military officer commands a higher ranked medical officer; and thus uses hierarchy as a means of power. One of the medical officers, a GP says:

That snot-nosed young lieutenant thought she could tell me what t-shirt to wear. She should have known better, you cannot tell an old man what to do just like that (Medical respondent 6).

In this example, a subaltern officer is in the command of a field officer, as was explained in the introduction. This quote shows this unusual situation is not just difficult for military officers, but also for medical officers. It can be hard to accept that an often younger and lower-ranked officer is their superior. Some medical respondents believe they are not treated with the amount of respect they deserve; they do not feel accepted in the military organization. A medical respondent says:

Military officers treat the medical officers as if they do not have any military knowledge. This might be true for some medical officers, but many medical officers are very well acquainted with the military. Military officers not making this distinction cause irritations (Medical respondent 11).

Medical respondents furthermore argue the military hierarchy has a pitfall since it is such a formal hierarchy. According to the respondents, this formal hierarchy blocks open communication and can therefore result in missing out on important information. The officers state the medical teams do behave in an informal manner which is necessary, because in an informal setting, people will not hesitate to pass on information to each other. As opposed to what is expected from literature (Witman, 2007:12), this shows medical officers behave less hierarchic than military officers.

A problem that often goes together with hierarchy is the division of tasks within a military medical unit. Most military officers believe the role of the medical officer is strictly an advisory one, despite their rank. They believe medical officers should not interfere with anything else besides the medical content. According to them, medical officers are only responsible for patients and for all things that require medical knowledge. According to the medical officers, military officers should not interfere with the primary care process. They believe military officers are responsible for among others logistics and the location of a military medical facility. It causes friction when officers interfere with each other's responsibilities, but it is very hard to prevent that from happening since responsibilities overlap. What are the things that require medical knowledge? Does that include ordering medical

supplies? Or is the latter the military officer's task since it can also fall under logistics? This shows it is often unclear who is responsible for what, and that often results in friction. In practice this can result in some things being done twice and some things not being done at all. To conclude, despite the fact that hierarchy can be useful when a decision has to be made on a split-second; it is also often a reason for irritations among the two categories of officers and therefore makes the relation complex.

After carefully studying the relation between military and medical officers, it is now clear their relation is a very complex one. However, the extent of the complexity depends on the setting. The respondents believe their relation with the other category of officers is even more complex during peace keeping missions than during peace enforcing missions. They believe this because the type of mission, peace keeping or peace enforcing, is a good indication for the amount of workload; and they believe the workload affects the complex relation. The respondents associate peace enforcing missions with a higher workload. When the workload is high, people focus on their tasks and there is no time and space for regulations and discussion; people tend to cooperate better. The respondents refer to the mission in Afghanistan as a peace enforcing mission and say chances are that such a mission often goes together with a higher amount of casualties and insecurity. Therefore the relationship between medical and military officers tends to be better in a peace enforcing mission. When the workload is lower, especially during peace keeping missions, there automatically is more room for discussion, formalities and regulation. This results in more mutual irritations between the two categories of officers. Medical respondent 7 says 'understress¹⁷' is more dangerous than stress and this has a negative impact on the relation between the medical and the military officer. Obviously, this also applies to other relations between other officers and to relations in general.

To conclude this paragraph, military and medical officers have a complex relation with a lot of deep-rooted differences. Some of these differences are that medical officers do not follow orders as easy as military officers do; they are more inclined to critically appraise an order. Furthermore, on the basis of the Hippocratic Oath, medical officers will do anything to help a patient, whereas military officers on the basis of the military assignment feel responsible for their colleagues. Finally, hierarchy and military discipline are embedded in the behavior of military officers, and not so much for medical officers. These differences will be analyzed in more detail in the next paragraph.

¹⁷ Understress can be understood as the tension people are confronted with when they are structurally employed below their capacities. This type of stress is thus not a result of working too hard, but of doing work that has no challenge.

4.2 Two conflicting habitus in the medical corps of the Dutch army

At first glance, the four described complexities with regard to conflicting interests, occupational culture, organization aspects and hierarchy, seem to correspond with the more general difficulties of managing medical professionals, as described in chapter 2. However, after analyzing the interviews the theory of managing professionals does not seem to be quite right for the relation between military and medical officers. Of course, the medical officers have a lot in common with the civilian medical professionals; the medical respondents say they their focus is on patient care and obviously they are characterized by specific knowledge. The military officers can be seen as third parties that focus on the entire process around patient care with the intent of providing care to military casualties. However, difficulties regarding managing professionals seem to be smaller in a military medical facility as opposed to a civil hospital. The respondents believe this is because a military facility is a lot smaller and only a small group of people are working there. They say there is only one team and the team members (both military and medical officers) are closely involved with each other and each other's work. Furthermore, they mention all team members are part of the military and they go on exercises and missions together and they seem to have a common goal, which they say is providing good care for "the boys and girls that risk their lives out there (Respondent 1)". What also seems to make a difference is the fact that the military is a non-profit organization with a government budget. As a result of this it seems that the military managers are less concerned with the financial aspects, compared to the managers as described in chapter 2 of this thesis and the description of managers by Witman (2007:174). After analyzing the interviews, it is expected that this lower concern for financial aspects may also be caused by the fact that military managers are closer to the process of patient care, because of the small scale of the medical facility. And by the fact that they feel connected to a wounded colleague; they might focus more on patient care compared to civilian hospital managers. It seems medical professionals working for the military feel less constrained in their autonomy; a medical respondent says: "we are not 'bothered' with legislation on efficiency that much (Respondent 11)." Quality of care is something that has the same amount of attention as within civil hospitals. However, whereas in civil hospitals the management interferes in quality of care with legislation on quality; in a military medical facility it is mainly the medical personnel that vouch for quality of care (Hahné, 2010).

Theory with regard to managing professionals thus seems not to be right for the relation between military and medical officers; will the concept of habitus perhaps help to better understand the complex relation? The concept of habitus can be explained as a set of socially learnt dispositions, skills and ways of acting, that often go without saying. A habitus is acquired through activities and experiences of everyday life. It is a product of in the past received dispositions; and through common circumstances a common habitus can originate within a group of persons. The concept of habitus brings a pattern to social life (Witman, 2007:38); this means it gives insight in how people think and act. Explaining the habitus of military and medical officers and their differences is therefore likely to help explain their complex relation. In this paragraph, the habitus of the military officers will be explained first. Subsequently, the habitus of the medical officers will be explained and compared to the habitus of the military officers.

The habitus of military officers working in the medical corps of the Dutch army

In chapter 2, a general description of the military habitus was given on the basis of nine different aspects. The biggest part of this general description seems right for military officers working for the medical corps of the Dutch army. However, there are some differences and these differences as well as remarkable points are discussed in this paragraph.

As was mentioned in chapter 2, hierarchy is important for the officers working in the medical corps; the respondents say it is crucial to have one person taking the lead, especially in stressful and threatening circumstances. Top-down communication in such a situation is very useful and prevents from chaos, stress and insecurity. According to the respondents hierarchy brings order and structure;

but it must always remain a remedy and not a goal. The respondents say there also is plenty of space for informal contact; addressing each other by first names or making critical remarks is possible. They believe hierarchy preferably not becomes a substitute for logic reasoning. Literature describes the military habitus is characterized by a strong notion of hierarchy; this seems not necessarily to be true for the habitus of military officers working for the medical corps. The officers do value hierarchy; but depending on the circumstances, informal communication is possible and sometimes even preferred.

