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SPECIAL TOPIC

Closing the Generational Gap in Surgery: Why So Angry?

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Summary: Significant and rapid changes in healthcare delivery are forcing surgeons into collaborative teams. Additionally, surgeons are faced with new bureaucratic requirements that do not directly impact patient care, but nevertheless require allocation of time and attention. Surgeons are required to communicate with an expanding group of individuals at various professional levels, adding further stress to daily tasks. Even the method of communication is undergoing rapid transformation. Some surgeons, especially those who are members of the Boomer or X Generation, find this revolution difficult to manage; whereas those who are members of the Y Generation may in fact be better equipped. Surgeons who either refuse to acknowledge these changes or simply lack emotional self-awareness run the risk of being labeled as disruptive. Behavioral techniques are explored which may help those surgeons who are having difficulty. *(Plast Reconstr Surg Glob Open 2016;4:e1087; doi: 10.1097/GOX.0000000000001087; Published online 4 October 2016.)*

Surgeons born into either the Baby Boomer (1946–1964) or X (1965–1984) Generations are now at, or approaching, the pinnacle of their career. These surgeons have witnessed extraordinary changes in both the operating room and the back office. Perhaps one of the most challenging areas of change, however, involves interpersonal communication within the health care environment. Health care delivery is undergoing a true cultural revolution: from the surgeon once being the commander in chief to now a contributing member of a collaborative team. This team no longer comprises only medical professionals, but also business, actuarial, and customer service experts. There is very little published literature to help guide surgeons who are caught in this tsunami of change. Those who fail to adapt quickly to these new norms are frequently labeled disruptive—whether warranted or not—finding themselves at odds with administrative leadership.[1]

To better understand why some surgeons find it difficult to adapt, it is necessary to review how this revolution evolved. Also important is understanding how the current group of trainees, born into the Y Generation (1985–2004), differ in outlook from their predecessors.

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IDENTIFYING CULTURAL SHIFTS BETWEEN THE GENERATIONS

Over the past several years, there have been significant changes in pedagogic techniques. For those surgeons who were trained before the Y Generation, the Socratic method remains the preferred mode of knowledge transfer.[2] This technique utilizes an interactive dialogue between a student and a mentor to develop a foundation for critical thinking. Areas of weakness are probed to help the student realize opportunities for educational improvement. Gaps in knowledge are revealed. Although this technique achieves its goals when performed appropriately, overzealous mentors can turn it into a "tell me what I am thinking" game, which of course is counterproductive. Moreover, mentors who continue to probe even after it is clear that the student lacks sufficient knowledge can be seen as potentially waging a personal attack.[3] When this occurs, the technique is known as pimping. This is how many of the Boomer and X Generation members were taught in surgical training. This methodology stresses individualism and rewards argumentative mastering of facts. This reflects the ideal that the surgeon is the singular leader for his or her patient.

In our current cultural climate, however, the Socratic method is viewed poorly. It can be perceived as too confrontational.[4] The student may not feel comfortable with

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such a public showcase. He or she may even call it a public shaming. The federal government currently defines bullying as "aggressive behavior" with an "imbalance of power."[5] Therefore, those surgeons who continue to practice this pedagogic technique risk sanction within their institution. Recognizing this cultural shift is important.

Another area of major change is data management. Technological advancements in the last score of years allow the Y Generation to eschew detailed memorization. Having information easily available online and within seconds means that memorizing individual facts is less important than knowing how to access those facts. Furthermore, mobile devices allow access to these facts within seconds from nearly any location on the globe. Someone needs only to browse through the internet to obtain what was once meticulously memorized. The hours spent collecting and organizing primary sources is no longer required. This results in less rote mental preparation. Unfortunately, this means that the Y Generation may seem less prepared. The reality, however, is that the Y Generation believes that it is completely appropriate to access the internet when factual information is required. This significant difference in attitude toward fact management can lead to misunderstanding between the teacher and mentor.[6]

Members of the Boomer and X Generation may feel that the Internet is not academically regulated; therefore, they question its accuracy. This opinion is reinforced by the myriad of patients presenting to the office who have researched their diagnosis before seeing the surgeon but have significant misinformation.[7] Although this is true for many popular websites which are publically edited, there are subscription-only academic sites which are essentially up-to-date electronic textbooks.[8] These private sites are edited and reviewed by experts. Members of the Boomer and X Generation must be aware of this evolutionary change; failure to acknowledge this can create unnecessary friction.

UNDERSTANDING THE ROOT CAUSE OF DISRUPTIVE BEHAVIOR: IS IT GENERATIONAL?

