Ways of interacting: The standardization of communication in medical training

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ABSTRACT

This study explains the effects of medical institutionalization on the framing of doctor–patient interviews. We draw on Weberian, Habermasian, and Foucaultian perspectives to explain the ways that occupational rationalities are embodied in doctor–patient encounters, and how these rationalities structure and are structured by occupational conceptions of medical clients. We use the results of participant-observer methods to demonstrate specific instances of the ways in which organization–client interactions are simulated in a standardized patient training programme. Finally, we discuss findings with respect to our theoretical perspectives, showing how each perspective contributes unique insights into understandings of organizations and the communities they serve.

KEYWORDS

communication • group communication • healthcare organizations • mental health and therapy • organizational culture • organizational theory

Organizational scholars have long studied the process of institutionalization in social life, often examining the implications for communities involved in the assimilation of institutional norms (e.g. Meyer & Scott, 1983; Scott et al., 2000; Zucker, 1988). It is generally agreed that institutionalizing social relations typically involves the re-working of logical frameworks for both the organizations involved and their clients (e.g. Meyer & Rowan, 1977; Meyer & Scott, 1983). In the field of medicine, for example, much work has been
done to show how medical models have both contributed to clients’ well-being and framed the ways in which those involved have come to see their bodies and minds (e.g. Conrad, 1992; Kleinman et al., 1978; Taussig, 1980). The medicalization of society (see Conrad, forthcoming; Zola, 1972) has both been heralded as a major feat of modern times, leading to the elimination of incalculable amounts of suffering, and criticized as a means of exerting power over local communities whose traditional practices are compromised by medicine, forcing researchers of medical occupations to find a balance between the apparent success of modern medicine and its sociocultural effects (e.g. Colson & Selby, 1974). One point that is often overlooked, however, in discussions of medical institutions is that of how such institutions themselves integrate new models of rationality, and how these models are reconciled with the existing medical order.

The current study examines a newly required component in medical education in the United States and abroad, the standardized patient (SP), as an example of how the medical community evolves to deal with clients. We argue that the use of simulated clients emerged as a revision of traditional medical logic, in order to create a social link between the institution and the individual that was felt to be missing in traditional service-providing techniques. We then use ethnographic field data to examine how this link creates not only a sensitivity to two-sided communication, but also has implications for power relations. Toward this end, we first describe the evolution of SP programmes, highlighting the ideological imperative for doctors to understand their patients through developing social skills. Second, we discuss the concept of medicalization using ideas of institutional and communicative rationality as well as power and discourse, to give a complex picture of these social skills as a tool for social control. We then present our field findings, giving concrete examples from a SP programme that demonstrates the processes we discuss. Finally, we show the implications of these findings for our understanding of institutions and the communities in which they function.

**The history of the standardized patient**

Doctor–patient communication patterns have become an increasingly important part of the medical research agenda over the last 30 years (see Arora, 2003; Morrow et al., 1983; Ong et al., 1995; Roter & Hall, 1992). The study of doctor–patient communication was based on the recognition that patients have unique life-histories and perspectives (Zandbelt et al., 2006), and that taking these perspectives into account leads to improved medical outcomes (e.g. Arora, 2003). Although some studies in this area
emphasize the importance of communication in creating relationships, which could be considered a value in itself (e.g. Roter & Hall, 1992), most studies focus on increased efficacy of information gathering in diagnostic situations, improved decision-making, and patient adherence to treatment recommendations (e.g. Ong et al., 1995).

The idea of using simulations of actual medical patients in the training of doctors was first introduced by Barrows and Abrahamson (1964), as a way to couch physician communication assessment in terms of realistic clinical settings (Swartz & Colliver, 1996). Psychometrician Geoffrey Norman later coined the term ‘Standardized Patient’ to describe the technique, which involved training actors to play the part of a patient with various medical conditions or psychological issues (Wallace, 1997). As most communication studies in this area already focused almost entirely on doctor, rather than patient, behaviour (for a review, see Arora, 2003; however, see Anderson & Sharpe, 1991), it stands to reason that standardizing patients would provide a controlled setting in which to assess doctors’ actions. Although the literature cited above emphasized unique patient histories, SP programmes, by creating various patient profiles, attempted to provide a realistic counselling simulation for doctors-in-training.

The first training programme to incorporate SPs took place at the University of Southern California in the 1960s, and drew widespread criticism for being ‘touchy-feely’, as it emphasized realistic interactions between doctors and SPs (Wallace, 1997). However, recent treatments of competence for medical practitioners demand SP-based training by noting that performance for medical personnel involves ‘a relational function – communicating effectively with patients and colleagues’ (Epstein & Hundert, 2002: 226). In line with this definition of competence, the US Medical Licensing Examination – the licensure test for physicians within the United States – incorporated a test of interpersonal and other clinical skills in 2004, and the Liaison Committee on Medical Education – the major accrediting body for medical schools within the United States and abroad – began requiring clinical skills training with SPs in 2005 to continue or obtain accreditation (Barzansky & Etzel, 2004).

