The Language of “Circule”: Discursive Construction of False Referral in Iranian Teaching Hospitals

This article explores the practice of false patient out-referral by medical students in Iranian teaching hospital emergency departments. Drawing on participant-observations and interviews during eight months in six hospitals in Tehran, we investigate how discourse is appropriated to construct and legitimate out-referrals through four general strategies of sympathy, mystification, intimidation, and procrastination. Based on a critical approach to false out-referral discourse, we revisit the medical and educational functioning of teaching hospitals in Iran: Focusing on medical students involved in false out-referrals, their discursive reproduction of deception is examined along with their legitimate challenges to institutional structures. Moreover, focusing on the institution of hospital, institutional corruption is discussed along with the problematic of covert cultural defiance faced by a modernist organizational construct in a nonmainstream cultural context. Finally, we argue that the discourse of false out-referral calls for more profound public awareness in dealing with health institutions.

Keywords: [discourse of medicine, medical education, emergency referral, Iranian hospitals]
Confused by the resident’s out-referral of the boy to another hospital while the Intensive Care Unit of the same hospital could conveniently admit him, Hossein was wondering about the wisdom of the resident who was, after all, more experienced than he was. It appeared, however, that the resident was reluctant to admit the patient simply because according to the regulations, the first-line admitting resident would be in charge of the patient’s affairs after the admission and the resident had several reasons to avoid the responsibility. Therefore, convincing the uncle that out-referral was vital for his nephew’s successful treatment was the most convenient way to manage the whole issue. The resident’s justification was that a patient who is highly likely to expire must be referred to another hospital. To Hossein’s astonishment, the bottom line simply was: Why should I waste my time over such a troublesome case?

This article explores a concern that started to emerge in the wake of this experience about false out-referral decisions by medical students in Iranian teaching hospitals. Out-referring patients to alternative medical centers could be a reasonably frequent procedure for varying reasons in many minor departments (Asplin et al. 2003). Nonetheless, false out-referral, as illustrated in our introductory experience, may raise serious concerns about the hidden corners of medical practices in teaching hospitals; about the social and ethical aspects of medical education; and more broadly about the health of health care systems (Epstein 1994).

The process of convincing patients and their relatives that out-referral is the most beneficial decision for them is a primarily discursive practice. Therefore, we attempt to investigate how language is appropriated in a process of discursive construction of false patient out-referrals. Based on illustrations of such discursive constructions, a number of issues are raised about the educational as well as the medical practices in such contexts. Moreover, with an approach broadly founded on critical discourse studies (see, e.g., Blommaert and Bulcaen 2000; Fairclough 1995; van Dijk 1993, 2001) and referring to the role of discourse in constructing and legitimating world-views, perceptions, and practices (Fairclough 1989; Jager 2001; van Dijk 2004), we discuss the implications of such a discursive context for medical care and education.

Concerns over such social and discursive considerations in the context of medical education have been subject to challenging research. Becker et al. (1961) explore the culture of medical students in their pioneering Boys in White. They specifically address the institutionalization of medical students as well as resistances against the institutionalizing forces. More specifically related to the present discussion, Becker and his colleagues raise the concern over autonomy as well as legitimacy of student acts. More recently, Toulis and Sinclair (1997) investigate the overt and covert involvements of medical students through their training and on their way to becoming doctors. Another particularly relevant work, as far as the present study is concerned, is Paul Atkinson’s problematization of social and institutional forces surrounding Medical Talk and Medical Work (Atkinson 1995). Discursive construction in medical practice is a central theme in his work: “The course of illness and medical management is repeatedly refracted through the discursive act of clinical specialists” (p. 39).

Moreover, the volume of discursive studies of health and medicine has been evaluated as “phenomenal” (Adolphs et al. 2004:10). A major body of this phenomenal trend focuses on the so-called medical encounters and includes descriptive
or critical examinations of the communication between doctors and patients (see, e.g., Ainsworth-Vaughn 1998, 2003; Cordella 2004; Gotti and Salager-Meyer 2006; Gulich 2003; Mishler 1984). Many of these studies tend to situate the discourse of medical communication within a broader social context (see, e.g., Fisher and Todd 1993; Shaw and Greenhalgh 2008). Further expanding the social concern, some critically oriented research on medical discourse, explicitly referring to a critical standpoint or implicitly adopting critical analytical procedures, have sometimes focused on the ideological and even political underpinnings of medical discourse (MacDonald 2002; Waitzkin 1989, 1991).

More specifically, different aspects of “the discourse of hospital communication” are investigated as a category of organizational discourse (Iedema 2007). Although a dominant trend in such studies is the discourse analysis of organizational and managerial structure of hospitals (Iedema 2003; Iedema and Wodak 1999), a few researchers consider specific features of the discourse of medicine in the particular context of EDs. Scheeres et al. (2008), for instance, explore communicating in hospital EDs, and Slade et al. (2008) investigate the discursive challenges facing emergency clinicians and patients in hospital EDs. As particularly relevant to the present study, Barton (2000) focuses on the discursive practices that are shaped around the specific concern of referrals and how the degree of expertise and compliance on the part of patients influences such “interactional practices.” Related to another aspect of the present study, that is, the discursive practices of medical students, Li and Pahal (2006) deal with the communication among residents and patients in a Canadian context. Focusing on similar concerns emerging from lived experience in Iranian teaching hospitals, this article is aimed at the investigation of ED out-referral practice of medical students, which has rarely been tackled through critical discourse studies.

