

Cryptic Knowledge in Healthcare: A Case Study of Cultural Silence and Strategic Concealment in Georgian Clinical Practice

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ABSTRACT

In many healthcare systems rooted in traditional, hierarchical cultures, knowledge does not always flow through formal policies or training manuals. Instead, it is filtered through trust, concealed in silence, or buried in unwritten rules. This paper introduces and explores the concept of cryptic knowledge—information that is known but intentionally concealed or selectively shared due to fear, loyalty, or institutional constraints. Using a case study of a state-affiliated (public) hospital in Georgia, the study investigates how medical professionals manage knowledge not just procedurally, but politically and emotionally. Drawing on 18 in-depth interviews conducted in Georgian and English, and supported by a human-centered thematic analysis, the research reveals a system where formal knowledge protocols coexist with underground knowledge networks built on trust, survival, and cultural codes. The findings uncover how silence is often strategic, how loyalty is weighed against truth, and how error reporting is reframed as risk—not reform. The paper proposes a hospital-specific Cryptic Knowledge Network Model, offering a new framework to visualize and understand how knowledge is filtered in emotionally unsafe or culturally rigid medical institutions. The study concludes with practical, interdisciplinary recommendations—spanning human resources, knowledge management, strategic governance, and AI-supported transparency tools—aimed at improving knowledge equity in post-Soviet healthcare environments. Far from theoretical, this study positions cryptic knowledge as one of the most overlooked realities of hospital life—and one of the most urgent to confront.

Keywords: cryptic knowledge, healthcare systems, organizational silence, knowledge management, psychological safety, fear-based communication, trust networks, medical error reporting, cultural hierarchy

1. INTRODUCTION

In healthcare systems around the world, the open transfer of knowledge—whether through formal protocols, verbal communication, or data reporting—is vital for patient safety, institutional learning, and professional development. Yet not all knowledge in clinical environments is shared openly. Much of it is passed quietly, hidden in coded conversations, or withheld entirely. This hidden layer of communication, referred to in this study as cryptic knowledge, plays an especially powerful role in societies where hierarchical structures, fear of blame, and cultural deference to authority dominate. In such settings, *the truth about what is known often lives in silence*.

This paper investigates how cryptic knowledge operates in the context of a state-affiliated hospital in Tbilisi, Georgia. The hospital, while not named for ethical reasons, is closely connected to Tbilisi State Medical University (TSMU)—one of Georgia's largest and a prestigious medical institution, located on Vaja Pshavela Avenue. Each year, thousands of both Georgian and international students complete clinical rotations across the hospital's departments, engaging in hands-on training under the supervision of senior physicians. On the surface, the institution appears aligned with global medical standards, promoting evidence-based care, academic rigor, and intercultural professionalism. However, interviews conducted within this hospital environment reveal a stark contrast between its public image and its internal practices.

What emerges is a system where mistakes are corrected but not reported, questions are filtered through informal alliances, and power dynamics define who gets to speak and who remains silent. These behaviors are not isolated incidents, but rather patterns rooted in Georgia's broader post-Soviet professional culture, where loyalty is prized, criticism is dangerous, and reputation often outweighs transparency. In such an environment, knowledge becomes political: knowing when to speak,

when to stay silent, and whom to trust with information is part of the survival toolkit of healthcare workers. Junior staff and students learn early on that admitting an error, questioning a superior, or formally documenting an issue can result in professional marginalization—or worse.

The term cryptic knowledge, as used in this study, refers to knowledge that is intentionally concealed, selectively shared, or emotionally encoded to navigate organizational life. It differs from tacit knowledge, which is hard to articulate but not purposefully hidden, and from knowledge hiding, which often implies self-interest or malicious intent. Instead, cryptic knowledge in this context is *strategic, cultural, and emotional*—a tool used by professionals to protect themselves, maintain group harmony, or signal allegiance in rigid institutional hierarchies. Its existence is especially visible in healthcare, where the cost of communication breakdowns can be life-threatening, yet cultural inhibitors make open dialogue risky.

This study does not seek to expose individual failures or criticize medical professionals. On the contrary, it aims to *highlight the systemic and cultural constraints* that shape the behavior of intelligent, well-trained individuals operating in complex environments. The findings draw from 18 semi-structured interviews, conducted in Georgian, with doctors, nurses, interns, and administrative staff across various hospital departments. To preserve authenticity, quotes in this paper are presented in their original simplified Georgian phrasing, accompanied by accurate English translations. The voices included here speak in the language of everyday workplace life—not formal policy—but it is in these informal expressions that cryptic knowledge most clearly reveals itself.

One participant described the unspoken reality of error management:

„თუ გახსნი პირს, შენს თავს დაანგრევ.“

(“If you open your mouth, you’ll ruin yourself.”)

Such statements are not only emotionally charged but culturally embedded, reflecting deep-rooted fears around exposure, shame, and retaliation. These fears are not unfounded. Several participants shared instances where reporting a problem led to social exclusion or career stagnation. Others described how they learned to “fix things quietly” rather than engage formal procedures. Across the board, trust—not institutional policy—determined what was shared, with whom, and when.

