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Physician Assimilation in Medical Schools: Dualisms of Biomedical and Biopsychosocial Ideologies in the Discourse of Physician Educators

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ABSTRACT
Although health communication research and popular literature on physicians have heightened aware-ness of the dualisms physicians face, research is yet to focus on the discourse of physician educators who assimilate students into medicine for dualisms of the biomedical (BMD) and biopsychosocial (BPS) ideologies. The study drew on a dualism-centered model to analyze the discourse of 19 behavioral science course directors at 10 medical schools for the emergence of dualisms in instantiations of BPS ideologies and for the management of dualism in discourse that instantiated both BMD and BPS ideologies as part of the curriculum. Dualism emerged in the BPS ideologies of "patient-centeredness" and "cultural competence." While a dualism between "patients' data" and "patients' stories" emerged in the patient-centeredness ideology, a dualism between enhancing "interaction skill" and "understanding" emerged in the cultural competence ideology. Moreover, the study found educator discourse managing dualism between BMD and BPS ideologies through the strategies of "connection" and "separation." The study concludes with a discussion and the implications for theory and research.

Physician assimilation in medical schools includes preclinical years one and two. The process unfolds in formal and informal settings through various communication exchanges between instructors and learners. The process can shape how students will interact with patients (Harter & Kirby, 2004; Harter & Krone, 2001) and has implications for their future medical practice such as patient grievance/dissatisfaction and medical malpractice.

Physician assimilation is also a process through which medical ideologies can be sustained and transmitted across generations (Apker & Eggly, 2004). Through assimilation, medical ideologies can flourish, flounder, or exist in various states of tension. Assimilation processes, therefore, have implications for how multiple ideologies are understood and managed.

Health communication research (e.g., Dean & Oetzel, 2014) and popular literature on physicians such as Atul Gawande's works (e.g., Gawande, 2003) have heightened awareness of the dualisms physicians face. For example, communication research on physician assimilation has highlighted learners' experience of dualism between bio-medical (BMD) and biopsychosocial (BPS) ideologies (Harter & Kirby, 2004; Harter & Krone, 2001; Zorn & Gregory, 2005). Yet, research has not examined the discourse of physician educators (PEs) who assimilate students into the medical profession for the emergence and management of these dualisms. Accordingly, the study drew on a dualism-centered model to analyze interviews with 19 behavioral science course directors at 10 medical schools for the emergence of dualism in their

instantiations of BPS ideologies and for the management of dualism in discourse instantiating both BMD and BPS ideologies. Dualism can be defined as antagonistic or nonantagonistic "clash" between a pair of "ideas or prin-ciples or actions" (Stohl & Cheney, 2001, p. 353). Through the constant comparative method accompanied by a prob-ing of emergent themes, the study identified dualisms in discursive instantiations of the BPS ideologies of "patient-centeredness" and "cultural competence." The study also found educator discourse that instantiated both BMD and BPS ideologies drawing on particular strategies to manage this dualism.

The article begins with a review of the literature. Upon presenting the research questions, the article covers the study's methodology before presenting the results and a discussion.

Communication and Physician Assimilation in Medical Schools

Communication research on physician assimilation has focused on discursive exchanges between instructors and learners (Apker & Eggly, 2004; Harter & Kirby, 2004; Harter & Krone, 2001; Hirschmann, 1999; Noland & Carl, 2006; Norander, Mazer, & Bates, 2011; Scheibel, 1996; Zorn & Gregory, 2005) in the preclinical (e.g., Norander et al., 2011) or clinical/residency years (e.g., Noland & Carl, 2006). The following section addresses the ideological implications of physician assimilation before considering the BMD and BPS ideologies.

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The Ideological Implications of Physician Assimilation

Molloy and Heath (2014) made three important claims about ideology: (i) ideology can be defined as taken-for-granted values and worldviews that shape actors' reality and provide guidelines for action; (ii) ideology exists at the levels of discourse, organization, and society; and (iii) "ideologies are multiple, complex, competing, and complementary" (p. 390). Furthermore, discourse produces, instantiates, and negotiates ideologies (Alvesson & Karreman, 2000).

Medical ideologies, in particular, are divergent values and worldviews in medicine about the defining features and foci of physician–patient interaction (Geist & Dreyer, 1993). Medical ideologies exist at the levels of society, health organization, and everyday discourse. Everyday discourse such as those of PEs or those involving instructors and learners can instantiate and negotiate medical ideologies. Indeed, studies of physician assimilation have established a relationship between discursive exchanges and a broader ideological context characterized by struggle. For example, researchers have considered how daily processes of assimilation navigate alternative and mainstream medicine (Harter & Krone, 2001; Miller, 1998), principles of allopathic and osteopathic medicine (Harter & Krone, 2001; Miller, 1998; Norander et al., 2011), and BMD and BPS ideologies (Apker & Eggly, 2004; Harter & Kirby, 2004; Harter & Krone, 2001). The article next reviews the literature on BMD ideologies.

