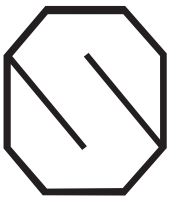

Managerial Culture, Workplace Culture and Situated Curricula in Organizational Learning

Aviad E. Raz and Judith Fadlon

Abstract

Seen from a perspective of symbolic interaction and social constructivism, organizational learning is a practical accomplishment that takes place among and through other organizational members. This study sets out to explore the social construction of organizational learning by examining the responses of members to a management-imposed teaching curriculum that contradicted basic assumptions regarding professional identity. We build on the results of recent ethnographic fieldwork which has investigated the incorporation of communication skills training in an Israeli medical school. This professional socialization is examined in terms of its theoretization by the management, its implementation in the curriculum, and its interpretation by supervising physicians and medical students. These various facets of meaning and their mismatches provide a concrete example for the study of situated learning in organizations. We conclude by exploring the meaning and interplay of managerial ideology, workplace culture and situated curricula in organizational learning.

Keywords: organizational learning, situated curriculum, professional socialization, communication skills training, medical school, Israel

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The concept of 'organizational learning' is not self-evident. Despite recent attempts to address the theoretical problem of individual- versus organizational-level learning, many of these attempts did not analyse the mechanisms, routines and products of learning in a concrete, observable fashion. The literature on organizational learning still lacks consensus as to how learning at the individual level is transformed into organizational-level learning (Popper and Lipschitz 1998). The conventional view of learning assumes a unilateral process of information transfer from a knowledgeable source to a target lacking that information. This process is supposed to culminate successfully with the acquisition of the body of data by the target audience. A similar view underlies functionalist theories of socialization (Parsons 1951). Proponents of organizational culture have likewise stressed the function of organizational learning in socializing the employee into dominant organizational values and professional roles (Van Maanen and Schein 1979). However, this view is challenged from various perspectives arguing, for example, that organizational culture is seldom integrative and coherent, and knowledge that emerges dynamically from daily interactions

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on the job and from 'theories in use' differs from espoused theories and training procedures (Argyris and Schon 1978, 1996). In many cases, different work groups and membership roles involve different forms of socialization of which management and employees have differing perceptions. It follows that organizational learning is very likely a practical accomplishment that takes place among and through other people in the organization. This study sets out to explore what happens when the management imposes a body of knowledge that contradicts basic assumptions regarding professional identity. For this purpose we focus on professional socialization to a particular occupational culture, namely the socialization of students in medical school. We build on the results of recent ethnographic fieldwork which has investigated the incorporation of communication skills training in an Israeli medical school. This curricular activity will be examined here in terms of its theoretization by the management, its implementation in practice, its interpretation by faculty and students, and its evaluation. These various facets of meaning and their mismatches provide a concrete example for the study of situated learning in organizations.

Professional Socialization and Organizational Learning: Between Formal and Situated Curricula

Following G. H. Mead's 'symbolic interactionism', learning should be regarded as a social process of interaction. From a complementary 'constructivist' or 'interpretive' perspective, learning should also be viewed in terms of 'situated action', where meaning is embedded in context and knowledge is not 'objective' but inter-subjective (Denzin and Lincoln 1994; Denzin 1997; Weick 1995). Scholars working in the tradition of symbolic interactionism and social constructivism have argued that professional learning studies need to undergo a 'paradigm shift' from the previously dominant cognitive model of learners as information-processing individuals to an image of learners as social actors whose learning is contingent on social interaction within specific socio-cultural settings (Weick 1993; Gherardi et al. 1998; Nicolini and Meznar 1995; Miner and Mezias 1996). To understand learning activities in organizations we therefore need to locate these activities within the organizational contexts that endow them with value, status, historical background and expectations (Senge 1990; Weick 1995). These contexts are conveniently subsumed under the rubric of organizational culture, which interconnects symbolic meaning, normative practices and material artefacts within the organization (Schein 1990, 1985; Martin 1992, 2002). Following our emphasis on organizational learning as social interaction, we stress that organizational culture is better viewed as constituted on two inter-connected categories: managerial and workplace cultures (Raz 2002). The first category, managerial culture, designates the perceptions of management and its top-down messages, systems, norms and artefacts. The second category, workplace culture, encompasses the everyday practices of organizational life as seen from the members' point of view. These two categories only partially overlap. The common area

designates congruity and acceptance, or 'devotion' (Barley and Kunda 1992). Workplace culture also provides room for counter-cultures and for workers' subversion of managerial ideology and control (Shenhav 1999). Managerial as well as workplace culture embody 'communities of practice' that are informal aggregations of people defined by the shared manner in which they do things and interpret events (Lave and Wenger 1991; Brown and Duguid 1991). Learning that takes place in specific communities of practice can promote or resist knowledge prescribed by managerial culture.