This paper is situated within the intersection of knowledge management, healthcare systems, and organizational behavior in post-Soviet contexts. It contributes to existing literature by reframing cryptic knowledge not as a fringe behavior but as a core, adaptive response to cultural and structural pressures in traditional medical systems. By analyzing how cryptic knowledge flows, who controls it, and what consequences it has for institutional learning, the study opens up a new pathway for understanding *how silence functions as both a shield and a barrier* in critical environments.

The central research questions are as follows:

1. How does cryptic knowledge emerge and operate within the clinical environment of a Georgian teaching hospital?
2. What emotional, cultural, and structural forces influence the concealment or selective sharing of knowledge?
3. What are the implications of cryptic knowledge for organizational learning, patient safety, and future medical professionalism in Georgia?

In answering these questions, this study introduces a *hospital-specific version of the Cryptic Knowledge Network Model*, designed to help healthcare leaders, educators, and policymakers visualize and address the informal knowledge systems that shape staff behavior and institutional outcomes. It argues that without recognizing and ethically managing cryptic knowledge, reform efforts will continue to overlook one of the most powerful forces operating behind the scenes in Georgian healthcare: *the silence that protects, and the silence that prevents progress*.

2. LITERATURE REVIEW

2.1. Beyond Tacit and Explicit: Positioning Cryptic Knowledge

The field of knowledge management has long been dominated by the distinction between explicit knowledge, which is documented and easily transferable, and tacit knowledge, which resides in personal experience and is difficult to articulate (Nonaka & Takeuchi, 1995; Polanyi, 1966). However, neither concept fully captures the deliberate concealment, strategic ambiguity, and socially coded communication often found in hierarchical or emotionally unsafe environments. This paper introduces cryptic knowledge as a distinct category: knowledge that is intentionally hidden, informally coded, and shared only under conditions of trust and perceived safety. Unlike tacit knowledge, which is unspoken because it is hard to explain, cryptic knowledge is unspoken because it is dangerous to reveal.

In clinical settings, this distinction matters. A senior nurse’s intuitive understanding of how to stabilize a patient is tacit. But a junior doctor’s decision to withhold information about a supervisor’s procedural error to avoid political backlash—that is cryptic. The motivation behind concealment is central. This paper aligns cryptic knowledge with the growing interest in emotionally intelligent knowledge behaviors, where what is known and what is shared are two separate negotiations shaped by power, culture, and fear.

2.2. Knowledge Hiding and the Fear of Exposure

Connelly et al. (2012) define knowledge hiding as the intentional attempt to withhold or conceal knowledge from others, even when requested. While useful, this framing often presumes a competitive or self-protective individual motive. In contrast, cryptic knowledge in healthcare may be relationally protective: designed to shield others, maintain harmony, or uphold group loyalty.

This behavior is particularly pronounced in collectivist or high-power distance cultures (Hofstede, 2001), such as Georgia's, where junior staff avoid challenging superiors and teams prioritize cohesion over transparency. As one hospital employee described during interviews:

„შეცდომა ყველას აქვს, მაგრამ ვინც იტყვის, ის უფრო მსხვერპლია.“
 (“Everyone makes mistakes, but the one who admits it becomes the scapegoat.”)

Here, knowledge hiding is not merely a flaw in systems—it is an emotional survival mechanism shaped by cultural codes.

2.3. Informal Communication and Trust-Based Micro-Networks

In rigid institutional environments, formal communication is rarely enough to ensure knowledge flow. Instead, informal communication becomes essential. Krackhardt and Hanson (1993) describe how informal networks of trust and influence often control more real decision-making power than the formal hierarchy. In Georgian hospitals, this plays out in coded advice, off-the-record corrections, and whispered warnings about how to behave.

Cryptic knowledge is often sustained through micro-networks of trust, especially among nurses, interns, and administrative staff who rely on each other to interpret what is really expected, beyond what is written in protocols. This echoes findings by Gherardi and Nicolini (2002), who argue that safety in clinical settings often depends not on formal instruction but on “ritualized practices” learned socially and discreetly.

2.4. Organizational Silence and Cultural Suppression of Reporting

The theory of organizational silence, first developed by Morrison and Milliken (2000), is highly applicable in healthcare. In environments where speaking up is seen as risky, workers intentionally withhold feedback, concerns, and even critical incident reports. In Georgian clinical institutions, this silence is amplified by cultural forces including:

- *Fear of shaming superiors*
- *Avoidance of direct confrontation*
- *Mistrust of non-Georgian evaluation models*
- *A lingering post-Soviet distrust in institutional reform*

These factors create an environment where the emotional cost of honesty outweighs its procedural value. As one mid-level administrator noted:

„აქ ანგარიშს წერა არაა დაგეხმაროს, არამედ დაგაზიანოს.“
 (“Here, writing a report isn't to help you — it's to hurt you.”)

Such sentiments confirm that psychological safety, a key prerequisite for healthy knowledge management (Edmondson, 1999), is often absent or inconsistently applied.

2.5. Ethical Resistance and Loyalty Over Accuracy

Unlike malicious knowledge hoarding, cryptic knowledge in hospitals may emerge from a deeply ingrained ethic of loyalty. Protecting a colleague's reputation, avoiding external audits, or shielding patients from distress are all cited as reasons for remaining silent. This is ethical resistance—a cultural logic that conflicts with formal knowledge management systems but makes emotional and relational sense to insiders.