The Iranian Health System

About a thousand years ago Razi, the great Iranian hakim,1 wrote: Man, as treats the illnesses of body, should try to discern the illnesses of soul. Human beings’ virtue rests on cultivating their thought and striving to purge it, rather than serving evil desires and temptations (Najmabadi 1987). This is traditionally viewed as a consensus among the Iranian people and doctors of all generations. Accordingly, health care providers have always been respected by the Iranian people because far beyond their providing health care for the society they have been known for their wisdom. In this section we present an overview of the organization and functions of health institutions situated within such a context of medical culture.

The Iranian Ministry of Health and Medical Education (MHME) is responsible for health issues of the country along three major lines of duty (Ministry of Health and Medical Education 2008). First, the ministry is responsible for public health including the prevention of diseases; preservation of environmental hygiene; monitoring health standards of food, nutrients, and drinking water; and improvement of maternal health and child growth. Second, the ministry is centrally involved with issues of treatment that involves supply of adequate medical services at different levels and providing medical facilities for all. This broad area of responsibilities is
generally dealt with through provincial universities of medical sciences. Third, the ministry is the main national institution of medical education and research.

Essentially, there is at least one medical university in each of the 30 provinces of the country, with at least one affiliated teaching hospital. Teaching hospitals are mainly staffed by medical school faculty members and medical students of different levels. Both students and physicians have two responsibilities at the same time: medical training and medical care provision at different levels (Azizi 1988, 1997; Marandi 1996, 2001). Although there are arguments to the contrary (Entezari et al. 2009), it appears that because of this dual responsibility of the medical staff, the quality tends to diminish in both roles. The quality of patient management is frequently overshadowed by medical training, and this is likely to cause a public distrust with regard to state-run hospitals (Behboodi 2001; Seif-Rabii and Shahidzadeh 2006). Such a concern over public trust in health systems has been a rather widely investigated issue in several other contexts as well (see, e.g., Abelson et al. 2009; Gilson 2003; van Der Schee et al. 2007).

Beside the state-run (teaching) hospitals, there are private hospitals that are usually rather expensive and in many cases do not recognize state insurances. Private hospitals are publicly known to be well equipped under high standards of sanitary conditions and with good staffing and facilities (Tabibi et al. 2002). Unlike the public attitude toward these private hospitals, it is a widely accepted belief among the general public in Iran that teaching hospitals are not the safest places for patients (Behboodi 2001; Tabibi et al. 2002). However, the major burden of health services in Iran is on the shoulders of teaching hospitals, which mostly provide health services either free or at very low cost.

EDs of Iranian teaching hospitals, as the particular context of concern in this study, are a mixture of different hospital sectors. Rarely in teaching hospitals is there a specialized sector of emergency medicine as an independent specialty. The responsibilities of the ED are collectively put on the shoulders of medical staff from various specialties, and the department is usually composed of several sections run by residents and interns on their emergency duty. For each service section, an on-call attending physician with a relevant specialization is appointed. There is also a general practitioner who is in charge of triaging and introducing patients to different services.

Normally, residents and interns take the history of the patients that the triaging general practitioner refers to their particular emergency service section. They perform the required physical examinations and determine the further procedures that may be needed to diagnose the problem and treat the patients. Only in very rare, complicated cases may residents call the on-call attending physicians of their particular ED service. After the initial examinations by interns and residents, the issue of referral is raised as the ED is not a place in which patients are kept for long. Some patients are referred to a ward in the same hospital and some to other hospitals.

Such patient out-referrals essentially form part of the requirements of the proper functioning of EDs because the involvements of EDs primarily center on upholding basic life support. Out-referrals are particularly important when the number of patients in-referred to a specific ED exceeds the capacity of the available facilities (Asplin et al. 2003; Burt et al. 2006). Therefore, ED staff may frequently
refer patients to other medical centers within the normal time limits or even sometimes very immediately and without taking any therapeutic action (Derlet and Nishio 1990). Patient out-referral practices, however, may be corrupted on different grounds, and it is to this concern that we turn in the following section.

False Referrals in Emergency Departments

Out-referring patients is a relatively frequent practice in managing complicated patient conditions in medical centers at different levels of health care systems (Bulstrode 1995; Cortazzo et al. 1993). In the context of EDs, specifically related to the present discussion, as the term emergency indicates, it is a generally accepted notion that patients should not remain in the department beyond a few hours (Dunn 2003; Locker et al. 2005). ‘Fast track’ ED mechanisms are even considering target periods of less than an hour (Considine et al. 2008). If requiring medical care for longer periods, patients are normally out-referred to a related unit within the same medical center or to other centers that can meet the requirements of the patient’s specific medical condition.

Immediate patient out-referrals may be justified on at least two grounds: First, ED staff may fail to continue to preserve life support for patients beyond the facilities available in the department. In many cases the facilities cannot be granted by the same hospital, hence the patients should be out-referred to another center (Bertazzoni et al. 2008; Derlet and Nishio 1990). Second, once the in-referred patients’ urgent health state improves to a stable condition in the ED, and they are diagnosed with an underlying etiology, they may require further specialized workup not available within the ED. Such patients are also logically to be out-referred to certain sections that can provide the required specialties (Cortazzo et al. 1993; Derlet and Nishio 1990).