The situated conceptualization of professional socialization and learning is becoming increasingly influential (e.g. Tsoukas 2002; Boud and Middleton 2003; Contu and Willmott 2003; Nonaka and Takeuchi 1995). Bogenrieder and Nooteboom (2004), for example, discuss the types and characteristics of learning groups by focusing on three related aspects: the types of knowledge and opportunities for learning, the governance of social relations, and structural features such as network density, stability and strength within the group. Other studies have focused on the difference between 'canonical' and 'non-canonical' or 'procedural' knowledge (Cohen and Bacdayan 1996), where knowledge and learning are seen as 'embedded' within team structure, interactions and shared beliefs (Edmondson 1999). As Orr (1990, 1991, 1995, 1996) observed, in his widely cited study of photocopier technicians, because technicians conceived of themselves as artful, heroic troubleshooters, they came into conflict with managers eager to proceduralize and standardize their work. Lave and Wenger (1991) used the notion of 'learning curriculum' in opposition to that of 'teaching curriculum', emphasizing the contrast between learning through engagement and co-participation in actual activities with other members of the community, and learning mediated through an instructor's participation and relying on an external view of what 'knowing' is about. Gherardi et al. (1998) introduced the concept of 'situated curriculum', which is part of the learning curriculum, in order to address the pattern of learning opportunities available to newcomers in their encounter with a specific community inside a specific organization. The situated curriculum is embedded in the general habits and traditions of the community, and it is sustained and tacitly transmitted from one generation to the next. As Contu and Willmott (2003: 284) explain,

> 'Within communities of practice, it is not the acquisition of skill or knowledge with a universal currency (e.g. textbook knowledge) that identifies the "competent" member. Rather, it is a demonstrated ability to "read" the local context and act in ways that are recognized and valued by other members of the immediate community of practice that is all-important. In this respect […] learning is not adequately understood as the transmission/acquisition of information or skill but inter alia involves the construction of identities.'

A similar conceptualization has been offered in socio-anthropological studies of medical socialization (Foucault 1967; Good 1994; Berg 1995). The way a medical student is taught to think 'anatomically' promotes depersonalization and objectification of the human being. Medical socialization conditions students to distinguish body from mind and to deconstruct the whole body into organs, tissues, cells and genes. As part of this learning

process, 'disease' is explained through biochemistry, physiology or infection. For the purpose of this study we focus on communication skills training as a form of professional socialization in medical education. While communication skills training has recently become an accepted part of the teaching curriculum in medical education, at present there is tremendous variation among medical schools in the way, and extent to which, communication skills are taught and assessed (Hargie et al. 1998). The most recent and comprehensive survey on communication skills education in North American medical schools was conducted by the Association of American Medical Colleges (1999). Of 144 medical schools, 76 reported that they used a combination of discussion, observation and practice in teaching such skills. The primary teaching methods were small-group discussions and seminars (91%), lectures and presentations (82%), student interviews with simulated patients (79%), student observation of faculty with real patients (74%) and student interviews with real patients (72%). Nearly half of the schools (45%) reported using rounds to teach communication skills. There is no standard curriculum for teaching communication skills, nor a coherent conceptual framework for evaluating the outcomes of such teaching. Recently, the National Board of Medical Examiners, the Federation of State Medical Boards and the Educational Commission for Foreign Medical Graduates have been working together in the US towards implementing a clinical skills examination using standardized patients, to be taken between the third and fourth years of medical school as part of the United States Medical Licensing Examination (Makoul 2003).

A major part of traditional medical socialization focused on the desensitization and emotional detachment of medical students (Hafferty 1988). This traditional socialization appears to be at odds with the concept of communication skills training. Our hypothesis is that, in order to fit into biomedical socialization, 'communication skills' and 'empathy training' had to be re-conceptualized as yet another clinical competence that promotes effective medical treatment. Such re-conceptualization emphasizes that empathy, for doctors, should be an intellectual rather than emotional form of knowing in order not to threaten professional objectivity and detachment (Halpern 2003).

The need for formal communication skills teaching and learning in health care education is well established, and a substantial body of evidence has also accumulated about the problems of communication between health care professionals and patients and the benefits of good communication (Silverman et al. 1988; Spencer and Silverman 2001). However, this induced change has yet to overcome more traditional perceptions of medical interviewing, in which prevailing student concerns are more often related to technical errors and communication with their superiors rather than with patients (Moss and McManus 1992). Interpersonal communication and empathy are overshadowed, in biomedical socialization, by the dominant values of objectivity, emotional detachment, authority and scientism (Halpern 2003). Hence the study of communication skills teaching in medical school could highlight the social construction of organizational learning since, while communication skills training is formally incorporated into the medical teaching curriculum,

its actual implementation and interpretation probably take place within the situated curriculum of medical students and their teachers as communities of practice.

Communication Skills Teaching in an Israeli Medical School

In a recent research study we investigated the communication skills training of first-year medical students in an Israeli medical school. Israel has one of the highest ratios of doctors to population in the world (472/100,000), and primary and hospital care are readily available (Shuval and Anson 2000). The Israeli medical system is characterized by authority and elitism rooted in European medical culture (Shuval 1992: 271–273), where for many years treatment was to be administered without explanation and asking for a second opinion was regarded as mutiny (Glick 1985).