Spender and Scherer (2007) call for attention to knowledge justice—the fair distribution, recognition, and use of all forms of knowledge in institutions. In the Georgian context, this means acknowledging that concealment is often not selfish, but tied to long-standing moral narratives about loyalty, duty, and protection.

2.6. Clinical Education, Internationalization, and the Practice Gap

Tbilisi State Medical University promotes itself as a hub of international medical education, attracting students from across Asia, the Middle East, and Europe. However, this outward-facing branding often fails to match internal realities. Clinical rotations place these students into systems shaped by local cultural habits that they are not prepared to interpret. For instance, while Western students may expect formal feedback, Georgian doctors may see this as unnecessary or even offensive.

This disconnect creates an environment where knowledge expectations are mismatched, and informal hierarchies often

override formal guidelines. Research by Leonardi (2020) shows that in hybrid institutions, digitalization and global exposure do not automatically dismantle traditional barriers—in fact, they can make them harder to detect.

2.7. Conceptual Gap and Study Contribution

While concepts like tacit knowledge, knowledge hiding, and organizational silence are well-documented, there is little research that links these themes in the context of Georgian clinical environments, or that treats cryptic knowledge as a distinct, culturally embedded phenomenon.

This study addresses that gap by offering:

- A new *conceptual category* (cryptic knowledge)
- A hospital-specific qualitative case study from Georgia
- A visual Cryptic Knowledge Network Model
- Real quotations in Georgian with English translations, to preserve cultural depth and emotional tone

In doing so, the study brings a regionally grounded, culturally honest, and methodologically rigorous voice to the global conversation on knowledge management in healthcare.

3. METHODOLOGY

This study employed a *qualitative case study design* to explore how cryptic knowledge operates within a state-affiliated hospital in Georgia. The selected institution, while unnamed for ethical reasons, is closely affiliated to Tbilisi State Medical University (TSMU)—one of the country's most established medical education center. Its departments host thousands of Georgian and international students for clinical rotations each year. Despite a formal commitment to international medical standards, internal communication patterns reveal the persistence of *cultural hierarchies, informal knowledge systems, and concealed error management practices*. This study aims to capture those patterns through a rigorous, context-sensitive, and ethically grounded methodological approach.

3.1 Research Design

A *qualitative exploratory approach* was chosen to understand the lived experiences and cultural logic that underpin knowledge concealment and informal communication within the hospital environment. The case study method, following Yin (2018), was appropriate for this investigation because it allowed the phenomenon of cryptic knowledge to be studied within its real-life context, especially where the boundaries between phenomenon and context are blurred.

The case is bounded by institutional affiliation (Public Hospital), geographic location (Tbilisi), and participant experience (clinical work within the same hospital). We have chosen this specific institution because we had senior international students and professors as our contacts working in the hospital. Although generalizability is not the aim of qualitative case studies, the depth, emotional insight, and contextual specificity of findings allows *transferability* to other post-Soviet or collectivist healthcare systems.

3.2 Participants and Sampling

The study included 18 participants purposefully selected for their embeddedness within hospital operations. Roles included:

- Junior (two) and senior physicians (three)
- Nurses and surgical support staff (four)
- Medical interns (Georgian (four) and international (two))
- Administrative as senior officers (three)

Participants were required to have at least 3 years of work experience within the hospital and direct exposure to communication, error reporting, or decision-making dynamics.

Sampling combined *purposive and snowball methods*, with initial access facilitated by the author's existing contacts at Tbilisi State Medical University. International medical students helped identify senior staff willing to participate. All participants provided verbal consent and were assured of anonymity.

To protect identities, no demographic table is presented; however, the sample was balanced across department types and staff levels. The diversity of viewpoints allowed for *triangulation of professional perceptions*, especially on sensitive issues like institutional silence and blame culture.

3.3 Data Collection

Data were gathered through *semi-structured interviews* conducted in Georgian (14) and English (4), depending on the participant's preference and background. Interviews ranged from 45 to 70 minutes and were conducted in quiet, private

hospital offices or via encrypted online channels.

Interview questions covered five domains:

1. *Experiences with hidden or unspoken knowledge*
2. *Mechanisms of informal information sharing*
3. *Perceived risks of reporting or transparency*
4. *Social dynamics of trust, fear, and protection*
5. *Perceptions of Hospital's role in promoting or overlooking these behaviors*

In addition to spoken interviews, participants were invited to submit *anonymous written narratives*, which 5 respondents provided. These narratives, collected through secure WhatsApp messages, allowed participants to describe critical incidents or cultural phrases in their own terms.

Selected quotations were transcribed in Georgian and presented with English translations, retaining the emotional rhythm and cultural subtext essential for interpreting cryptic knowledge.

3.4 Data Analysis

All interviews and written narratives were transcribed verbatim and analyzed using thematic analysis, as outlined by Braun and Clarke (2006). This approach was chosen because of its ability to systematically identify, analyze, and interpret recurring patterns of meaning across diverse accounts—particularly suitable for exploratory studies investigating complex, culturally rooted phenomena like cryptic knowledge.

The analysis followed the six established phases of thematic coding:

1. *Familiarization with the data*

The researcher immersed in the transcripts and written texts multiple times to identify subtle linguistic cues, emotional tones, and recurring cultural expressions.