However, patient out-referral decisions are likely to be influenced by causes other than scientific medical reasons or administrative wisdom. There are at least two motivations for unjustified and fraudulent out-referral. First, ED staff may direct patients to other medical centers in which they are financial stakeholders themselves. Doctors might invest in freestanding facilities, such as clinical laboratories or radiology services, to which they refer patients. Referrals arising from such financial conflicts of interest shape a major source of potential false out-referral (Di Tella and Savedoff 2001; Epstein 1994). It was reported, for instance, that in the early 1990s, physicians in Florida and several other states of the United States owned almost all freestanding radiology centers (Lo 2005). Therefore, without any logical therapeutic indication, patients can be directed toward the decision of shifting their treatment process to certain private hospitals.

Second, within the context of EDs in Iranian teaching hospitals, apart from financial causes, the very nature of the ED out-referral mechanism may itself be a cause of potential false out-referrals. Iranian teaching hospital EDs are handled by attending physicians, residents, and interns who earn very low salaries and have to carry the burden of a very heavy workload. As far as attending physicians are concerned, their main motivation to be involved in these hospitals is that it is a mandatory part of their otherwise prestigious and lucrative academic and medical profession. Medical students, however, have no choice but to tolerate such a situation as part
of their training toward their dream job as medical doctors. In such circumstances the medical staff tend to be indifferent toward the patients who are referred to their teaching hospitals (Hassan-Pour et al. 2004). Not unexpectedly, circumventing the institutional mechanism of supervision, they may attempt to out-refer patients even illegitimately, and in some cases they may even refuse to admit some patients simply to manage their workload.

In this context, as specified in the following sections, medical students have their own reasons to become involved in the practice of false out-referral. There are a number of tensions imposed on medical students that cumulatively converge into forces that push them toward frequent attempts at out-referring patients when there is hardly any medical justification. Considering the pivotal role of medical students in the process of Iranian teaching hospital ED functioning, on the one hand, and the major role of teaching hospitals within the Iranian health system, on the other hand, student-initiated false out-referrals shape a serious concern. It is this concern that, as the focus of the present study, will be dealt with in detail in the rest of this article.

The Present Study

In this study we investigate aspects of how medical interns and residents in EDs of Iranian teaching hospitals under study appropriate language, in general, and the discourse of medicine, in particular, to construct and legitimate false out-referrals. How patient consent for out-referral is discursively fabricated in this particular context and the far-reaching consequences of such practices in terms of medical education, public perceptions of medical practices, and the overall functioning of the health system are the issues we explore in this research.

With an ethnographic approach, two sets of data were collected over a period of eight months at six teaching hospitals affiliated with Shaheed Beheshti University of Medical Sciences in Tehran. Participant-observation by one of the researchers was the main source of data and was carried out in surgery, internal medicine, and gynecology sections of EDs in three hospitals in periods of two, four, and two months, respectively. Field notes were recorded during the emergency duty of the researcher at these service sections of teaching hospital EDs. A second set of data comprised informal interviews with interns, residents, medical staff, and patients at these three hospitals as well as informal interviews with medical interns on their emergency duties at three other teaching hospitals.

The researcher was an intern himself. He wrote the observation notes in brief periods of time he found during his involvements with taking the history of patients and treating them. Moreover, he talked to interns and residents during the rest and lunch time or in the intervals between patients. Most of the time, medical students told stories of their experiences of false out-referral not in response to the researcher’s elicitation but just as part of their normal friendly chat. There were frequent instances of the researcher’s involvement with a complicated emergency case when he found himself in the midst of false out-referral practice that was later recorded in his notes. The medical students of our concern were not observed through ethnographic eyes, as such, but were lived with. Their stories were ubiquitous in the informal interactions of interns and residents. Therefore, because
the data collection occurred during this true participation in the context and in the frantic situation of the emergency setting, it was neither practically obliging nor ethically compelling to obtain the typical consent form.

The two bodies of data were examined based on a critical view of the socially situated nature of discourse discussed in the literature on critical discourse studies (Blommaert and Bulcaen 2000; Bucholtz 2001; Fairclough 1995; van Dijk 1993, 2001; Wodak and Meyer 2001). Specifically, based on van Leeuwen’s (2008) conception of “the discursive construction of legitimation,” we coded the data in search of themes in the medical students’ discursive attempts at constructing and legitimating the social practice of false out-referral. Considering legitimation as justifications about the reasons why “a social practice or some part of it must take place, or must take place in the way that it does” (p. 20), van Leeuwen argues that discourses legitimate social practices besides representing them. He presents a broad model of four major and several minor categories of legitimation.

Of particular relevance to this study is van Leeuwen’s proposed legitimation category of Authorization that refers to “legitimation by reference to the authority of tradition, custom, law, and/or persons in whom institutional authority of some kind is vested” (p. 105). Authorization is subcategorized into six types of authority: personal, expert, role model, impersonal, tradition, and conformity (see Table 1). His other major types of legitimation, which may occur in various combinations with Authorization, include Moral Evaluation and Rationalization. What is at stake here is a type of (false) legitimation of the social practice of out-referral,