According to many authors, SPs filled a niche in the medical occupation by providing an objective way to measure doctors’ performances in clinical setting without the biases of class-based evaluation, and at the same time, improving the training of medical students by adding a focus on interpersonal skills in dealing with patients (e.g. Razavi et al., 2000; Vu et al., 1992). In addition, however, Wallace (1997) suggests that the practice reflects a growing recognition within the medical community that well-being is an outcome of lifestyle patterns and not simply treatment of deviations from
normal bodily functioning. From this perspective, understanding the story of the patient is a crucial part of medical education, with the implication that sensitive practitioners must be able to locate the ‘lifeworlds’ (e.g. Schutz & Luckmann, 1973) of patients as a site of the institutional rationalities of the medical community.

From a social scientific standpoint, the history of SPs can thus be read as the recognition of a field of social life (the personal life of patients) that is critically important to the success of institutional action, and involves bringing into the institutional purview new areas of social life. What is interesting about this movement is that, on the one hand, what was formerly considered non-rational (i.e. human interaction) had to be integrated into a technical field, while on the other hand, in order for this to be achieved, interaction had to be institutionally framed in a medically palatable way. In the following section, we outline the theoretical perspectives we use to understand the thesis that standardized patients are a mechanism that integrates the lifeworlds of individuals into institutional practices. These practices, we argue later, are keys to achieving the institutional goals of benefiting the patient and, at the same time, legitimizing a technical scientific apparatus that regulates and defines social life.

**Theoretical approaches to medicalization**

As a basis for theorizing the tension between human interaction and technical standardization, we will track the evolution of a central line of thought in social theory, beginning with theories of rationality in modern society and developing into communicative and power-centred views. We argue that Weberian approaches to rationality, used by Habermas as a central piece in his theory of communication, provide a starting point to a coherent tradition that has been appropriated by social scientific studies of the medical field. We then describe a post-structuralist approach to power in discourse that both continues this tradition and highlights key difficulties in this approach. We turn now to each of these lines of thought.

**Rationalization in medicine and the idea of communication skills**

**Institutional rationality**

Beginning with Weber (1968, 1992), the idea that the modern age can be characterized by the growing rationalization of society became an important basis for contemporary social science. Rationalization here refers to the
social process whereby segments of society are specialized according to technical functions, which are differentiated and separated into bureaucratic institutions within a society (Freund, 1968). Modern society, according to this view, is subject to increasing rationalization, culminating in the organization of life through the regulation of social relations, based on technical expertise, using standardized procedures to achieve specified goals (Elwell, 1999; Freund, 1968). Ultimately, Weber argues, the progressive rationalization of society leads to an ‘iron cage’, in which members of a society become constrained by the very structures that they have created.

The concept of rationalization is echoed in medical anthropology literature discussing the concept of medicalization, a growing paradigm in the understanding of medical institutions since the 1970s (Conrad, 1992; for a review of early literature, see Conrad & Schneider, 1980). The concept of medicalization is summed up in the idea that medicine represents a social domain in which bodily processes are framed around rational/scientific processes. This standpoint, within the anthropology literature, is often contrasted with cultural views of the body as a space controlled by the individual, magic, or other social processes that are not rooted in scientific rationalism (e.g. Anderson, 1996). By integrating the body and mind into a world governed by predictable laws, the scientific view forms the groundwork for technologies that are used to control bodily processes (e.g. neurochemical ‘imbalance’) and avert maladies by restoring bodily systems to ‘normal’ functioning.

An important observation in the medicalization literature, strongly rooted in Weber’s theory of modern institutionalism, is that the sphere of activity seen as rational increasingly encroaches upon spheres formerly seen as outside the domain of the rational (e.g. Kirmayer, 1992; Zola, 1983). This process is the basis for the ‘iron cage’, and has been used to explain organizational isomorphism between medical institutions (e.g. DiMaggio & Powell, 1983; Fennell, 1980), as well as the encroaching of medical categories on society as a whole (e.g. Illich, 1976). Illich described this process as ‘the medicalization of life’, where increasingly individual tendencies become seen as ‘medical’ in nature, leading to the proliferation of medical categories. Examples of this process can be seen in the recently ‘discovered’ maladies such as hyperactivity disorder (Conrad, 1975) and alcoholism (Schneider, 1978), as well as the medicalization of processes such as childbirth (Schlenzka, 1999) and death (e.g. Shavelson, 1995).

More recent academic approaches have recognized the medical community’s attempt to integrate these critiques into its philosophy of patient care. Armstrong (2002), for example, discusses how the medical community has increasingly recognized social dynamics that underlie purely
technical practices, and has attempted to reconfigure its self image to fit concerns of colonization. Originating from both internal critiques (Balint, 1955) and the external study of medical practices by anthropologists and sociologists (e.g. Waitzkin, 1989), medicine began to realize the importance of dealing with socio-emotional features of the doctor–patient interaction, thus calling into question a simplistic model of rationalization (Williams, 2001; Williams & Calnan, 1996) to explain more contemporary medical approaches.

Medical interviewing and counselling thus differ from traditional approaches to medicalization in an important way. The latter process involves the use of a rationalizing discourse to categorize bodily processes. Medical counselling training, however, as we discuss later, takes diagnostic discourse itself as its object, attempting to use both rational and emotional discourses to formulate a diagnosis. This diagnosis is always a part of a rational medical framework. However, the recognition that the process of diagnosis is inherently discursive, and not purely formal/deductive, requires a different approach than a pure Weberian rationalism.

