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## Special Topic

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# Bridging the Generation X Gap in Plastic Surgery Training: Part 1. Identifying the Problem

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*Every few hundred years in Western history there occurs a sharp transformation. Within a few short decades, society rearranges itself—its world view; its basic values; its social and political structure; its arts; its key institutions. Fifty years later, there is a new world. And the people born then cannot imagine the world in which their grandparents lived and into which their own parents were born. We are currently living through just such a transformation.*

—Peter Drucker<sup>1</sup>

Today's workforce is unique. Never before has there been such a generationally diverse American workplace. That diversity can both frustrate and challenge long-established standards. As anyone who has children between 12 and 30 years of age can attest, the "generation gap" can produce a gulf of misunderstanding. It was this apparent generation gap that led the Association of Academic Chairmen of Plastic Surgery (AACPS) to consider an in-depth exploration of the problems that many program directors were having relating to their integrated younger trainees, to more senior independent residents, and even to young faculty members. These communication problems were revealed in informal conversations at successive meetings of the AACPS, and a member survey confirmed perceptions. Therefore, our organization began to examine the generation gap in earnest.

### WHAT IS THE GENERATIONAL PROBLEM?

To understand the issues more completely, it is necessary to appreciate the composition of

today's workforce. There are four age cohorts working in our society (Table I); three are now widely employed in surgical workplaces and the fourth will be joining the workforce in the next few years. Although these groups share some traditional work values, they differ on such important issues as the role of authority, employee/employer loyalty, use of telecommunication, and what constitutes a good day's work. Their lifestyle preferences and social values also differ.

The two groups that are predominant in the workforce today, and of greatest interest for the education of plastic surgeons, are the Baby Boomers and Generation Xers. In general terms, Boomers are between 42 and 62 years of age, whereas Generation Xers are between 22 and 42 years of age. These ages are not rigid limits but are meant to be guidelines for this discussion. Being an Xer is often more an attitude than an age. In the United States today there are more than 60 million men and women (27 percent of our workforce population) who are considered Xers, making them the second largest generation in the United States.

Listed in Table II are 12 ways in which Boomers and Xers tend to differ. Although the differences might seem to be sufficient to blunt effective communication between a Boomer program director and an Xer resident, this is not necessarily the case. As might be expected, there are issues that are certain to produce differences that lead to conflict, but those differences can be productively resolved by devel-

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TABLE I  
Shaped by Our Times

	Generation			
	World War II	Baby Boom	Generation X	Millennial
Age (yrs)	≥62	42–62	22–42	2–22
Outlook	Practical	Optimistic	Skeptical	Hopeful
Work ethic	Dedicated	Driven	Balanced	Ambitious
View of authority	Respectful	Love/hate	Unimpressed	Relaxed, polite
Leadership by	Hierarchy	Consensus	Competence	Collaboration
Relationships	Personal sacrifice	Personal gratification	Reluctant to commit	Loyal
Perspective	Civic	Team	Self	Civic

oping awareness and maintaining open lines of communication.

*How Significant Is the Generational Problem in Plastic Surgery?*

There was an excellent response to our AACPS member survey. Ninety-eight surveys were returned, representing more than 70 of the 87 programs in the country. Questions addressed the faculty members’ ability to relate to, communicate with, and understand Generation X residents. There were also questions regarding perceptions of the residents’ view of authority, ability to assimilate knowledge, and independence, compared with trainees in previous years.

The results of the survey were revealing. The faculty members recognized that they had problems relating to the residents’ work ethic (70 of 98 responses) and they reported that they had personally experienced a problem understanding “where the residents are coming from” (56 of 98 responses); however, they had not experienced significant problems communicating expectations, policies, and procedures to residents (79 of 98 responses).

Faculty members perceived that residents view residency not as a career but rather as a job (59 of 98 responses). It was thought that residents do follow diplomatic routes of communication most of the time (72 of 98 responses). In addition, the residents seemed to respect authority most of the time (78 of 98 responses), seemed to be team-oriented, and were as independent as those in the past (72 of 98 responses), but they were definitely more adept than the faculty members at assimilating and applying technology (76 of 98 responses). Some of the communication/perception issues are reflected in the following selected comments program directors added to their surveys.