The same goes for discipline; when the military respondents are asked about discipline, they say they highly value it. The respondents think discipline is a remedy to prevent from problems in other areas. They say discipline is critical because they depend on each other. Physical appearance is an important aspect of discipline within the military, because “we are the army’s business card and it is important to look professional (Military respondent 10).” The respondents believe low discipline sends out a negative signal. Although the respondents agree on the importance of discipline, they also agree there are certain limits to it:

Discipline must be useful. Normally I want my people to wear a correct uniform, but whenever it is functional to take off their jackets while treating a patient, they can do so. As long as they wear it whenever they go outside the hospital. There are moments in which discipline, or at least physical appearance, has a lower priority (Military respondent 9).

This means discipline is an important part of the military officer’s habitus, but as was the case with hierarchy, they are willing to step away from it when it seems dysfunctional. Discipline in one aspect of the military culture and as was also explained in the theoretical framework, all respondents agree they have a common military culture. One of the respondents nicely illustrates this by saying all soldiers are “made out of the same mold (Military respondent 10).” The respondents thus agree a military culture exists, but they also see there are different subcultures within this culture. They say there is a big difference between the navy, the air force and the army, but also within the army, for example between the infantry and the medical corps. This view indicates the right perspective on military culture might actually be the differentiation perspective instead of the integration perspective (Soeters et al., 2006:239), which the majority of literature on military culture suggests (Ibid.). It seems there are differences in habitus between for example infantry and medical corps¹⁸. So we may say that within the military habitus there are some slight differences.

Despite the differences between the different branches, military officers working for the medical corps form a group; when the military respondents were asked to describe themselves they all gave short answers and many of them started by saying they are transparent, honest and straight to the point. Most of them describe themselves as social and righteous; another term that was used to describe themselves was disciplined. When they were asked whether they see themselves as soldiers, all respondents stated they do. These matching descriptions confirm military officers are a group and are indeed ‘made out of the same mold’. They say they have a strong connection with the military, also after work hours; this confirms the institutional orientation toward the job. Most respondents believe their job is without a doubt a way of life; but it differs per function: “I now have a desk job. Previously, when I was a platoon commander, my work felt more as a way of life (Military respondent 9). The respondents do agree this institutional orientation is changing towards an occupational one. When the respondents are asked why they started working for the military, they all start by saying the variation in the job is what attracted them. They mention they were attracted by the adventure, being outside and staying fit in combination with an academic training. Furthermore they mention they want to work with people. They also believe they have personally

¹⁸ And maybe even between units of the medical corps that support infantry units and units of the medical corps that support cavalry units, but for the sake of clarity that is not taken into account in this research.

changed because of their jobs; they believe the military service has become a part of their individual lives. Their goal is to provide care for the 'wounded warrior'.

Literature suggests the military organization has a special position within society (Wilson, 2008). The military respondents however argue this is certainly not the case in The Netherlands; the medical respondents agree to this. According to the respondents, the status of a soldier differs per society and in time. The respondents say, at this moment, the military has a very low status in The Netherlands and they regret that. They argue their status is low because the Dutch society does not know what the military exactly does. "They only see us whenever a dike breaks and soldiers are filling sandbags (Military respondents 5 and 10)." Most respondents believe Dutch society sees the military as an item of expense, because they do not see the relevance.

When the respondents were asked about cost containment and cost awareness, their answers show a lot of variance. Some respondents believe soldiers and also the military as an organization are becoming more cost aware. Other respondents say there is a difference between missions abroad and exercises back home. They believe cost awareness is low during a mission, because soldiers then feel entitled to all available resources since they are 'out there'. Another respondent adds that cost awareness can also differ per person; the respondent believes officers are more cost aware than privates. A few respondents do not believe soldiers are cost aware, "and yesterday I witnessed that that can even apply to a commodore¹⁹ (Military respondent 9)." Most of the medical respondents also do not believe the military is cost aware. Cost awareness thus is not an important part of the habitus of military officers working for the medical corps; this confirms their goal is to provide care for wounded colleagues instead of focusing on the efficiency of the process.

The respondents agree external influences have a big impact on the military. They mention the changed conditions for employment and societal changes as the main causes. These influences resulted in employers not accepting irregular working hours anymore. Soldiers nowadays want to go home at 5 o'clock, because they have families to take care for. Previously, those families would live with them and move with them from one place to another. Nowadays that is impossible, since most women also have jobs. This tendency of going home at 5 o'clock is strengthened by the fact that soldiers feel they do not get much in return for their hard work. A military respondent illustrates this:

There are soldiers who were sent abroad 6 times in 10 years. They were divorced twice and the military now says they do not need them anymore. That does not stimulate working hard (Military respondent 9).

The respondents say this change has a big impact on the military culture. They believe the culture is not as close as it used to be. Soldiers are more and more becoming normal colleagues and less comrades. The respondents say a way of life also does no longer apply to the military that much. They also mention the military is outsourcing a lot. They mention the canteens are now run by a for-profit company. But they also mention the partnership between the Dutch military and several hospitals across The Netherlands, as was explained in the introduction. The respondents furthermore say the military has invested a lot in education and in the introduction of protocols for quality improvement in the medical corps. These changes confirm the development that was described in paragraph 2.3 and these developments show the military habitus is subject to change. It seems they make the military habitus more comparable with the military medical habitus; this will be further explained below.

¹⁹ A commodore is a military rank used in many navies. It is comparable to a one star general, or a Brigadier General.

To conclude, it is shown that military officers working for the medical corps of the Dutch army have their own habitus. For the bigger part this habitus matches the general description of the military habitus presented in chapter 2, but sometimes it is slightly different. Military officers working for the medical corps are more moderate with regard to i.e. hierarchy and discipline. Infantry officers for example often value those points more; they will step away from it less easy²⁰. This means there is a common military habitus in the Dutch army; but within this habitus there are differences between officers from different branches.

The habitus of medical officers working in the medical corps of the Dutch army

In chapter 2, a general description of the medical habitus was given on the basis of different aspects. This paragraph presents the results of the habitus of medical officers in the Dutch army; the military medical habitus, using the same aspects. Furthermore, a comparison is made with the military habitus which was explained above. The medical respondents say they, just like the military officers, have a hierarchy. However, their hierarchy is much more based on age, experience and knowledge. They say they preferably do not use military hierarchy or any form of hierarchy, instead they use logic reasoning. One medical respondent says:

I cannot shut down my mental capacity like many soldiers can; I do not just give or follow orders like that. Actually it is praiseworthy how they do that (Medical respondent 8).

In their opinion, hierarchy, especially the military hierarchy, can be an obstruction for open communication. Therefore, they say their hierarchy is not very strong and allows informal communication. This hierarchy differs from the military hierarchy, but it also differs from the civilian medical hierarchy; the civilian medical habitus depends more on hierarchy than the military medical habitus. The number of medical professionals working in a hospital may be an explanation for this difference (Mintzberg, 2006:202). The number of medical specialists differs a lot between these two medical facilities, and in case of a big group of specialists, hierarchy might be essential for the organization.