Our study followed the communication skills training of a class of 70 first-year medical students during 2002–03. Students' average age was 22.7 years (range 18–28) and 42% were male. Data was collected through participant observation in classes and lectures that, although intended for first-year students, were open to attendance, and through focus groups that were part of the regular evaluation of the communication programme. Personal details regarding the identity of speakers and participants were deleted in order to protect their anonymity. A research assistant observed and took notes in the various activities conducted throughout the year as part of communication skills training, such as relevant lectures on communication, introductory communication skills workshops, debriefing workshop for supervising physicians, and feedback sessions conducted by supervising physicians. Semi-structured focus groups were conducted with students (n = 210) who participated in communication workshops as part of their activities in first-year clinical settings. Four such focus groups, each consisting of 17–19 first-year students, were held each year during 1999–2001 following a series of sessions conducted in clinical settings. The focus groups were moderated by a communications teacher and sometimes by a physician, and included questions about the communication skills training conducted in each clinical setting, the introductory lecture, the workshops and the interviews with patients. The moderator asked these questions in the same way but in an open-ended manner. While the focus group was structured around these standard questions, open discussions also developed around particular questions. Comments written by the participants on feedback forms were analysed, reaching agreement between the researchers on categorization of attitudes related to each activity. Disagreements were resolved by discussion. In addition to participant observation and focus groups, we also analysed educational texts and evaluation tools used in communications skills training in order to elicit the 'espoused ideology' of communication skills training in medical school. These texts included the teacher's and students' communication skills handbook and the various performance evaluation forms administered as part of communication skills training.

Managerial Culture and the Teaching Curriculum

The medical school we discuss is affiliated with one of Israel's universities and has a strong community health services orientation. The school has a six-year curriculum in which basic sciences, clinical medicine and public health constitute the main areas of teaching. Student involvement in clinical studies begins in the first year through a programme of early clinical teaching. This is in contrast with the more traditional sharp demarcation between pre-clinical and clinical teaching programmes.

The early clinical programme in the first year comprises one full day each week. Pedagogic activities in this first-year programme include communication skills training, observation and contact with patients, and workshops based on specific themes. Students take a basic communication workshop at the beginning of the academic year, where the focus is on the importance of the interview in the physician's care of his/her patient as a whole person in the community. The workshop is taught by a communication expert (PhD, non-physician) and focuses on acquiring interview techniques through role-playing. Students then practise their communication skills by interviewing patients in four different settings — paediatrics, obstetrics and gynaecology, internal medicine, and geriatrics. In each of these settings, activities are conducted in the hospital and in the community. In each setting, students interview patients as part of their continuing acquisition of communication skills, receive feedback from supervising physicians and behavioral scientists, and discuss relevant concepts such as cultural variations in health beliefs and models of doctor–patient relationship. In this manner communication studies that include didactic sessions and practical exercises are integrated into the first-year clinical curriculum. The communication skills component changed hands in the course of its existence and each time a new teacher took responsibility for the course, its contents were changed, although the basic structure remained intact.

Workplace Culture and the Situated Curriculum

While the 'espoused ideology' of communication skills training in the medical school we studied was based on the medical school's bio-psycho-social approach stressing patient-centred medicine and community orientation, in practice communication skills training was implemented not as a goal in itself, but as a means for patient education and for improving treatment outcomes. The preliminary communication workshop, for example, emphasized 'patient-centred interviewing' as a clinical competence. The message was that empathy was important as an interviewing skill in medicine and that its use could help the physician obtain a reliable history and understand more clearly the aetiology of the disease. Empathy was presented not only as promoting effective communication but also as cost-effective, saving much time and expense in the long run. A similar message was encapsulated in an introductory lecture on 'communication in the first-year curriculum',

delivered each year to the new cohort of students by a physician, a prominent staff member of the medical school, as part of the summer course for first-year students. The lecturer began his talk by explaining the need for communication skills training in medical school, which he did not take for granted but rather laboured to justify on the basis of patients' complaints. The lecturer then proceeded to tell a few stories that concerned the negative consequences of 'bad communication' for medical treatment, consequences ranging from misunderstandings to unintended deaths and malpractice lawsuits. It was usually the patient, and not the doctor, who was blamed for the misunderstandings portrayed in these stories.

While students did not resist the idea that communication was important for medical purposes, some of them expressed disagreement when instructed to ask patients questions that did not seem to be directly connected to anamnesis (the process of inquiry related to the patient's medical history and current complaint). For many students, professional identity required social distance in order to maintain the professional authority of 'the doctor'. While communication instructors insisted on the importance of the 'bio-psycho-social interview', many students preferred the traditional concept of anamnesis which focuses on eliciting medical information. The challenge to professional identity was strongly felt during discussions that concerned empathy as a communication skill. As one student said in a communications workshop: 'We don't come here to patronize, but patients come to doctors because doctors know better, so the doctor has to have more authority than the patient.' As a result, the communications teacher retracted and took a defensive position. The above-mentioned exchange should be regarded as a critical incident in organizational socialization (Schein 1985). It illustrates how organizational culture is dynamically formed through groups in training. The criticism of students and the response of the communications teacher construct a negotiated order that is the basis for established norms (Schein 1990). Critical incidents like this demonstrate that, while managerial perceptions are important, the reality of organizational culture is also constructed in everyday interactions, by creating ad hoc responses to internal cultural challenges.

