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PERSONAL VIEW

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Bridging generation gaps in medical education: a "light bulb moment" at the Association for Medical Education in Europe annual conference in Barcelona

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ABSTRACT
Generation gaps have been described before and so have ways to deal with them. But they were mainly focused on the teachers. We would like to bridge these generation gaps, not only by creating awareness but also by learning from each other. This leads to better equipped doctors across all generations and promotes lifelong learning instantaneously.

Consciously or unconsciously, medical education theory underpins our work as clinician educators. One often has a "light bulb moment" when the theory behind everyday practice is revealed, so that the practice is now deepened. At the Association of Medical Education in Europe (AMEE) conference this year in Barcelona we had one of those "light bulb moments" as part of an initially idle conversation between strangers. This is a theory that resonated so significantly with our everyday work and many of the challenges of this work that we wished for it to be shared so as to start a broader conversation.

The Generation Gaps is a simple but powerful theory, that a person's worldview is influenced by the context of when they grew up, and that this context is universal to the generation concerned (Howe & Strauss 1991).

Many generations have been described, but currently there are three generations at work in medicine. The first generation is "Baby Boomers". Born between 1945 and 1965, their collective experiences included the moon landing, civil rights and the introduction of birth control. There were limitless possibilities: anything could be done if the determination was there. With Baby Boomers the job is a major part of the individual identity, and respect is based on accomplishment.

The second generation is called "Generation X", born between 1965 and 1982, often had both parents working outside the home and as a result were more independent. Their collective experiences were that of the Challenger disaster, Chernobyl, the recession of the 1980s. As a result "Gen X" can be more cynical of government and organization, working to live and not living to work. Gen X is more gender neutral.

The third generation is "Millennials", born between 1982 and 2002, with a collective experience of widespread use of technology as well as small families and protective parents with "helicopter" style of parenting. To them, everyone is connected, no matter where they are living. With high self-esteem, this generation is also race and gender neutral. Millennial are global citizens, with a casual interpersonal style that may seem impolite to older generations.

Practice points

- Awareness of generation gaps is one step
- The challenge is to embrace the differences and learn from each other
- Leading to better equipped doctors across all generations and promoting lifelong learning instantaneously.

Obviously, people are complex and no one theory can describe every interaction – but the joy of this theory for us was that it identified a concept that resonated deeply with work – this becomes more interesting is when the generations interact. To every one person their view is valid. To others they may be alternately selfish, disrespectful or condescending, and these are not good features in a relationship. The Baby-boomer Professor may dislike the Millennial use of devices during a lecture, wondering whether the students are concentrating. The Millennial students may resent the hierarchy of clinical medicine and education and use all possible moments to share their opinions and resonate their thoughts with others, despite of their 'spot on the ladder'. The Gen X doctor may be irritated by the Millennial interjections during a consultation.

How do we bridge these gaps? Like most things in life, awareness helps, but by itself awareness alone is not enough. For example, teachers teach without knowing what the future will look like (Robinson 2006). We are teaching our students not knowing what clinical practice will look like in ten years: how hospitals will look like, operating rooms will function, or medical files being stored. Ten years ago it was unimaginable for Baby Boomers and Gen X-ers that we could get life-saving information swiping our

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mobile devices. Technology is quickly developing, faster than education can grasp. Despite the many positive developments throughout the years, many due to technology, it is important to also acknowledge the fact that within medical education these generation gaps might hinder medical education and satisfactory performances of medical students and educators.

We need to acknowledge these generational differences when teaching, providing feedback and working with each other. Millennials not only have high expectations of their employers, but they also set high standards for themselves (Meister & Willyerd 2010). They want to be successful, and in order to become so, they wish constant feedback from their employers.

In medical practice feedback provision is not always visible, constantly or direct. Therefore, residents might feel they are missing out on important direct feedback of their actions, and thereby their career. Several suggestions might become the topic of a broader discussion. For instance, reverse mentoring might be a solution- Millennials matched to senior colleagues and assigned to teach them about e.g. use of social media or medical technologies like electronic patient files. This will of course also lead to seniors giving feedback to the Millennials. Life-long learning is thus influenced by learning from each other. Learning events need to be engaging and worth everybody's time, with competent use of technology, frequent positive feedback, gentle negative feedback and the explicit aim that we are investing in success and in the coaching of being successful in training "future proof residents".

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Disclosure statement

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