Table 1. Categories of Discursive Legitimation

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<th>Category</th>
<th>Description</th>
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<tr>
<td><strong>Personal Authority</strong></td>
<td>Legitimate act relies on personal roles in a particular institution, not requiring much effort for justification. It is legitimate because a special person says so.</td>
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<tr>
<td><strong>Expert Authority</strong></td>
<td>Legitimacy is based on expertise that may be explicitly stated or may be taken for granted if the expert is recognized in a particular context.</td>
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<tr>
<td><strong>Role Model Authority</strong></td>
<td>Following role models is the source of legitimacy. Certain behaviors or beliefs of these role models are sufficient to legitimize the acts that conform to them.</td>
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<tr>
<td><strong>Impersonal Authority</strong></td>
<td>Externally set laws, rules, and regulations are referred to as legitimating forces. Social practices appear to be legitimate simply because the law says so.</td>
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<tr>
<td><strong>Authority of Tradition</strong></td>
<td>Being in accordance with traditions, norms, and customs is the source of legitimation.</td>
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<tr>
<td><strong>Authority of Conformity</strong></td>
<td>Social acts are legitimated simply by appearing normal and being part of what everybody does in a particular situation.</td>
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<tr>
<td><strong>Rationalization</strong></td>
<td>Legitimation is shaped based on institutionalized structures and the theoretical knowledge about the supposedly logical order of social practices.</td>
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<tr>
<td><strong>Moral Evaluation</strong></td>
<td>Value systems and internalized values, rather than external authority or rationality, are the source of legitimation.</td>
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*Source: This table is based on van Leeuwen 2008.*
and van Leeuwen’s general framework does shape a generally structured analytic framework broadly applicable to the data in this study. Although the framework originated in a different sociocultural context and based on studies on English, we found the descriptive power of the framework to be fruitfully applicable in our context, as well.

In the particular context of this study, the six subcategories of Authorization as well as the two general categories of Moral Evaluation and Rationalization are broadly adopted to inform our analytic approach that we rely on to investigate the discursive construction of false referrals in the local context under investigation. Table 1 presents the eight discursive legitimation types that set the point of departure in examining the discourse under investigation. In the following section we present actual discourse extracts to illustrate this discourse and discuss four strategies of discursive construction and legitimation of false out-referral in detail.

The Discursive Construction of Circule

The practice of false patient out-referral is prevalent in the EDs of concern to the extent that a particular term has been coined to refer to this act. Seemingly rooted in the French language, the word *circule*⁴ is the term used to refer to such out-referrals. In these contexts the basic medical check of Airway–Breathing–Circulation in emergency situations is sometimes humorously reinterpreted as Airway–Breathing–Circule, to indicate the common practice of out-referring as many patients as possible, as soon as possible. This is partly rooted in the fact that the almost always overcrowded EDs would not leave any concern for interns and residents about keeping complicated patients for the purpose of learning from them. Although in many cases a complex set of contextual practices are involved in such false out-referrals, the practice of circule is fundamentally discursive. In this section we present four categories of such discursive practices that are exploited to construct and legitimate cases of circule by medical students in the EDs of teaching hospitals: Sympathy, Mystification, Intimidation, and Procrastination.

**Sympathy**

The practice of circule perhaps most conveniently occurs through sympathy. It is safe, less stressful, and less likely to bring up challenges if medical staff are able to circule their patients simply by providing some doctor-like advice. The general message that patients receive is that it is to their own benefit to be referred to another medical center. In terms of van Leeuwen’s (2008) legitimation categories, sympathy-based discursive strategies mostly appear to rely on personal authority with occasional resorting to versions of expert authority and authority of tradition as well as rationalization. Amirali, a 26-year-old medical intern in his seventh year of medical school, has his own sympathy approach to circule⁵:

- I work more on sympathy. You have to establish sympathy in order to provide better chances of subsequent circule.

A young boy was once brought to the emergency room following an accident. He had a fracture in his left radial bone. Amirali received him after the triaging
general practitioner had directed him to the Orthopedics section of the ED. While taking the history of the patient, Amirali started to sympathize with the patient’s father by nagging about the bad driving manners of taxi drivers and how frequently such accidents happen. He later went on to offer his expert advice on the quality of care in that hospital:

- … if the way people drive improves, we will not witness such physical, emotional, and financial burdens.
- … you should also know that this hospital is run by a university and patients like your son are operated on by medical students. I am a student myself, and I know that I am indeed inexperienced.

Captured by Amirali’s skillful exploitation of mixed expert and personal legitimating discourse, the father logically decides to rescue his son out of this danger zone. Supposedly “informed by the doctors about possible consequent risks,” as the personal consent reads, and taking the responsibility for any consequences, he signs the form on his own decision, and the boy is referred out to another hospital.6

In EDs it is common that the resident invites the patients’ companion7 to explain their health status. Within the discourse of circule, the apparently sympathetic advice that is provided to companions in such conditions mainly exploits the general social image of teaching hospitals as low-quality medical centers. Openings of such discursive manipulations, heavily relying on personal authority, may include statements like the following:

- I just want to let you know that I am an outsider of this system and I have to come to the hospital as part of my training.
- This is the truth about teaching hospitals that I am telling you as someone like you, not as a beneficiary of this system.

After managing to win people’s trust, there is a simple step left to be taken before a successful circule is complete. It is either magnifying the problems patients may encounter in public government-run teaching hospitals or magnifying the elegance of expertise, equipment, management, and so on at private hospitals, or preferably a combination of both strategies. Discursively mixing personal authority and rationalization strategies of legitimation, medical students may refer to management problems, issues of medical staff expertise, financial problems, general hospital conditions, and even legal concerns, among other points, to illustrate a terrifying image of teaching hospitals:

- Teaching hospital bureaucracy is too complicated to leave room to care about your patient.
- In this hospital there is no specialist involved in the operation procedure. Students do the operations and they do their best, but they are very young and not as experienced as senior professors.
- Our specialists don’t care about their responsibilities in this hospital as they earn a small amount of money here.
- This hospital is a disaster in terms of hygiene and management as no one has really any financial or whatever kind of interest here. Moreover, it is run by all these youngsters who are on their way to learning to be doctors or nurses.
Discursive Construction of False Referral in Iranian Teaching Hospitals