Communicative rationality

In his two-volume opus, *The theory of communicative action* (Habermas, 1981), Habermas used Weber’s institutional theory as a basis for a far-reaching theory of social interaction. Habermas builds on the insights of institutional theory to discuss how political and economic structures begin to colonize the lifeworlds of individuals, providing institutional standards and rules for action which are unquestioned by participants and, due to the social embeddedness of these institutions, are unquestionable. According to Habermas, modern thinkers from Kant onward have rightly emphasized the achievement of social progress through rational action, but have downplayed the intersubjective consensus necessary for such a rationality to emerge (Flyvbjerg, 1998). As a consequence, the rational systems which emerged through modernism became blind to the discursive, communicative practices that constitute social truths.

Communication, in this conception, is considered as discourse which is ‘oriented to achieving, sustaining, and reviewing consensus’ (Habermas, 1981: 17). While communicative action is rational, this rationality is not considered constraining, but emancipating, forming the basis of personal expression in a free society. Communicative rationality reflects the inner values, emotions, and motivations of a community, and thus provides a mutually respectful link between the individual and the social. In this way, communicative rationality is seen as key to a democratic society.
As we shall see, the philosophy of medical interviewing and counselling seems to share a prima facie assumption of Habermasian theory, in the importance of discursive practices in truth-seeking. The medical sociology literature has addressed how doctor–patient interviews provide a micro-setting for the larger project of medical rationalization (e.g. Fisher & Todd, 1993; Mishler, 1984; Waitzkin, 1983, 1991). This literature places significance in what Conrad (1992) terms the ‘interactional level’ of medicalization. At this level, medicalization is something that occurs at the interface of doctor and patient, through their discussion and interpretation of facts. The medical interview is an arena in which consensus on the causes, processes and remedies of illness can be reached through dialogue, working directly on the lifeworlds of patients through discourse (Mishler, 1984). This literature has drawn on Habermas’s work in describing doctor–patient interviews (e.g. Greenhalgh et al., 2006; Mishler, 1984; Waitzkin, 1989).

The study of medical interaction has, in particular, drawn from Habermas’s notion of communicative competence (Habermas, 1981), in positing ideal formal conditions in achieving therapeutic goals through communicative practice (e.g. Cassell, 1985; Labov & Fanshell, 1977). According to Habermas, communicative competence is based on the recognition that successful speech involves mastering not only the informational or grammatical structure of speech, but the social structure as well, and that communicative rationality occurs when the goal of mutual relatedness and understanding is embedded in the communicative act. Because this goal forms the basis for communicative acts, competence essentially involves an idealized relationship, referred to by Habermas as a universal pragmatics of speech (Habermas, 1979).

Intuitively, a notion of communicative competence underlies any approach to communication training that contrasts effective and ineffective communication techniques. We argue that such techniques imply an ideal speech situation in which members exhibit, among other things, open-ended questions, attentive silences, and avoiding sarcasm or interruptions (Zandbelt et al., 2006). While Habermas’s notion of communicative competence refers to ideal conditions of a communicative act whose end consists in democratic communion, in practice this involves the formulation of specific protocols or procedural rules for achieving ideal results. The result is the stressing of patient interaction rules in achieving therapeutic goals (e.g. Hyde, 1986; Labov & Fanshell, 1977). Cassell, for example, stresses the importance of sensitivity to paralinguistic cues, such as intonation and pitch, in making diagnoses (Cassell, 1985). However, medical communication is often framed as facilitating doctor influence over patients, who tend to be more compliant when, for example, doctors share more information (Ong et al., 1995).
type of focus, in Habermasian terms, seems more aligned with strategic, rather than communicative, action (Habermas, 1981). As we shall see, the strategic use of speech acts is an overt learning goal in the SP programme, and both SPs and medical students are given strict rules of interaction in the conduct of a medical encounter.

The above-mentioned emphasis on structured interactions introduces a power element into ‘open’ dialogue between doctors and patients, threatening to exert a repressive force that underlies the very open dialogue codified by these rules. Armstrong (1984), for example, argues that recent attempts to understand the ‘patient’s view’ are themselves ways of exerting subtle power while maintaining a veneer of sensitivity. Such criticisms, often based on a view that power relations are inherent in language, give rise to a questioning of the Habermasian point of view, that is, the view that liberating rationality is possible in discourse within a social field. Such a view of power was used by post-structural thinkers (e.g. Foucault) as a powerful critique of Habermasian theory, and so it is to this critique that we now turn.

**Communication and power relations**

As some scholars have noted, one difficulty with rationalistic views of discourse is that they overlook power dynamics inherent in communicative forms (e.g. Crespi, 1987; Rorty, 1991). Such critiques hold that the search for diagnostic solutions through rational discourse falls prey to an assertion of consensus that becomes transformed into a binding principle (Nietzsche, 1974), a critique that Foucault drew upon in formulating a history of scientific thought that exposed the Realpolitik of the rational scientific enterprise (e.g. Flyvbjerg, 1998). According to this critique, discourse is never free of interests, and it is the task of the scholar to uncover the ‘working of institutions which appear to be neutral and independent’ (Chomsky & Foucault, 1974: 171).