The habitus of medical officers thus differs from the military habitus on the aspect of hierarchy. Both military and medical officers work with a certain hierarchy, but the military hierarchy still seems to be more top-down and formal than the medical one. This different habitus on the subject of hierarchy is the cause for some of the problems regarding hierarchy as a friction point. Since the military habitus is more focused on hierarchy; military officers believe they can derive power from this hierarchy. This can lead to irritations among medical officers, since they are afraid hierarchy blocks open communication. Furthermore, they simply are not very pleased by top-down communication. This means this difference in habitus is the reasons for a part of the friction regarding hierarchy. However, the biggest problem with hierarchy is the difference in military ranks between medical and military officers. This rank itself has no connection to the concept habitus. What possibly follows out of these ranks is certain behavior among the officers: medical officers wearing their rank with pride and military officers using their rank as an authority. This suggests that, although the rank itself is not part of the habitus, it does have a direct impact on the habitus. It seems a big part of the complexity concerning hierarchy can be explained by the different habitus.

When the medical respondents were asked about discipline, they say they value military discipline, but to them there are limits. They believe military discipline is important for safety aspects, but they say it should stay useful. The medical respondents agree they do not always comply with military

²⁰ This can probably be explained by the differences in working circumstances; infantry men usually work under more dangerous conditions in which i.e. hierarchy and discipline are highly valued. However, explaining the differences in habitus between infantry officers and military officers working for the medical corps is beyond the scope of this research.

discipline since in the end; their priority is with patient care. This suggest, at this point, their habitus agrees more with the medical than with the military habitus. One of the GPs illustrates this:

I agree physical appearance is important, especially since I am an officer. However, I do not care which t-shirt I am wearing, as long as it is clean (Medical respondent 6).

It seems military and medical officers are quite different with regard to discipline. Even though military officers sometimes decide to step away from discipline as was explained above, they still attach a bigger value to discipline than medical officers; especially to physical appearance. Medical officers carefully consider when to follow military discipline. They tend to make their own decision in this and that makes them different from most soldiers. Military officers become agitated when medical officers do not comply with certain rules concerning discipline; and medical officers feel irritated when military officers explain their uniform is incorrect or tell them what to wear or how to behave. This appears to be a difference between the two habitus and this clearly leads to irritations and makes the relation complex.

When the medical respondents were asked about culture, they say they do not have their own military medical culture. However, they also agree they are not fully embedded in the military culture; they refer to themselves as the 'odd one out'. This answer suggests the culture, as far as there is a culture, can best be described by the fragmentation perspective instead of the differentiation perspective, which holds for civilian medical professionals (Soeters et al., 2006:239). The respondents believe their behavior and habits are a mix of the military and the civilian medical culture. They say they do not belong to the military culture, because they usually have not had military training and cultivation. Neither do they feel equal to civilian doctors, since they have a different way of working. The military doctors say they are more independent and better able to cope with unknown situations. However, the respondents believe there are differences between professional medical officers, reserve medical officers and the medical officers who work for hospitals that have a contract with the military. The respondents believe professional officers are more embedded in the military culture than the other two types of medical officers. This also implies a fragmentation perspective. Professional officers are believed to be more embedded because they work for the military 24/7. They go on missions and military trainings, but they also experience day-to-day military life on a military base. This makes them more familiar with military proceedings, culture and habits; they are more embedded in the military habitus. Reserve officers and officers that work for the collaboration between the military and civilian Dutch hospitals tend to be more embedded in the civilian medical habitus; they have more experience in working for civilian hospitals and are more embedded in that culture. It seems as if there are differences in the military medical habitus.

When the medical officers were asked to describe themselves, they gave different self-descriptions. For example, one respondent mentioned to be straight to the point and another mentioned to mainly be a 'non-conformist'. This is very different from the military respondents; their self-descriptions did not vary much. This suggests medical officers are indeed individuals and this goes together with the lack of a common military medical culture. This makes the military medical habitus different from the civilian medical habitus and the military habitus. When they were subsequently asked whether they see themselves as soldiers, they answered they are a doctor in the first place. They refer to themselves as military doctors, but being a doctor comes first. This suggests they are more embedded in the medical habitus than in the military habitus. However, they add this can also depend on the situation: in some situations being a soldier stands out. One respondent explains:

Being a soldier stands out when a doctor has to improvise and perform medical actions in difficult circumstances. Because of that, military medical professionals differ from civilian medical professionals (Medical respondent 6).

Another respondent, a health and safety doctor with a lot of military experience says being a human being and a family man stand out. The respondent claims never to feel like a soldier but more like a doctor. Because of the amount of military experience, one would expect this respondent to feel more like a soldier. However, since this is not the case, this is a lead that medical officers are more embedded in the medical habitus than in the military habitus. Again, the respondents think there is a difference between the three types of medical officers. They believe professional medical officers will be more inclined to feel like a soldier than reserve medical officers. This again means professional medical officers are more embedded in the military habitus and the other two types are more embedded in the medical habitus.

Just like the military officers, the medical officers also believe the military has changed them. However, they are more skeptical. They believe a job always changes a person and they also say they believe the military just strengthened some of the personal characteristics they already possessed. The medical respondents say their goal is to provide good quality patient care to all patients. Just as with their civilian medical colleagues, the Hippocratic Oath has become part of their habitus. On the basis of this habitus, doctors will do anything to help the patient. This clashes with the military officers; on the basis of their military habitus, the military officer will use time and means efficiently for the benefit of especially wounded colleagues. This results in a conflict and it appears that a conflict of interests in fact is a conflict of habitus.

What is remarkable is that some medical respondents add that their focus also is more on the 'wounded warriors'. This can be illustrated by the following quote in which one of the medical respondents explains how a conflict of interests with a military officer can be solved or actually prevented. The quote regards the problem of having enough available beds for the benefit of military casualties:

The gate of the base would be locked, so local patients would be restrained from entering the hospital. When I never know about a patient and when I never see this person, I do not have to treat him or her (Medical respondent 11).

Closing the gate means doctors now do not have a responsibility over possible wounded locals standing at the gate. This means there will be no conflicting interests or responsibilities; closing the gate is a practical solution to prevent from difficult ethical problems²¹. It also becomes evident that medical professionals sometimes think along with military operations. The respondents explain medical officers think of lists of patients who could be discharged early in case of a large number of military casualties. A medical officer says:

Of course we make lists in the backs of our heads about which patients, either local or military, can possible be discharged early in case of a big amount of (military) casualties (Medical respondent 12).

The fact that medical officers see the closed gate as a solution to conflicting interests and the fact that they think of lists of patients who could be discharged early, makes it clear they want to come to an agreement with military officers; they are willing to give in a little to reach consensus. It also suggests they have different responsibilities besides providing care to any patient. It seems in this respect, they differ from civilian medical professionals, because this example demonstrates their focus is on supporting wounded soldiers. With regard to this point, the military medical habitus appears to have more in common with the military habitus.

²¹ One could also question whether closing the gate in itself is an ethical solution.

When the respondents were subsequently asked whether they see their jobs as a way of life, they unanimously say they do not. They say their work is just a job, although they do like it very much. This means they have an occupational orientation towards their jobs (Soeters, 2000:467; 2006:241) and this orientation seems to be related to the embeddedness of medical officers in the military organization. Although there are differences between the three types of medical officers, medical officers appear not to be fully embedded in the military. This embeddedness is especially lower for medical officers that do not work for the military fulltime and often do not have a lot of military experience; the amount of experience also appears to be related to the status. Doctors in the military earn more status when they have more military experience, especially experience in missions. They believe this experience makes them more embedded in the military culture. Furthermore, the respondents believe the amount of status they receive differs per individual. They say officer-cadets i.e. are more critical towards the medical profession than privates. Within the military, the respondents believe the development with regard to the loss of status, which is described in literature, is less present. They think this is because they usually are the only doctor available, especially during a mission. Some respondents think their status within the military has even grown, because of their life-saving work during the recent mission in Afghanistan. A medical officer says:

In Afghanistan, the medical corps has proven its effectiveness. This was the first mission in years in which soldiers had to entrust doctors with their lives and they witnessed what the military doctors are capable of (Respondent 11).