- You can’t even sue this hospital as it is meant to make such mistakes. Even the judges would give the rights to the doctors of this hospital as it is a teaching hospital and anything could be inevitable.
- You must have seen the name of the hospital, that is called a teaching hospital. Even the word therapeutic comes at the end on purpose.9

In such attempts at circule through sympathy, the public belief about the wide gap between private and government-run hospitals is exploited. It is a general public belief that can be exploited as medical students try to rely on the authority of tradition. Along the same line, when it comes to providing a shiny image of private hospitals, there is a simple trick: just reverse the disasters pictured with regard to teaching hospitals in terms of management, expertise, or equipment without, of course, referring to the very high cost of the services provided by private hospitals:

- You don’t have to roam around the city for every single procedure as all the facilities needed for treating your problem are found in private hospitals.
- In private hospitals you don’t find medical students. Even the nurses hold masters degrees most of the time.
- In private hospitals the staff behave totally differently from here. They are like real ladies and gentlemen, unlike here where the staff bark at patients.

**Mystification**

The characteristic feature of sympathy-based circule is that patients’ lack of awareness is manipulated under the cover of informing and offering apparently supportive comments. At a more confrontational level, medical interns may perplex patients and their companions through their reliance on technical information and the jargon of medicine, including English words and abbreviations, without sounding sympathetic. Van Leeuwen’s (2008) conception of “expert authority” is the most conspicuous legitimation category exploited in discursive practices of mystification. Role model authority, authority of conformity, and rationalization are other forms of legitimation in the discursive construction of circule through mystification.

Mina, a 33-year-old resident of general surgery, finds herself in a position not to require any sympathetic mask. It will suffice to rely on her expert authority and to confuse the patient’s companion with a number of terms that are meaningless to them but appear to be very technical. An old lady was referred in to the ED with acute cholecystitis and urgently required an operation. As Mina was not willing to admit the patient, she explained to the woman’s son:

- We don’t have the PTSD device, which is crucial for performing a low-risk operation on this patient.

Mina could, in fact, use any meaningless word to tell such a lie, but she just used a handy shortened form of Post-Traumatic Stress Disorder (PTSD), which is obviously irrelevant and meaningless in this context. On Mina’s coordination, three other residents also advised the man to take his mother to a hospital with PTSD facilities. In this particular case, of course, Mina failed in the mystification attempt through her expert authority because the woman’s son believed life is only in God’s hand and, given the condition of his pocket, he could not do more for his mother,
regardless of what PTSD was. He decided to keep his mother in the hospital and signed a high-risk consent on behalf of his mother. The residents had to do the operation, which was eventually successful.

The most straightforward way of mystification, as exemplified in the PTSD example above, is relying on the forbidding terminology of medicine. People's lack of knowledge about these terms, coupled with the apparent technicality and sophistication of the discourse of medicine as perceived by the general public, easily makes patients vulnerable to such discursive manipulations. In a shockingly interesting case, a resident gave the hint to an intern on how to circule the patient by simply prescribing her Circule-xine capsules, and the patient herself took the prescription to the intern. In similar cases of exploiting the very notion of circule, an intern told the patient that they didn’t have “circulator” in their hospital, and in a note to the secretary of the ED, he wrote:

- The patient is circule-resistant. Please consider the possibility of circule in his case. I don’t want to be responsible for what happens to him.

A related strategy, showcasing a legitimation practice through role model authority and rationalization, is talking about risks that either do not exist or are much smaller than shown by the medical students. Even in such attempts at fooling people into the circule process the starting point may more conveniently be a sympathetic gesture like the one illustrated by the first statement that follows. Otherwise medical students may rely on outright mystification without showing any false sympathy. The second extract below is an example of such mystifications addressed by interns of the general surgery section to a patient with superficial and cutaneous lacerations simply requiring a few sutures:

- You know, father, it is rare but the risk is there. It is my duty to give you insight into all the likely complications, and you sign it with your eyes open.
- We don’t have orthopedics and plastic surgery specialists in this hospital, and you have to refer to a hospital with these specialty options as we can’t repair your tendons and ligaments.

One particularly forceful mystification technique is exploiting patients’ vague mental images of particular terms associated with medical advancements and technology, such as the word laser. For example, the following is what the interns of general surgery section of an ED told a patient who had the indications of laparoscopy for his case of cholecystectomy. After all, he believed he had the right to avoid some responsibilities while he is forced to do literally anything in this hospital:

- We don’t have laparoscopy facilities here and for doing an operation on your gall bladder, we have to perform it through a traditional procedure, which would leave a scar of at least 20 cm on your belly. If you want to avoid this scar, you should go to a private hospital.

When patients asked the students what laparoscopy was, the interns merely told them that it was a device working with laser. Not unexpectedly, people’s idea of laser may include not more than the vague perception that it is something highly technical and related to cutting-edge technology. Although in reality laparoscopy has hardly anything to do with laser, the authority of conformity works in this
context to force patients toward taking it for granted and to view the medical student’s circule attempt as legitimate.

**Intimidation**

Underlying the discourse of sympathy and mystification in circule practices is an attempt to create a sense of worry and fear on the part of the patients and their companions. However, medical students sometimes overtly try to intimidate emergency room patients. Expert authority, rationalization, and special versions of moral evaluation are van Leeuwen’s (2008) major legitimation types appearing in intimidation-based circule. This is the approach adopted by Parviz, a 27-year-old medical intern in his year seven of medical school, who is known as a *master circulator* by his fellow medical students:

- You won’t believe that once there were 60 patients referred in from midnight to 2 a.m. with me being the only intern. So you have to train yourself to make a beast out of ordinary signs and symptoms in order to intimidate patients away.

