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# Exploring the Emergent Identities of Future Physicians: Toward an Understanding of the Ideological Socialization of Osteopathic Medical Students

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## Abstract

This project brings contextual factors to the forefront of socialization research by investigating how medical ideology relates to the formation of the identities of students of osteopathic medicine. In particular, we investigate their attitudes toward, the role of communication in, and the expression of emotion in health care delivery. Through in-depth interviews with students about their vocational development experiences, we began exploring their emergent identities as future practitioners of osteopathic medicine. Three themes emerged from a constant comparative analysis of data, including (a) selecting osteopathic medicine, (b) encountering osteopathy, and (c) students' emergent identities. These themes, and their respective subthemes, are discussed in terms of the story they tell about the role of technology, as developed and practiced through the scientific method, in the rationalization of professional identities.

Educational institutions are important cultural sites that affect students' socialization into occupations. Over the past decade scholars have focused their research efforts on understanding how and what students learn about work roles and professions as they progress through school (e.g., Jablin, 2000; Smith & Kleinman, 1989; Struben & Clair, 1994). Medical

schools represent important specialized venues, teaching students, among other things, about the manner in which they are to communicate with other members of the field, the public, and clients (Good, 1994; Morowitz, 1993; Sharf, 1993; Spiro, 1993). Underscoring the importance of medical socialization is the assumption that the future of health care providers' professional identities are constrained by the interaction norms learned during their vocational development. Professional training teaches individuals special codes or languages allowing members of occupations to communicate with one another and, as argued by Jablin and Krone (1995), these codes "affect how members of the occupation or profession view the world and conceptualize and talk about problems, events, activities and people" (p. 624).

A growing body of literature addresses socialization and the development of health care providers' professional identities. However, this work has several shortcomings, including its focus on the clinical rather than preclinical years of education and its lack of attention to contextual influences (e.g., Bosk, 1979; Coombs, 1978; Hardy & Conway, 1978; Smith & Kleinman, 1989; Stelling & Buchner, 1979). Hafferty (1988) argues that scholars have neglected earlier but formatively important stages in the socialization process (a notable exception is Good & Good, 1989). This gap in past research is accentuated by the fact that the discourse of early medical socialization serves as a site of identity construction cultivating particular value sets. This study focuses on the preclinical socialization of students in an osteopathic medical school—a context often ignored by both organizational and health communication scholars. In critiquing extant literature for its lack of attention to contextual factors, Sharf (1993) argues, "Doctors and patients do not talk with one another in a vacuum. . . . These encounters occur within professional, institutional, political, and sociocultural contexts that should be taken into account" (p. 36). To date, research on medical socialization has focused on mainstream western medicine, sometimes called "allopathic" medicine and practiced by M.D.s,<sup>1</sup> while neglecting other ideologies of health and healing that coexist in our medical infrastructure and that are bound to influence socialization into the health profession.

Osteopathic medicine was founded by Dr. Andrew Still, an M.D. who came to reject the prevailing medicine of his day primarily due to its reliance on drugs and surgery (Still, 1897). Originally, the differences between osteopathy and mainstream medicine lay in osteopathic practices centering on treating the body by improving its natural functions through osteopathic manipulation therapy (OMT). Through the manual manipulation of bones and soft tissue, OMT aims to restore the body's structural integrity so it can function in a natural and healthy way. Throughout its history, the osteopathic profession has fought to gain acceptance as a legitimate form of medicine while resisting absorption into allopathic medicine. In recent years, osteopathy has come to terms with the use of drugs and other mainstream modalities in treatment (Miller, 1998). Although it bears more resemblance to allopathic medicine than it did 125 years ago, osteopaths still maintain a "separate but equal" identity through their formal rhetoric, titles (Doctor of Osteopathy, D.O.), professional associations (American Osteopathic Association), and licensing procedures. Yet, today only one-third of practicing osteopaths use OMT in their treatment protocols on a regular basis (Guglielmo, 1998). Lack of reliance on the very therapies that originally

distinguished osteopathy from mainstream medicine has led many to assert that the profession of osteopathy is experiencing an "identity crisis" (e.g., Cassileth, 1999; Guglielmo, 1998; Miller, 1998). "Today, as throughout the profession's history," Miller (1998) argues, "osteopathy is beset by questions about professional *identity*" (p. 1741). The context of osteopathy provides a unique opportunity to explore the socialization of students in a profession whose ideological uniqueness is contested.

All discourses are contextual, or embedded in historical, political, and cultural settings. Furthermore, processes of socialization are both discursive and material (Clair, 1999). In other words, the meaning of work is created through rhetorical and discursive practices that are dialectically produced simultaneously with the material practices of organizing labor (Giddens, 1979). Yet, extant literature on organizational and occupational socialization has been criticized for ignoring the ideological dimensions of socialization as well as the ways in which socialization is connected to the larger macro-level societal issues, structures, and practices (Allen, 2000; Bullis, 1999; Bullis & Stout, 2000; Clair, 1999). Lupton (1994, 1998) argues for a social constructionist perspective that examines participants' accounts of their lived experiences to illuminate the intersection of macro-societal forces and the micro context in which discourse takes place. In problematizing the ideological aspects of socialization into the osteopathic profession, we direct attention to how particular value sets are maintained or contested through various socializing agents. We explore students' accounts of their preclinical socialization experiences in order to understand how socialization discourses serve as sites of reproduction of meaning and ideological formations (Giddens, 1979). Societal practices and rituals of all sorts are often sites for contest or struggle over meaning—in this case, about competing ideologies of medicine, the role of osteopathy in the health care industry, and the identities of osteopathic physicians.