This quote shows there is a strong indication that the mission in Afghanistan resulted in an increased status for the medical officers. Afghanistan was the first mission in which the medical professionals were able to show what they are capable of; which is providing care under extreme conditions. The mission in Afghanistan showed the medical corps is indispensable and as a result of their good work they received respect.

When the respondents are asked why they started working for the military, they all include in their answer they are interested in traumatology and the variation in work the military offers. They say being a military doctor includes more than just seeing patients. They mention physical activities, advising military commanders with regard to the medical assistance and the 'adventure' makes their job interesting.

Another aspect that is used to describe the habitus of medical officers in the medical corps is related to money. According to literature, cost containment is a hot issue within healthcare (Drummond et al. 2005). Literature explains medical professionals by nature want to do whatever is necessary for a patient, but that nowadays they are becoming more cost aware. Within the military, some of the medical respondents say they are cost aware. However, they directly add military doctors are less cost aware than civilian doctors. They say this is because civilian GPs for instance, have to be cost aware because if they are not they will go bankrupt. Since military GPs also work as a civilian GP for one day a week, they often become more cost aware than other military doctors. On average, it seems medical officers, just like military officers, are not so cost aware and this suggests their habitus is driven by patient care and not by financial aspects. Therefore, financial aspects will play no role in their complex relation.

With regard to (recent) developments; both the military and the military medical habitus are subject to change; they both have been investing more in quality by focusing more on education and protocols. What is especially remarkable and interesting is the development among military officers: more shiftwork mentality, less commitment to the military culture and the military no longer is a way of life; this is a development towards a more occupational orientation. This development results in a decline of the gap between military and medical officers; the two habitus converge. According to the respondents, this results in a better relation with more mutual understanding:

“The military culture is changing or better: fading and it is slowly starting to show more resemblances to other cultures... This also means we now have more in common with the medical culture and this should result in an easier cooperation with medical officers (Respondent 3).”

However, the military respondents are a bit critical about this development; they do not see the development within the military habitus as a positive one, but they do believe in the improvement of the relation with medical officers.

To conclude this paragraph, it appears that medical doctors in the military, medical officers, have their own habitus. This habitus is slightly different from the civilian medical habitus as described in chapter 2; and will be referred to as the military medical habitus. The military medical habitus deviates from the civilian medical habitus on culture, hierarchy and the goal from military doctors with regard to patient care. The habitus deviates from the military habitus on hierarchy, military discipline, culture, self-description and the position within society. The military medical habitus seems to be a combination of the military and the civilian medical habitus. The mix of this combination appears to differ per type of officer; professional officers are more embedded in the military habitus and reserve officers and officers that work for the collaboration between the military and civilian Dutch hospitals are more embedded in the medical habitus.

In this paragraph the military and military medical habitus were explained and compared, and after doing so it seems the differences in habitus are linked to the complex relation between the two types of officers. The assumption that was made on the basis of theory about the concept of habitus holds. Theory describes a habitus makes social life predictable (Jenkins, 1992:)(Witman, 2007:37) and it was therefore assumed that explaining the habitus of military and medical officers would help explain their complex relationship. The assumption holds; the differences in habitus indeed helps to clarify the complex relation. What also clarifies the complexity of the relation is the extent to which the medical officers are embedded in the military organization. As was explained above there are three types of medical officers. Professional medical officers work for the military fulltime and reserve medical officers and the medical officers who work for hospitals that have a contract with the military only work part-time. The difference in work experience affects the embeddedness and a higher embeddedness of the medical officers in the military seems to have a positive effect on the relation with the military officers. Finally, it appears that the complex relation can be explained by the differences in habitus and the extent to which medical officers are embedded in the military organization.

4.3 Good decision-making by means of 'tinkering'

In the previous paragraph the habitus of the military and medical officers was described and compared. It was concluded that medical officers have their own habitus which differs from the civilian medical habitus; this habitus is referred to as the military medical habitus. Military officers also have their own habitus which for the bigger part matches the general description of the military habitus presented in chapter 2. The military habitus and the military medical habitus differ a lot; mainly on the aspects of culture, hierarchy and goals with regard to patient care. However, the two habitus seem to co-exist. Despite their different and even conflicting aims, beliefs, values and ways of behaving and acting the military habitus and medical habitus seem to go together. In this paragraph it will be explained how this is done.

Annemarie Mol (2010) uses the concept of tinkering to indicate how different values and ways of behaving and acting -she uses the word 'goods'- can go together in daily practice by ways of tinkering. With 'goods' Mol means the deeply held values and beliefs of what is right and wrong, and what should be strived for. Mol shows that such goods can be conflicting. She uses the daily practice of 'food' or 'eating' in a nursing home. Annemarie Mol points out that food has several values or goods which can be opposing. Food can for example be nutritious or tasty or go hand in hand with cosiness, but as Mol explains, these goods can conflict (Mol, 2010:216). Mol explains taste and atmosphere or cosiness are related; a better atmosphere makes food taste better. In the nursing homes, the atmosphere is for example created by colored napkins, but also by having a conversation during dinner. However, conversations only take place when the food and serving assistants sit with the people; by eating and talking together they can make a better atmosphere and thus affect the taste of the food. Unfortunately for the people, the assistants are also needed to help the people that are physically incapable of eating by themselves. This means cosiness is not available to those who are capable of eating by themselves. This shows nutritional values and cosiness clash; yet, in the daily practice of the nursing home these values or goods are tinkered with (Mol et al., 2010:13). This is for example done by offering dinner to the physically capable of eating together in the dining room at set times. In this way they can also enjoy the cosiness of a nice conversation with one of the assistants. The physically incapable are offered to eat later in their own room. In this way they get the support they need. A disadvantage is that they do not enjoy the cosiness of eating together with all the other people. Another disadvantage is that their food is usually already put on a plate; this means they have no choice about what to eat; which is another value of food. Mol explains the quality of care depends on reaching a compromise between more goods; quality of care is thus a matter of tinkering, of finding suitable solutions to situations at hand and bringing these together (Mol, 2010:226).

How is this example of food in nursing homes related to the military world? We may use the work of Annemarie Mol to understand how the military and medical habitus are brought together. Here we do not talk about food but about military operations and saving lives on the battlefield. In the relationship between military and medical officers, the most notable opposing goods are their goals: medical officers are mainly focused on good care for any patient, whereas military officers are focused on the entire (logistic) process around patient care with the intent of providing care to military casualties. Other opposing goods are the officers' ways of thinking and acting; for example their ways of communicating and their approach of discipline. How are these goods brought together in daily practice? The respondents show there are multiple ways.