“Resident wants lifestyle with little or no emergency room call . . . will not accept hand cases in practice.”

“Most residents envision themselves as cosmetic surgeons . . . it’s difficult to maintain interest in general plastic surgery.”

“Want protected time to read, casual dress. A married male demanded time to go to his first grader’s parent-teacher conference.”

“There is a different style of learning and

TABLE II  
Generational Delineators\*

	Xers	Boomers
Perspective on work	Job	Career
Communication	Blunt	Diplomatic
Authority	Unfazed	Impressed
Approval	Indifferent	Seek validation
Resources	Scarce	Abundant
Policies and procedures	Mistrustful	Protective
Reliance	Self-reliant	Team-oriented
Work ethic	Balanced	Driven
Focus	Task and results	Relationship and results
Technology	Assimilated	Acquired
Entitlement	Merit	Experience
Perspective on the future	Survival	A better world

\* From Raines, C., and Hunt, J. *The Xers and the Boomers: From Adversaries to Allies—A Diplomat’s Guide*. Menlo Park, Calif.: Crisp Publications, 2000. Pp. 31–39.

teaching, which we must master for this generation.”

“I think this is more of a ‘coastal’ problem than one in ‘middle America.’”

“Resident is planning pregnancy during second year of residency.”

“On-call resident will finish a late case—as opposed to the chief resident, even if it is a very complex case.”

“Residents have a ‘what can they do to me’ attitude . . . it’s as if there is no substantive consequence for their behavior.”

“Knowledge base is a veneer; few residents show a desire to ‘learn everything’ about a topic anymore.”

“A resident recently told me that I work too hard. I am routinely in hospital before residents and leave after them.”

“Less willing to come to emergency room to see patients . . . wants to use technology to bypass clinical examination (e.g., computed tomographic scan of facial trauma patient viewed at home to avoid seeing patient in emergency room).”

“When asked to see a patient or unexpected problem, resident states ‘I’m not on call today.’”

There were also some positive comments.

“Residents want to learn and be successful . . . when we respect them and listen to their concerns, they appreciate it. I have no generational problem with residents.”

“I don’t see problems with our residents, but I do see what you are getting at with the medical students.”

“Our current integrated residents are the best group I have ever worked with anywhere, far, far superior to independent residents of 5 to 10 years ago.”

#### *Purposes of the Generation X Retreat*

On the basis of the results of the survey and these comments, the AACPS leadership decided to plan a retreat that could not only identify these problems more clearly but also attempt to establish methods for dealing with this generation gap. The purposes of the retreat were (1) to explore the work orientation and learning style of Generation X residents, (2) to educate program directors with practical information on understanding and relating to Generation Xers’ values, approaches to problems, work ethic, and communication preferences, (3) to determine what changes could be made in the tradi-

tional methods of education, discipline techniques, and accountability for dealing with Generation Xers, and (4) to provide program directors with practical solutions and tools for teaching and working more effectively with today’s residents.

#### *Format of the Generation X Retreat*

Because there was little written information about this generation gap within medical education in general, with none for plastic surgery in particular, a decision was made to seek expertise from the business world. After some research and telephone interviews, a decision was made to use Claire Raines as our facilitator. She is considered one of the nation’s leading experts on generations at work and is the author or co-author of four best-selling books on the topic, including *Generations at Work: Managing the Clash of Veterans, Boomers, Xers, and Nexters in Your Workplace*, *The Xers and the Boomers: From Adversaries to Allies—A Diplomat’s Guide*, and *Beyond Generation X: A Practical Guide for Managers*. She is also a highly regarded consultant, whose clients include Microsoft, Toyota, American Express, and Coca-Cola.

After some discussions between Ms. Raines and the AACPS leadership, a decision was made to use a variety of teaching methods to accomplish our goals. These methods would include division of the attendees into small groups, which would be presented with case histories for problem solving, large group distillation of concepts derived in the smaller groups, and didactic presentation of some related materials.