The Biomedical Ideologies

Mishler (1984) referred to BMD ideologies as the "voice of medicine." These are physician-centered ideologies concerned with the physician's clinical reasoning, diagnostic capabilities, and decision making. These ideologies value the physician's scientific/technical expertise, objectivity, and emotional detachment when interacting with patients (Apker & Eggly, 2004). Patient health/illness is conceived in reductionist ways that focus on biology, body, and disease (Hafferty, 1988). Indeed, patient health/illness is attributed to biological causes and solutions. The BMD ideologies find their clearest expression in the medical curriculum through basic science courses such as anatomy and pathophysiology.

Research points to the pervasiveness of BMD ideologies. For example, Apker and Eggly's (2004) study of morning report discourse between faculty and residents of an internal medicine program found faculty privileging the voice of medicine in their discursive attempts at crafting residents' professional identities. For a 14-year period, Hafferty (1988) interviewed more than 400 physicians and students in four medical schools about cadaver stories told in anatomy labs. He found that the stories functioned to instill and initiate the values of emotion control, emotional competence (withholding empathy), and emotional distancing in medical aspirants.

The Biopsychosocial Ideologies

In contrast to the BMD ideologies are BPS ideologies. The BPS ideologies emerged in reaction to perceived limitations of BMD ideologies (Engel, 1977). Mishler (1984) referred to them as the "voice of the lifeworld." They are patient-centered ideologies concerned with the contributions of patients' contextual and subjective worlds to health/illness (Apker & Eggly, 2004). Also important to patient health/illness are contributions of the physician–patient relationship such as physician's patient-centeredness, emotional connection, and shared decision making (Frankel & Quill, 2005). These ideologies find expression through behavioral science and medical ethics courses.

Research also points to the presence of the BPS ideologies in medical schools. For example, Harter and Kirby (2004) found student interaction with standardized patients sustaining values such "patients as people." Harter and Krone (2001) found BPS ideologies such as holism and recognition of the socio-emotional aspects of health.

Multiple Medical Ideologies

A few studies have acknowledged coexisting medical ideologies and the relationship among them. Zorn and Gregory (2005) wrote, "medical schools have for some years been attempting to deal with the tension between objectifying and humanizing elements of medical training" (p. 228). Harter and Krone (2001) wrote "central to students' professional identities is an apparent dialectical tension that requires them to, as one participant explained, 'strive for a balance between emotional expression and yet clinical objectivity'" (p. 77). Apker, Propp, and Ford (2005) found nurses managing dualism between emotional attachment and detachment in healthcare teams by enacting attachment with equal or lower-status teammates and detachment with physician teammates.

The Dualism-Centered Model

To address dualisms, different forms of dialectical theory have been developed (Baxter & Braithwaite, 2007). One form—from organizational studies—can be referred to as a dualism-centered model (Olufowote, 2015; Putnam, Myers, & Gailliard, 2014). The model focuses on antagonistic or non-antagonistic "clash" between a pair of "ideas or principles or actions" (Stohl & Cheney, 2001, p. 353). Dualisms experienced as antagonistic involve feelings of conflict and irreconcilability. Dualisms understood as nonantagonistic involve feelings of accommodation and interrelatedness that can engender sophisticated coping processes (Gibbs, 2009).

The model assumes that dualisms can be experienced as either dialectics, contradictions, pragmatic paradoxes, or double binds (McGuire, Dougherty, & Atkinson, 2006). Dialectics involve complementary ("both/and") dualisms (Olufowote, 2011). Contradictions involve dualism between mutually exclusive ("either/or") alternatives (Tracy, 2004). Pragmatic paradoxes are "pragmatic or interaction-based situations in which, in the pursuit of one goal, the pursuit of another competing goal enters the situation (often without intention) so as to undermine the first pursuit" (Stohl & Cheney, 2001, p. 354), for example, a photographer asking a subject to be spontaneous (Tracy, 2004). Double binds are especially debilitating paradoxes where actors are prevented from escaping the paradox (Stoltzfus, Stohl, & Seibold, 2011). Tracy (2004) found correctional officers who constructed dualisms as antagonistic suffered burnout, but

those constructing them as nonantagonistic experienced creativity and transcendence.

Managing Dualisms

Seo, Putnam, and Bartunek (2004) offered five strategies for managing dualisms: selection, separation, integration, transcendence, and connection. *Selection* favors one side of a dualism while ignoring the other. *Separation* recognizes both sides but separates them based on level, time, or topic. *Integration* recognizes both sides but combines them in forced ways or ways that dilute each side. *Transcendence* reframes the dualism by forging a new concept that dissipates the original tension. *Connection* recognizes both sides by respecting their individual integrity and connecting them in mutually beneficial ways.