One way relates to the way of communicating. Both military and medical officers say the communication with each other should be clear. They are aware of their mutual differences and therefore they believe they have to communicate about everything to make sure both parties are on the same side. The danger of not having open communication is a misunderstanding, since the officers are so different. This will be explained more; military officers say they are familiar with the fact that they are often perceived as blunt. Typical military behavior, such as the use of military slang

and their tough attitude, is not appreciated by medical officers and would cause irritations because it is different from the way of communicating they are used to. Therefore military officers say they take this into account while communicating with medical officers. They try not to be too direct and to avoid the use of typically military abbreviations; they even try to meet with the medical officers by talking in their language of medical terminology. The military officers say they are really focused on having good communication. This way of approaching the other type of officers suggests military officers are aware of differences between the two officers and that they are willing to come to an understanding; they want to reach a balance in order to be able to work together. This example shows that the two categories of officers have different ways of communicating that are tinkered with by putting themselves in the other officer's position.

Another way of tinkering is based on becoming familiar with each other and each other's strengths and weaknesses. The military respondents for example explain that they know medical officers are not always familiar with military proceedings; they are fully embodied in the military culture and they always are the 'odd one out'. The military officers say they often understand this. They believe the medical officers cannot be blamed for their ignorance and as a result they often accept it:

They (medical officers) often do not have a lot of military experience, because they only get military training a few days per year. That is not their fault. If there is someone to blame it would be the organization. The situation irritates me, but I understand it. Some medical respondents actually feel bad themselves about not being able to meet up with the expectations (Respondent 10).

Tinkering is also used with regard to discipline; in particular physical appearance. Physical appearance is very important within the army; one of the military respondents says: "we are the army's business card and it is important to look professional (Military respondent 10)." This means they believe bad appearance sends out a negative signal and both the military as the medical respondents agree medical officers often do not comply with the expectations with regard to physical appearance. However, as opposed to what one might expect this does not often lead to problems. Medical officers argue the rules with regard to their uniform are not always workable for them. They say it is often better to take off a jacket or a bulletproof vest whenever it is worn, because it enables them to move around the patient better. Military officers often understand the medical officers' arguments and they often allow them to wear what they think is best. They do add that they want all military personal to wear their uniform correctly whenever they go outside or to take protective measures, such as wearing a bulletproof vest, in case of high risk situations. This example shows that the opposed goods of physical appearance and the functionality of this physical appearance can go together by tinkering; by leaving space not to follow up on the highly valued habits of the military's physical appearance.

A way of tinkering that was explained in 4.2 is the fact that medical officers sometimes think along with military operations. In this case, the opposed goods are the officers' different goals. With regard to these different goals, military officers are tied to their military assignment and they need to ensure the availability of free beds in case of military casualties. In practice, this often means they order medical officers to discharge local patients early. Of course, discharging patients early is not in line with the Hippocratic Oath, but the medical respondents explain they think of lists of patients who could be discharged early in case of a large number of military casualties. A medical officer says:

Of course we make lists in the backs of our heads about which patients, either local or military, can possibly be discharged early in case of a big amount of (military) casualties (Medical respondent 12).

This quote shows patients will be discharged in case there actually are military casualties. In this way the good of the military officers is complied with; since military casualties can be treated when needed. However, patients are often not discharged early with precaution; the medical officers make lists but only use them in case of emergencies. In this way, not many patients are discharged early while military casualties can be treated. This example shows that by means of tinkering, both goods can be met.

Another way of tinkering also relates to the officer's opposing goals with regard to patient care. As was explained earlier, a conflict can arise with regard to the treatment of local patients. On the basis of the Hippocratic Oath, medical officers have to treat any patient. This can conflict with military officers since their good is to provide care to military casualties and they may not be able to make means available for the treatment of local patients. An ultimate way of balancing these two goods is to close the gate of the military base. Closing the gate restrains locals from entering the hospital and when a medical officer never knows about a patient he or she does not have the obligation to provide care. At the same time; the military casualties can get the care they need. This example shows that by means of tinkering there will be no (known) conflicting interests or responsibilities; closing the gate is a practical solution to prevent from difficult ethical problems. The fact that medical officers see the closed gate as a solution to conflicting interests and the fact that they think of lists of patients who could be discharged early, makes it clear they want to come to an agreement with military officers; they are willing to tinker to reach a balance.

It was explained how the concept of tinkering can balance opposing goods and it seems as if tinkering always is the solution to balancing these goods, but there also are disadvantages. Tinkering means that a consensus between two or more opposing goods is strived for and a consensus means that one or more goods have to 'give in' in order for a consensus to be achieved. In practice, this means that opposing goods for example with regard to patient care; the Hippocratic Oath versus the military assignment, will often not both be achieved. This was illustrated in the two examples about conflicting interests. In both examples, the good with regard to the military assignment is achieved; beds are available for military casualties. The good with regard to the Hippocratic Oath on the other hand, has to give in to reach a consensus; local patients are sometimes discharged early for the benefit of military casualties or are not even treated at all. Despite of these disadvantages, the two types of officers are able to create a balance by tinkering. In this way they reach a situation in which working together is possible; but the opposing goods will always remain next to each other.

It was explained above how the concept of tinkering can help to understand how the military and medical habitus can co-exist; and according to the respondents this results in a situation in which working together is possible and preferable. All respondents believe that the decision-making process in military medical units is best done together. The officers consider what options they have and this usually results in a joint and therefore supported decision. They believe in teamwork, multidisciplinary decisions and the quality of joint decisions. The military respondents do say in the end they are responsible for a decision; so in the end they can settle the matter. The respondents say this also depends on the nature of the decision. When a decision concerns something medical, the medical officer's opinion or advice is generally followed up. A medical respondent confirms this:

When a decision has medical consequences, my advice can have a big impact, also on a military operation. I once decided to shut down a water source, because I had reason to believe the water was contaminated (Medical respondent 6).

In case a decision does not have medical consequences, a military commander might make a decision by him or herself. A respondent says not to feel completely comfortable about a decision, when a medical officer does not agree. Another respondent says:

Sometimes a decision has to be made on a split second; therefore some decisions cannot be made together. In such situations, a medical officer just has to do what is decided; but such decisions are not preferred (Military respondent 10).

This quote shows, in the end, medical officers are below military officers in terms of hierarchy. When the respondents were subsequently asked whether they think the quality of their relation with the other category of officers affects decision-making, only a few think the relation has no impact. These officers do not believe that a bad or a good relation will affect the quality of a joint decision. One respondent avoids the question by explaining why the quality of a relation should not affect decision-making:

Decisions are made on the basis of a standard protocol and when this protocol is followed, non-relevant matters will not have an impact on the decision (Military respondent 1).

This quote shows the influence on decision-making is a sensitive subject and it seems as if this respondent does not believe in tinkered decisions. However, most respondents do believe the relation can have an effect on the decision-making process and the implementation of a decision. They believe the relation can both have a negative as well as a positive impact on decision-making. The respondents think a good and solid relation will result in better communication and therefore a better decision. They agree cooperation in the decision-making is easier when the relation is good, because you then listen to each other. In case of a less solid relation, chances are that the officers behave less open towards each other. The tendency to push through individual choices will be bigger and the willingness to cooperate with each other will be lower. This will result in decisions of lower quality since they are made individually. How big this influence can be is hard to say since the quality of decision-making is not measurable.

The explained balance between the two different habitus that is achieved through tinkering implies that, however complex, the relation between the two types of officers is often not bad and does therefore not have to negatively affect the decision-making process. All respondents believe the key concept for a good relation between medical and military officers is good and open communication and respectful behavior. They state they usually have a good relation with the other officer. The officers are often able to reach a consensus by which they are able to work together. In fact, since the relation is good and since decision-making is preferably done together, the decision-making process might actually be influenced positively by the cooperation between military and medical officers.