After the completion of the introductory communication workshop and before the beginning of clinical interviewing, a short workshop was scheduled for the physicians responsible for supervising the first-year clinical activities. This workshop, conducted by the principal communications teacher, was designed to share with the physicians the experience gained in the introductory communication workshop and the responses of students to communication skills training. However, the situated curriculum that surfaced in the workshop was very different from the intended teaching curriculum. To begin with, the workshop was limited to only one hour owing to schedule constraints imposed by the physicians. In addition, only the physicians affiliated with one of the four clinical settings arrived at the meeting and subsequently another meeting had to be held. Following workshop activities, some of the students commented that they were not getting any relevant feedback on communication skills from the supervising physicians in medical

interviewing activities. The most prevalent comment among these students was that the supervising physicians were only interested in the medical information that students were able to obtain from the patients they had interviewed during the workshop. The doctors' feedback to the students following the interview did not contain any reference to the communication skills and empathic competence taught in the introductory communication workshop, but instead focused on the medical information that was discussed in the interview. This lack of cooperation from the supervising physicians in charge of interviewing sessions distinguished the situated curriculum of communication skills training from its intended teaching curriculum, and sent a strong derogatory message to students regarding the real value of communication skills training in the workplace culture of medical school. While there were a few doctors who were open to and respected the contribution of communication skills training to medical socialization, most of the doctors were ignorant of the message, the techniques and the language of communication skills training and, when hearing of them for the first time during workshops or meetings, refrained from using them. The following analysis of a medi-drama workshop further demonstrates the mismatch between the teaching curriculum as designed by the management and the situated curriculum that has emerged in communication skills training.

The Medi-Drama Workshop

Simulation exercises role-played by actors are accepted methods for teaching in medical schools worldwide (Hardoff and Schonmann 2001; Fortin et al. 2002). The first-year clinical studies in the medical school we studied included a workshop on the subject of the adolescent patient, in which the communication workshop involved students from the drama department of a high school, who played the patients' roles. The purpose of this communication workshop was three fold. First, it was meant to help students, who were already interviewing patients on the wards, to practise interviewing on sensitive areas such as menstruation, sexual relations and birth control, without feeling embarrassed. Second, it was designed to illustrate to students that avoiding these issues would lead to failure in diagnosing the medical problem. Third, the workshop was designed to allow students to practise interviews with patients who were aggressive, shy or overly familiar and talkative.

The exercise began with a doctor–patient role-play, during which one student from the group volunteered to confront one young actor. The student would then interview the patient and sometimes the communications teacher conducting the workshop would stop the interview and suggest a different avenue for interviewing. When the role-play was completed, the young actor and the students were asked to describe their feelings during the simulation and the actor was asked to evaluate the student's performance. Other students who had watched the role-play would suggest other possible ways of conducting the interview and then a portion of the interview was re-enacted, evaluated and discussed. Each role-play and discussion took about 45 minutes and usually two to three cases were exercised at each meeting.

To illustrate this activity, three vignettes are presented.

1 A 14-year-old girl complains of tiredness and weakness for several weeks. Her appetite has decreased and lately she has refrained from going out with her friends at weekends. System review revealed frequent prolonged menstrual periods with blood clots. The presentation may be interpreted as associated with psycho-social problems, but the probable diagnosis of dysfunctional uterine bleeding resulting in severe anaemia points to the patient's complaints. Adolescent girls frequently feel uneasy about discussing issues relating to their menstrual periods, and young medical students, especially males, are embarrassed to discuss these issues with patients. This exercise was designed to allow medical students to practise asking questions on these issues and also to probe psycho-social issues which might be behind the shyness of this interviewee.
2 A very talkative, cheeky, self-confident and over-familiar adolescent comes to see the doctor because she had fainted in gym class. The medical student has to take control of the interview by overcoming the constant interruption by the youngster, and then to discover that the adolescent, who is sexually active, has not been using contraceptives and is pregnant.
3 A very uncooperative and aggressive adolescent comes to the doctor to ask for a medical certificate in order to join the local gym. The patient is very uncooperative about sharing information on her eating habits and constantly urges the doctor 'to get on with it'. The challenge here is to overcome the patient's aggression and the temptation to give her the medical certificate and get rid of her. Conducting a comprehensive interview leads to the discovery that the adolescent is anorexic.

Self-report evaluations filled by students following the medi-drama workshops showed that the workshops were well received and viewed as effective. Indeed, these communication workshops were seen as realistic, experiential learning without having to worry about harming or insulting patients (a universal concern of student beginners), and allowing for immediate feedback. The positive reactions of the medical students might therefore be explained by the fact that the workshop was 'not real', allowing them more degrees of freedom in comparison to real-life situations. Another interpretation, however, would consider the positive response of students to the medi-drama workshops in light of the situated curriculum that surfaced in these workshops.