2. *Initial coding*

Descriptive and interpretive codes were generated inductively, with a focus on identifying expressions related to concealment, fear, trust, loyalty, hierarchy, and informal networks. Codes were applied at the semantic and latent level, allowing for both direct statements and underlying meanings to be captured.

3. *Generating candidate themes*

Codes were grouped into broader conceptual themes, including: “*Fear of Reprisal*,” “*Strategic Silence*,” “*Coded Communication*,” “*Loyalty over Accuracy*,” and “*Institutional Double Standards*.”

4. *Reviewing themes*

Themes were refined by reviewing them across all participant types (e.g., nurses, junior doctors, administrative staff). Cross-case memoing was applied to compare how similar behaviors manifested differently based on role, authority level, and clinical department. For example, fear among nurses tended to be about retaliation, whereas for interns, it was about professional exclusion.

5. *Defining and naming themes*

Each theme was given a concise definition and narrative scope. Particular attention was given to culturally loaded expressions in Georgian, such as:

„აქ თუ სიმართლეს იტყვი, დარჩები მარტო.“

(“If you tell the truth here, you’ll be left alone.”)

These phrases were treated not just as quotes, but as conceptual anchors reflecting collective norms.

6. *Producing the final narrative*

The final set of themes was structured to tell a coherent story about how knowledge flows in the hospital environment—not through formal systems, but through micro-networks of trust, fear management, and emotional navigation.

To support data management and rigor, the researcher used NVivo 12 software to track code frequency, co-occurrence, and participant type. Visual coding queries helped identify which themes were dominant in specific roles (e.g., administrative staff disproportionately mentioned the avoidance of formal documentation). This enabled deeper insight into how structural position shaped knowledge behavior.

Additionally, analytic memos were used during coding to document insights, reflexive thoughts, and contradictions

encountered in the data. For example, in one memo, the researcher noted the contrast between a senior doctor's narrative that "mistakes must be hidden to avoid audits" and an intern's experience that "if I report something, I might lose my reference." These contradictions helped sharpen theme boundaries.

Finally, quotations were translated carefully from Georgian to English to preserve emotional tone, cultural specificity, and pragmatic meaning. The researcher avoided formalizing or sanitizing the language, choosing instead to present quotes in their original simplified Georgian phrasing with natural English equivalents. This was essential to remain faithful to how cryptic knowledge manifests linguistically in the Georgian clinical setting—through indirect warnings, euphemisms, and fear-laden colloquialisms.

This analysis process ensured that the resulting themes were both data-driven and contextually grounded, offering a reliable foundation for the model presented in the Discussion section and helping illustrate how systemic silence, emotional self-protection, and informal loyalty codes govern the transfer—or withholding—of knowledge in Georgian healthcare environments.

3.5 Trustworthiness and Ethical Considerations

The study follows Lincoln and Guba's (1985) criteria for qualitative rigor:

- *Credibility*: Ensured via triangulation of interviews and narratives; follow-up clarifications from willing participants.
- *Transferability*: Achieved by contextualizing all themes within the specific Georgian clinical setting.
- *Dependability*: Documented through an audit trail of code development, memo writing, and theme revisions.
- *Confirmability*: Enhanced by reflexive journaling, peer debriefing, and anonymized transcripts.

All participants were informed of the study's goals, and *no identifying data were retained*. Translation of quotes was performed with cultural sensitivity and cross-checked by bilingual academics at TSMU.

3.6 Limitations

- Due to the nature of cryptic knowledge, some behaviors may remain undisclosed even in trusted interviews.
- The index model introduced in 3.4 is exploratory and interpretive—not designed for inferential analysis.
- As the hospital's name is withheld, institutional context is presented indirectly, which may reduce external validity for non-local readers.

Nonetheless, the depth of voices, cultural precision, and thematic consistency provide a strong foundation for interpreting cryptic knowledge in this and similar environments.

4. FINDINGS

This section presents the core themes that emerged from interviews and narrative submissions, revealing the informal systems through which knowledge is concealed, selectively shared, or emotionally negotiated in the hospital environment. The voices of participants—from nurses and interns to administrative staff and senior physicians—consistently pointed to the presence of a *culture of silence*, shaped by fear, institutional rigidity, and protective loyalty. Despite the hospital's formal association with international medical education and global standards through Tbilisi State Medical University (TSMU), the internal climate often reflects *traditional, post-Soviet, and socially conservative values*, where criticism is equated with betrayal and formal reporting is seen as self-harm.

4.1 Fear as a Barrier to Knowledge Flow

Across nearly all interviews, fear emerged as the most immediate reason for knowledge concealment. This fear was not abstract, but deeply *personal, professional, and historical*. Participants described environments where even well-meaning feedback or minor error reporting could lead to blame, exclusion, or institutional retaliation.

„აქ შეცდომის აღიარება ნიშნავს, რომ სამსახურს რისკავ.“

(“Here, admitting a mistake means you're risking your job.”)

One nurse described how she witnessed a procedural mistake during surgery but chose not to speak up:

“I said nothing. Because I knew if I speak, I will be the problem—not the mistake itself.”

The implication is clear: *the cost of truth-telling is often higher than the risk of silence*. Several junior staff members confirmed that formal systems for reporting complications exist, but these systems are rarely used unless absolutely unavoidable—and even then, often through back channels.