Rationale and Research Question(s)

Health communication research (e.g., Amati & Hannawa, 2014) and popular literature on physicians (e.g., Gawande, 2003) have increasingly drawn attention to the dualisms physicians face. Although several assimilation researchers have acknowledged student experience of coexisting BMD and BPS ideologies (e.g., Harter & Kirby, 2004; Harter & Krone, 2001; Zorn & Gregory, 2005), research is yet to focus on the PEs who assimilate them into the profession. The study focused on the discourse of these drivers and designers of physician assimilation processes for the emergence and management of dualisms of the BMD and BPS ideologies. Accordingly, the study posed the following research questions:

RQ1: Which dualisms emerge in PE discourse that instantiates the biopsychosocial ideologies of their behavioral science curriculum?

RQ2: How does PE discourse that instantiates both biomedical and biopsychosocial ideologies manage this dualism of their behavioral science curriculum?

Method

The first author interviewed 19 behavioral science course directors at 10 schools of medicine. Behavioral science courses are required during the preclinical years and have a variety of titles such as "Physician, Patient, and Society" and "Patient-Doctor I."

Study Sites

The 10 universities (five private, five public) averaged 29,640 total students (range: 12,000–45,000) and 2,500 full-time faculty (range: 1,200–4,500). The medical schools averaged 627 students (range: 360–1,000) and 1,453 faculty (range: 420–2,500).

Participants

Sixteen described themselves as course or co-course director. The remaining reported their titles as associate course director, coordinator, and small group leader. They averaged 48.82 years of age (range: 35–62). Eleven were females. Seventeen were European Americans (89%), one International, and one "Other." Fourteen were MDs (eight in internal medicine, two each in family medicine and pediatrics, and one each in endocrinology and psychiatry), four had PhDs (two in psychology and one each in bioethics and physiology), and one had a MA degree.

Procedures

Upon Institutional Review Board approval, a research team conducted a search of medical schools' websites and contacted course directors of behavioral science courses. Participants were offered $25 gift cards for participating. The first author conducted and audio recorded all interviews. The interviews relied on a semistructured protocol, which facilitates flexible dialogue through open-ended questions and interviewer discretion in question ordering and paraphrasing. The first author posed several questions (e.g., nature of course, course goals). Evidence of saturation was present by the 17th interview. The interviews averaged 22 minutes (range: 11–40).[1] Verbatim transcriptions of the interviews resulted in more than 140 single-spaced pages.

Data Analysis

To address RQ1, the authors adapted the constant comparative method (CCM) to a seven-step collaborative process. The CCM is a systematic process for discovering themes that consists of identifying units, open coding, and axial coding (Corbin & Strauss, 2008).

In the first step, we identified the most basic unit of analysis in the data (Glaser, 1978). Analysts can base data analysis on units such as words, transcript lines, and themes. We focused on semantic relationships or units of meaning (Spradley, 1979). A unit of meaning captures each instance (e.g., words, turns at talk) of participants' contributions on phenomenon of interest to analysts.

We began by defining the BMD and BPS ideologies. To complement our definition, we created a two-column chart that contrasted key ideas (e.g., emotional attachment, emotional detachment). We did not apply our definition and chart in a deductive manner. Rather, they sensitized us to traditional and innovative adoptions of the ideologies. We identified units in three transcripts. As we read them, we kept asking ourselves, "An instance of biopsychosocial (BPS) ideologies being expressed is X," with X serving as units. We were attentive to both explicit and implicit instantiations of BPS ideologies.

In the second step, we began the process of open coding. Glaser (1978) defined open coding as "coding the data in every way possible" (p. 56). Simply, every unit could receive

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[1] The 11-minute interview was conducted with the only participant to self-describe as an "associate director." To complement this interview, two more were conducted with "course directors" at the same medical school.

multiple codes. We began coding by discussing each unit and then providing condensed handwritten labels for the unit in the margins of the transcripts. We coded in ways that preserved the natural language and expressions of participants. We then used the handwritten codes from the three transcripts to develop an electronic initial coding scheme for BPS ideologies.[2]

In the third step, we evenly divided the remaining 16 transcripts and used the initial coding scheme to assist independent coding. We took detailed notes as we coded independently.

In the fourth step, after concluding independent coding, we met, compared our coding results, and collaboratively revised the initial coding scheme by adding codes, collapsing codes, and eliminating codes. The revised coding scheme consisted of 21 codes for BPS ideologies.