### **Socialization and the Osteopathic Profession**

Organizational socialization can be broadly conceptualized as "a central process through which individual-societal relationships are mediated," according to Bullis (1993), or more narrowly defined as "a process through which newcomers become organizational members" (p. 10). Jablin's (1987) model is representative of most assimilation models and identifies three stages in the "process" of socialization: (a) anticipatory socialization, (b) organizational assimilation, and (c) organizational exit. Anticipatory socialization refers to the sense making that occurs prior to an individual's entry into a specific organization. The formation of expectations about a particular organization, job, or a career in general typifies this stage. Jablin divides the assimilation stage into an encounter period, including the newcomer's initial contact with an organization, and metamorphosis, during which the individual begins to acquire specific behavior, work skills, norms, and values appropriate to the organization. The final stage of organizational exit involves the process by which an individual begins to disengage and eventually leaves the organization. A thorough review of literature on all stages of socialization is beyond the scope of this article and is available elsewhere (e.g., Jablin, 2000). We narrow our discussion specifically to research on medical socialization and the health care industry.

The study of medical socialization and the development of physicians' professional identities began with the classic works of Merton (1957) and Becker, Geer, Hughs, and Strauss (1961). Such work highlighted structured training programs as constituting important elements in anticipatory socialization, and subsequently, medical educators have been striving over the past five decades to improve the training of neophyte physicians (e.g., Good & Good, 1989; Hafferty, 1988; Morowitz, 1993; Sharf, 1993; Sharf & Poirier, 1988). An analysis of curricular elements including the sequencing of activities, the kind of experiences available, and the formal mechanisms of evaluation, yields important data concerning how students are socialized. These processes are discursive formations that are both ideological and situated in historical moments of production. However, research to date has been criticized for ignoring the ideological dimensions of socialization (Bullis, 1993). To that end, we conceptualize training programs as discursive practices that position individuals in certain ways. This implies a dialectical relationship between a particular discursive event and the situation, institution, and social structure that frames it. As argued by Wodak (1997), "discourse constitutes situations, objects of knowledge, and the social identities of and relationships between people. . . . It is constitutive both in the sense that it helps sustain and reproduce the social status quo, and in the sense that it contributes to transforming it" (p. 6). We approach ideological analysis of discourse as institutional lived experience where the discourse of everyday living unconsciously sustains certain value sets.

Contemporary socialization theory also ignores the influences of socio-historical and organizational contexts. "Research usually does not address historical, political, or local circumstances that might influence newcomers' realities," argues Allen (2000). "A need exists to situate and analyze socialization studies according to historical, societal, and organizational/institutional factors that may influence how organizational members interact with one another" (p. 182). In other words, political, material, and social influences have substantial influence on the development and maintenance of role expectations, communication expectations and behaviors of health care professionals, and providers' evolving identities. The context of osteopathic medicine provides a unique opportunity to explore how macro-societal forces affect and are influenced by socialization discourses. Since its existence, the profession of osteopathy has struggled simultaneously to distance itself ideologically from mainstream medicine while attempting to gain legitimacy in the health care industry (Miller, 1998).

For decades, medical doctors held a virtual monopoly as the principal providers of health care services. Their dominance was partially established early in this century through state licensing and regulation and was enhanced during the century's middle decades by third-party reimbursement (Cooper, Laud, & Dietrich, 1998). This professional sovereignty, however, is now being challenged. Today, there are approximately 40,000 practicing doctors of osteopathy (D.O.s) in the United States (Guglielmo, 1998)—twice as many as fifteen years ago. There are now 19 osteopathic medical schools in the country, an increase from 5 in the mid-1960s. Several societal forces have been cited for the increase in the number of osteopathic physicians (and other "alternative" health care providers), including the financial costs of technology-driven health care, the limits of mainstream medicine in dealing with chronic and terminal disease, the increased service orientation of our

culture, the lack of attention to socio-emotional aspects of health care delivery, and the patients' rights movement (Cassileth, 1999).

In describing socialization into allopathic medicine, Coombs (1998) highlights the medical stigma against expressing one's emotions and the general ambiance of unemotionality within medical schools: "This apparent institutional indifference to the emotional side of medical students may be perceived as another of the deliberate, if unacknowledged, processes of socializing doctors" (p. 85). Also speaking to students' entrance into the world of allopathic medicine, Good and Good (1989) argue that patients are transformed into "objects" of the medical gaze due to many institutional factors including teaching methods that pay minimal attention to social and personal characteristics of patients. M.D.s are socialized toward nonemotionality and what scholars and practitioners have labeled "professional detachment" (Lupton, 1994), "instrumental rationality" (Good & Good, 1989), and "detached concern" (Lief & Fox, 1963). M.D.s often approach the interactions with patients from the disease-centered perspective (e.g., treating flu symptoms) and tend to seek patient compliance with their "orders" (Geist & Dreyer, 1993).

One perceived characteristic of the osteopathic profession is its emphasis on creating healing partnerships involving the patient in decision-making processes (Cassileth, 1999). In other words, an osteopathic practitioner is trained to treat a person with flulike symptoms. The evolving identity of the osteopathic profession is also situated in a context in which the number of health-care options is on the rise, with current estimates suggesting that "alternative medicine" is a \$27 billion dollar industry (e.g., Eisenberg, Kessler, Forster, Norlock, Calkins, & Delbanco, 1993; Wetzel, Eisenberg, & Kaptchuk, 1998). Defining and delimiting the sphere of alternative health care is a difficult task. Terms such as "alternative," "unconventional," and "unorthodox" are used in reference to practices outside mainstream medicine and often carry connotations of "something less than" and "out of the ordinary." Many practitioners define alternative medicine as including all "holistic" forms of therapy outside of the mainstream medical model and include osteopathy as "alternative" (e.g., Page, 1995), while others define alternative medicine as including "unproven" therapies and exclude osteopathy as alternative (e.g., Cassileth, 1999). Barrett (1999) argued, "the pseudoscience within osteopathy can't compete with real science." It is within this contested terrain of "what constitutes alternative medicine" that the profession of osteopathy must rhetorically struggle to define itself.