To add a surgical perspective to the retreat, we asked Dr. Gary Dunnington to speak. Dr. Dunnington is professor and chairman of the Department of Surgery at Southern Illinois University and is a recognized authority on the education of surgical residents. He is past president of the Association for Surgical Education and is active in the Association of Program Directors in Surgery. Dr. Dunnington opened the retreat with a presentation titled “Good to Great Education: Bridging the Generation X Gap in Surgical Training.” Topics addressed included the rationale for the development of Accreditation Council for Graduate Medical Education competencies, the 80-hour work week, models for assessing graduate medical

education, and technical advances used for educating surgeons (such as surgical skills training laboratories).

To prepare background information for the retreat and to familiarize the facilitator with the problem, AACPS members were asked to provide typical scenarios that they thought might be representative of the generation gap problem. In addition, members were asked to provide the names and telephone numbers of Generation X residents who would consent to an anonymous interview by the facilitator, to provide a realistic candid view of residents in training and those who had recently graduated.

#### SUMMARY OF FINDINGS OF THE RETREAT

The findings of this retreat are detailed below and are the result of both prepared material and open discussions facilitated by Ms. Raines, in small groups and with all attendees (Table III). Although the majority of those in attendance were Boomers, there were a number of Xers (primarily junior faculty members) who contributed their thoughts. In addition,

the telephone survey of Generation X residents provided valuable insights.

#### *Residents: Yesterday and Today*

The first area that was addressed during the retreat was a comparison of the strengths and weaknesses of yesterday's residents and those of today. This proved to be revealing and provided a balanced view of the similarities and differences between the two generations. These insights were the result of open discussions by the attendees.

Typical residents of the Baby Boom generation (that of most program directors) had distinct strengths, including dedication, a strong work ethic, a willingness to take personal responsibility, respectfulness, focus, idealism, and ready acceptance of the existing educational system. However, yesterday's residents frequently placed their careers ahead of their families, were less diverse, resisted change, and had difficulty delegating responsibility.

Typical Generation X residents have quite

TABLE III  
Attendees of the AACPS November Retreat

Stephen B. Baker, MD Georgetown University	David Larson, MD, Arun Gosain, MD Medical College of Wisconsin	John Persing, MD Yale University
Scott P. Bartlett, MD, Kris Gallagher, MD, Linton Whitaker, MD University of Pennsylvania	W. Thomas Lawrence, MD Sutherland Institute, Kansas University Medical Center	Linda Phillips, MD University of Texas Medical Branch, Galveston
Michael Bentz, MD, Karol Gutowski, MD University of Wisconsin	Paul Manson, MD, Navin Singh, MD, Craig Vanderkolk, MD Johns Hopkins University	Joseph Serletti, MD, Joseph Losee, MD University of Rochester
James Chang, MD Stanford University	Stephen Mathes, MD University of California, San Francisco	Lester Silver, MD Mt. Sinai Medical Center
John J. Coleman III, MD Indiana University	Austin Mehrhof, MD, Andrea Pozez, MD Medical College of Virginia	Roger Simpson, MD Nassau University Medical Center
Chris Demas, MD Dartmouth-Hitchcock Clinic	Stephen Metzinger, MD Louisiana State University	Thomas Stevenson, MD University of California, Davis
Gregory Dumanian, MD Northwestern University	Amit Mitra, MD, Susan Smith, MD Temple Hand Center	Henry Vasconez, MD University of Kentucky
Raymond Dunn, MD University of Massachusetts	Michael Neumeister, MD, Stephen Milner, MD Southern Illinois University	Nicholas Vedder, MD University of Washington, Harborview Medical Center
Greg Evans, MD University of California, Irvine	R. Edward Newsome, MD Tulane University	Charles Verheyden, MD Scott and White Clinic
Thomas Gampper, MD University of Virginia	Walter Okunski, MD Lehigh Valley Hospital	Douglas Wagner, MD Summa Health Systems
Robert Grant, MD New York Presbyterian Hospital	Christian Paletta, MD, Kerri Woodberry, MD St. Louis University	Robert Walton, MD, Rob Lohman, MD, Larry Gottlieb, MD, David Song, MD University of Chicago
Juliana Hansen, MD Oregon Health Sciences University	Seth Thaller, MD, Zubin Panthaki, MD University of Miami/ Jackson Memorial Hospital	William Zamboni, MD University of Nevada, Las Vegas
Lawrence Ketch, MD University of Colorado		Jim Zins, MD, Randall Yetman, MD Cleveland Clinic Foundation
W. John Kitzmiller, MD University of Cincinnati		