Although the majority of Y Generation is too young to lead medical panels at this time, some members of the Boomer and X Generation are being accused of demonstrating disruptive behavior during stressful work situations. When a surgeon yells or belittles a member of the health care team, what does this mean? There is zero tolerance in today's environment for this type of behavior. It is labeled "disruptive" as it takes the focus off of the mission and negatively impacts safety.[9] In general, a superficial root cause analysis finds that the disruptive behavior is due to frustration on the part of the surgeon.[10] Critical instrumentation not being available, radiologic scans not posted as requested, and patient positioning being suboptimal can be triggers for a surgeon to react with an outburst. Given the outburst, now it is the surgeon's behavior that is addressed by his or her supervisors. The focus of these discussions becomes the surgeon's unacceptable (disruptive) reaction, not the actual triggering event. The disruptive surgeon is left to figure out how to better manage his/her emotions or face likely discipline or even termination. Sometimes, the disruptive surgeon is asked to attend behavioral modification courses. But digging deeper, root cause analysis reveals that simple frustration is not an adequate explanation for disruptive behavior. Rather, it is the feeling of helplessness or loss of control experienced by the surgeon which sparks the actual emotional reaction.

What causes a seasoned surgeon to experience helplessness? The answer is complex in today's health care environment. From increasing patient's demands to shrinking reimbursement, the surgeon feels attacked from all sides. However, one of the biggest culprits is most probably how the surgeon feels that he or she is constantly apologizing for things which are not within his or her control. Saying "I am sorry" to patients for hospital transport delays, long surgical turnover times, unexpected billings, and decrease in personal attention—all these are beyond the authority of the surgeon, yet the patient holds the surgeon responsible. The surgeon is still viewed by many patients as the controlling authority in all facets of care, when in fact the surgeon no longer fills that role given the recent and rapid changes in the delivery of medical care.

Personal recognition of this fact is the key for a surgeon to manage his or her own negative behavior. An adaptive surgeon from the Boomer or X Generation must acknowledge the current cultural climate if he or she wishes to survive emotionally. Just as general surgeons who failed to accept the introduction of laparoscopic cholecystectomy found themselves below the standard of care, so too surgeons must evolve in this new cultural era or face extinction. Quality improvement is still possible, but it now must be managed constructively within the confines of the organization. The surgeon is no longer able to demand improvement by simply acting out. He or she can no longer harangue colleagues or staff into providing better quality. Simply stated, the surgeon no longer manages all aspects of health care delivery. The surgeon should still set the example by championing the patient, but he or she must use the current language of discourse to achieve that goal. For example, by describing the daily errors which occur in medical care as microaggressions against the patient, the surgeon can capture the attention of those in charge of quality improvement. Health care facilities have in place mechanisms to report, review, and correct errors. These need to be respected by the surgeon; otherwise, he or she runs the risk of disciplinary action. The only way to improve patient care in today's culture is to acknowledge this reality by addressing quality issues using the existing administrative framework.

BUREAUCRATIZATION OF MEDICAL CARE

Another generational trend altering the landscape is the migration of physicians from independent practices to employed models. The financial strain of rising costs with shrinking reimbursement has led many physicians to seek employment directly from hospitals or large medical groups. Moreover, hospitals are incentivized to focus on buying practices to maintain a strong referral base for

lucrative service lines. Although most of the employed models focus on internal medicine and family practice, surgical practices are involved as well. Data from the Medical Group Management Association point to an overall increase of nearly 50% of physician employed practices.[11] The American Medical Association shows a similar trend of nearly one-third of physicians being partially or fully employed by a hospital in recent years.[12]

These growing employment models accelerate generational change, forcing members of the Boomer and X Generation into situations which they find unfamiliar. The resulting conflict is rooted in expectations. Members of the Boomer and X Generation initially saw themselves as leaders of an independent economic realm; in contrast, members of the Y Generation function as individuals who fit into a larger team. This loss of independence for the Boomer and X Generation is an unwelcomed dilution of personal accountability. Frustrated patients may not necessarily be seen as a personal failure by the Y Generation; however, to the Boomer and X Generation, these patients are a symptom of a dysfunctional health care system. The Boomer and X Generation have difficulty understanding and/or accepting this loss of personal responsibility. Nevertheless, except for medical issues within their scope of practice, surgeons of the Boomer and X Generation should no longer accept personal responsibility for the issues which are beyond their expertise. That is not to suggest that members of the Boomer and X Generation abandon their patients to the myriad of nonmedical problems which arise in the delivery of health care, but rather help guide patients to solve these problems without taking direct ownership.