Our project explores if and how these ideological struggles are manifest in osteopathic students' accounts of their preclinical years of socialization. Of particular interest to a focus on ideological struggles are which terms, definitions, norms, and narratives become the paradigms for action in given situations (Carey, 1989; Grossberg, 1993; Hall, 1985). We began with the following research question, broad enough to allow for an exploratory understanding of students' sense-making about their preclinical socialization experiences:

What do students' accounts of socialization experiences reveal about their ideological positioning during preclinical years of medical education?

## **Methods of Data Collection and Analysis**

In order to uncover the nature of socialization experiences from the perspective of the social actors, we relied on qualitative methods of data collection and analysis. A qualitative standpoint afforded us a framework from which to explore and emphasize how social experience is created and given meaning by participants (Denzin & Lincoln, 1998). Furthermore, interpretive designs are uniquely suited to exploratory investigations in which specific variables are not easily identifiable (Creswell, 1998), as in the current project. Informants and the first author engaged in semistructured, in-depth interviews designed to sample events and incidents indicative of theoretically relevant concepts. We chose interviewing as our method of data collection because interviews are among the most common and most powerful tools interpretive researchers rely on to try to understand social actors' experiences and perspectives (Creswell, 1998; Fontana & Frey, 1998; Lindlof, 1995). We embraced the perspective that interviews are forms of discourse shaped by the asking and answering of questions and constructed jointly by the interviewers and respondents (Mason, 1993). Once data were collected, in order to generate an understanding of medical students' meanings for physician patient relationships, we moved continually between inductively derived categories and data. The following sections describe the participants and setting involved with the project as well as the data collection and analysis procedures.

### ***Participants/Setting***

Participants attended a school of osteopathy in the midwest that considers itself an "alternative" to western biomedical models of medicine. Stratified purposeful sampling techniques, in which both first year and second year students were represented, guided the selection of full-time students at this institution. The Director of Medical Assessment helped recruit participants. The recruitment process consisted of announcements in courses and through e-mail, and through referrals from initial informants. A total of 29 interviews were conducted with 15 women and 14 men. The average age of the participants was 24, with ages ranging from 22 to 29. Eighteen of the participants were in their second year of medical school; 11 were completing their first year of school. We purposefully selected first- and second-year students because part of our rationale lies in Hafferty's (1988) argument that previous research has failed to examine medical school socialization during preclinical years of education—early yet formative times in students' educational experiences. We stopped collecting data after 29 interviews because we had reached the point of saturation where additional data no longer shed new light upon issues of interest (see Creswell, 1998; Lindlof, 1995).

### ***Data Collection and Analysis Procedures***

Informants participated in semistructured, in-depth interviews. All interviews were conducted on the campus of the medical school and lasted approximately 60 to 90 minutes. During the interviews, open-ended questions were asked to encourage detailed explanations. An interview protocol was developed based on the goals of the study and past literature. Questions on the interview guide asked participants to describe their vision of the "ideal" physician-patient relationship, how the experience and expression of emotion fit

in their perspective on appropriate physician-patient interactions, and what significant events in their medical training contributed to the development of their perspectives on physician-patient relationships. Additionally, we adapted a version of the memorable message interview schedule originally created by Knapp, Stohl, and Reardon (1981) in order to tap into how informal conversations throughout the students' professional socialization have helped to construct their identities. Previous researchers have used adapted versions of memorable message questions to yield interesting findings about socialization processes (e.g., Stohl, 1986). The interview guide provided a consistent framework for each interview allowing the first author to function as a conversation facilitator, asking open-ended questions to encourage detailed explanations.

In order to get as clear a picture as possible and have permanent artifacts ideally suited for transcription purposes, the interviews were audiotaped. Transcription of the interviews yielded over 600 pages of discourse. The transcripts were reread while playing the original tapes to ensure accuracy of the transcriptions and to note special emphases or cues that might affect interpretation. A constant comparative method was used to analyze the data (Lindlof, 1995). This method of thematic analysis has been advocated by communication scholars (e.g., Clair & Thompson, 1996; Tretheway, 1997) because it allows researchers simultaneously to code the data and categorize it into developing themes or patterns. The first stage required the assignment of data-text incidents to categories. We continually compared each new incident to previously organized data in order to determine its goodness of fit. Next, the categories and their properties were integrated. Explicit decision rules were developed inductively to account for each category's defining properties.

The accuracy of the findings was verified through a member-checking process in which the first author solicited several informants' views of the findings. In member checking processes, Stake (1995) and Creswell (1998) recommend asking participants to examine rough drafts of the findings in which words of social actors are featured. Consequently, five participants were provided a three-page summary of the results as well as tables of significant statements that consisted of themes and representative quotes from interview transcripts. The first author met with these individuals to gather their reflections on the credibility of the findings. New information and insights gleaned during member checks were included in the database.

## **Results**

Themes emerging from the data analysis are presented in a format that highlights participants' retrospective sense-making about their socialization into the profession of osteopathic medicine. First, themes describing how individuals account for their entry into the osteopathic medical profession are discussed as they reflect anticipatory socialization experiences. Next, we described the influential agents and agencies shaping students' developmental experiences. Finally, we highlight various aspects of these students' emerging professional identities including their orientations toward osteopathy, the nature of communication in their future relationships with patients, and the experience and expression of emotions within such relationships.



### *Selecting Osteopathic Medicine*

Anticipatory socialization generally refers to choice-making and information seeking of individuals prior to formal entry into an organization or profession (Jablin, 1987). Three themes emerged from analysis of participants' reflections about their decision to enter osteopathic medicine. These themes—cultural background, direct experience with osteopaths, and choice by default—illustrate the sense-making processes engaged in by individuals to explain, and in some cases justify, their occupational choice. We draw particular attention to the emotionality involved with participants' entrance into osteopathy.