Yet, as we have also seen, best decisions may be strived for but cannot always be reached. They are tinkered with, and still, sometimes tinkering is not an option. Sometimes a decision has to be made on a split second and as a result of that these decisions are made alone; usually by military officers. Sometimes in very rare situations, decision-making cannot be done together at all because the relation between the two types of officers is bad. One of the medical respondents explains how a bad relation with a military officer can affect decision-making:

When the relation is not going well, I will stop communicating to my commander. I will then make my own decisions (Medical respondent 6).

This quote clearly shows a bad relation is undesirable. It was explained earlier that both categories of officers believe decisions are best made together; they believe this is better for the quality of a decision. A bad relation between military and medical officer may lead to bad communication between them or worse, no communication at all. This again results in individually made decisions which are, according to the respondents, of less quality. The officers might still try to come to an agreement, but in practice tinkering does not necessarily always lead to a happy ending.

5. Conclusions, discussion and recommendations

The central question discussed in this thesis is: *How can the complexities in the occupational relation between medical and military officers in the medical corps of the Dutch army be explained and to what extent can these complexities affect the decision-making process in medical units?* Making reflections based upon the theoretical framework and empirical analysis, I will try providing an answer to this question next; continuing with some critical notes concerning this study. Subsequently, I will conclude with recommendations concerning the cooperation between military and medical officers and further research.

5.1 Conclusions

The first sub question of this research is: *Which complexities are encountered in the relationship between military and medical officers and how are these complexities perceived by both groups?* This research finds there are four possible complexities; the first complexity is conflicting interests. Conflicting interests are mainly about opposing responsibilities between military and medical officers. On the basis of the Hippocratic Oath, medical officers are responsible for helping any patient and on the basis of the military assignment; military officers often focus on 'wounded warriors'. These opposing responsibilities of interests are likely to result in a medical ethical dilemma and that hinders the relation between the officers.

The second complexity is about differences in culture. Friction may arise when officers are not aware of or do not take into account each other's culture. This may happen when medical officers behave individualistic or when military officers treat medical officers as if they do not know a thing about military life. An important part of culture is discipline; discipline may lead to friction when military officers believe the amount of military discipline among medical officers is low. Friction with regard to discipline may also arise when medical officers experience military discipline as dysfunctional.

The third complexity is organizational aspects. An aspect that may hinder the relation is the fact that medical and military officers often do not know each other before going on a mission. Moreover, teams often rotate during a mission which results in a new process of getting to know colleagues. This causes irritations for both medical and military officers, because, in both situations, the new medical or military officer will be confronted with a team or a commander that is already set and that is used to do things in a certain way. It will therefore be very difficult for the newcomer to make changes, also when those changes would mean an improvement.

The fourth and final complexity in the relation between the two officers is hierarchy. Hierarchy is part of the military organization and it is also very much intertwined with military culture. Friction with regard to hierarchy is mainly caused by ranks. Medical officers are given high ranks but with regard to hierarchy, they can be under the command of a lower ranked military officer. This may lead to mutual irritations. High ranks raise expectations with regard to military discipline and knowledge and medical officers often cannot live up to these expectations; this irritates military officers. Medical officers, on their turn, get irritated when military officers use their hierarchy as a means of power; they do not like the formality of the military hierarchy. To conclude this sub question, military and medical officers have a complex relation with a lot of deep-rooted differences and the respondents also perceive it as such.

The second sub question is: *How can we understand the habitus of military officers in the medical corps of the Dutch army?* The military habitus is characterized by companionship, as a consequence military officers first of all are focused on taking care of the 'wounded warrior'. They feel a responsibility to provide care to their colleagues. Furthermore, military officers value the hierarchic, top-down way of communication and relations. However, they also leave room for informal communication when preferred. The military habitus is also characterized by discipline. Military

officers highly value military discipline and they can get irritated when other officers do not comply with it. However, they understand not everyone can live up to their ideas of discipline. The habitus is also characterized by a strong culture. Military officers are team players and they have a lot in common; their self-descriptions even show a lot of similarities. They feel a strong connection with the army; however they do say this connection is slowly fading. The military is changing from a way of life to a normal job; soldiers' perspectives change from the institutional perspective towards a more occupational perspective. Finally, it is shown that military officers working for the medical corps of the Dutch army have a habitus that slightly differs from the general military habitus as explained in chapter 2. For the bigger part this habitus matches the general description of the military habitus, but sometimes it is different. Military officers working for the medical corps are more moderate with regard to i.e. hierarchy and discipline. This means there is a common military habitus in the Dutch army; but within this habitus there are differences between officers from different branches.

The third sub question is: *How can we understand the habitus of medical officers in the Dutch army?* An important point of the habitus of medical officers is the Hippocratic Oath. On the basis of this oath, medical officers feel responsible for providing care towards any patient. However, in the end their focus also seems to be more on the 'wounded warrior'. Like the military habitus, the habitus of medical officers also includes hierarchy. However, their hierarchy is more based on experience and knowledge and actually they preferably do not use any form of hierarchy. In this respect, their habitus is different from the military hierarchy, but also from the civilian medical habitus. Discipline is also part of their habitus, but again to the medical officers there are limits. With regard to culture, they do not seem to have a strong common culture; medical officers are individuals. They do not have a strong relation with the military; the occupational perspective prevails. What is remarkable is that there are big differences between the three types of medical officers. Professional officers appear to be more embedded in the military culture compared to reserve officers and officers that work for the collaboration between the military and civilian Dutch hospitals. It appears that the habitus of medical officers deviates from the both the military habitus and the civilian medical habitus. The habitus deviates from the civilian medical habitus on culture, hierarchy and the goal from military doctors with regard to patient care; and from the military habitus on hierarchy, military discipline, culture, self-description and the position within society. The military medical habitus seems to be a combination of the military and the civilian medical habitus; a military medical habitus. The mix of this combination appears to differ per type of medical officer.

The fourth sub question is: *What are the differences and similarities between the military and the medical habitus and to what extent do these outcomes affect the complexities between military and medical officers in the Dutch army?* The military and military medical habitus differ the most on the aspects of culture, discipline, hierarchy and goals with regard to patient care; it appears their habitus conflict. These differences in habitus help explain the complex relation between the two types of officers, since "the most improbable practices are therefore excluded, as unthinkable...(Bourdieu, 1992 cited by Jenkins, 1992:81)." This means that deviating ways of thinking and acting, differences from the own habitus, will be excluded and seen as unthinkable; opposing habitus are thus likely to conflict. After describing and comparing the military and the military medical habitus and after explaining how the opposing habitus are linked to the complexities in the relation between military and medical officers; it seems that the assumption that was made on the basis of the theory about the concept of habitus holds. The opposing habitus indeed helps to understand the described complexities in the relation between medical and military officers working in the medical corps of the Dutch army.