In the fifth step, we used the revised coding scheme to collaboratively code a majority of the 19 transcripts. This process served to confirm the viability of the revised coding scheme.

In the sixth step, we sought to identify connections between existing codes and discussed which codes to collapse into themes. We remained true to the spirit of constant comparison by constantly comparing the units the codes referenced in making decisions about collapsing codes into themes. Through discussion, we arrived at seven primary themes for BPS ideologies.

In the seventh step, we transitioned to axial coding where we attempted to identify broader relationships between themes (Corbin & Strauss, 2008). We reduced the seven themes to four. We then closely probed the units of the four themes for dualisms. We concluded that dualisms emerged in two themes. For RQ1, we reported only on the two themes with dualisms.[3]

To address RQ2, we coded all the transcripts for BMD ideologies, and we separated those transcripts that contained *both* BMD and BPS codes (six transcripts). While reading these particular transcripts, we drew on the dualism-centered model as a device for sensitizing us to how course directors were managing the dualism in their behavioral science curriculum.

Results

The study first addresses RQ1 on key dualisms that emerged from BPS themes. Second, the study addresses RQ2 on the management of dualism between BMD and BPS ideologies.

RQ1: Dualisms in Instantiations of Biopsychosocial Ideologies

A central dualism to emerge from the "patient-centeredness" BPS theme was that between "patients' stories" and "patients' data." The article summarizes the patient-centeredness theme

before elaborating on the dualism between patients' stories and patients' data.

Patient-centeredness

Course directors repeatedly emphasized their desire for students to be patient-centered. PE 20 put it this way, "I think we very much want our students at every level of training to be very, I'll say even person-centered, and we use the term, the medical term, patient-centered." By twice qualifying his remark with "very," he expressed instructors' deep desire for students to be highly patient-centered. PE 13's contributions begin to supply educators' understanding of this concept when she said, "Well, one of the things that I think is incredibly important, and is at risk right now, is their commitment to the primacy of the patient. And I think increasingly self-interest is predominating." Patient-centeredness is described as "incredibly important," challenged by "predominant" physician self-interest, and involving physicians' commitment to assigning primary importance to patients. PE 11 explains further the course directors' understanding of patient-centeredness:

> What we also hope that we're reinforcing is a sense of how to approach both patients as well as patient problems. So, for instance, I think the idea of being patient-centered, where you're really looking at the patient at the center of the care that you're delivering is one of the principles that we hope that is reinforced and one of the attitudes that we hope that they possess so that they're putting patients before their own needs.

He understands patient-centeredness as an approach, a principle, and an attitude that instructors hope students will acquire. Similar to PE 13, patient-centeredness requires physicians to prioritize patients and to put their needs and interests ahead of the physician's. Moreover, he understands patient-centeredness as "an approach to both patients and patient problems." The participant's distinction between "patients" and "patient problems" is important because it introduces a dualism between patients' stories and patients' data within the theme of patient-centeredness. While a focus on patients' stories fosters empathy and deep understanding of individual patients and their experiences, a focus on patients' data relies on the physician's application of data gathering techniques that facilitate the solving of patients' problems.

Patients' Stories

Course directors encouraged students to hear patients' stories, to gain the understanding of patients' experiences from stories, and to respond positively and with empathy. In terms of hearing stories, students were encouraged to hear stories that conveyed patients' lived experience with illness, their experience with the healthcare system, and their lives beyond illness. In describing his course, PE 5 shared a small group activity where students interviewed patients and family members, "The focus of the interviews and the focus of your [students'] interactions with them [patients] will be to get their view of what it's like to have a chronic illness and to interact with the medical care system." In small groups, students learned to hear patients' stories about their lived experience with

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[2]The coding scheme contained columns for agreed-upon codes or labels and alphanumeric designations for each code (allowing reoccurring units in the transcripts to receive these designations rather than labels). The scheme also contained spaces to record the location of identified units such as transcript page numbers and new emergent codes.

[3]To demonstrate the confirmability of the dualisms, we located exemplars from the verbatim transcripts. These exemplars are presented free of linguistic disfluencies so as to improve comprehension and readability.

illness and the healthcare system. In addition to hearing stories, students were expected to gain understanding of patients and their experiences. In describing some of the long-term goals of her course, PE 7 stated "that they [students] really understand how hard it is for people to go to doctors, to be sick, to pay for the doctor visits, to take their medication, to do all the things that we expect people to do." She wanted her students to *really understand* patients' lived experience with illness and the healthcare system.

