Residency as Identity Transformation: The Life Stages of the *Homo medicalis*

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Our appreciation of human life cycles and stages is about 150 years old, contrasted with hundreds of thousands of years of human existence. We recognized that children were not small sinful adults, as the Victorians preferred to view them—not homunculi, but in a developmentally distinct phase in human growth. This was the beginning of understanding human development and distinct stages in a person's life. Along came Freud, who further defined the stages of human life with the childhood developmental stages of oral, anal, phallic, latency, genital/puberty and adolescence, followed by adulthood.

The stages of child development were expanded by Freud's daughter Anna, who essentially revealed the life of the mind of a child.[1] Freudian pioneers like Peter Blos and August Aichhorn revealed that adolescence comprises many substages; they elucidated the concept of adolescent "acting out" through delinquency and that these rebellions are transient in many.[2] Anna Freud felt that the stage turmoil of adolescence is so profound that one should be wary to render a diagnosis during this life cycle, for even psychotic symptoms could disappear. These important pioneers of the human psyche revealed the developmental stages and cycles of life and defined them by affective and cognitive milestones.

The concept of life cycle, stage, milestones, and ongoing development was further pioneered by a student teacher in Anna Freud's school for children. Erik Homburger Erikson, who as a developing and unemployed artist found employment there through his friend Peter Blos, discovered psychoanalytic adolescence. Erikson understood that life cycles do not end after adolescence and that distinct cycles with needs, goals, and crises continue until death.[2] It is unclear to many in the field of life stage psychology when these stages begin and end, and adolescence until age 30 is not unusual. Also, each stage develops an identity that does not disappear completely when the next one begins. The structures of the prior stage can be changed, altered, sculpted, and carried wholly or piecemeal into the next cycle. This profoundly alters our view of the power of the life stage/cycle, for the effect of prior stages does not die or wither away but remains an active influence. How active these life stages are, their ultimate complexity, and their relevance to understanding the human psyche, behavior, cognition, and identity needs appreciation.

This may help us better understand medical residency as a life-altering and identity-transforming period in a young person's life. Residency is where young people with a medical degree actually assume the personality and identity of "doctor" in its first and perhaps final incarnation. However, this fact seems to be contested by many for a host of reasons. First, we divide and famously compartmentalize our lives into work, personal, family, civic, and community components that we view and respect as separate. Second, we struggle and bumble over what is legal reality versus what are social, psychological, and biological realities. The legal opinion on the status of teenagers and young adults in school, college, and residency, versus the learners'/trainees' relationships to their teachers, bosses, and leaders, appropriately but confusingly protects young people by determining that teachers are not *in loco parentis*. This important legal precedent—established to protect the autonomy of susceptible youth and to avoid abuses—ultimately drove wedges and schisms into real and life-altering influences by role models. Embracing the precedent, teachers refuse or demur the role of models and accept a distant relationship with trainees; for they are not the biological parents, though they are surely the trainees' role models, with life-influencing and sustaining impact throughout their lives. This abrogation of strong bonding relationships was a relief to and a lesser emotional burden on teachers that allowed them less authority and blame within the lives of young people, with the concomitant diminished influence and likelihood of accusation or possibility of injury, trauma, or abuse to young developing identities.

Another of the many wedges between trainees and teachers in medicine was Osler's historically dominant yet contested essay *Aequanimitas*,[3] in which Osler prescribed an emotional distance. The pre-Flexnerian and peri-Flexnerian eras were rampant with mysticism, magic, varieties of alchemy in the practice of medicine (including hysteria), and charismatic and uncontrolled emotionalism on the part of both patients and doctors. Osler's Victorian and male-dominant ideas of the time attempted to introduce the

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newly applied ideas of science in the practice of medicine. It maintained a rigid, nonemotive austerity, yet it is still invoked as canon.

I suspect Osler, the great innovator, would wince to know the present status quo and that the static ideas he invoked over 100 years ago are still applicable. He would likely have paraphrased Bacon's rule to follow the newest science and the oldest literature.[4]

Operating *in loco parentis*, linked to *Aequanimitas*, permits an emotional schism to exist between mentors and trainees and presently reinforces the emotional distance of out-of-date aequanimitas, serving a regrettable dual purpose. Additionally, the unfortunate terminology of *in loco parentis—loco* colloquially understood as crazy—underscores the splitting away of emotions from the very likely intense interactions trainees have with mentors, it reinforces disconcerting messages, and it can be viewed as insecurity and abandonment.