#### *Culturally-based preferences*

Seven of the participants grew up in countries outside of the United States, including Russia, Venezuela, and Iran. All of these students attributed their choice of osteopathic medicine at least in part to its similarity with practices of medicine in their native countries. One woman commented:

I come from Russia. And both of my grandparents are physicians there. And mmm, the medicine they practice is different than here in the states. They don't have much equipment. And they practice more alternative medicine. What they practice is really more in line with osteopathy, although they don't call it that. So I guess it was natural for me to look for more of an alternative road.

This passage illustrates the student's perception that osteopathic medicine is more consistent with medical practices in her homeland than is mainstream U.S. medicine. The aforementioned woman and another student from Russia both mentioned that the lack of reliance on technologies is an important similarity between osteopathy and Russia's medical infrastructure.

Other international students suggest that the holistic approach to medicine espoused within osteopathic ideology—an ideology that avoids dichotomizing reason and emotion—parallels the nature of health-care delivery where they were raised. "In Iran, where my Dad is a doctor, their concept of ah medicine is holistic. Even though they get the title M.D., they practice a holistic approach with the uh patients. It's just that their titles are M.D.," said one man. Another informant shared the following:

Latin American medicine as a whole, you can relate it more to osteopathic medicine because it is more holistic. And, it is based on a very strong doctor patient relationship. And, it's still not insurance oriented, not HMO oriented. In Venezuela, you will probably see the same physician your whole life. I mean, for everything you will see the same doctor.

For these interviewees, osteopathic medicine was a more appealing choice due in large part to macro-societal norms associated with their cultural heritage.

Although the international students chose osteopathy because of cultural traditions, one American student commented that his exposure to another culture played a large part in his decision to choose osteopathy.

I left the country for a couple of years and was doing some service work overseas. I served in a volunteer capacity as a missionary. And, umm, I got to observe and be a part of the healing process from the perspective of a care giver. And then I came back to the states and started applying to medical schools. The more I learned, the more I realized that osteopathic philosophies were more in line with my own personal ideas of what medicine should and needs to be based on my previous experiences thus far in medicine.

These excerpts suggest that preferences for continuity between culture and self as expressed through occupational choices are important determinants in one's decision to pursue osteopathic medicine as a career. As one participant suggested, "I felt like it would just benefit me so much more as a physician in the future to go through a program that teaches the same things and the same philosophies and ideas that I already had espoused myself." All cultures have socially sanctioned as well as limited, marginalized, quasi, and auxiliary modalities of treatment (Loustaunau & Sobo, 1997). Embedded in participants' accounts of their occupational choices are reflections of their broader culture and its mainstream norms, values, and beliefs. This theme illustrates the important role of environment in the social construction of professional identity as discussed by other scholars (e.g., Miller, 1998).

*Direct experience with osteopathy*

Although the decision to pursue osteopathy was guided by cultural experiences for some students, others described significant life experiences that influenced their choice. Many of these students described narratives involving themselves or significant others where osteopathic medicine provided an appropriate and successful treatment for themselves or a family member, often when their mainstream doctors did not provide successful therapy. One participant commented:

I experienced osteopathy first hand in high school. I'd been having chronic back pains for about three years off and on. I'd been diagnosed with a herniated disc and was told by my orthopedic surgeon that I'd never run again and that you know I'd have to lead a pretty mellow life. And I was racing triatholons at the time I was told this, and I, you know, said, I am not going to believe this. So I went to a D.O. and was treated with manipulation twice. And I was pain free basically for two years. And I started training for triatholons again. And now I feel like telling my orthopedic surgeon—look at me!

Another woman shared a different narrative illustrating this theme. "One of the things that really sparked my interest was the way osteopaths were able to, you know, help my Dad." This participant went on to describe how her Dad had developed a rare illness when she was in high school. "And I went with him to John[s] Hopkins and Mayo and spoke with many physicians for several years. Every time I was drawn to the osteopaths and their way. Their way of healing. They were really compassionate with my Dad while most of the other doctors were really cold."

Although the above instances illustrate major encounters with osteopathy, other participants described cumulative experiences. One man indicated that osteopathy was a natural choice due to his collective experiences with a particular osteopathic doctor, which contrasted with his experience with M.D.s in HMO-type clinics:

I have had really good experiences with an osteopathic physician that my sister-in-law works for. You know, I was impressed by the kind of treatment I received. You know the hands on manipulation. And just the way he approached diagnosis and history taking and just his relationship with patients. My other experiences had been in more clinic HMO-type settings which are never conducive to any kind of, you know, great patient doctor relations.

The major and cumulative experiences shared by participants illuminate factors that helped shape their preferences for osteopathic medicine. Participants' epiphanies, coupled with their culturally based preferences, suggest that the choice to pursue osteopathic medicine for many students is a reflection of their lived experiences in the realm of medicine.

#### *Choice by default*

Although most students consciously selected osteopathy, a few participants, interestingly all men, suggested that it was the profession of osteopathy that chose them. An overwhelming majority of men interviewed suggested that their decision to become doctors of osteopathy was made out of necessity, not because of a deep-seated affinity toward osteopathic practices. As one participant said:

I didn't get into allopathic schools the first two years I applied. Obviously, I got in here. That was my second year of the application process. And to be honest, don't pass this around, but I think I came here essentially because I didn't get into medical schools. I don't want it to seem like I settled, but this is the only school I got into.

Today, the biomedical model continues to serve as the yardstick for judging the social acceptability of other systems of health care including osteopathy (Cassileth, 1999). The identity struggles that the profession of osteopathy experiences in public discourse were apparent in the accounts of many of these participants. To several of the male participants, osteopathy measures up as "the next best thing" relative to traditional medical school training.