This culture of fear is not just emotional but *deeply embedded in the structure of the hospital*, reflecting what one

administrative officer called “soviet-style habits wrapped in modern titles.”

4.2 Trust-Based Knowledge Micro-Networks

In the absence of safe institutional channels, knowledge flows through *informal relationships and whisper networks*. Participants repeatedly described how they rely on trusted colleagues—not official supervisors or reporting systems—to navigate clinical expectations, hidden rules, and past incidents.

„თუ ვინმეს არ ენდობი, არც გარისკო არაფრის თქმა.“

(“If you don’t trust someone, don’t even risk saying anything.”)

These micro-networks operate as **emotional safety nets**, especially for interns and new staff. Many said they learned more from hallway conversations and WhatsApp groups than from orientation manuals or official briefings. However, this approach is **inherently exclusionary**: those outside these circles—especially international students, new hires, or less charismatic staff—are left out of vital institutional knowledge.

While these trust circles serve as a protective mechanism, they also **reinforce inequality**, favoritism, and silence around mistakes. In some cases, loyalty to a supervisor or department head meant covering up critical issues that affected patient care. As one young doctor explained:

“There are many things you don’t say, because your loyalty today decides your promotion tomorrow.”

4.3 Strategic Silence and the Politics of Reporting

Several participants shared that when errors occur, the first instinct is not to report but to assess the *social consequences of speaking*. Whether a mistake is minor or serious, its fate depends less on its clinical severity and more on the personalities involved, hierarchy, and internal alliances.

„თუ უფროსი რაღაცას არასწორად აკეთებს, უბრალოდ შებრუნდები და გააგრძელებ შენს საქმეს.“

(“If a supervisor does something wrong, you just turn around and keep working.”)

In one narrative, an intern described how a misdiagnosis was noticed by junior staff but not escalated because the responsible physician had an “untouchable” reputation.

“We talked about it between ourselves, but nobody said anything officially. It was just understood that ‘nothing happened.’”

This normalization of silence around mistakes is *deeply dangerous*—not only for patient outcomes but for the learning culture of the institution. Errors become invisible. Staff protect themselves, not the system. And when things go wrong, blame is often pushed downward.

4.4 Cultural Loyalty vs. Professional Accountability

An important cultural insight emerged around the theme of *loyalty*. Many participants did not view silence as cowardice, but rather as *morally justified* protection of colleagues. This kind of “ethical silence” was especially evident in nurses and mid-level staff, who felt that reporting a colleague could destroy relationships and team unity.

„პასუხისმგებლობა ყველას გვაქვს, მაგრამ გაცემას სჯობს გაჩუმება.“

(“We all have responsibility, but sometimes silence is better than exposing someone.”)

While loyalty is a virtue in any team, in this context it often replaces accountability. Several participants explained how performance evaluations and feedback systems were reduced to a formality, with real assessments made informally based on political alliances.

“In our hospital, your reputation is not about your skill but about who you never offended.”

This reflects a core tension in the Georgian professional environment: social cohesion is often prioritized over procedural integrity. While this may preserve surface harmony, it compromises institutional learning, innovation, and patient safety.

4.5 International Standards vs. Local Practices

Perhaps the most striking contradiction came from those involved in medical education. Several professors and clinical trainers openly admitted that the formal curriculum taught to international students is not practiced internally.

“We teach them international protocols, but then send them into a ward where none of it applies.”

Students from countries such as India, Nigeria, and the Middle East frequently expressed confusion when real-world practice contradicted what they were taught. This disconnect between policy and practice undermines both trust and educational credibility.

One international student shared:

“In the lecture they say to report mistakes and protect patients. But in the ward, if you ask too many questions, they stop letting you help.”

This phenomenon reveals a symbolic internationalization—where policies are adapted to attract global students, but internal culture remains closed, traditional, and politically sensitive.

Summary of Findings

These five themes demonstrate a consistent pattern: knowledge does not flow freely in this institution. It is filtered through fear, loyalty, and hierarchy. Mistakes are corrected but never documented. Advice is whispered, not written. And silence—though it feels safe—is often the reason why lessons are never learned.

The problem is not a lack of intelligence or ethics among staff. On the contrary, participants displayed deep emotional intelligence and moral reasoning. But they are operating within a system that punishes transparency and rewards alignment.

This case study challenges the assumption that institutional policies alone can ensure safety or learning. Unless cultural inhibitors are named, understood, and addressed, cryptic knowledge will remain the default mode of communication.

In the next section, the Cryptic Knowledge Network Model will illustrate how these informal flows operate in relation to trust, fear, resistance, and hierarchy—and offer practical recommendations for improving knowledge equity in Georgian hospitals.

5. DISCUSSION

The findings of this study reveal a complex system in which knowledge is not absent but actively managed through silence, coded behavior, and protective social logic. This type of communication—what we define as cryptic knowledge—operates beneath formal protocols, shaping how medical professionals navigate fear, power, and loyalty. In the context of Georgian hospitals, especially those affiliated with state institutions like Tbilisi State Medical University (public hospitals), cryptic knowledge is not an anomaly but a structural feature. It is *learned, normalized, and emotionally reinforced* by a professional culture shaped by tradition, hierarchy, and post-Soviet legacy.