The construction of communication skills in the medi-drama workshops was based on three elements: (1) conducting an interview that touched on bio-psycho-social aspects of the patient's complaint; (2) dealing with intimate themes without embarrassment and with a contrived use of empathy; and (3) uncovering a 'medical secret' which the simulated patient did not reveal unless asked the correct questions. These elements underpinned the medi-drama workshop and were reinforced by the vignettes, the actors and the teachers. A concise description of a typical interaction that took place in the medi-drama workshop should help illustrate how the actual role-play was navigated in a way that led students to 'take the role of the doctor'. We

describe for that purpose a typical interaction characterizing the enactment of the second vignette (cheeky adolescent who fainted in gym class and was found to be pregnant). The actor who played the role of the simulated patient tried to monopolize the interview, asking the interviewer questions such as 'How are you doing?' and 'What is your name?', and rambled on about various topics such as a detailed description of all those who were with her at the time she fainted. The interviewers would answer politely, disclosing their first name, and displaying patience with the actor's seemingly endless stories. As the actor rambled on, the interviewers soon realized that if they did not gain control over the interview, they would not be able to arrive at a diagnosis. They therefore took control, interrupting the simulated patient and asking questions. When asked by one interviewer how she spends her time and if she goes out at night often, the actor replied enthusiastically, mentioning three of her favourite clubs in the city, and asked: 'Don't you know these clubs?' When the student paused to answer, the actor burst out again: 'Don't you ever go to parties? How old are you?'

Student: 'Hmmm … Let me see … I finished my MD … I'm thirty-five.'

The audience laughed and the student continued:

Student: 'So, ahhh … when you go out, how much do you drink?'

Actor: 'One glass.'

Student: 'And do you smoke?'

Actor: 'No.'

This exchange demonstrates how students who played the role of the interviewer assumed that they needed to take the role of 'the doctor' rather than be themselves; this is why the student reacted to the question 'How old are you?' by not giving her actual age but rather the age she would presumably be after completing her MD studies. At this stage of the interview, the interviewer — who by now has constantly interrupted the patient using the sentence 'I'd like to get to the point' — continued by asking questions about the patient's boyfriend, whether they used condoms ('almost always'), the pill ('no'), and when was her last period (about two months ago). The facilitator encouraged the student by saying 'now this is a good question' and the actor's replies became more informative and to the point. When the student suggested a pregnancy test, at first the actor said: 'What for?' but the student insisted, saying 'Let's do it so we both feel on the safe side.' After the actor agreed, the audience would often applaud.

This exchange illustrates how gaining and retaining control of the interview was constructed in the medi-drama workshop as a clinical technique alongside empathic listening to be employed for the effective elicitation of medical information. This contradicted the school's perception of empathic communication as a goal in itself, and was congruent with the norms presented by the supervising physicians throughout the year's activities as well as with the traditional view of the doctor's role that many of the students subscribed to. The contrived use of empathy by students can be demonstrated by citing a

typical exchange from another interview conducted with an actor simulating a patient who was very shy and reticent to provide information (first vignette). The interviewer confronted the patient's shyness by using empathic formulae such as repeating the patient's answer and asking her for her thoughts on the problem, but often in an impatient tone and body language, not pausing to give the patient time to gather herself and respond. For example:

Student: 'So, I understand you've had this problem for quite some time. What do you think is causing this problem? What?'

Actor: 'I don't know really.'

Student, *pausing to sigh*: 'Well, then I'll just have to continue asking.' *Laughter from audience.*

Exchanges between the interviewer and the other students observing the interview was quite a common occurrence in these simulated interviews and served to momentarily break the fabric of the contrived drama and provide relief from the tension of interviewing. This occurred through laughter, breaks in the interview, or applause, as demonstrated in the above-mentioned observations. Exchanges with facilitators usually conveyed the message that 'just talking' to the patient was not enough as long as it did not lead to diagnosis, even though in their first year students were not supposed to have the medical knowledge required to arrive at an accurate diagnosis. For example, when a student who conducted a very empathic and sharing interview but did not arrive at a diagnosis concluded by saying that he would give the patient permission to work out at the gym (third vignette), the teacher did not commend the interviewer for his efforts but instead said: 'Are you really going to send her off now like that?', implying that the interview was not over because the problem had not been revealed. Indeed, in such cases the teacher would encourage the interviewer to continue with the questioning.

It should be noted that all these simulations (created, examined and approved by physicians) were framed around a 'problematic' patient. This was perhaps necessary in order to develop the students' communication skills. The important thing, however, was that in contrast to the humanistically oriented meaning attached to empathy and patient-centred communication in the teaching curriculum, the actual role-play led students to 'take the role of the doctor' by conducting a medical *inquiry* and displaying control. The interview unfolded as a 'detective story' in which students sought to unveil the truth about the medical problem, while the 'patient' tried to keep it a secret. In this manner the simulated interview reproduced the power relations stereotypically inherent in the doctor–patient relationship. It also reproduced the biomedical premise concerning the factual, physiological basis of the disease. The medi-drama workshops thus reproduced the conventional *workplace* cultural construction of the medical interview, the physician's role and the patient's role.