Yet a third reason for wedge and schism, beyond misguided *in loco parentis* and Victorian *Aequanimitas*, is that there are no life stage dynamics unique to residency training—that the conflict between identity-seeking active adolescence and young adulthood is (1) completed prior to residency, (2) nonexistent, or (3) the private affairs of the trainees. The logical conflict is that these statements are all true and believed simultaneously. As faculty we may see ourselves as simply "Google": we supply the information, the rules; the life changes are ultimately the sole responsibility of the trainee, who we mostly approach as age neutral and interact with detachedly, with minor variations—no differently from us, unless we simply treat them as schoolchildren.

Were we to adopt the Identity Transformational Residency, what criticisms would this more empathically demanding stance of the residency era, life-cycle alteration, and role-modeling challenges provoke? Caveats abound, including the potential for paternalism and potential further authoritarian abuse, based on inherent and realistic wide authority gaps and status-rigidity among faculty, trainees, and patients. Though the Latin *in loco parentis* means "in place of parents," we are not the parents of our residents and should not enter that overemotional, coercive arena.

How can we walk this fine line? Through empathy and kindness. To be aware of our power and the ability to injure as much as to influence, yet to positively modify and help co-construct and co-create professional (and yes, personal) identity. Also, beware of the turbulence of this stage: medical training is a life-altering epicycle that further stresses the adolescent and young adult's anxious and torrential streams that are mingling in our "apprentices." This understanding of the many transient, intense turbulent stresses and unrevealed anxieties to both apprentice and teacher must be met with indulgence; otherwise trauma and injury may prevail. This trauma and injury will damage (or hurt) young physicians all-around, and ultimately when they become the older doctors, this trauma will include the next generation of trainees and their patients. Essentially, this viewpoint argues that tough love is mostly an excuse to be tough. Beware, for the unintentional creation of negative identities is possible.

What are some of our tools to carry out this program? How do we profoundly alter and affect these lives of others and their lifestyles in perpetuity? The transference and mingling of emotions are evident, profound, and a given—not a reality or impact to be belittled. We are also the purveyors of humanization of many of life's great tragedies, and we must make this explicable to a generation of novice physicians. We nurture, mature, grow, and transform by multimodal communication in every venue in which we do communicate, and by professionalism—not only as rigid laws and commandments, but *professionalism* as a verb: the hidden acculturation, socialization, and action-ethics that are yet ill-defined and underacknowledged by our profession and that must be synonymous with trust and security. We must mirror back to the trainee the best empathy model they contain and are developing, and that we must possess. Historically, these holistic educational approaches were referred to as Bildung, in which invested teachers addressed the emotional, civil, and communal lives of trainees—they were the Mr or Mrs Chips. These role-modeling/identity-altering relationships, with full disclosure to each others' emotional presence, surely co-constructs the *Homo medicalis* and removes much of the inadvertency and serendipity in our present approaches. Further, it cannot be done alone; it does take a committed village of like-minded community. The power of these processes will help fortify the trainee for empathy and creativity, and that is the most powerful inoculation to counter our greatest challenges: personal cynicism and organizational narcissism.

This brief essay cannot attempt to better fashion and delineate what we do in the educational process, and it awaits the longer study. Its aim, in anticipation of incubating a longer work on the theory of graduate medical education, is to reflect on the perspective that residency training is a pivotal life-cycle event for trainees that converts them from Ms or Mr to Dr, which will be their mystique, moniker, and identity for life. It is an identity that comprises about 1 quarter of 1% of all citizens in the United States—indeed, there are many more elected politicians in America than doctors. The title of doctor presupposes a profoundly life-altering identity change that affects all aspects of a person's work, private life, and indeed cognition and action. If we appreciate the profound identity changes that occur during the active and intrusive era of the residency life stage, we may consider how we can do this differently. We may regard those whom we allow to train physicians differently and seriously reconsider what educational resources our teachers of apprentices need.

We need to appreciate that young physicians wrestling with adolescence and young adulthood and trying to

integrate their identity with the additional pressures of becoming a doctor with life-and-death powers is surely an Eriksonian life crisis. Fortunately, with most life crises, we survive them well enough to move on, with acceptable baggage. But what an opportunity to help co-construct the lives of doctors who presently bear higher rates of burnout, depression, divorce, and cynicism than most professions, and to create better empathy and "hope of joy" (Antoine de Saint-Exupéry)—and this is doable with what we know now about student-centered education, going back to John Dewey,[5] clinical and depth psychologies, group psychology, and the array of studies in life-cycle research and therapy.

It will be a challenge to readjust perspective that a central operant condition of residency training is life cycle, but we must all walk down this path together. As I continue to work through a number of these issues in a longer piece, I look forward to learning from my colleagues to better understand what we do during residency training, where we are going, and where we may successfully go.

References

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