5.1 Revisiting the Core Themes Through a Knowledge Management Lens

From a knowledge management perspective, the five key findings—fear, trust-based micro-networks, strategic silence, cultural loyalty, and the disconnect between formal standards and local practices—reflect a *knowledge ecosystem that is emotionally intelligent but procedurally fragile*.

Rather than seeing these behaviors as dysfunctions, this study frames them as adaptive strategies in an environment where speaking up is perceived as risky. The emotional calculus involved in whether to report, remain silent, or warn a peer informally demonstrates the presence of unwritten organizational rules, which often carry more weight than formal guidelines. These unwritten norms are reinforced not only by top-down structures but also by peer expectations and social codes.

5.2 The Cryptic Knowledge Network Model (Hospital-Specific)

To synthesize the thematic findings and visually represent the informal flow of information in the studied hospital, this paper introduces the Cryptic Knowledge Network Model, specifically adapted for the healthcare context of a public institution affiliated with state university.

The model captures how knowledge in this environment is not openly shared through formal channels, but rather *strategically filtered, protected, or concealed* through a culturally embedded system of trust, fear, resistance, and hierarchy. It highlights the *cyclical and self-reinforcing nature* of silence and informal communication in clinical environments shaped by tradition, authority, and reputation.

Cryptic Knowledge Network in a Georgian Clinical Teaching Hospital

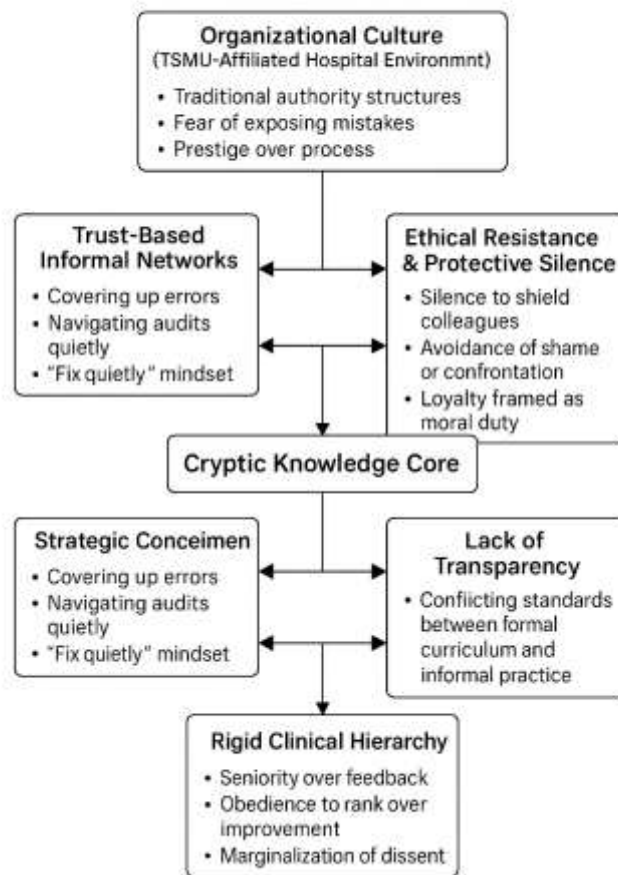


Figure 1. Cryptic Knowledge Network Model for Georgian Hospital System

Organizational Culture

At the top of the model lies the broader organizational culture, shaped by the hospital's affiliation with state medical university. Although the institution outwardly promotes international standards and academic rigor, the *internal climate remains traditional and hierarchical*, with implicit values that prioritize compliance, reputation, and seniority over transparency and feedback. This culture sets the foundation for how knowledge flows—or fails to.

Trust-Based Informal Networks

Instead of relying on institutional mechanisms, staff and students navigate their professional lives through *informal, trust-based micro-networks*. These include:

- Senior nurses discreetly mentoring interns,
- Peer-based survival strategies among junior doctors,
- Off-the-record warnings passed quietly in hallways.

Access to these networks is selective. *Outsiders—especially international students or newly hired staff—are often excluded*, leaving them without critical knowledge about real hospital norms. These micro-networks serve as a protective infrastructure, but also create *gatekeeping dynamics* that reinforce inequality and silence.

Strategic Concealment

Within these informal spaces, individuals develop strategies for intentional concealment—not out of malice, but out of necessity. Staff describe “fixing things quietly,” avoiding documentation, and intentionally bypassing reporting systems to

protect themselves or others.

Such concealment often revolves around:

- *Avoiding audits or disciplinary action,*
- *Shielding a respected superior from blame,*
- *Minimizing disruptions during clinical rotations.*

This behavior is not disorganized—it is *methodical and predictable*, forming a hidden layer of clinical decision-making.

Ethical Resistance and Protective Silence

In many cases, silence is not rooted in fear alone, but in *ethically motivated resistance*. Nurses and interns frequently described situations where they remained silent not because they were afraid, but because they believed *reporting a colleague would be disloyal or unfair*.

In this context, *moral codes around loyalty and solidarity* take precedence over institutional reporting expectations. While this ethical silence protects individuals, it prevents shared learning and leads to the repetition of avoidable mistakes.