The fifth and final sub question is: *How does the complex occupational relation between the medical and military officers affect the decision-making process in medical units?* As was explained, the military habitus and the military medical habitus differ a lot. However, despite their different and

even conflicting aims, beliefs, values and ways of behaving and acting the military habitus and medical habitus seem to go together and this is done through tinkering. Annemarie Mol (2010) uses the concept of tinkering to indicate how different values and ways of behaving and acting -she uses the word 'goods'- can go together in daily. In the relationship between military and medical officers, the most notable opposing goods are their goals with regard to patient care and for the officers, tinkering means that sometimes medical officers give in with what the military officers want and at other times, it is the other way around. An example of tinkering relates to solving conflicting interest with regard to making beds available prior to a high risk military action. Making beds available means that a military officer can ask a medical officer to discharge patients early. Discharging patients early clashes with the habitus of the medical officer. However, they are willing to reach a consensus: medical officers sometimes make lists in the back of their heads about which patients could be discharged early in case of an emergency. The officers tinker with their goals to reach a balance. The concept of tinkering can thus help to understand how the military and medical habitus can co-exist; and according to the respondents this results in a situation in which working together is possible and preferable. It appears decision-making is best done together; military and medical officers agree the best decisions are made as a team. In some decisions, the military officer is decisive and in other decisions, mainly with regard to medical aspects, a medical officer is decisive. Decision-making is preferably done together, but the occupational relation can affect the decision-making. A bad relation appears to be negative for decision-making; unfortunately, this thesis does not answer to what extent. However, the explained balance between the two different habitus that is achieved through tinkering implies that, however complex, the relation between the two types of officers is often not bad and does therefore not have to negatively affect the decision-making process. In fact, since the relation is good and since decision-making is preferably done together, the decision-making process might actually be influenced positively by the cooperation between military and medical officers. Yet, as we have also seen, best decisions may be strived for but cannot always be reached. They are tinkered with, and still, sometimes tinkering is not an option. The officers might still try to come to an agreement, but in practice tinkering does not necessarily always lead to a happy ending. Sometimes a decision needs to be made on a split second and then all goods may not be considered and sometimes the relation between the two types of officers is so bad that tinkering is not an option.

To conclude, the complexities in the relation between medical and military officers (conflicting interest, culture, organizational aspects and hierarchy) can be explained by their opposing habitus and by the extent to which medical officers are embedded in the military organization. The complex relation can affect the decision-making process. A bad relation may result in an inferior decision. What is remarkable is that the two different types of officers have found a way to work together by means of tinkering. This shows, however different, in the end the two occupational groups co-exist.

5.2 Discussion

This study aimed at explaining the complexities in the relation between military and medical officers and at explaining the impact of those complexities on decision-making within a medical unit. The first part of the question was clearly answered, but answering the second part was more difficult than expected. This can partially be explained by the interviews; in the first five interviews the questions on this subject were not asked in the right way. The respondents were asked whether medical respondents can affect the decision-making process instead of whether the quality of the relation can have an impact. Even though the respondents gave interesting answers, these answers were not very useful since the question was posed wrongly. Moreover, this is a very delicate debate. Respondents will not easily tell it when a bad relation has had an impact on decision-making and the quality of a decision. Besides this, it is very difficult to answer this question for the respondents. It is very hard to notice whether a relation affects decision-making when you are in the process yourself. For future research it is therefore advisable to observe the relation between military and medical

officers for a while and maybe than get a better overview on how and to what extent this relation affects decision-making.

A possible bias in this study is the position of the researcher. The study aims at the relation between military and medical officers and I am a military officer myself. Although I have not worked as an officer yet, I already am part of the military habitus. This means there is a chance my starting point is biased. Throughout this research, I have done my best not to judge or to take a position and I hope I have succeeded in this.

There are some interesting points for future research. First, this research points out that the military habitus and the military medical habitus are converging because of recent developments, this was explained in paragraph 4.2. It is interesting to investigate this development and to examine whether the two groups are indeed becoming closer because of developments. Second, the interviews indicate there are differences in personal characteristics and behavior between military and medical officers. This research showed individual behavior is part of the explanation for the complex relation between them. For future research it is interesting to thoroughly examine the officers' personal characteristics to be able to say more about its impact on the complex relation. Personal characteristics might even be useful in deciding which officers are going to work together.

5.3 Recommendations

This study shows the complexities in the relation between military and medical officers can be understood by their conflicting habitus. However, this habitus is very much intertwined with personal characteristics and organizational aspects. One of these things is the military rank and also the fact that medical officers are difficult to distinguish from military officers. As explained in paragraph 4.1, high ranks among medical officers can lead to irritations and it can be confusing when medical officers are not recognizable as such. A possible and easy solution to this problem is to make a visual distinction between medical and military officers, for example by giving medical officers a different color of grade insignia. This possible solution needs further research, because it seems to be an easy solution. However, this research shows medical officers sometimes value their rank and making such a visible distinction could create new problems.

Other things that create friction are specific knowledge among both categories of officers and a short preparation time before a mission and the changing teams. This research shows it is desirable that medical officers have a clear notion on how the military works and what the military culture is. On the other hand, it also shows it is desirable that military officers have an idea about medical work and especially about the medial responsibilities that follow out of the Hippocratic Oath. On the basis of these outcomes, I advise the military to draw attention to the exchange of this knowledge. Furthermore, I would like to advise the military to make sure medical and military officers know each other before going on a mission. Another advice is to look into the changing of teams. This research shows there is a lot of discontinuity and reinventing the wheel. I advise the military to do more with so called lessons learned.

6. References

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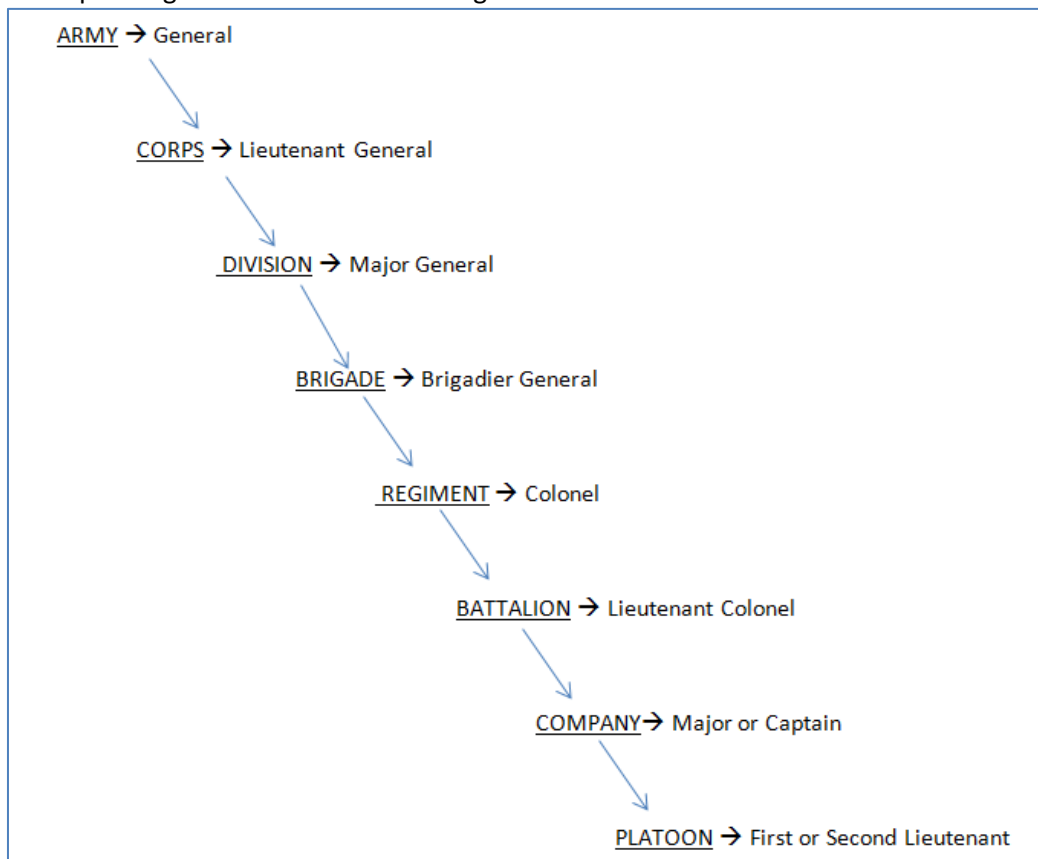
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7. Appendices

Appendix 1: A complete overview of aspects that help to explain the appeal of professionalism as a managerial tool (Evetts, 2011).