These male students characterized their choice of osteopathy as a "decision by default" and described such choices as creating "emotional dissonance." However, such dissonance appeared to be counteracted by a deep desire or passion to practice medicine. "At the time, the only thing I knew about osteopathy was, you know, it's just some other philosophy. But I didn't care because I just wanted to get into medicine," said one man. Another noted, "I just wanted to get in somewhere. Anywhere. And ironically enough, this was the only school that I was accepted to. At that point, I didn't really know anything about osteopathy." In short, these participants seemed to resolve the emotional dissonance created by

rejection from their preferred schools by focusing on the opportunity osteopathy provided to enter the medical profession as a doctor.

Of striking interest in the theme "choice by default" were the gender differences reflected in these participants' accounts. In listening to men and women talk about why they chose osteopathy, we were struck by how men described osteopathy as "the next best thing" to scientific medicine; whereas women (in general) were drawn to the holistic orientation espoused by the osteopathic profession. These participants' accounts reflect societal norms that have been identified by previous scholars, including the tendency for women to be more emotionally sensitive and expressive than men (e.g., Kunkel & Burlison, 1998) and more prone to engage in work requiring what Hochschild (1983) called "emotional labor." These accounts are also consistent with work that highlights how men in the United States tend to be socialized as rational actors who exhibit a hierarchical, competitive mind set, while women in general are often socialized to emphasize interdependence with others (Allen, 1996). Furthermore, various sources (e.g., the media, family, teachers) frequently convey messages regarding "feminine" and "masculine" occupations, which can potentially influence individuals' choices of occupations. In the context of our dominant value system, it is not surprising to see that more male participants were initially drawn to the scientific, rational approach of biomedicine, whereas more women participants reported being drawn to the holistic aspects of osteopathy. Socialization into various occupations, after all, usually reflects the dominant culture's norms, attitudes, and values (Allen, 2000).

Taken together, these themes provide insight into the sense-making processes by which these individuals account for their occupational choice. For some, osteopathy represents a philosophical alternative to mainstream medical practices while for others osteopathy provides a second chance for entry into the medical profession. Regardless of the path leading to osteopathy, participants expressed contentment with the end result: "I guess it was fate, cause I love it here," "I am really happy here now," "Coming here was a surprise. But it has been a nice surprise." Each of the themes illustrate the complexity and emotionality involved with anticipatory socialization for students who select to study at institutions that follow alternative ideologies of medicine.

### *Encountering Osteopathy*

The entry/encounter period of socialization occurs when employees actually enter the organization and involves the day-to-day patterns in which employees try to make sense of their new environments while being subjected to practices and norms of the organization and its members (Jablin, 1987). Our analysis suggests that role models play a particularly important role in the lives of these medical students during their encounter with osteopathy. Furthermore, when asked about significant experiences in their formal training thus far that have had an impact on them, the participants emphasized frequently the problem-based learning components of this school's curriculum. These themes are consistent with this school's attempt not only to treat medical encounters holistically but to also teach in a holistic manner—a manner recognizing and embracing the socio-emotional aspects of health and healing.

*Role models*

Role models, including older students, teachers, and physicians, provide an important source of information and influence on the development of medical students' interpretative schemas about their future roles. In many ways, role models seemed to encourage the neophyte physician to identify with the values associated with osteopathy. One woman talked about a mentor and his relationships with his patients, as an exemplar of what she wanted to become:

He just set the example. He was hands-on and the example that he set for the two weeks that I was with him was like, wow, If I can be just one quarter of the doctor that he is. And it wasn't necessarily his medical knowledge, but the whole package. Every single patient that he saw, whether they were there for a disability, Medicaid patient, whatever, he treated them like an old time friend. One of the best things about being with him was just his way of setting the example.

In fact, all of the interviewees talked about the importance of role models in their developing orientations toward health-care delivery. Many participants, including this man, talked about wanting to emulate certain characteristics they observed in others: "There is one resident, and this guy, I really like the way he approaches his patients and ever since I've watched him I have wanted to develop my skills so that I could, even mimic his interviewing skills."

Although many students discussed positive role models, students also described mentors in terms of what they did not want to become. One student commented, "I've followed doctors that, you know, when they come out of the office they make fun of the patient. I, I absolutely hate that." Regardless of the nature of how role models influence students, it is clear that they are important agents of socialization. "One thing about medicine, it's definitely a career where you take a lot of different things from different physicians and that's how you become a physician." Many mentors were described as expressing a variety of emotions in their professional roles. In one sense, the actions and interactions of mentors can be viewed as important vehicles for passing on the philosophical values of osteopathy. Interactions between role models and students seem to serve as sites where osteopathic values are clarified and represented.

*Patient encounters*

One of the main objectives of medical education is to help students develop the ability to solve medical problems. This particular osteopathic medical school, consistent with other osteopathic institutions, has recently integrated several problem-based components into their curriculum. The goal of these collective components is to provide students with opportunities to develop clinical diagnostic skills by working with patients or through observing others work with patients. Students often told us that the problem-based components of their school's curriculum provided them with opportunities to experience the socio-emotional aspects of medicine. Although students discussed several significant experiences including the geriatric patient encounter, the "shadow a physician for a day" program, and role

playing, they mentioned most often the importance of their preceptorships and the standardized patient program in the development of their holistic outlook toward physician-patient interactions.

Preceptorships occur immediately after students complete their first year of medical school. Each student is assigned to a different doctor(s). During preceptorships, students follow and observe osteopathic physicians. Although students' experiences varied from observing family practitioners to hospice-based physicians, they overwhelmingly emphasized how the preceptorship became a reality check. "In one sense, my preceptorship reminded me of what I am here for. You know, I felt like a doctor," said one woman. Some students not only observed their doctors but actually participated in the healing process. "I was considered like an extra hand, a helping hand in the office. You know, when the doctor got swamped, I was picking up extra patients for him and doing H and Ps and that sort of thing," said one interviewee. Another commented, "I was in an emergency room and I got to actually glove up and hold somebody's hand. Someone who had just been in a fight with a fanbelt."