Cryptic Knowledge Core

At the center of the model is the Cryptic Knowledge Core—the hidden knowledge that governs how things *actually* work inside the hospital. This core includes:

- Known-but-unspoken procedural workarounds,
- Coded language for sensitive issues,
- Historical “don’ts” that are never written but deeply internalized.

It is this core that staff rely on more than formal documentation or clinical guidelines. To access it, one must be trusted, culturally fluent, and socially cautious.

Fear of Reprisal and Lack of Transparency

The cryptic knowledge core is sustained by two reinforcing forces:

1. *Fear of Reprisal*: Fear of demotion, exclusion, ridicule, or lost opportunities discourages open disclosure.
2. *Lack of Transparency*: Institutional systems rarely model openness or reward disclosure, leading to a normalization of secrecy.

As one participant put it:

“The more you know, the less you say—because knowing makes you responsible.”

This dynamic creates *emotional risk around information sharing*, making silence safer than participation.

Rigid Clinical Hierarchy

At the bottom of the model lies the hierarchical system that locks this cycle into place. Decision-making is concentrated at the top; feedback is discouraged from below. Medical interns are expected to obey, not question. Nurses manage emotional labor invisibly. International students are seen but rarely heard.

Rather than disrupting the system, this rigid structure absorbs and reinforces the behavior patterns above, completing the cycle of cryptic knowledge.

In sum, this model illustrates how knowledge in the studied hospital flows through non-transparent, emotionally loaded, and culturally coded pathways. Unless these pathways are acknowledged and redesigned, efforts to improve clinical communication, education, or safety will be resisted—not because staff are unethical or disengaged, but because the system teaches them that to speak is to risk everything.

This understanding now informs the practical recommendations in the following sections.

5.3 Cultural Contradictions in the Internationalization Narrative

A recurring theme in both interviews and literature is the *symbolic internationalization* of Georgian medical institutions. Hospitals formally adopt Western curricula, attract international students, and teach global standards. Yet internally, these standards are inconsistently applied or quietly bypassed, especially when they conflict with entrenched local norms.

This contradiction places both local and international students in a precarious position. They are expected to act with global professionalism while embedded in environments that penalize transparency and operate according to local, often unspoken, codes. It also creates an illusion of reform without addressing the *emotional and cultural conditions that shape behavior*.

5.4 Ethical Dimensions of Silence and Loyalty

One of the most striking insights is that *not all silence is unethical*. In fact, much of the knowledge concealment reported in this study is framed by participants as *ethical resistance*—an effort to avoid harming colleagues, triggering institutional backlash, or losing team trust.

This challenges binary narratives around openness as good and concealment as bad. In some cases, silence is an act of care. But without systemic support for *psychological safety*, even ethical silence becomes a threat to collective learning and patient outcomes.

A culture that rewards *quiet loyalty* over constructive dissent becomes *epistemically unjust*—certain voices are silenced, certain truths remain untold, and certain mistakes are repeated.

5.5 Toward Knowledge Equity in Georgian Hospitals

The goal is not to destroy the informal systems that protect people—but to create environments where trust and transparency can coexist. Georgian hospitals do not need more policies. They need safe mechanisms to surface cryptic knowledge without punishment, and to invite learning without fear.

5.6 Managerial and Educational Recommendations

Based on the findings and model, the following recommendations are proposed:

1. Establish Psychological Safety Circles

- Facilitate *regular team reflections* (not just audits or evaluations) where junior and senior staff can safely share concerns.
- Use a *neutral facilitator* unaffiliated with department hierarchy to moderate.
- Implement *no-blame case discussions*, focused on learning, not consequences.

2. Recognize Informal Mentors and Whisper Networks

- Acknowledge the *emotional labor* done by nurses, midwives, and interns who help others navigate hidden systems.
- Formalize this role as “Peer Orientation Officers” or trusted knowledge liaisons.
- Encourage *horizontal sharing spaces* without managerial oversight to preserve trust.

3. Reinforce Cultural Sensitivity in Medical Education

- Prepare international students for the *real-world gap* between global theory and local practice.
- Offer *reverse training* for Georgian staff to explore how international students interpret their actions.
- Integrate *critical dialogue* into TSMU’s curriculum that invites both local and foreign students to question and reflect together.

4. Develop Anonymous Knowledge Capture Channels

- Allow anonymous incident reporting and reflection tools that do not trigger direct investigation unless patterns emerge.
- Combine this with narrative reviews rather than legalistic documentation.
- Use qualitative data to monitor shifts in emotional climate and fear perception.

5. Shift the Language of Reporting

- Replace terms like “violation” and “disciplinary” with “*improvement opportunity*,” “*collective lesson*,” or “*pattern detection*.”
- Language reform alone cannot fix culture—but it can begin to signal change.

5.7 Final Reflections

This study does not claim to have solved the cultural challenges of knowledge sharing in healthcare. But it *names what is usually unspoken*, and offers a framework to see silence not as a void, but as a signal—a signal of where systems are failing emotionally, not just procedurally.

For Georgian hospitals to move forward, they must treat cryptic knowledge not as a threat, but as an invitation—to redesign trust, revisit silence, and reimagine accountability as a shared, not punitive, responsibility.