After gaining understanding, students were expected to respond positively and with empathy. As an example of a positive response, PE 4 shared, "What I try to equip the students with is some appreciation of the patient's experience of illness." He wanted his students to truly value patients' stories. An example of responding with empathy comes from participant #5 who stated, "For the students through these interactions to be able to get a sense of what that's like to live with that [life-shortening disease] *yourself*." He wanted students to know what it is like to live with a specific illness. In hearing patients' stories, course directors encouraged students to really understand individual patients and their experiences and to respond with empathy.

Patients' Data

In contrast to the emphasis on patients' stories, course directors also emphasized patients' data. Patient data refers to various types of patient health information (e.g., symptoms, medical history) that physicians draw on to solve patients' problems. The educators emphasized patients' data in two ways: (1) student learning of strategies (e.g., techniques) for gathering data from patients during interviews, and (2) student learning of how to use patients' data to solve patients' problems. PE 15 offered the following example, "What I want them to be able to do is to understand what the data they need to get is and to understand the process of getting it." He later offered a data gathering strategy when he stated, "And to understand that this is the interpersonal encounter, that the ability to get the data is based on establishing a relationship." PE 2, on the other hand, contributed the strategy of open-ended questions, "the most important thing I'd like them to have when they finish the course is to really have mastered the basic medical interview course skills. So, data gathering, really using open-ended questions."

In addition to teaching strategies for gathering patients' data, course directors also taught students how to use patients' data to solve patients' problems. They first acknowledged that physicians can be heavily focused on patients' problems. PE 20 stated, "And there can be a lot of interest in getting to know a patient's pathology and the pathophysiology, and that's an important part of rendering care." Participants then forged an explicit link between data gathering and problem solving. For example, PE 11 stated, "when you think about solving clinical problems, the first thing you do is you gather data." He later elaborated on the link between data gathering and problem solving, "once you've gathered it all in a hypothesis-driven manner, how do you analyze and put together what you've gathered so that it makes sense and so that you can solve the problem." While the course directors' emphasis on patients' stories was designed to foster deep understanding of and positive emotions toward individual patients and their

experiences, their focus on patients' data was designed to facilitate the learning of techniques for collecting data from patients and the use of such data to solve medical problems.

To further illustrate the dualism between patients' stories and patients' data, we present a moment of "clash" where one emphasis collided with another. This moment helps to clarify the differences between the clashing pair and provides an example of how some members of a medical school experienced and managed this dualism in the moment.

A moment of "clash." PE 8 provided such a moment of "clash" when she discussed a course exercise where her students interacted with patients.

> And then the hospital one is, again, just how do you get somebody's story more than how to take a medical history. But, it's how do you find out what the experience of their illness is like. And they struggle a little bit with 'I don't know how to take a medical history.' And we're like, we don't want you to take a medical history we want you to just be curious about what it's like for them to have cancer.

The students of PE 8's course met the exercise with the assumptions governing an emphasis on patients' data. They approached the exercise thinking they needed to conduct a medical history that would allow them to solve the patient's problem. They did so perhaps because the emphasis on patients' data is prevalent in medicine. Yet, while operating under this assumption, they are forced to admit their lack of ability and skill to perform a medical history. The instructors, on the other hand, in antagonistic fashion, have selected an emphasis on patients' stories to the detriment of emphasizing patients' data. As such, they attempt to shift students away from the discourse of patients' data to that of patients' stories. They explicitly told students not to take a medical history. Rather, they wanted them to possess an empathic curiosity about patients and to focus more on stories that conveyed the patient's lived experience with illness (e.g., cancer).

The article next introduces the cultural competence theme before considering the dualism to emerge from this theme between "enhancing understanding" of patients with cultural and social identity differences and "enhancing interaction skill" with diverse patients.

Cultural Competence

Course directors drew on the "cultural competence" term to refer to either cultural differences or social identities (e.g., race). A reference to cultural differences came from PE 11, who stated "a thread of culture that runs throughout both years" of his course "focused on how to gather the patient's perspective on illness, with culture being a situation which, it's increasingly likely that their conception of illness and our Western medical conception of illness may be different." Similarly, PE 1 described an objective of his course as, "how to approach the patient, how to understand the difference in cultural ethnic background."

Cultural competence was also a reference for social identities. For example, PE 13 stated, "We introduce them to the… physician-patient relationship…We look at ways in which culture, ethnicity, race, faith, spirituality, socioeconomic status, and other dimensions of individual and collective identity shape the moral beliefs and commitments of patients as well

as physicians." Similarly, PE 12 stated, "They talk about attitudes towards sexual orientation and race. There are a couple of sessions on cultural competence." Additional social identities course directors mentioned during the interviews were those of disability and gender.