In contrast, simulated interviews with translators, which focused on cultural and linguistic barriers to communication without employing a 'medical mystery' plot, did not garner such positive responses from students. In a

similar manner to traditional practices of biomedical socialization such as the medical write-up, the medical interview and the case presentation, the simulated interviews preferred by students constructed the person as a patient, a case and a medical project.

Discussion

Since the population studied here consisted of first-year students, their responses cannot be the result of medical socialization, but probably represent the mismatch between the implementation of communication skills training and students' and faculty's images regarding the physician's professional identity. Further research on the socialization of medical students along their six-year course of studies is needed in order to verify that communication skills training did not change the traditional pattern of medical socialization but was rather appropriated by it. It is possible that at their young age, first-year students may not yet have gathered enough experience to incorporate the 'anatomical model' into a broader philosophy of health care. It was indeed the medical school's espoused ideology that anatomical knowledge can be re-integrated into a more holistic framework of medicine (the 'bio-psycho-social model'). A longitudinal study is needed to test this possibility. However, the findings of this study suggest that the situated curriculum of communication skills training that has emerged in first-year activities — including the communication course, the supervised clinical interviews and the medi-drama workshops — reflected not an exception but the rule. First, studies of medical socialization have shown that, even when communication skills training is introduced as part of pre-clinical teaching programmes, the patient-centred approach that is emphasized during this early stage proves to be inconsistent with the disease-centred (biomedical) approach practised during clinical education and on the wards (Benbassat and Baumal 2001). Second, the simulated interviewing replicated a traditional model of achieving and maintaining control of the interaction, even though more recent approaches support sharing control, decisions and information with the patient. Interestingly, the empathic formulae were used to this purpose. Third, physicians who participated as teachers and supervisors in communication skills training also propagated the traditional values of biomedical culture while often diminishing the importance of open communication. The majority of physicians in the medical school we studied lacked the conceptual orientation and the training to implement the teaching curriculum in communications. However, for the students we studied, these physicians had much higher status in relation to their non-MD communication teachers.

Our findings show that at the individual level, learning communication skills involved not so much a cognitive internalization of data as an active process of participatory appropriation (Rogoff 1995). Indeed, many students resisted the teaching curriculum of communication skills and played an active part in defining their own learning opportunities. Students' responses, the feedback of supervising physicians, and the negotiations of communication

teachers constructed a situated curriculum that was shaped by the patterns of interpersonal engagement and arrangements between participants. In contrast to the personal and idiosyncratic situated curricula described, for example, by Gherardi et al. (1998) in the context of construction site managers, the situated curriculum we observed gradually took the form of a shared arena of negotiation, which was in conflict with the teaching curriculum — a tension not addressed by Gherardi et al. (1998).

At the organizational level of analysis, several explanations can be provided for the mismatch between the medical school's perception of communication versus its implementation and interpretation within workplace culture. Institutional theory would argue that communication skills training in medical school is a formal structure that reflects a myth and ceremony (Meyer and Rowan 1977). Medical schools, according to this perspective, were forced to adopt the fashionable practice of 'communication skills training' due to increasing market pressures that drove them to increase their social legitimacy through normative isomorphism (DiMaggio et al. 1983). While this may explain the difficulties of newly introduced communication skills training in other medical schools, it is less relevant to the medical school studied here which had been originally established with the ideology of patient-centred medicine and had implemented communication skills training long before this became the new trend in medical education. Indeed, the focus on communication skills training in the medical school we studied was not the result of globalization or of more recent local changes in the health market in Israel, such as its opening up for competition in 1995 as a result of the National Health Insurance Law (Chinitz 2000). It is possible, however, that the focus on communication as being cost-effective (reducing the potential for patients to 'shop around', make complaints or bring malpractice suits) was connected to the growing competition among Israeli health maintenance organizations following the National Health Insurance Law of 1995 as well as to the influence of the Patient Rights Law, which came into effect in 1999.

Conclusion

In a similar manner to other medical schools, communication skills training in the medical school we studied was incorporated into a strong workplace (and perhaps occupational) culture emphasizing task-orientation, scientism, efficiency, hierarchy and authority. As one of the medical students interviewed in another study of biomedical socialization in the US typically summed it up, 'medical school teaches not to talk with people and learn about their lives and nurture them. You're not there for that. You're a professional and you're trained in interpreting phenomenological descriptions of behavior into physiological and patho-physiological processes' (cited in Good 1994: 78). This incorporation explains the emergence of situated learning in which communication skills were constructed as an instrumental clinical competence. This phenomenon presents the complex interplay between managerial culture, workplace culture and situated curricula within organizational learning. We

would like to offer here, in conclusion, several viewpoints that can be used to reflect on this complexity and to provide directions for future research.

First, situated curricula are multi-faceted. We can categorize the situated curricula that emerged in medical school into two different parts: affective (communication with patients) and instrumental (anatomical/clinical knowledge that leads to diagnosis and treatment). While in managerial culture these parts were seen as complementary and equally important, in workplace culture the former (affective) part was subsumed under the latter (instrumental) part. In addition, the instrumental part of the curriculum, unlike the affective part, was much more frequently reviewed, examined and measured within formal as well as situated learning.