Throughout our conversations, students framed the benefit of their preceptorships in terms of observing how "real" physicians interact with patients, sometimes in emotionally rich situations:

Dr. Murphy had to tell the parents that their son had leukemia. And I remember him setting down with those parents, and I mean he was to tears and crying with parents. And I really think that was important for him to do. Physicians cannot just remain cold to situations like this. In fact, I think if physicians showed more emotions there would be a lot less lawsuits. If someone is experiencing a loss, to share that with them, to grieve with them is completely appropriate. I learned that from Dr. Murphy.

In reminiscing about her preceptorship, one woman commented, "I felt like a doctor. And I felt like all those 20 hours a day that I spend here is actually, you know, not just something to memorize day in and day out. It will all be worth it."

The standardized patient (SP) program also appears to provide students with an opportunity to revisit the interpersonal reasons why they chose a medical career. "In one sense they [standardized patient interactions] remind us of what we're doing," indicated one participant: "You know, cause we can get so focused on the science tests and they remind us that someday we are going to be interacting with real live patients." The term standardized patient is an umbrella term for patients who are hired and trained to simulate illnesses in a consistent fashion (Barrows, 1993). At this medical school, the purpose of the SP program is to provide students with an early introduction to patient care without endangering real patients. Students gain experience in taking a history and physical, explaining treatment protocols, breaking bad news, requesting an autopsy or organ donation, and other communication challenges common to physicians. Moreover, the SP program is part of the assessment of medical students' clinical skills. In addition to their comprehensive board examinations, students must pass 24 standardized patient interactions. When asked about significant experiences during their formal training at this school, all of the interviewees

discussed the SP encounters. As suggested by one student, “they (standardized patients) remind us to not treat people like a list of symptoms. . . . These are real people whose families and work are affected by their medical situation.”

The interviewees focused on how the SP interactions provided the “hands-on” opportunities to manage uncertainty and emotionality associated with the healing professions. As stated by one person:

I’ve never been in a role where I am the one interviewing and trying to find out what the problem is and so it was a new role to step into. It was good ‘cause I think it’s good to throw yourself off balance and out of comfort zones. That’s when you tend to really learn. So I was glad for that. I’m looking forward to the others cause I need to be kicked out of those comfort zones every once in a while.

In terms of preparing to work with future patients, one person suggested, “You can read all about how to interview someone and how to do a physical exam. You can even watch another doctor. But what it comes down to is that you don’t know until you do it yourself.”

Whether students talked about experiences during their preceptorships or within standardized patient interactions, they emphasized the benefits associated with such early exposure to the socio-emotional aspects of clinical interactions. Underscoring the importance of these accounts is Jablin & Krone’s (1987) argument that early experiences are critical “to the development of attitudes and behaviors consistent with organizational expectations” (p. 713). At this point, the interviewees are still in the encounter phase of socialization as they are still seeking information and learning about their roles in the field of osteopathy. Although their identities will continue to evolve throughout their professional careers, it seems clear that these early training opportunities provide formative experiences for these students. Even at this early juncture in their training, they are able to articulate various ways in which role models and components of problem-based curricula are shaping their own professional identities. To conclude the findings section, we present several core themes characterizing the emergent identities of these students.

### *Emergent Identities*

The interviewees provided several insights into what it generally means for them to practice osteopathic medicine. These students perceive osteopathy to be an art—a healing art—and they describe osteopathy as being a holistic form of medicine: “Treat the patient, not the lab value. You know as opposed to allopathy where you treat a disease process or symptom, osteopathy is more looking at the whole person,” said one student. Another stated:

We look at other factors besides the specific chief complaint that the patient has. We look more at the whole person whereas allopaths will tend to focus more on the presenting problem. Osteopaths do that too but we try to incorporate the spiritual, social, and other aspects of the patient’s life that may relate to the problem.

Participants also described osteopathic medicine as being a nonintrusive, inexpensive, and economical approach to health care that is particularly well suited to chronic pain/problems: "Osteopaths practice cost effective medicine. I think one reason why we are more cost effective is because of the whole body approach. We look at clues that the body's telling you as to what's wrong." Another student suggested, "In terms of patient care, we are not only inexpensive but also practical. We don't put the patient through needless pain, time, expense." These participants' accounts indicate that the holistic philosophy of osteopathy is consistent with macro-societal forces requiring health care providers to be cost-effective and efficient.

The interviewees envision future physician-patient relationships using metaphors that emphasized an active role on the part of the patient including partnerships, teamwork, and friendships. "Unless you enter patients as active participants in their health care, you know, it's not gonna be successful. So I think it's a partnership in which the doctor and patients are both making the decisions," said one student. Another noted that, "The ideal doctor patient relationship is like a friendship. A doctor should be someone that a patient could come to and tell them something that has been going on in their mind, in their life. An honest and open relationship." Although some of the metaphors (e.g., parent) suggest a more dominant role for the physician, the interviewees overwhelmingly emphasized the importance of relationships characterized by respect, rapport, listening, and honesty. "My first impulse is to say that of almost a parent. But that somewhat bother me because it has a paternalistic edge to it. And, I think sometimes there is too much of a paternalistic feeling in medicine."

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." On the one hand, students perceive emotional expression as consistent with a holistic approach to medicine, "Feeling and expressing emotions goes along with our "mind, body, spirit" philosophy of medicine. Along the lines of an open, honest relationship between physician and patient, feelings should be shared." However, students also discussed the need to "have a certain degree of separation and be able to pull back. It will kill ya if you don't. It will just eat at you." Another person remarked, "if you care too much obviously you will destroy yourself and burn out."