Course directors also mentioned health disparities as they discussed cultural competence. PE 8 did so as she discussed cultural competence as cultural differences, "And to talk a little bit about disparity of health. And, it's a little bit sort of what is culture and how do you take that into account." Participant #12 did so as she spoke of cultural competence as social identity, "cultural competency education elicits kind of defensiveness on the parts of the students. But I think, too, a lot of them are surprised when they hear about some of the real problems there are in healthcare delivery to underserved populations." PE 17 also spoke to health disparities as a function of social identity, "We also tackle lots of specific subjects like working with gay, lesbian, bisexual, transgender patients. Looking at practice patterns and how while they should be impacted by evidence, they are often impacted by ignorance and prejudice."

Enhancing Understanding

A dualism between enhancing understanding and interaction skill emerged from the cultural competence theme. The article first covers the emphasis on enhancing understanding before that of interaction skill. Course directors sought to enhance the understanding of cultural and social identity differences. While responding to an interview question on the important course topics emphasized, PE 1 replied, "One, of course, is understanding cultural differences, cultural ethnic and social differences." Although it may appear, at first, that this participant's use of the term "understanding" was arbitrary, other participants also used this term when describing the goals of cultural competence education. For example, PE 8 described a different behavioral science course offered in her medical school with cultural competence education: "Ok, so that course is geared to where it's developing their *understanding* of different social groups." Similarly PE 12 reinforced a focus on "understanding" when she spoke of the expectations for students that clinicians communicated to educators, "I mean clinicians tell us they need to be equipped with good *understandings* of ethics and confidentiality and things like this." She continued by stressing how difficult it is to equip students with such understandings before their clinical experiences and gave the example of cultural competence, "But, really, until they start taking care of patients, any visceral *understanding* of that is very hard to do. A particularly difficult example is something like racism cultural competence."

Enhancing Interaction Skills

Although educators emphasized enhancing student understanding of differences, they also emphasized enhancing students' interaction skills with diverse patients. The educators discussed course exercises designed to improve students' skills at interviewing diverse patients. PE 8 described a case exercise of a lesbian with a knee problem, "one of our first cases is a

lesbian who's got a knee problem. And the focus of the exercise is on the knee problem, but they all sort of talk about the fact that she's gay and sort of how do you incorporate that in a natural way in your interviews." PE 11, on the other hand, described a training session focused on developing students' skills in working with medical interpreters, "We have a very concrete session that talks about the skill of working with an interpreter and, so, that's part of the culture thread." In another example, PE 19 described a course exercise with patients with disabilities, "We have patients with disabilities. So, focusing on subpopulations while really learning interviewing skills." The dualism, on one hand, pointed to an emphasis on enhancing students' understanding of cultural and social identity differences and, on the other hand, pointed to an emphasis on improving students' skills in interviewing diverse patients.

A moment of "clash." A moment of clash clarifies differences between the clashing pair and provides an example of how participants managed the dualism. PE 8 provided such a moment while she compared the cultural competence elements of her course with that of another required behavioral science course offered at her medical school:

> And they do talk about doctor-patient relationship in the context of ethnicity or, I'm trying to think, it's gay and lesbian issues. And it's a bigger group, so it's a discussion group. They don't practice skills. Ours is very skill-based. Theirs isn't. And they tend to like our course a lot. The students like our course a lot better.

This participant's contribution can be approached from different perspectives. From the perspective of the medical school, it is apparent that the school offers cultural competence education for its students through several courses. Perhaps because of an explicit understanding of a clash between "understanding" and "skill," the school, in a non-antagonistic fashion, accommodated both sides of the dualism but separated cultural competence education based on particular courses. This is a form of the "selection" strategy. While PE 8's course emphasized "skill," the other course emphasized "understanding." In reference to the other course, she earlier stated: "that course is geared to where it's developing their understanding of different social groups." PE 8's contribution can also be approached from the perspective of her students. She mentioned that students have a preference for her skills-based course. For students, the dualism appears to be antagonistic in that they have a clear preference for the skills-based course. While the dualism between "understanding" and "skill" emerged from the BPS ideology of "cultural competence," the study also focused on the broader dualism between BMD and BPS ideologies.

RQ2: Managing Dualism between the Biomedical and Biopsychosocial Ideologies

The dualism-centered model presents five strategies for managing dualism: selection, separation, integration, transcendence, and connection (Seo et al., 2004). For RQ2, the study found educators' discourse managing dualism between

instantiations of the BMD and BPS ideologies of their curricula through the strategies of connection and separation.

Connection

Through connection, PEs acknowledged commitments to both ideologies, yet they sought to connect them in mutually beneficial ways. An example comes from PE 1, who said the following after describing how his course sought to instruct students on understanding, approaching, and speaking to patients with cultural ethic differences.

> The second phase is to grow upon that to apply the communication skills to actual pathology, because it coincides with the learning of pathophysiology and pathology, and to do that in the setting of examining a patient. First, the different organ systems, the heart, the lungs, the eye, and what have you. But in time, at the end of that year, to be able to face a new patient with a given problem, to take a complete history and physical.