Second, situated curricula can be thought of as emerging following the juxtaposition, in one organization, of different — and possibly conflicting — managerial and workplace cultures. Communication skills training was added to the teaching curriculum by a management that wanted to impart a humanist orientation to medical students. As intended, communication skills training thus posed a challenge to the workplace culture of experienced physicians characterized by a medical orientation. A longitudinal study is needed to find out what the end result of this challenge was. Yet our findings show that in the first year — a formative stage of professional socialization in medical school — it was the situated curriculum of communication skills training that took precedence over the teaching curriculum. In this manner, the situated curriculum demarcated the territories of influence of managerial and workplace cultures. We hypothesize that a strong occupational culture (e.g. that of physicians) would promote the construction of situated curricula when a conflict is generated between managerial and workplace cultures.

Third, the conflict between the situated curriculum and the teaching curriculum is usually not resolved in a simple or unidirectional manner. Rather, organizational dynamics unfold in a way that often retains cultural complexities and contradictions between the management and communities of practice, as well as among different communities of practice in the same organization.

Fourth, situated curricula can be thought of as indications of communities of practice. As Tsoukas (2002) argues, communities of practice were initially seen as facilitating knowledge flow within communities of like-minded practitioners, but more recently, it has been pointed out that communities of practice constrain knowledge flows through the organization. It follows that communities of practice can be both instrumental and dysfunctional in the eyes of management (Robinson 2001). The subjective and interpersonal interpretation of participants, as illustrated by the medical students in this study, can influence the evolvement of the community of practice in one way or another.

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References

Argyris, Chris, and Donald Schon
1978 *Organizational learning.* New York: Addison-Wesley.

Argyris, Chris, and Donald Schon
1996 *Organizational learning II: Theory, method and practice*. New York: Addison-Wesley.

Association of American Medical Colleges
1999 'Contemporary issues in medicine: Communication in medicine' (Report III of the Medical School Objectives Project). Washington, DC: Association of American Medical Colleges.

Barley, Stephen, and Gideon Kunda
1992 'Design and devotion: Surges of rational and normative ideologies of control in managerial discourse'. *Administrative Science Quarterly* 37: 363–399.

Benbassat, Jochanan, and Reuben Baumal
2001 'Teaching doctor-patient interviewing skills using an integrated learner and teacher-centered approach'. *American Journal of the Medical Sciences* 322/6: 349–357.

Berg, M.
1995 'Turning a practice into a science: Reconceptualizing post-war medical practice'. *Social Studies of Science* 25: 437–76.

Bogenrieder, Irma, and Bart Nooteboom
2004 'Learning groups: What types are there? A theoretical analysis and an empirical study in a consultancy firm'. *Organization Studies* 25/2: 287–313.

Boud, David, and Heather Middleton
2003 'Learning from others at work: Communities of practice and informal learning'. *Journal of Workplace Learning* 15/5: 194–205.

Brown, J. S., and P. Duguid
1991 'Organizational learning and communities of practice: Toward a unified view of working, learning and innovation'. *Organization Science* 2/1: 40–57.

Chinitz, David, *editor*
2000 *The changing face of health systems.* The Israel National Institute for Health Policy and Health Services Research. Jerusalem: Gefen.

Cohen, M.D., and P. Bacdayan
1996 'Organizational routines are stored as procedural memory' in *Organizational learning*. M. D. Cohen and L. S. Sproull (eds), 403–430. London: Sage.

Contu, Alessia, and Hugh Willmott
2003 'Re-embedding situatedness: The importance of power relations in learning theory'. *Organization Science* 14/3: 283–297.

Denzin, Norman K.
1997 *Interpretive ethnography: Ethnographic practices for the 21st century.* Thousand Oaks, CA: Sage.

Denzin, Norman K., and Yvonne S. Lincoln, *editors*
1994 *Handbook of qualitative research*. Thousand Oaks, CA: Sage.

DiMaggio, P., J. Powell, and W. Walter
1983 'The iron cage revisited: Institutional isomorphism and collective rationality in organizational fields'. *American Sociological Review* 48: 147–160.

Edmondson, Amy
1999 'Psychological safety and learning behavior in work teams'. *Administrative Science Quarterly* 44: 350–383.

Fortin, Auguste, Frederick Haeseler, Nancy Angoff, Liza Cariaga-Lo, Matthew S. Ellman, Luz Vasquez, and Laurie Bridger
2002 'Teaching pre-clinical medical students an integrated approach to medical interviewing'. *Journal of General Internal Medicine* 17/9: 704–711.

Foucault, Michel
1967 *Madness and civilization.* New York: Random House.

Gherardi, Silvia, Davide Nicolini, and Francesca Odella
1998 'Toward a social understanding of how people learn in organizations'. *Management Learning* 29/3: 273–299.

Glick, Shimon
1985 Symposium on 'Patients' Rights'. Ben-Gurion University Medical School (in Hebrew).