These perspectives rest on the idea that communication is inherently power-laden. In order to do justice to a Foucaultian view of power, however, it is necessary to clarify the notion of power being used, which differs from traditional notions of power as one-way domination. According to Foucault, power is a relational property within a discursive instance; it does not belong to anyone, but emerges in the ‘techne’ or practices of people in concrete instances (Foucault, 1978). This is not to say that domination does not take place, but rather, that this domination exists within a field of relations that defines the actors involved. In the field of communication skills, for example, some work has been done analysing communication techniques (e.g. smiling, making eye contact), as Foucaultian techne, putting outside of the sphere of
negotiation the relational styles workers use in dealings with clients (Townley, 1993).

In such a view, the doctor–patient communication episode might be seen as a ritual where enactments of power-defining practices are brought together to define doctors as authoritative and patients as submissive. Both doctor and patient participate in this ritual discourse, which is constitutive of the medical field (Foucault, 1972, 1998). Following this idea, some work has been done in the field of medical anthropology using Foucaultian perspectives to examine power relationships in medicine (e.g. Kuipers, 1989; Waitzkin, 1991). Armstrong’s (1984) view, mentioned above, uses the notion of a historically situated discourse to argue for a power-based view of medical interactions, while Steedly (1988) discusses medical discourse as centred around the institutional imperative to assert order. The work of Howard Waitzkin (especially 1989, 1991) has gone from a highly rationalist/ Marxist critique of power in medical interviews to a view much more in line with Foucault, especially the ‘confessionalist’ perspective on interviews in which the medical interview becomes a forum for institutional surveillance (e.g. Foucault, 1978). What is common here is a questioning of the historical purposes of rational truth-seeking, as well as a shift from viewing rationality as an ideal state to a view which sees rationality as a practice or technology forming part of the normative structure of the institution of medicine (Kuipers, 1989). As we saw above, the institutionalization of communication skills involves a similar movement from ideal speech competence to the regulation of specific speech practices. For example, Ong et al.’s (1995: 904) review of patient–doctor communication is framed in terms of the ‘ingredients’ of functional relationships. Because Foucault focused on the historical development of social practices, it stands to reason that using a Foucaultian perspective allows us to theorize not only the ends or objectives of such programmes, but also the techne or practices by which they are actualized, and to reflect on distortions that might occur in this process.

Summary

In the brief review above, we have attempted to show how institutional understandings of medical interactions grew out of a process involving a conceptual model of doctors and patients’ social roles. We have attempted to argue that, using different theoretical perspectives, this model can be viewed as an immutable structural logic (e.g. Weber, 1968, 1992), as a discursive logic (e.g. Habermas, 1981), or as an ideological practice (e.g. Foucault, 1972, 1998). In the following section, we describe the findings from a
participant-observer study of one such training programme, in order to illustrate specific ways in which the ideas above are actualized in a medical setting.

**Method**

The setting for this study was a SP programme in the medical school of a large US university. The programme was responsible for the training of medical students at varying levels of their education. While many of the above theoretical points may be relevant for medical education more generally, as well as both the field of medicine and potentially other technical fields that involve communication, we limited our study to the SP programme in particular. This is because the use of trained communication ‘dummies’ involved in such a programme provides a unique way to resolve the issue of communication standardization that merits analysis. Thus, while like all ethnography our results are meant to hold general lessons (e.g. Peacock, 1994), the empirical claims we make are limited to this local setting.

The SPs were hired employees of the programme, and ranged in tenure with the programme from one month to 13 years. The job of the SPs was to act the role of a patient with a certain set of medical issues, ranging from lifestyle issues, such as smoking or lack of exercise, to terminal illness, such as cancer. The SPs were given detailed profiles of their roles, and were trained to play the roles as would an actual patient with the specifications given (in some cases this included the application of face make-up and other theatrical props to enhance the ‘reality’ of an illness). These roles varied according to the particular student assessment, and ranged from a simple entrance interview to more physically invasive bodily examinations and ethically sensitive interviews such as bad news interviews, where the doctor-in-training either had to inform the patient of terminal illness, or the terminal illness of a loved one. SPs were matched to cases on the basis of physical similarity (e.g. age, gender, ethnicity) to the standardized case. In some cases, the SPs were allowed to give feedback to the medical students, and in others, a separate facilitator would give feedback based on the interview. In some cases, no feedback was given.

The lead author took part in the programme as a SP, working in four separate training programmes over a space of approximately six months over spring/summer 2004. Participation in the sessions lasted approximately 10 hours per week. Each programme began with a training session that lasted from one to three hours each, for a total of approximately 120 hours of participation in the programme. Data collection took the following forms:
a) field notes taken throughout hiring and training phases; b) notes taken between interviews and during breaks, in the form of remembered data (collected immediately following the encounter, so as not to lose information): notes included informal talks with other SPs, observations before and after SP sessions, and group periods when SPs would gather and discuss both work and non-work related topics; c) as part of the SP role, each employee watched videos of other doctor–SP interviews that were recorded live. Notes were taken throughout these encounters in parallel with the interviews. While some SPs were observed more than once during these sessions, multiple viewings were always interviews with different medical students, ensuring that each video interview was a unique interaction. d) All written materials given out during training and before each new case, consisting of information about the programme and descriptions of the different SP roles, were collected as data.