- Control of the work systems, processes, procedures, priorities to be determined primarily by the practitioner/s;
- Professional institutions/associations as the main providers of codes of ethics, constructors of the discourse of professionalism, providers of licensing and admission procedures, controllers of competences and their acquisition and maintenance, overseeing discipline, due investigation of complaints and appropriate sanctions in cases of professional incompetence;
- Collegial authority, legitimacy, mutual support and cooperation;
- Common and lengthy (perhaps expensive) periods of shared education, training, apprenticeship;
- Development of strong occupational identities and work cultures;
- Strong sense of purpose and of the importance, function, contribution and significance of the work;
- Discretionary judgement, assessment evaluation and decision-making, often in highly complex cases, and of confidential advice-giving, treatment and alternative ways of proceeding;
- Trust and confidence characterizing the relations between practitioner/client, practitioner/employer and fellow practitioners.

Appendix 2: An overview of military units, ranked from biggest to smallest unit, and the corresponding ranks of the commanding officers.



Appendix 4: Overview of differences and similarities between the military habitus and the military medical habitus

	Military Habitus	Military Medical Habitus
Hierarchy	Top-down communication crucial, especially in stressful and threatening circumstances. Hierarchy is a remedy to prevent from chaos. There also is plenty of space for informal contact.	Hierarchy based on experience and knowledge; hierarchy is not very strong, there is room for informal communication.
Discipline	Discipline is critical because soldiers depend on each other, physical appearance is especially important. There are limits to discipline, it should stay functional.	Military discipline is useful for safety but it must stay useful. Their priority is with medical discipline, they do not always comply with military discipline. Especially physical appearance.
Culture	A strong military culture as a result of working, eating, sporting and sleeping together. Within this culture subcultures exist. Differentiation perspective on culture.	No common military medical culture. Neither fully embedded in military nor in civil medical culture. Behavior and habits are a mix of military and civil medical culture. There is a difference between the 3 types of medical officers. Fragmentation perspective on culture.
Self-description	Transparent, honest and straight to the point. Also social and righteous. Another term that was used to describe themselves was discipline. Team player. Goal: medical care for the wounded warrior.	Self-descriptions vary between all the respondents. Individuals Goal: medical care for all patients
Feel like a soldier?	All have a strong connection with the military, also after work hours	Only 1 respondent feels like a soldier. The others feel like military doctors; doctor usually stand out. 1 respondent never feels like a soldier.
Changed by the military?	All believe they have changed; they believe the military service has become a part of their individual lives	All believe a job always changes a person. However, the military just strengthened some of the personal characteristics they already possessed.
Way of life?	Divided answers. 4 respondents say way of life, 2 are more reserved and 1 says just a job. Institutional orientations towards the job.	Work is just a job. Also for respondents with a lot of military experience. Occupational orientation towards the job.
Why a job in the military?	Adventure, being outside and staying fit in combination with an academic training. Furthermore working with people.	Interested in traumatology and the variation in work, the military offers.

Status / position	Soldiers have a low status in The Netherlands.	Notable position, but it is changing. Doctors more and more have to defend what they are doing. Within the military status still high and less influenced by developments.
Cost awareness	Divided answers. Most respondents say they are not cost aware at all, other say soldiers are becoming more cost aware because of budget cuts. Cost awareness seems not to be an important part of the military habitus.	No unanimous answer. However, all respondents agree civilians medical professionals are more cost aware than military medical professionals. Cost awareness not an important part of the military medical habitus.
Becoming part of the military culture	Education, cultivation and separation from the "world outside. A step-by-step process to become part of the group; in which especially the missions abroad help a lot.	Medical officers hardly have any military education and cultivation. Taking part in missions abroad helps to become part of the culture or group.
Developments	<ul style="list-style-type: none"> - Shiftwork mentality; - Military culture less strong; - No longer a way of life (towards occupational orientation); - Outsourcing; - Investing in education; - Quality improvement. 	<ul style="list-style-type: none"> - Change of status, however less experienced within the military; - Defensive medicine; - Working with protocols for quality; - Better quality of care; - More bureaucracy.

Appendix 5: List of respondents

Respondents	Medical/military officer	Rank	Years enlisted	Experience
Respondent 1	Military officer	Lieutenant Colonel	32	Called up for military service in 1980. Started as a non-commissioned officer with the artillery. Switched to medical corps in 1991. Several experiences as a military commander of a medical unit and several missions abroad.
Respondent 2	Military officer	Captain	10	Started at the KMA in 2002, predestined for the medical corps. Several experiences as a commander of a medical unit and several missions abroad.
Respondent 3	Military officer	First Lieutenant	7	Started at the KMA in 2005, predestined for the medical corps. Works as a commander of a medical platoon and went on one mission abroad.
Respondent 4	Military officer	Captain	14	Started at the KMA in 1998, predestined for the medical corps. Several experiences as a commander of a medical unit and with missions abroad.
Respondent 5	Military officer	Major	16	Started at the KMA in 1996, predestined for the medical corps. Several experiences as a commander of a medical unit and several missions abroad.
Respondent 6	Medical officer	Lieutenant Colonel	30	Called up for military service in 1982. Got medical degree before military service. Became a GP after military service and then re-joined military service voluntarily. Worked as a GP for the military ever since. Experience with several missions abroad.
Respondent 7	Medical officer	Major	11	Got medical degree in 2000 en voluntarily joined the military in 2001. Works as a military GP. Experience with several missions abroad.
Respondent 8	Medical officer	Lieutenant Colonel	24	Called up for military service in 1988. Got medical degree before military service. Participated in two elite military trainings. Works as a military health and safety doctor. Experience with a mission abroad.
Respondent 9	Military officer	Major	22	Started at the KMA in 1990, predestined for the medical corps. Several experiences as a commander of a medical unit and several missions abroad.
Respondent 10	Military officer	Major	18	Called up for military service in 1994. Started as a non-commissioned officer with the infantry. After military service continued to work for the military, as a nurse. Went to the KMA in 2001 to become a military officer within the medical corps. Experience with coordination of workforce; especially medical professionals. Several experiences with missions abroad.
Respondent 11	Medical officer	Colonel	22	Called up for military service in 1989. Previously worked as a professional medical officer; as a military doctor. Nowadays works as a reserve medical officer. Anesthetist. A lot of experience with missions abroad.
Respondent 12	Medical officer	Colonel	39	Called up for military service in 1973. Got medical degree before military service. Worked as a reserve medical officer ever since. A lot of experience in military trainings, none in missions abroad.