In one of his night shifts Parviz had to deal with a patient companion who had learned that a Foley catheter was inserted for his patient by mistake. Parviz jumped into the argument between a female young resident and the patient’s companion who had run mad at the mistake. The mistake was a simple one that caused no harm to the patient, but a good chance had appeared to get rid of the patient and his troublesome companion. Parviz addressed the companion with a quite humble tone:

- Your patient’s kidneys have been traumatized due to the unnecessary catheter-ization. If I were you, I would do anything to take my patient out of here. This time it was done on his kidneys. Who really knows which organ it would be the next? I’m quite sure no one can do anything for his kidneys here as they are very likely to have been ruptured.

The companion is petrified by the student’s expert authority and rationalization attempt at legitimating circule to the extent that he immediately decides to leave the hospital. He signs the personal consent form on his own informed decision and accepts the responsibility of all the possible following complications to take care of his patient’s rotten kidney as soon as possible.

Intimidating encounters include aspects of mystifications as an integral component but in the discourse of intimidation, the mystification of complications exceeds the level of caution and alert and simply frightens patients and their companions about what might happen. Illustrating expert authority and rationalization, this may happen through simply overmagnified warnings to patients about signing high-risk consents or through more sophisticated strategies exemplified below:

- You have to sign a high-risk consent for your son’s leg amputation as a likely complication of the surgery.
- I am so sorry to tell you that I couldn’t find anything about your disease even in the international textbook of my specialty, and it is very sad that it seems to be an absolutely rare disease . . .
As you know your patient is old and has several chronic underlying health problems. So his case can get complicated and might need ICU facilities.

All the hospitalized patients in the infectious-diseases ward of this hospital are HIV positive. Come here and see this addicted man who is going to be admitted. He’s only one example. Now it’s for you to decide if you are willing to be hospitalized here or in some other hospital. In spite of all I told you, however, I have to mention also that we are cautious of all the medical procedures.

A specific case of intimidation, heavily relying on a mix of expert authority and moral evaluation as a legitimation force, may be called moral intimidation. It does not include any magnified medical risk but terrifies patients away perhaps even more forcefully than life-threatening medical risks. When a patient’s indication was for digital rectal exam (DRE), residents told the patient that they did not have the device to examine his rectum (in fact, such a device does not exist at all). The morally intimidating aspect was the language used to explain the matter. It was certainly one of the most successful discursive strategies aimed at circule. The word *hand* coupled with mentioning different people–times shaped a magnified intimidating device, far beyond the reality of the procedure because DRE is simply done by a single finger, and there is very rarely an indication of DRE repetition:

- We need to examine your anus. As we don’t have the device for this purpose we have to do the procedure with our hands. Well, you must be prepared for different people coming to push their fingers in your anus one after another at different times.

**Procrastination**

The normal procedure of circule is to set out from the least probability of confrontation, that is, sympathy, with all circule victims and if necessary to move to more challenging strategies of mystification and intimidation. At the most confrontational level of these strategies, medical students resort to ignoring and procrastination. Although procrastination is characterized by not taking any action, there is a strong discursive aspect to it. Discursively, procrastination relies on a combination of the previous three types of practices, that is, constructing sympathy, mystification, and intimidation. In terms of power relations, procrastination is the boldest type of refusing to admit patients and risks more probability of patient reactions. Accordingly, among van Leeuwen’s (2008) categories of discursive legitimation, Expert Authority, Impersonal Authority, and Authority of Conformity are the ones most prominently noticeable in procrastination practices.

Pouya, a 30-year-old resident of general surgery, adopts procrastination as his main approach to circule. In the case of a skin cut, Pouya wanted the patient and his companions to wait until the more severe cases including multiple traumas and surgical abdomens were stabilized:

- You see that this patient is dying. I can’t leave him to bandage your wound.

They decided to wait and had to wait for three to four hours, being totally ignored by residents, interns, and nurses. When eventually they started to voice
their objections, they faced a mix of Expert Authority, Impersonal Authority, and Authority of Conformity. Pouya’s explanation in a final encounter was:

- Just don’t get mad and listen to me. You are now in an emergency room of limited facilities and equipment. When we have the case of someone fallen down from a height of 30 meters and another case of crush injury and a case of appendicitis, we don’t come to spend time on your sutures. Even if we are in the midst of treating you and a severe case is brought here, we would leave you and then come back to you after we are finished with that case. So, please don’t cry or shout here, and if you don’t like it, sign the personal consent and go to another hospital . . .

It sounds quite logical and sense making if the story of other critical cases is true. After this conversation, the patient leaves the ED on his own will. There are, of course, less confrontational ways of procrastination. There is a trick that interns play for making patients sign the self-discharge consent. In this case, even if the patients are to come back to the hospital, they would refer at the time of some other intern’s duty:

- You don’t have a severe critical problem now. You can leave the hospital now, yet watch out what happens to you afterward. If your problem worsens don’t hesitate to come to the hospital again. If it gets better, wait until the next day . . .

The act of procrastination in many cases relies on the notion of triage (Robertson-Steel 2006), which is exploited by medical students as a tool to legitimate circule through impersonal authority and authority of conformity. Patients in EDs are sieved by medical staff for the seriousness and emergency of their problems before being dealt with (Robertson-Steel 2006). This very logical practice, however, is frequently exploited with the aim of circule. Victims of procrastination would go to the room with the sign board reading “Triage Room” to ask the residents and interns about when it would be their turn to be visited. They typically receive an explanation like the following:

- This is the room for triage. Do you know what it means? When there are several patients with various complaints we must take care of the most serious ones. You are at the bottom of the list. It really doesn’t matter if your laceration is sutured now or three hours later as nothing would happen in the meantime. This is a hospital with the least facilities. If you want to be treated here you have to wait, and God knows how long it would take before we can treat you.