Several important nuances should be mentioned in order to clarify the limits of our research question. First, since the situations under study were not actual care situations, and did not involve actual patients, the doctor–patient relationship being studied is in fact an institutionally simulated doctor–patient relationship. Thus, the value of the study is in describing the ideals of the communication situation promoted through a professional socialization mechanism, and the process of putting these ideals into practice in a structured setting. It is not a description of the effects of doctor–patient interviews on doctors or patients, since, strictly speaking, there are neither doctors nor patients in this study. The virtue of this approach is that it presents a pastiche of doctor–patient relationships, and highlights the pre-established professional identities that trainers struggle to make real for doctors-to-be. Our study attempts to explore the core values in a medical socialization programme specifically, and while ultimately it may inform our views about processes in medicine and indeed technical fields generally, we should stress that such generalization, if informative, is also speculative.

We began the study with the general theoretical perspective discussed in the previous section, in order to ask the questions: do SP interviews embody processes of medical rationalization? If so, is this rationalization imposed bureaucratically, or does it emerge as a discursive product between the parties involved? If such a discursive construction does in fact occur, can the discourse be considered as occurring ‘democratically’, that is, on equal terms between civil actors, or is the discourse shot through with power relations that reflect institutional controls? Finally, we desired to know if the medical setting could provide unique answers to these questions that would not only help us understand the site of our study, but might inform how we conceptualize these theoretical views themselves.
Results

Rationalization in the medical interview

In the spirit of Weberian rationalism, the patient encounter was found to be heavily formalized, in terms of the expected behavioural roles of the doctor-in-training and the SP, and in the contextual backdrop against which these roles were enacted. In the following section, we describe how specific processes, both formal and informal, provide a conceptual frame in which the SP programme becomes an agent of professional formalization with regards to the patient encounter. We then describe how the outcomes of the encounter are submitted to formal processes of assessment and surveillance that ensure the transfer of formalized ‘soft skills’ as an outcome of the process.

First, the role of the SP programme as a component of the medical field has usually been discussed as a tool which allows psychometrically valid evaluation (e.g. Colliver et al., 1994). However, as a part of professional education, its role as a socializing agent cannot be understated. Both with regards to medical students and the SPs interviewed, we argue that the programme works to frame and promote institutional views of doctor and patient roles. Below, we describe some of the main features of this establishment of roles.

The patient role

It’s about you. This is about you.

(SP trainer)

Not surprisingly, the standardized patient programme promoted a stylized and formal role for interview patients. In fact, the major goal of such programmes is to formalize the assessment of doctor interviews by providing medical students with an object of study that remains stable and objective, so that students can be compared without the ‘noise’ introduced by natural variation in patient populations (Swartz & Colliver, 1996). As a result, the doctor is introduced to the patient as an ‘ideal type’ (Weber, 1949) that requires a specified set of information gathering and social support modules in order to exhibit positive outcomes. Thus, inherent in the SP concept is the idea of a bureaucratically established patient identity.

During SP training, it became obvious that this formalized identity was structured according to a standard narrative built in to each patient case. Each SP was urged during training to ‘build the scenario in your mind’, to fashion his/her behaviour after what one would expect from the life-story of the case.
At times, this included extrapolating the standardized life-narrative beyond the scope of the case, but always in line with what the role character ‘would have done’. For example, in a situation where the SP case involved conflict with the patient’s mother, SPs were told ‘you need to have a story for her’. Similarly, to answer questions not covered in the case, SPs were instructed to ‘just try to tie it in so it makes sense’. When the written case outlined an aggressive and demanding patient, the SP was to make sure that this demeanour was consistent throughout the interview. While embodying the ‘sense’ of the case, however, SPs were instructed to faithfully enact the written case given, and not to deviate from the cases under any circumstances. Thus, individual symptoms, personality types, and even social contexts of the role (all outlined in written form) were formalized in order to give a rational prototype upon which the scientific gaze of the doctor-in-training could turn.

That the prototype of the SP allows a rationalized diagnosis of medical conditions does not imply that the roles enacted by SPs are those of rational individuals. On the contrary, in many of the patient cases, the patient role is replete with socially and emotionally complex factors that the students must attempt to reconcile within their diagnostic model. For example, in one case, the progressive and terminal illness of ‘Andrew’ took place against the backdrop of his quiet, withdrawn demeanour. As the simulated illness progressed, this social unease turned into depressive and suicidal ideation. As a result, the interviewer, in order to deal with the patient appropriately, needed to address Andrew’s loneliness and depression, and provide a realistic vision of hope for a person who had, in the words of the trainer, ‘never made a big splash’.

It is easy to see why the cases were designed in this way: as a test of interpersonal skills, the doctors-in-training must be able to navigate their way through a complicated web of personal issues, in order to achieve a diagnosis despite, and sometimes because of, their adeptness at dealing with these factors. As such, the ability to formulate a proper medical application is dependent on the ability to use both factual and socio-emotional information in a way that is communicable to the patient, who is framed as an emotional and socially embedded being, not privy to the highly specialized procedures of the doctor.

In fact, however, when this patient role becomes institutionally standardized in a patient case, the role takes on a second function, that of an ideal form to which the SP must aspire. Standardized patients within the role of ‘Andrew’, for example, were trained to intentionally deny the possibility of Andrew’s rational agency in the handling of his own illness, instead relying on advice-seeking behaviour, such as asking ‘what would you do, doc’? In practice sessions during the training, SPs who overly questioned the
authority of the doctor or who took charge of self-diagnosing discourse were corrected with the rhetorical question, ‘is that what Andrew would really do?’ In addition, the SPs, when giving feedback, were specifically trained to only give feedback about immediate emotions and perceptions (i.e. ‘when you said that, it made me feel . . .’), and avoid feedback that provides alternative rational models for doctor behaviour (e.g. ‘I think it would be more effective if . . .’). As such, one could describe the patient role as a purified object of study that provides the raw material needed for the doctor to produce a scientific conclusion.