Although this dialectical tension was apparent in the data, participants generally articulated more positive benefits, for both the patient and the physician, as a result of the physician's willingness to express emotions. Some participants perceive the expression of emotion as a way to establish and maintain equality within physician-patient relationships. In fact, one person suggested:

In my opinion, not expressing emotion puts them [doctors] up above the patient further. Medicine in general in today's world is too cold and too corporate anyway, and I think that if the physician is not showing emotion he furthers and strengthens that image of medicine.

Another person noted, "If I am going to view the doctor-patient relationship as a team, then I need to be a team player. And by that, I'm gonna have to give emotionally to the



relationship." Another agreed and contrasted the emotionality of osteopathy with the world of allopathy:

The teachings of osteopathy, I think, promote the exhibition of emotion more so than allopathic medicine. . . . I guess one of the reasons I like the whole idea of being a D.O. is because there's a lot of touching, you know manipulation. The touching I think helps D.O.s to be more empathetic [*sic*] with patients. And I think patients react well to that.

The image of the ideal physician emerging from the interviews is not limited to one who knows relevant factual information and implements medical intervention. Rather, participants stressed that their capacity for caring and dialogic interactions is integral to their future relationships with patients. As the current findings illustrate, emotions play meaningful roles in these neophyte osteopathic practitioners' emerging professional identities. Although these future physicians recognize the importance of maintaining clinical objectivity with patients, they also acknowledge the value of an emotional connection with patients.

Participants' identities appear to be partially formed based on personal comparisons with practitioners espousing different medical philosophies. Throughout our conversations, students shared their perceptions of similarities, differences, and tensions between osteopathy, allopathy, and other "alternative" forms of medicine. Underscoring some students' discussions about the place of osteopathy in the modern medical establishment is the perception that allopathy and osteopathy are becoming more similar: "I think as time progresses, we're really starting to take from each other's philosophies. I don't think there is as much distinction as there used to be. The differences are lessening all the time," commented one student. Another participant noted: "We have always looked at the mind, body, spirit integration, whereas allopathic medicine I think is just starting to. But for osteopathic medicine, it has always been a tenet of ours." Questions of identity for these osteopathic students appear to be centered on comparisons to allopathic medicine.

The relation of osteopathic medicine to mainstream medical practice is also reflected in what students did not emphasize as part of their unique identity. One hundred twenty-five years ago, Osteopathic Manipulation Therapy (OMT) was at the crux of differences between osteopaths and allopaths. The participants in this study attended one of the few osteopathic schools that still teach OMT. One student highlighted manipulation when discussing the nonintrusive nature of osteopathy: "There's lots of things you can do to improve someone's quality of life that don't include drugs and surgery. I think by doing manipulations and touching them rather than just giving pills, we practice less intrusive medicine." However, most participants did not discuss such therapies as central to their identities. In fact, one person suggested that "the tools of the trade aren't that much different anymore. I think it's the philosophy that's different. Ours is more holistic, I guess you could say." These students have constructed identities for themselves as members of the osteopathic profession that uses a more holistic approach and fewer technical tools than mainstream medicine.

Participants' professional identities also appear to be based partially on comparisons between osteopathy and other "alternative" forms of healing. More specifically, these students suggested that osteopathy is more rigorous in terms of the scientific training that they receive. One person noted:

Some of the aromatherapy people, you know, they finish high school and take a three week course from the lower Slobovian Institute of Aromatherapy and come out an expert. And you know they learn how to treat your bronchitis by sniffing particular scents [laughter]. While there might be some truth to it, at the same time, if your bronchitis is really bad, maybe you should go get it treated with something besides eucalyptus.

Although students agree that they are, as stated by one person, "alternative in the sense that we have a different philosophy," they consider themselves as more legitimate and acceptable in mainstream society than other forms of alternative medicine. "I think the level of training is part of what distinguishes osteopathy from other alternative medicines. And a lot of it is just societal acceptance. For instance, 50 years ago osteopathic medicine was alternative. And maybe 15 years from now acupuncture will be mainstream."

As indicated earlier, the technological imperative as practiced and developed through the scientific method is a strong ideological force influencing our health care system—including the professional identities of health care practitioners. The establishment of a rational, scientific basis for diagnosis and treatment has resulted in a societal emphasis on the importance of rigorous scientific examination. Scrutiny directed toward other forms of alternative medicine, which was expressed by several participants, illustrates this rationalizing and legitimizing force. In one sense, students' discourse represents attempts to distance osteopathy from certain "extreme" forms of alternative medicine. Participants' discourse also appears to position osteopathy as a middle ground between mainstream medicine and "alternative" medicine—an integrative ground of sorts in which elements of various medical ideologies can find space to prosper—as long as those elements are consistent with osteopathic philosophies.

## **Discussion**

The results illustrate how processes of ideological formation are embedded in socialization discourses. Specifically, students' accounts of their preclinical experiences reveal how the value sets associated with osteopathy are reproduced through early socialization experiences. In some cases, pedagogical choices (i.e., standardized patients) serve as discursive sites emphasizing dialogic communication and a holistic approach toward medicine that recognizes socio-emotional aspects of health and healing. Interactions between students and role models also appear to clarify and represent the values of the osteopathic profession. Students' accounts also revealed important elements of osteopathic medical socialization that we believe are broader reflections of the "rationalization" of medicine in our culture. In many ways, these participants' accounts reflect the dominant biomedical model and its value system. For instance, students used intergroup comparisons with other forms

of medicine as a way to articulate their own professional identities. Central to such comparisons appears to be our cultural assumption, well recognized by these students of osteopathy, that allopathic medicine is the "true" or benchmark medical system.