A sympathetic surgeon listening to a patient who is upset about waiting for an authorization to undergo a radiologic scan must not take direct ownership of this problem. This means surgeons of the Boomer and X Generation must acknowledge that ultimate power within the health care delivery system no longer rests in their grasp. A surgeon, attempting to help the patient, will not accomplish positive change by yelling at someone in the radiologic facility or the insurance company. In the past, this may indeed have been the solution. Nor will he or she effectuate positive change by demanding the office staff move faster to obtain the authorization. A better response in the current culture is to provide the patient with detailed information about how to contact those who are directly responsible, so that the quality improvement infrastructure can properly address the issue within the confines of the system. The surgeon can serve as a navigator who helps overcome the inefficiencies of the system, but the surgeon must recognize that the power to effectuate direct and rapid change is gone. This strategy does not evade the issue, but rather is a direct outcome of the current path of health care. Quality measures, including patient satisfaction, are one of the new metrics by which organizations are ranked and reimbursed. There are phalanxes of bureaucrats who are paid to manage this. Surgeons should no longer clash in the front line of this battle, as the tension it creates outweighs the rewards.

As a group, members of the Y Generation feel more comfortable collaborating with nonmedical personnel who are in supervisory roles. In an employed model, this may even result in the following recommendations issued by nonmedical supervisors which have direct medical consequences. Members of the Boomer and X Generation should be aware of this significant shift. For example, nonmedical supervisors of a surgical practice may ask employed surgeons to direct patient traffic to a specific facility, despite surgeons not wanting to operate at that location. Although this potentially impacts patient care, the employed physician truly has little choice. As long as the standard of care is met at the recommended location, employed physicians will find it difficult to argue when their own termination is possible. There is no legal violation for self-referral when the surgeon is employed by an entity which also owns the facility.[13,14] Members of the Y Generation understand this much more than the previous generations.

When hired by a large employer such as a hospital or multispecialty group, members of the Y Generation are not disturbed by many of the nonmedical requirements (attending town halls, using the electronic medical record, and satisfying physician quality reporting) deemed as intrusive by those of the Boomer or X Generation. Members of the Y Generation are team-oriented, expect flexibility, and anticipate employment over ownership.[15] Simply put, this attitudinal gap is the cause of much misunderstanding.

The Y Generation recognizes that individuals are indeed replaceable and sees itself as working better in groups. Social media has democratized the work place, allowing immediate communication. Job postings are now much more available to the public. This is true for employed physicians. In today's economic climate, there are few rainmakers in medicine. Surgeons may threaten to take their volume out of a facility, if they are unhappy. However, from the perspective of the hospital administration, this volume can be replaced. Facilities are concerned about volume; the source is less relevant.

The Y Generation has been working in monitored environments for years. The rise of the cell phone has been called "the world's longest umbilical cord" and is directly blamed for helicopter parenting.[16] Children who were given trophies for simply participating in sports—now as adults—have vastly different expectations on the definition of success. Vernacular expressions such as work–life balance have crept into the lexicon. Universities are struggling with members of the Y Generation who are demanding "safe spaces" and lashing out at those facilities which fail to accommodate.[17] In medical training, the Y Generation has a maximum of an 80-hour work week and a defined minimum amount of time allowed between sequential shifts.[18] A report from the Accreditation Council for Graduate Medical Education regarding the reduction of resident duty hours states, "The impact on resident education, especially in terms of operative experience is worrisome, but well-being appears to have improved."[19] As a result, the Boomer and X Generation must be cognizant that the Y Generation simply may not have as much technical experience as they did at the same stage of their career.

COPING WITH THE CHANGES

The evolution of health care delivery demonstrates that the surgeon is no longer in charge, but he or she is still expected to deliver professional health care which satisfies the standard within his or her scope of practice. Nevertheless, the surgeon may still feel that he or she is responsible for many things which are now out of his or her control. For plastic surgeons who take pride in the visual outcome of their surgical accomplishments, this may be particularly difficult. The same surgeon who adeptly sculpts a breast from abdominal tissue after cancer resection should be able to help a patient rapidly obtain urgent testing the following morning in the hospital to evaluate new-onset chest pain. The patients recognize the immense skillset required to accomplish the surgical feat of reconstruction; however, the bureaucracy does not. In this particular scenario, the surgeon must recognize the feeling of helplessness when entering computer orders to obtain an urgent electrocardiogram and chest X-ray. Years ago, the surgeon may have been able to simply order these tests emergently with just a verbal command to the nurses from the bedside. Nowadays, the surgeon may be required to personally enter orders electronically with justifying and supporting diagnoses, despite the urgency of the situation, so that the hospital charges are captured. The surgeon must not react with anger at a transporter or a nurse who requests the surgeon to follow hospital policy. A negative reaction by the surgeon takes the focus off of the actual problem and creates unnecessary collateral damage. The surgeon must first accomplish the pressing issue to help his or her patient. Afterward, the surgeon may address the lapse of quality within the established infrastructure of the system. A report to the Quality Improvement Team outlining deficiencies is the appropriate answer to this dilemma. This will also require follow-up and perseverance by the surgeon to improve a defective system. Although members of the Boomer and X Generation may feel this is an exercise in futility, the reality of the current environment offers few other productive solutions.