The doctor role

Unlike the SPs, the students whose job it was to simulate the doctor role in the interview were not standardized per se, but were actual people in their ‘true’ roles. In addition, since the interviews were often for assessment purposes, it was important that students be differentiated along a distribution of evaluative grades, in order to draw distinctions between students. Thus, while the patients in the interview were defined as homogeneous, the doctors were there specifically to be individuated (more on this further in the article). However, this individuating of the medical students used a set of assessment tools and expectations that were firmly rooted in an institutional vision of an ideal role identity. In other words, the medical students were evaluated according to specific written criteria (evaluation questionnaires ranging from 20 to 80 questions), outside of which no positive or negative behaviours could be used for assessment.

In following this standardization of assessment, part of the SP training included a test of their ability to successfully identify doctor behaviours included in the assessment. Examples of doctor discourse were given to be rated by SPs, and their assessments were corrected until they fit the assessments given in the training materials. In this way, deviant cases (i.e. those in which norms are not properly embodied; Silverman, 2001) are pointed out to the group and dealt with before the critical moment when the SPs will engage the doctors-in-training. While the ostensive purpose of this procedure was to promote reliable measurement, it also ensures that the medical students be judged according to identical behavioural criteria across interviews. In this way, SPs were exhorted to give assessments of patient interviews in ways that matched the idealized criteria of the training programme. In the following, we describe some elements of these criteria.

First, the doctor role in the interview was concerned with fact-gathering about patient concerns. This fact-gathering, in order to be effective, was to be couched in an interpersonal style of openness that
allowed the standardized patient to divulge information comfortably. According to the SP trainers, ‘it is their job to give you opportunities’. The doctors-in-training were assessed on their fact-gathering effectiveness and on these stylistic factors, which included ‘eye-contact’, ‘posture’, and ‘jargon-free language’. One of the main purposes of the SP interviews was to promote such interpersonal stylistics and to measure their application according to operational criteria such as eye-contact.

At the same time, the interview was also taught as a kind of genre, directed by the medical students, whose structure was conventionalized into particular generic forms (cf. Orlikowski & Yates, 1994, on organizational genre). The questioning pattern of the doctors was assessed on its organization, which in turn, was assessed by its audience impact: ‘If you [the SP] are confused, it [the interview] is not organized.’ Doctor–patient questions were to begin as open queries, and become progressively more focused until a specific cause was isolated from all possibilities, leading to an accurate diagnosis. In those cases where a previously made diagnosis was to be explained, the doctor was to ‘frame it in terms of tests and evidence’, and to ‘always focus on action’. In addition, in no circumstances were patient emotions to be ignored; rather, these emotions were to be used constructively to formulate action plans, while drawn out emotional musings were to be underplayed. Ultimately, SPs were informed that the doctor’s role was to make patients ‘hope for the best, while preparing for the worst’.

While a more in-depth examination of the particular discursive elements of this stylistic genre might be warranted, it is sufficient here to stress that the genre, in almost parodying fashion, reflects an enlightenment view of scientific inquiry, in which the interview begins with a buzzing confusion of unorganized data, and with the help of the insightful questions of the scientist, this confusion is narrowed into a set of testable theses and, ultimately, an accurate diagnosis. Promoting the acknowledgement of interpersonal processes throughout this procedure, while central to the purported goal of the SP programme, gains legitimacy in the process mainly because: 1) it prevents socio-emotional processes exhibited by the patient to become obstructions to the fact gathering; and 2) it allows particularly socio-emotional causes of illness (e.g. stress, unhealthy living habits, etc.) to enter the interview as diagnosis-relevant information.

The communicative construction of the patient’s lifeworld

The previous discussion highlighted the structuredness of doctor–patient interaction that is key to the SP interview process. We now discuss ways in which discourse in the SP programme works to negotiate rational norms, and
imposes rationality not only as an a priori scientific ideal, but as a social practice.

The first point that should be brought out is that the inclusion of communication skills as a medical technique is itself a tempering of scientific rationality with ‘soft skills’ (Lazarus, 1988), and constitutes a shift in the way that medical practice is conceptualized (Kleinman, 1980). In the patient interview, it is acknowledged that the only way to reach a sound medical opinion is to discuss important issues with the patient. During SP training, this was phrased in the imperative ‘they’ve got to probe’. That is, SPs were trained only to allow scientific discovery after an in-depth process of discussion. Examples of this kind of probing included follow-up questions and instigating discussions of matters that the patient might not like to discuss, such as changing diet or smoking behaviour. The imperative to probe was framed as a key part of training doctors; however, we hold that it also reflects an epistemological shift in the conceptualization of medical practice, from that of pure observation to that of interactive truth discovery.