This educator sought to connect BPS instruction on cultural competency with student learning of pathology from basic science courses. Students were required to connect these emphases in the behavioral science course while examining actual patients. Similarly, PE 10 offered the following shortly after speaking about a course focus on self-awareness of attitudes, biases, and values that inhibit physicians' care of patients: "there are also a series of clinical framework lectures that relate the skills that you're learning in small groups to clinical presentations of disease that are connected to all those basic science lectures that you learn." The speaker's course sought to "relate" and "connect" an emphasis on reflective care with an emphasis on communicating about disease. Another example comes from PE 11 in his response to the question on what he would like his students to be equipped with upon completing the course:

> Another thing that we've tried to make sure that they achieve right from the start of the course, where it used to be called "Medical Interviewing and Clinical Problem Solving," is we tried to connect the communication skills with solving patients' problems and being a doctor, because of the general conception that was perceived, and I think still exists, at the time, is if a doctor solves your problems, then that person is a good doctor. Whereas there's plenty of doctors who solve problems but aren't perceived as treating people well. So, I think marrying those two and saying you have to do both of these, is something that we want students to take away from this.

PE 11's course, originally titled "Medical Interviewing and Clinical Problem Solving," tries to "connect" and "marry" an emphasis on problem solving with an emphasis on humane treatment. Besides "connection," the study also found educators' discourse drawing on "separation."

Separation

The study also found course directors drawing on the separation-by-time strategy. This strategy recognizes both sides of a dualism but separates them based on time (Putnam et al., 2014; Seo et al., 2004). Findings suggest that educators placed more emphasis on BPS ideologies in their first-year courses and BMD ideologies in their second-year courses. PE 8 provided an example of the BPS emphases of her first-year course. She began by saying, "Well, these are 1st year students." A few moments later, she continued:

> And I also personally, and I guess my co-director, want them to be curious about patients, which is something that I struggle with the students a lot. Because [school] medical students tend to be incredibly bright but very interested in research. And, so, we want them to sort of keep the patient firmly in mind and to be curious about where the patient comes from, what the patient is thinking.

From this contribution, we learn that PE 8 and her codirector want the first-year students of their Ivy League university to be patient-centered and interested in patients' stories. PE 1's first-year course also incorporated BPS ideologies: "In the first year it's to introduce students to some of the fundamentals of communication skills. How to approach the patient, how to understand the difference in cultural ethnic background of the patient."

In their second-year courses, the educators placed more emphasis on BMD ideologies. PE 20 provided an example of this growing emphasis[4]:

P: And an element of the physical examination that's reserved for more specialty time and teaching in year 2 include the neurological examination, female breast, male and female genitalia examinations, and the male prostate examination.

I: Ok

P: The male GU exam is taught in our urology clinics. And the female breast, GYN examinations in year 2 are taught within a simulation lab experience.

I: Ok

P: Again, one of our primary goals come end of year 2 is that we hope the students, certainly with our revised curriculum, will feel more at ease in a clinical setting, meeting with people as patients conducting medical interviews, performing related physical examinations, and certainly in year 2 starting to do more integration of information, processing of information. They're getting more disease-based training on an organ-specific basis and being able to apply that to patient care situations, being able to, hopefully, mature in their clinical reasoning, pattern recognition, to engage in some process of patient assessment and treatment plans under the guidance of their clinical skills faculty.

PE 8's second-year course emphasized student performance of various physical exams, training in diseases and human organs, and clinical problem solving. PE 11 also spoke to the BMD ideologies of his second-year course when he stated, "When we really focus on in the second year when they're starting to gain some knowledge, so that they can use it, we say, first of all, when you think about solving clinical problems, the first thing you do is you gather data." His second-year course focuses on clinical problem solving and patients' data.

Discussion

Drawing on a dualism-centered model, the study probes the discourse of 19 PEs who assimilate students into the medical profession for the emergence of dualisms in instantiations of

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[4]In interview excerpts throughout the article, "P" refers to participant and "I" refers to interviewer.

the BPS ideologies of their behavioral science curriculum and for the management of dualism in the discourse that instantiates both BMD and BPS ideologies. For RQ1, a dualism emerged between "patients' data" and "patients' stories" in the BPS ideology of "patient-centeredness" and another dualism between enhancing "understanding" and "interaction skill" emerged in the BPS ideology of "cultural competence." For RQ2, the study found educators' discourse drawing on the strategies of "connection" and "separation" to manage dualism in discourse instantiating both BMD and BPS ideologies.