On a scale of 1 (low/ineffective) to 10 (high, consistently effective), how would you rate your Program Director's current performance on the following criteria. For each criterion, please include a sentence or two that explain your rating.

- 1) **Serving as a mentor and role model** Rating \_\_\_\_\_  
 Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- 2) **Acting as an advocate for Residents** Rating \_\_\_\_\_  
 Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- 3) **Demonstrating integrity (honest and ethical)** Rating \_\_\_\_\_  
 Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- 4) **Focusing on continuous improvement of the Program**  
 Rating: \_\_\_\_\_  
 Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

FIG. 1. Tool for resident assessments of the program director.

different strengths. They are skilled in accessing and using data, are more well rounded, with varied interests and knowledge, are balanced, are more reflective of the demographic features of the United States, can integrate technology into work, and are willing to challenge the status quo. However, the group found them to be financially vulnerable, less willing to accept personal responsibility, less respectful of authority, less relational (with more ties to computers and technology), and often juggling a variety of other responsibilities, many not related to medicine at all.

Today's Generation X residents have additional challenges to face, including an average student loan debt of \$100,000, an expectation that they will be sued, the public's perception that they are "just in it for the money," and the belief that doctors are no longer revered by the public. On the positive side, they are more secure once in a program, and there is a great deal more advocacy and support for today's plastic surgery residents.

Paradoxically, although Generation X residents are more likely to resist structure and

authority, they will live and practice within a system that is increasingly more restrictive and constrained. Therefore, today's residents will actually have more to adapt to and they will need to be better at adapting than their predecessors.

#### *Qualities of a Good Program Director*

The next area addressed was what makes a good program director, from the viewpoints of both program directors and residents. In facilitated discussions by the attendees, the following characteristics were compiled (in rank order): (1) mentor/role model; (2) advocate, with demonstrable concern for residents; (3) has integrity (is honest and ethical); (4) program-focused, providing a good training program with a thoughtful, reflective curriculum; (5) fair; (6) good listener; (7) good teacher; (8) good operating surgeon; (9) connected and active in the professional community; (10) creative thinker; (11) decisive; (12) diplomatic; (13) able to make unpopular decisions when necessary and stand by them; (14) charismatic (connects with people); (15) performs/promotes research; (16) financially savvy; and (17) good negotiator.

As might be expected, there were more similarities than differences when the comments of the residents were presented. These included the following (not necessarily in rank order): (1) is a good role model (sets an example in the way he/she deals with patients and is dedicated to patient care, research, and teaching); (2) is approachable (someone you can talk to about just about anything); (3) is well-known, so that the trainee can say "I'm under . . ." and people around the country know the name; (4) has a sincere interest in the residents and really gets to know them (meets with them once or twice a year to see how they're progressing, rather than merely seeing them in the introductory meeting and then not interacting with them unless there is a problem); (5) advocates for residents (defends the resident at a moment's notice, within reason, supports the resident, and is "in our corner"); (6) is thoughtful and open about the program, frequently evaluates the program to see what is working and what needs to be corrected, and keeps the program to the highest educational standards; (7) creates a learning environment, a place where residents

can grow and learn and where they want to be (as opposed to have to be); and (8) is honest and trustworthy (sticks to his or her word, even if politically incorrect).

With identification of the top four qualities of a good program director, as derived from the information described above, a tool for resident assessments of the program director (Fig. 1) was developed, which could be used anonymously by faculty members and residents to determine the effectiveness of the program director. In addition, program directors could query themselves in these areas, for self-assessment.

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#### REFERENCE

1. Long, J. *Generating Hope*. Downers Grove, Ill.: InterVarsity Press, 1997.