In line with this interactive perspective, a major focus was that of remedying communicative pathologies on the part of the doctors-to-be. SPs were told to be understanding of doctors who ‘had no idea’ of patient interaction skills, as many of them were ‘doing this for the first time’. Here, we see a clear reflection of Habermas’s (1981) notion of remedying communicative pathologies as a way of reaching rational consensus. The instructions to be patient with doctors who were overly formal is an implicit recognition of the traditional difficulties of technical fields in dealing with socio-emotional complexities, and an attempt to remedy this difficulty. The irony is that the urge to patience is given as an instruction within a standardized setting, such that while we may applaud the goal of patience, the notion of implementing patience as a technique seems to reproduce the very logic it attempts to soften.

A second way in which communication became a keystone for scientific diagnosis was through the concept of contemplative stages of lifestyle change (Prochaska & DiClemente, 1992). Each SP was given written materials and trained to understand illness consciousness as the outcome of four discrete patient stages, where the job of the doctor was to correctly identify the current contemplative stage of the patient and act accordingly. Within the programme, it was held that these stages in lifestyle change (i.e. smoking, stressful living, diet, etc.) determine the types of communicative approaches that doctors must take. The first stage, precontemplation, describes a patient who has little or no thought about changing, requiring an approach that includes awareness raising without excessive pressure to change. The contemplative stage follows, in which the patient is thinking about change, and
the interviewer must motivate through giving options for action and telling inspirational success stories of change. The *preparation* stage occurs where the patient is ready to begin action, and should be helped in making plans. Finally, the *maintenance* stage involves reinforcing positive behaviour and teaching coping mechanisms to prevent relapse.

The assessment of contemplative stages was stressed as a key factor in enabling the doctor-in-training to adequately interact with the patient. While the stages themselves were theoretically imposed on the conversation, they amounted to speech rules (cf. Austin, 1962; Searle, 1969) that allowed structured dialogue that could lead to consensus and, ultimately, patient acceptance of medical conclusions. Without a view of the doctor's role as a communicator, in addition to a scientific observer, the use of contemplative stages would be meaningless. The use of this technique reflects, in our opinion, a view of rationality as a dialogic phenomenon which progresses along a continuum of development, with the ultimate goal being the establishment and maintenance of a medico-rational model.

**Power relations in the discourse**

In Habermas's (1981) discussion of social interaction, it was stressed that within civil institutions, a prerequisite for the emergence of communicative rationality was the ability for actors to communicate on equal footing, without power differentials and status norms that deflect true communication. However, as discussed above, many scholars have critiqued this ideal, which reflects an enlightenment view of a society unrealistically stripped of power relations (e.g. Foucault, 1972).

For example, many scholars have pointed out that the ability to define situations is inherently power-laden, allowing issues to be framed according to the mandates of a single party, despite the free discussion allowed within the spectrum of discourse (e.g. Chomsky, 1998; Foucault, 1972). This is certainly the case within the patient interview, where throughout the communicative act, the diagnostic power remains with the doctor-in-training. While it is true that the discussion of causes and context in the interview take place in an interactive discussion between patient and doctor, it is the doctor who has the final diagnostic authority.

In addition to the power of the doctor to define the modes of behaviour that best suit the patient (e.g. quitting smoking, eating healthy food, etc.), there is clearly a motivation on the part of the doctors-in-training to shift the views of the patient to conform to those of the medical community, which are the ‘correct’ views. This was very evident from discussions with interviewers post-interview, who mentioned, among other
things, that it was obvious that ‘of course you take your meds, of course you quit smoking’, that ‘the key question is whether they are ready to do something different’ (emphasis added), and that ‘[patients] are in a different world. You have to get in their world’.

The expectation, discussed above, that doctors ‘had to probe’ gives a similar picture of the relationship between doctors and patients embodied in the patient interview. The patients are framed, in the words of one SP facilitator, as from a ‘different world’, but in addition, it is the job of the doctor to overcome this difference, not through equal compromise and collaboration, but through an integration which (sensitively) colonizes the world of the patient. While the doctor must be attentive to the contemplative stages of the patient, these stages are not themselves negotiable, and must inevitably lead toward the action and maintenance stage. Thus, within the SP interview, the Habermasian notion of power-based systems is ever present even in the communicative act.

Finally, the institutionalization of power relations through the one-sided integration of differences can be informative because it shows us that power exists through the medical dialogue and not only in the absence of dialogue, but also because of the specific forms that the doctor/patient differences take. For example, as previously discussed, SPs are specifically trained to refrain from giving analytical or rational feedback, and are instead supposed to give feedback only in terms of perceptions and emotional reactions. By framing feedback as perceptual/emotional and not cognitive, the SP is presumed to represent the everyday populace who is not well versed in technical medical reasoning. However, embedded within this role dichotomy is also a hierarchical framing of role identities, such that the correctness of the medical diagnosis is built into the doctor’s role, and the patient, while crucial for success, is only important insofar as he/she can be motivated to provide raw information and emotional readiness feedback. According to Erickson (1999: 113), ‘without a clear diagnosis, the full technical apparatus of modern medicine cannot be brought to bear on the case, and this is aesthetically, intellectually, and morally unsatisfying for physicians’. As such, the doctor role rests on an ‘aesthetic, intellectual, and moral’ imperative to draw clear boundaries around the patient, who, as a normal citizen, is not capable of such self-defining activities.