Previous communication research on physician assimilation has established the coexistence of BMD and BPS ideologies (e.g., Apker & Eggly, 2004; Harter & Kirby, 2004; Harter & Krone, 2001; Zorn & Gregory, 2005). This study is unique in the theoretical perspective provided by the dualism-centered model, its focus on the discourse of PEs, and its queries of dualisms in instantiations of BPS ideologies and management of dualism in instantiations of BMD and BPS ideologies. Furthermore, although findings of the BPS ideologies of "patient-centeredness" and "cultural competence" resonate with previous works that outline the defining elements of the BPS approach such as emotionality and holism (e.g., Mishler, 1984), the dualisms of this general approach have not been scrutinized. As such, findings of the dualisms between "patients' data" and "patients' stories" and "enhancing understanding" and "enhancing interaction skill" make unique contributions to communication research on physician assimilation. In addition, though previous research comments on how medical trainees are coping with dualism between BMD and BPS (e.g., Harter & Krone, 2001), the study's findings of how PEs and medical schools are managing this dualism (i.e., strategies of connection and separation) also make a unique contribution to the literature.

The study's findings can be usefully reframed in terms of whether actors are confronting dualisms in antagonistic or nonantagonistic fashion. Dualisms can be understood in antagonistic (e.g., contradiction) or nonantagonistic (e.g., dialectical) fashion. Tracy's (2004) study suggests that dialectical understandings of dualisms lead to healthier outcomes than contradictions or paradoxes. PE 8 provides an example of *both* antagonism and nonantagonism. Her interview suggests that she selects, for her course, an emphasis on patients' stories that leads her to shift students away from emphasizing patients' data. This implies antagonism in managing this dualism, particularly if patients' data are not emphasized anywhere else in the course. On the other hand, her medical school may be managing the dualism between "understanding" and "interaction skill" as nonantagonistic. Such may be the case if the medical school is offering one course emphasizing the understanding of diverse patients and another emphasizing interaction skills. Although the school may have such intentions, educators who are choosing to emphasize one side of the dualism at the expense of the other may be constructing the dualism as antagonistic.

This study also contributes to the dualism-centered model (McGuire et al., 2006; Tracy, 2004). First, this model has not been used in communication research on physician assimilation. By using the model, the study acknowledges that physician assimilation shapes and is shaped by antagonistic and nonantagonistic clash between pairs of "ideas or principles or actions" (Stohl & Cheney, 2001, p. 353). Second, in using the model to examine multiple medical schools, the study gains an institutional-level understanding of behavioral science courses. For example, a small minority of the educators' discourse instantiates both BMD and BPS ideologies, suggesting that these courses are mostly grounded in BPS ideologies. Third, the study's finding on instructors' use of the separation-by-time strategy poses a challenge to future research uses of the model. While this strategy is based on the assumption of a mutually exclusive bipolar dualism (i.e., actors embrace one side of the dualism at one point in time and the other at another point in time), the study's finding paints a more complex picture. We are challenged to conceive of dualism as gradient rather than bipolar. Although the extreme ends of the gradient contain each side in its purest form, the sides also progressively shade off into one another. As actors embrace either end of the gradient, they are also embracing more of that end than the other. Although educators' discourse separated the ideologies by time (i.e., BPS in the first and BMD in the second), their discourse on each year instantiated more of one ideology than the other (e.g., they instantiated more BMD than BPS ideologies while discussing the second year).

Limitations and Future Research

The study has a few limitations that can be remedied in future research. First, a small sample of interviews was coded as grounded in both BMD and BPS ideologies. Although courses with both ideologies may be rare in the institutional field of behavioral science courses, future research can be based on a larger purposive sample that targets courses containing both ideologies. Second, the study was mainly limited to course directors. As such, it lacks the perspective of other types of behavioral science instructors. For example, most of the courses have clinical faculty (e.g., preceptors, volunteer clinicians) who mentor students. It would be interesting to get their perspective. Third, the study is limited by focusing solely on behavioral science courses. It is possible that basic science courses today also speak to BPS ideologies. If such is the case, instructors may confront and manage dualism in particular ways.

Conclusion

This study drew on a dualism-centered model to understand the discourse of PEs who assimilate students into medicine. Through the CCM and deep probing of emergent themes from interviews with 19 behavioral science course directors at 10 medical schools, dualisms of the BPS ideologies of their behavioral science curriculum emerged along with the strategies their discourses drew on to manage course dualism between BMD and BPS ideologies. A dualism between "patients' data" and "patients' stories" emerged in the BPS ideology of patient-centeredness and another dualism between enhancing "understanding" and "interaction skill" emerged in the BPS ideology of cultural competence. Moreover, in drawing on the strategies of "connection" and "separation" to cope with dualism between BMD and BPS ideologies, educators understood this dualism as nonantagonistic.

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