Good, Byron J.
1994 *Medicine, rationality, and experience: An anthropological perspective*. Cambridge: Cambridge University Press.

Hafferty, F.
1988 'Cadaver stories and the emotional socialization of medical students'. *Journal of Health and Social Behaviour* 29: 344–356.

Halpern, Jodi
2003 'What is clinical empathy?' *Journal of General Internal Medicine* 18/8: 670–678.

Hardoff, Daniel, and Shifra Schonmann
2001 'Training physicians in communication skills with adolescents using teenage actors as simulated patients'. *Medical Education* 35/3: 206–209.

Hargie, O., D. Dickson, M. Boohan, and K. Hughes
1998 'A survey of communication skills training in UK schools of medicine: Present practices and prospective proposals'. *Medical Education* 32: 25–34.

Lave, J., and E. Wenger
1991 *Situated learning: Legitimate peripheral participation.* Cambridge: Cambridge University Press.

Makoul, George
2003 'Communication skills education in medical school and beyond'. *Journal of the American Medical Association* 289/1: 93–94.

Martin, Joanne
1992 *Cultures in organizations: Three perspectives.* Oxford: Oxford University Press.

Martin, Joanne
2002 *Organizational culture: Mapping the terrain*. Thousand Oaks, CA: Sage.

Meyer, J., and B. Rowan
1977 'Institutionalized organizations: Formal structure as myth and ceremony'. *American Journal of Sociology* 83: 340–363.

Miner, A., and S. Mezias
1996 'Ugly duckling no more: Pasts and futures of organizational learning research'. *Organization Science* 7/1: 88–99.

Moss, F., and I. McManus
1992 'The anxieties of new clinical students'. *Medical Education* 26: 17–20.

Nicolini, D., and R. Meznar
1995 'The social construction of organizational learning: Concepts and practical issues in the field'. *Human Relations* 48/7: 727–746.

Nonaka, I., and H. Takeuchi
1995 *The knowledge creating company*. Oxford: Oxford University Press.

Orr, Julian
1990 'Sharing knowledge, celebrating identity: Community memory in a service culture' in *Collective remembering*. D. S. Middleton and D. Edwards (eds). Newbury Park, CA: Sage.

Orr, Julian
1991 'Contested knowledge'. *Anthropology of Work Rev.* XII/3: 12–17.

Orr, Julian
1995 'Ethnography and organizational learning: In pursuit of learning at work' in *Organizational learning and technological change.* C. Zucchermaglio, S. Bagnara, and S. Stucky, (eds). Berlin: Springer.

Orr, Julian
1996 *Talking about machines: An ethnography of a modern job.* Ithaca, NY: ILR Press.

Parsons, Talcott
1951 *The social system*. New York: Free Press.

Popper, Miha, and Raanan Lipshitz
1998 'Organizational learning mechanisms: A cultural and structural approach to organizational learning'. *Journal of Applied Behavioral Science* 34: 161–178.

Raz, Aviad
2002 *Emotions at work: Normative control, culture and organizations in Japan and America.* Cambridge, MA and London: Harvard University Asia Center.

Robinson, Viviane
2001 'Descriptive and normative research on organizational learning'. *International Journal of Educational Management* 15/2: 58–69.

Rogoff, B.
1995 'Observing sociocultural activity on three planes: Participatory appropriation, guided participation, and apprenticeship' in *Sociocultural studies of mind.* J. Wertsch, P. Del Rio, and A. Alvarez (eds). Cambridge: Cambridge University Press.

Schein, Edgar
1985 *Organizational culture and leadership*. San Francisco: Jossey-Bass.

Schein, Edgar
1990 'Organizational culture'. *American Psychologist* February: 109–119.

Senge, Peter M.
1990 *The fifth dimension: The art and practice of the learning organization.* New York: Doubleday.

Shenhav, Yehouda
1999 *Manufacturing rationality.* Oxford: Oxford University Press.

Shuval, Judith
1992 *Social dimensions of health: The Israel experience.* New York: Praeger.

Shuval, Judith, and Ofra Anson
200 *Social structure and health in Israel.* Jerusalem: Hebrew University, Magnes Press.

Silverman, J., S. Kurtz, and J. Draper
1988 *Skills for communicating with patients*. Oxford: Radcliffe Medical Press.

Spencer, John, and Jonathan Silverman
2001 'Education for communication: Much already known, so much more to understand'. *Medical Education* 35/3: 188–190.

Tsoukas, Haridimos
2002 'Introduction: Knowledge-based perspectives on organizations: Situated knowledge, novelty, and communities of practice'. *Management Learning* 33/4: 419–427.

Van Maanen, John, and Edgar Schein
1979 'Toward a theory of organizational socialization'. *Research in Organizational Behavior* 1: 209–264.

Weick, Karl
1993 'Conceptual options in the study of organizational learning' in *Learning organizations.* M. M. Crossan, H. W. Lane, J. C. Rush, and R. E. White (eds). London, Ontario: Western Business School, London and the University of Western Ontario.

Weick, Karl
1995 *Sensemaking in organizations*. Thousand Oaks, CA: Sage.

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