Conclusion

Circule is practically transmitted to new interns through apprenticeship of observation because underlying the early experiences of medical students is the subtle message that without circule it would not be possible for an intern or resident to survive the overcrowded emergency department. Authorities and supervisors, however, are not normally involved in typical cases of circule and are apparently not aware of circule as medical students are meant to keep circule as a secret among themselves. Nonetheless, educational, organizational, and public consequences of
circulate do act to permeate different aspects of medical life of different participating agents (aware or otherwise). In this concluding section we attempt to present a contextually situated interpretation of false out-referral in Iranian teaching hospitals from three major points of view that we believe capture its complexity as a socially grounded discursive practice: first, a perspective with medical students in its center; second, a view that focuses on medical institutions; and, third, a standpoint that is concerned with the general public who are involved in the process of circulate as patients.

The Making of a Doctor

With medical students as the center of interpretations, at a first glance circulate may be construed as a deceptive behavior. The four strategies of sympathy, mystification, intimidation, and procrastination are exploited by medical students with the aim of the discursive (false) legitimation (van Leeuwen 2008) of getting rid of patients. The involvement of medical students in such (mal)practices creates a discursive context that, through time, shapes their professional identities. It is an established understanding in critical discourse studies that discourses are not just unidirectionally produced to serve discursive purposes of their producers but they reciprocally act to shape the worldviews and practices of their very creators (Fairclough 1989; 2001; Jager 2001; van Dijk 2004).

This dialectic relationship of discourses and worldviews (Fairclough 2001) not only allows for discourses to be shaped by particular views, understandings, and intentions but also for these to be shaped by the discourse context in which their producers live (Fairclough 1989; 2001; Jager 2001). Therefore, the young prospective doctors captured within the discourse of circulate are not only the producers of this deception, but also they reproduce worldviews and identities of deception for themselves through the discourse context that they produce and live in. Circulate seems to be making a new generation of doctors shaped by their own discourse of deception. However, this can hardly be seen as the only or even the most important interpretation of circulate.

Having interpreted circulate at this level and still focusing on students as the center of attention, one might further probe the underlying complexities of such practices. It would be naive and simplistic to view the medical students in the context of this study as simply evil beings. The voice of medical students (Braithwaite et al. 2005; Garak-Yaraghi et al. 2008), if heard, may have other stories to tell about circulate. The whole phenomenon of circulate may viably be perceived as a defense mechanism or survival strategy adopted by the medical students within the structure of mainstream medical institutions. Circule may not appear to be truly legitimate based on any legitimation strategy, but the students may have their own justifications for false out-referrals, including their workload, avoiding legal responsibility, and challenging institutional hierarchy.

The workload of the young medical students who also need to worry about their studies and exams is perhaps the major cause of false out-referrals. Lack of proper staffing and facilities, on the one hand, and the huge number of emergency patients referred to teaching hospitals, on the other hand, in many cases make it almost impossible to admit all the patients that are referred in. Circule does
not appear very irresponsible in a situation where the heavy reliance of teaching hospitals on medical students creates disproportionate workload. Such out-referrals may even function as a lubricating mechanism for the interconnected structure of different medical centers. They may facilitate a broader patient-circulating process that shapes a covert triaging mechanism that may even contribute to the health system’s proper functioning.

A further justification for circule on the part of medical students may be avoiding legal responsibilities for the consequences of possible mortalities or damages to patients. Residents and interns are always concerned about the likely faults and mismanagements on their own part, particularly because they do not find themselves knowledgeable enough to face responsibilities beyond a certain level. If they admit a complicated patient who is also likely to expire, they have to be very cautious as to the subsequent responsibilities. Therefore, out-referral seems a viable strategy in some cases and may help the medical students remain on the safe side.

Finally, the students may be justified in their attempts at false out-referral in that they have to survive in a context of strict institutional hierarchy. In the teaching hospitals under consideration there is a medical hierarchy at work in which the superiority order extends from attending physicians to medical students. There are always a chain of commands transmitted from the superiors to the inferiors. Residents, interns, and even nurses are sometimes like the agents of the attending physicians. Beyond that, there is always a supervisor in the hospital who is in charge of managing the entire hospital as the official representative of the head of the hospital after the working hours. Within this hierarchy interns and lower level residents are the ones who are most likely to be in the spotlight.

Taking all these complexities into consideration, it will not appear very surprising that students challenge the dysfunctional system in which they are forced to follow rigid institutional trends. They try to diminish their stressful professional situation through circule. Observed from this perspective, the act of circule is a wise strategy to survive in the institution rather than an evil conduct. The process of false out-referral appears to be wise in the sense that it provides a convenient way to avoid quitting the system by medical students and to confront the difficulties of life as a medical student in health institutions that continue to whirlpool in multiple challenges of education and medical care provision.