This hierarchically distinct doctor identity is reflected in the following suggestion by trainers to a doctor-in-training: ‘Write [diet advice] down on a prescription pad and stick it on the fridge. That note will mean much more than Aunt Sally’s advice’. Here we see how the power relation of the doctor to the patient becomes evident, by comparison to other non-doctors, in this case, the medically non-legitimized role of ‘Aunt Sally’.
As discussed above, a power-based approach that uses Foucault cannot simply characterize the doctor role as oppressive of the everyday person, here referred to as ‘Aunt Sally’. Rather, we must recognize that the establishment of a medical training that teaches doctors that they are authoritative over and above everyday actors is here used as a way to better patient outcomes. This betterment takes into account the patient’s perspective in using persuasive tactics that resonate with the patients, rather than formal doctor-directive to take one’s medicine. However, the explicit establishment of hierarchy here also circumvents the ideal of rational communicative action, creating a typically Foucaultian mixture of care and control.

Discussion

The significance of the above findings rests upon the assumption that one way to better understand the world of work is by examining occupational fields in terms of the kinds of logic they promote, and the processes by which these logics emerge. Social scientific approaches to the medical field have treated at great length the rational-scientific model as applied to bodily processes, often from a perspective emphasizing dominion and social control (e.g. Kirmayer, 1992; Szasz, 1963; Zola, 1983). The current treatment attempts to more closely examine how the rational-scientific model is promoted within one setting in the medical field. While we do not claim that the standardization of medical practices is wholly or even primarily the outcome of such training, the SP programme is one space in which the institution of medicine meets the lifeworlds of non-medical experts, and that this interface is interesting because it deals not with the traditionally technical elements of medical practice, but with the attempt to render technical the traditionally humanistic area of interpersonal communication. Because this programme has the function of training and assessment, we believe that it provides an ideal setting for examining the propagation of institutional structures. In order to better examine these structures, we have attempted to view them from the lenses of various paradigms, each of which provides its own insights into the process involved.

We believe that examining this issue using distinct but historically related paradigms provides several benefits for study. Institutional and communicative rationalism provide an interesting way to locate standardized patients in between ‘system’ and ‘lifeworld’ elements of medical socialization (Habermas, 1981). In addition, the power-based view of discourse provides a way to navigate between these dimensions of social life, recognizing the power relations in diagnostic interviewing while recognizing that
discourse, participation, and taking the patient perspective transform this power relation from one of domination into one of co-constitution (Foucault, 1978). Thus patients as subjective agents are allowed and encouraged to participate in the diagnostic process, but this participation is contingent upon the systemic pre-definition of the subjects themselves.

More generally, studying the medical setting as a seat of institutionalized power discourses is an ideal way to point out the application of these theories in modern life. In some respects, the medical diagnosis forms a quintessential prototype of the process of technical rationality, mediating relations between body, mind, and institution. The medical diagnosis can thus inform a general discussion of truth-seeking in modern institutions. In this way, the evolution of diagnostic techniques may mirror the evolution of social ways of knowing, by questioning and improving techniques by which decisions about bodily processes are made. According to our findings, the programme reflects an awareness of the importance of communicative rationality, while underplaying the continuing marginalization of the patient through: 1) the framing of the patient as a visceral, non-rational being; and 2) the simultaneous homogenization of patients and the individuation of doctors though the concept of a SP.

Finally, while our analysis has emphasized the power relations which structure counselling interviews, it is important to stress that this article is not an argument against the use of standardized patient programmes specifically, or communication skills programmes more generally. We believe that this caveat is essential because describing internal contradictions or mixed messages in a social logic is often seen as an attempt to invalidate or undermine this logic (e.g. Cuddon, 1991). This is not necessarily the case. It may be, for example, that the medical profession is inherently pulled between the technical and the human sides of its practices, such that an SP programme may be carving a precarious path between conflicting values. It may also be that such distinctions are deeply ingrained in modern conceptions of subjects in relation to their technological creations, such that one could not fairly expect the medical profession to shake off fundamental concepts that are more generally rooted.

To make an abstract point more concrete, a trained doctor may have the ability to define ailments in ways that patients do not, and thus asymmetrical power relations may result in benefits to the patients. Referring to the earlier example, it is difficult to argue that ‘Aunt Sally’ should have primacy or even equality in the diagnostic dialogue when compared to a licensed physician. Thus, showing anti-democratic elements within a patient interview is not to say that we must change the way that doctors interview, because perhaps democracy does not make sense in a diagnostic interview. However, the key point is that people do value deliberative democracy, even
in medical settings, and as this value grinds against the technical, non-negotiable formalism of medicine, interesting institutions arise that encode these contradictions (Barley & Knight, 1992). This analysis is not meant to subvert the definitional authority of doctors, but to point out these surprising and innovative forms, as the development of doctor-education comes to recognize the complex nature of human illness. As these advances continue, it is the task of the social scientist to track how complex social forms of power and interaction develop from them.

The preceding point raises the need for a generalized examination of the ways in which occupational fields, through their technical emphases, frame relations between stakeholders and employees, and how these relations in turn reinforce these emphases. Advances not only in medicine, but in economics and management among others, provide models which are often instrumental in focus, elaborating new technologies that allow them to reach institutional goals. Without discounting the instrumental benefits of such advancements, it is important to recognize that they often depend on ideas about how people interact, and in turn impose these ideas on the interactions themselves, reconstituting social orders with varying degrees of success. The underlying current of thought in this article is that understanding the interface between occupational logics and social interactions is key both to the success of instrumental advancements and to the social scientific goal of understanding society at large.

References


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