6. CONCLUSION AND STRATEGIC IMPLICATIONS

This case study has revealed a deeply rooted pattern of knowledge concealment and informal communication in a public Georgian hospital. Through the lens of cryptic knowledge, the study demonstrated how healthcare professionals—far from being negligent or disengaged—actively navigate a system that discourages transparency, penalizes disclosure, and rewards silence. What might appear externally as a lack of knowledge flow is, in reality, a complex and adaptive response to *fear, institutional rigidity, and deeply internalized loyalty codes*.

While this case focused on a Georgian clinical environment, its findings resonate across *Eastern Europe and other post-Soviet healthcare systems*, where similar cultural features persist: high power distance, traditional authority structures, reluctance to question seniority, and emotional risk associated with disclosure. In such systems, the *real rules of survival are unspoken*—learned through observation, shared quietly in trusted circles, and protected at all costs.

6.1 Strategic Recommendations for Human Resources

To address cryptic knowledge at its roots, healthcare HR departments must shift from compliance-driven frameworks to culture-sensitive trust-building mechanisms. This includes:

- *Reframing Evaluation Systems*: Move away from punitive, audit-focused performance appraisals. Replace with developmental feedback models that invite staff reflection without risk of career harm.
- *Psychological Safety Metrics*: Integrate qualitative indicators of psychological safety into regular HR monitoring. Use anonymous feedback loops to assess whether staff feel safe reporting concerns.
- *Peer-Led Induction Programs*: Replace top-down orientation with horizontal mentoring models, where experienced staff explain both formal protocols and informal realities in an ethical and balanced way.
- *Ethical Conflict Coaching*: Offer HR-supported mediation when silent ethical conflicts emerge, allowing staff to process moral dilemmas without institutional fear.

6.2 Knowledge Management (KM) System Innovations

Traditional KM systems focus on documentation, databases, and procedural compliance. In settings where *silence and cryptic logic dominate*, this approach fails. Instead, KM strategies should include:

- *Narrative-Based Knowledge Capture*: Encourage narrative submissions from staff—anonymous or attributed—on lessons learned, ethical dilemmas, and workarounds. Archive them as cultural assets, not violations.
- *Cultural Translation Layers*: Develop internal knowledge translators—staff who can bridge formal protocols and actual practice. These roles can help identify and “de-code” cryptic knowledge so that it can inform official policy.
- *Tacit-Ethical Mapping*: Use thematic mapping tools to document emotionally and ethically embedded knowledge flows, allowing leadership to visualize where informal behavior is compensating for formal system weaknesses.
- *Role-Specific KM Hubs*: Rather than centralized knowledge systems, create micro-KM systems by unit (e.g., surgical, pediatrics), each with its own trusted stewards who reflect local trust dynamics.

6.3 Strategic Management and Policy-Level Recommendations

Leaders of public and university-affiliated hospitals must move beyond surface reforms. To dismantle the cycle of cryptic knowledge, strategic management documents should:

- *Acknowledge Organizational Silence*: Include honest sections in annual reports or internal documents acknowledging that informal communication governs much of the system—and articulate steps to address it without blaming staff.
- *Align International Standards with Local Realities*: Reform strategies should not just import Western procedures, but *bridge them with Georgian/Eastern European realities*. Strategic plans must define how international expectations will be culturally internalized.
- *Incentivize Transparency through Structure*: Build reward structures for ethical whistleblowing, error reporting, and cross-role feedback. These should be *non-punitive, reputation-safe, and process-integrated*.
- *Appoint Knowledge Culture Officers*: Assign internal leaders to monitor the emotional and social culture of knowledge—not just technical flows. These roles would sit alongside compliance officers but focus on *trust, inclusion, and unvoiced insight*.

6.4 AI and Digital Solutions to Support Transparency and Knowledge Equity

Artificial intelligence is not a cure-all—but in this context, it offers targeted opportunities to detect patterns, create safe sharing platforms, and equalize access to knowledge. Recommended solutions include:

- *AI-Powered Narrative Scanning Tools*: Implement NLP (natural language processing) systems to analyze anonymized narratives or staff reflections. These tools can detect common pain points, fear zones, or repetitive error language—without breaching privacy.
- *Dynamic KM Assistants*: Equip each clinical unit with an *AI assistant* that reminds staff of guidelines, offers clarification, and learns from narrative feedback to update protocols in plain language.
- *Anonymous Reporting Bots*: Develop chatbot-style feedback portals, where staff can anonymously describe errors, cultural tensions, or knowledge blockages. These can be routed to a neutral knowledge committee.
- *AI-supported Emotional Risk Mapping*: Use sentiment analysis on internal surveys, narratives, and informal feedback to create *maps of emotional safety zones*—guiding leadership on where interventions are most needed.

6.5 Final Reflection

This study contributes not only to the field of knowledge management and organizational behavior but also to the strategic future of healthcare systems rooted in traditional cultures. It shows that cryptic knowledge is not just a challenge of systems—it is a mirror of our professional values, fears, and inherited behaviors.

Fixing this problem cannot be reduced to digital upgrades or international accreditations. It demands a reimagining of professional trust, a redesign of HR and KM practices, and a humble but bold admission that culture—not just policy—drives behavior.

Leaders who listen to silence, map the cryptic, and embrace complexity will not only improve learning but also protect what matters most in healthcare: the lives of patients, and the dignity of those who care for them.

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