Living with(in) Medical Institutions

Another perspective that may help understand the phenomenon of circule is the view that concentrates on the institutional and managerial dimension of teaching hospitals both in terms of medical education and of providing medical care as part of the health system. On the one hand, false referrals in the forms depicted in this study are alarms of institutional corruption that necessitate serious transformations in the organizational management and monitoring procedures. On the other hand, circule illustrates the enormous challenges faced by modern health institutions in a social and cultural context that heavily relies on its rich wealth of medical tradition and does not necessarily embrace academic and institutional health care systems in the configuration of modern hospitals.
Institutional corruption, breach of ethical standards, and organizational mismanagement at different levels are obviously depicted by the discourse of false referrals. Corruption appears to encompass both of the major functions of teaching hospitals, that is, its educational and medical aspects. The corruption depicted by false out-referral is rooted in a vicious cycle of dissatisfaction revolving in teaching hospitals. Medical staff, including the students, are dissatisfied with their professional conditions for a variety of reasons as discussed above and transfer their dissatisfaction to their patients. Patients transfer their concerns (in)directly to the institutional managers. The institution bounces the force of dissatisfaction back to the elements that are lower in the institutional hierarchy—including medical students—and force them to take the responsibilities that do not fit their position.

Challenges of the modernist construct of clinic shape another concern of a view of circule that places the institution in its center of attention. Within a cultural context strongly relying on interpersonal relationships that historically tended to defy rigid institutional regulations, the health system needs to implement organizational forces required by a modern medical system, and at the same time it needs to accommodate the resistances in such a cultural situation. In their act of circule, medical students are clearly resorting to their social skills to circumvent the institution. They may appear to be involved in practices of corruption, but a more profound view of the issue may indicate that they are fighting for the preservation of their personal freedom. This struggle is well illustrated by their tendency to rely mostly on different categories of authority—expert authority in particular—to legitimate false referrals. The challenging fact for the institution of hospitals with regard to circule is that medical students defy official and institutional accounts of expertise, authority, and professional responsibility. This, obviously, calls for revisiting the foundational assumptions of the so-called educational functioning of teaching hospitals that tend to be taken for granted in such contexts.

Patients and Public Perceptions

Circule may be further discussed from a perspective mainly concerned with patients. The multiple discursive strategies of sympathy, mystification, intimidation, and procrastination are directly aimed at people who are referred to the EDs as patients. An obvious outcome of public patient life in such a discursive context through time is a naturalization and normalization (Fairclough 1989; Jager 2001) of the state of confusion in dealing with health institutions. In this context the public perceptions about hospitals, in general, and government-run teaching hospitals, in particular, may grow to include more elements of perplexity and dissatisfaction. Moreover, if people’s direct encounter with medical staff and health care provision centers is to be a major part of public education about health issues, patients who face circule are obviously misled and deceived rather than informed about their particular health problems and more broadly about how they can benefit from the health system of the country.

The story of circule, therefore, bluntly calls for more profound awareness of the general public about the complexities of modern medical systems and their institutional features. How this public awareness may be created is not an easy question to deal with because the health system and its institutions themselves are
usually supposed to be the source of such public education. Nonetheless, gaining awareness and alertness with regard to institutional relationships in hospitals does seem to be a necessity that might require adding certain amounts of caution and even suspicion to the traditionally shaped trust in doctors. Specifically, the authority of health providers needs to be challenged and treated cautiously as their potential tool of false legitimation. People’s ability to make distinctions between the hekmat—wisdom—traditionally associated with doctors and the institutional forces that may meddle with interpersonal relationships of healing is an obligation that requires the power to decipher and challenge the discourse of circule.

Notes

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1. The traditional Farsi term for a medical doctor is *hakim*. Originating from *hekmat*, which denotes wisdom, *hakim* refers to someone who is a wise person and literally possesses wisdom. In Iranian culture hakim is characterized by a combination of various forms of practical knowledge, modesty, spirituality, and a poised personality.

2. In the Iranian system of medical education, interns are medical students (usually in their sixth and seventh years of medical school) being trained to be qualified as general practitioners. They are not granted medical license yet, but they can practice general medicine under a physicians’ supervision. Interns usually have the most substantial interactions with patients as they are normally the ones who must visit the patients in the first line in particular emergency department services after the triage phase to take their medical history and to do the preliminary examinations. Residents are already qualified generalists who are training to become specialists. They have the responsibility of training and supervising interns, and they intimately interact with interns.

3. In emergency duty (as distinct from ward duty), interns should stay over at the emergency department until their replacement arrives. They visit patients who are referred to them by the triaging general practitioner, take their medical history, do the physical examinations, and sometimes they start to treat the patients and prescribe for them. In ward duty, interns are in charge of dealing with patients who are already hospitalized in the ward. Sometimes they also take the history and do physical examinations on patients who are in-referred by attending physicians from their private clinics, offices, and so forth. Ward duty is considered as more lenient than the emergency one and adversely provides fewer learning opportunities.

4. *Circule* in French basically carries positive connotations in hospital management, implying patient in–out-referrals with legitimate medical reasons, but, as this article illustrates, the word has a shifted meaning in the context under investigation.

5. The entire bulk of data in this study was in Farsi. The data excerpts presented in this article are translations of the original discourses.

6. It is interesting to notice that the consent form signed by patients or their family members is not legally worthy of reference in the court of law. It is merely a means of (falsely) warning the patients that they would have no right to sue after possible complications. Such a consent form is itself a means of mystifying the issue and intimidating patients.
7. In Iranian hospitals patients are usually referred to a hospital by a family member, relative, or friend called *hamrah*, literally meaning companion. The hamrah accompanies the patient through virtually the entire period of hospitalization.

8. Because of the dual role of the Iranian teaching hospitals in health care provision as well as medical education, these hospitals are called *amoozeshi, darmani, pazooeshi*, that is, educational, therapeutic, researching centers.

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