Although the United States encompasses a great variety of health-related ideas, philosophies, and practices, the core of our health-care system is based upon a biomedical model that generally has not supported recognition of or sensitivity toward diversity in health care delivery (Baer, 1989; Lupton, 1994; Page, 1995). The discourse of participants in this study suggests that philosophies of medicine that are different than allopathy are often still dismissed or devalued. At the same time, these students dismissed other forms of "alternative" medicine (e.g., aromatherapy) that are not as scientific as osteopathy. Abraham Flexner (1910), in his classic assessment of American medical education, predicted that nonmainstream forms of medicine would be "co-opted" into the modern medical fold. Along with other scholars (Loustaunau & Sobo, 1997), we believe that Flexner was only partially correct.

Medical "syncretism" is a term coined to reflect the process of one group's borrowing or adapting medical remedies, knowledge, and techniques of treatment and diagnosis from another group (Laguerre, 1987). Medical syncretism in our society is reflected in the voices of the individuals who participated in the current study. Many students expressed similarities between mainstream medicine and osteopathy; yet, their accounts also illustrate that they perceive continuing differences between the disciplines. Of particular interest in the current findings is how students, at least at this school of osteopathy, relied on value-centered discourse to differentiate themselves from mainstream physicians rather than technical "tools." For decades, osteopathy defined itself through its techniques (OMT), whereas now it seems to be defining itself through the values inherent in its holistic ideology. In fact, only two participants discussed OMT as central and distinctive to their chosen profession. These results reflect national data indicating that fewer schools and osteopathic physicians are teaching and practicing OMT (American Osteopathic Association, 1999). As mainstream medicine continues to become more humanistic and patient-centered, and osteopathy relies less on OMT, it will be interesting to see how ideological uniqueness between competing philosophies is negotiated. Future research should explore how tensions between allopathic, osteopathic, and other philosophies are resolved, perpetuated, or ignored.

We began this project expecting to hear somewhat different accounts from these students of osteopathic medicine than previously reported accounts from mainstream medical students about their emotional socialization experiences. The lived experiences of osteopathic students whose voices are reflected in the current study are different from previously reported descriptions of medical education in terms of emotional distancing and instrumental rationality (e.g., Coombs, 1998; Fineman, 1993; Good, 1994; Hafferty, 1988; Rothman, 1999). In stark contrast to the disabling qualities of allopathic medical education (Good & Good, 1989), this osteopathic institution appears to help students maintain "caring attitudes while developing the knowledge and skills of the competent physician" (p. 309). Although participants recognized the importance of "clinical objectivity," they also characterized willingness to express emotions as an essential aspect of their professional

identities. Moreover, the participants suggest that emotional expression is one characteristic that distinguishes them from allopathic physicians. Throughout the interviews, students identified several mechanisms through which they became familiar with what it means to be an osteopathic physician. Importantly, students described several opportunities in which they were forced to confront the socio-emotional aspects of health care early in the preclinical years of education. Specifically, participants described problem-based curricula, including standardized patient interactions and preceptorships, as providing them with valuable "hands-on" experience in clinical situations prior to their residencies. Moreover, students emphasized that role models are instrumental in shaping their perspectives on health care. This is consistent with other socialization literature emphasizing the importance of role models in establishing role expectations (e.g., Jablin, 2000; Rothman, 1999). It is through such socializing agents as role models and the school's curriculum that the holistic ideology of osteopathy appears to be reproduced.

Questions remain for additional inquiry. These participants suggested that the art of healing and emotional expression are intertwined. What was not clear in our discussions was how the dialectical tension between emotional expression and clinical objectivity can be managed in such a way that both can coexist. To investigate this dialectical tension and its management, the perceptions of other osteopathic students and more experienced physicians need to be explored. Certainly two limitations of the current project are a relatively small sample size and a research design that yielded a snapshot based on data collection and analysis at one point in time. Our goals include following these participants as they progress through their training and careers and increasing the number of participants whose voices are included in this research agenda.

Finally, future researchers should explore the gendered nature of medical socialization. All of the male students who grew up in the United States indicated that their primary reason for choosing osteopathy was because they could not get into a mainstream medical school, even describing osteopathy as the "next best thing" to what they originally hoped or planned. It appeared that these men had to eliminate cognitive dissonance in order to create consistency between their original goals and their training in the osteopathic profession. These results suggest that socialization processes are, in fact, not universally experienced. Future research should continue to explore socializing discourses that encourage particular identities for particular groups (i.e., men and women). Because gendered relationships are pervasive in organizational life (e.g., Allen, 2000; Bullis & Stout, 2000), the socialization practices through which gendered relations are reproduced must be understood.

Underscoring this project is the belief that anticipation of, approach toward, and early involvement in medical school subculture is a critically important phase in the emotional socialization of physicians (Hafferty, 1988). Even at this early stage in their medical training, osteopathic students were able to articulate how their professional identities are being shaped by curricula, experiences, and mentors. Additionally, these students were able to describe what they viewed as the essential characteristics of osteopathic medicine. Based on these findings, it is evident that the socialization processes medical students encounter are important elements potentially shaping the nature of health care. Continued explora-

tion of medical socialization can provide valuable insight regarding how medical philosophies and physician identities are socially created and maintained—social constructions that ultimately have a significant impact upon our health care system.

## Notes

1. The Bantam Medical Dictionary (1990) defines allopathy as “a system of medicine in which the use of drugs is directed to producing effects in the body that will directly oppose and so alleviate the symptoms of a disease” (p. 13). However, lay people in our culture rarely use the term “allopathic physician.” Likewise, allopathic physicians rarely refer to themselves as such; rather, they consider themselves medical doctors.
2. For instance, a recent survey indicated that one-third of allopathic schools now offer elective courses in alternative treatments (Wetzel et al., 1998) and many schools are integrating communication skills training in their curriculum (Sharf, 1993).

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