Those surgeons from the Boomer and X Generation who are aware of their own emotions during these critical interactions—and have the ability to control themselves—will adapt better to this changing environment. This concept is known as *emotional intelligence* and it signifies how well an individual both identifies and manages his or her own response to stressors.[20] Moreover, there is evidence that emotional intelligence can improve with age and/or training.[21,22] Working to improve emotional intelligence has been shown to result in improved well-being.[23]

CONCLUSIONS

Major changes are occurring in health care, all of which directly affect the surgeon but over which the surgeon has little jurisdiction. Meanwhile patients still look to the surgeon as the leader, however, the facts dictate otherwise. The surgeon is faced with competing responsibilities and, at times, conflicting desires. Nevertheless, the surgeon must focus on the patient. Shortcomings in the system will occur. The surgeon must learn coping techniques—both individually and within their institution—to manage these issues in a constructive manner.

Will members of the Boomer or X Generation push back? Will members of the Y Generation ever feel disrespected enough to seek greater independence? The present culture no longer rewards the heroic fight. In fact, there are mechanisms in place to squash those who try.[24] Without the support from patients, the system is unlikely to change. Until there is a stronger demand for change directly from the patients, members of the Boomer and X Generation should heed the cues from the Y Generation if they wish to remain active members of the health care team.

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REFERENCES

1. Zbar RI, Taylor LD, Canady JW. The disruptive physician: righteous Maverick or dangerous Pariah. *Plast Reconstr Surg.* 2009;123:409–415.
2. Shulman L. Knowledge and teaching: foundations of the new reform. *Harvard Educ Rev.* 1987;57:1–23.
3. Tufade T, Elsner J, Haines ST. Best practice strategies for effective use of questioning as a teaching tool. *Am J Pharm Educ.* 2013;77: 1–9.
4. Reifler DR. The pedagogy of pimping: educational rigor or mistreatment. *JAMA* 2015;314:2355–2356.
5. Available at: http://www.stopbullying.gov/what-is-bullying/index.html. Accessed April 12, 2016.
6. Eckleberry-Hunt J, Tucciarone J. The challenges and opportunities of teaching Generation Y. *J Grad Med Educ.* 2011;3:458–461.
7. Fallis D, Fricke M. Indicators of accuracy of consumer health information on the Internet. *J Am Med Inform Assoc.* 2002;9:73–79.
8. Available at: http://www.uptodate.com (captured 04/12/16).
9. Available at: https://www.jointcommission.org/jc_physician_blog/revisiting_disruptive_and_inappropriate_behavior (captured 06/09/16).
10. Cochran A, Elder WB. A model of disruptive surgeon behavior in the perioperative environment. *J Am Coll Surg.* 2014;219:390–398.
11. Medical Group Management Association. Demographics-medical practice table 8: majority ownership. In: *Physician Compensation and Production Survey: 2012 Report Based on 2011 Data.* Englewood (CO): Medical Group Management Association; 2012.
12. Kane C, Emmons D. Policy research perspectives: new data on physician practice arrangements. *Am Med Assoc.* 2013. Available at: http://www.nmms.org/sites/default/files/images/2013_9_23_ama_survey_prp-physician-practice-arrangements.pdf Accessed April 12, 2016.
13. Available at: https://www.cms.gov/medicare/fraud-and-abuse/physicianselfreferral/index.html (captured 05/28/16).
14. United States Code 42 – The Public Health and Welfare; Chapter 7 – Social Security; Subchapter XVIII; Part E - Miscellaneous Provisions; 1395nn.

15. Available at: http://www.modernhealthcare.com/article/20150919/MAGAZINE/309199979 (captured 05/26/16).
16. Available at: https://coe.uga.edu/news/archive/mullendore-cell-phone-is-umbilical-cord-for-helicopter-parents (captured 04/12/16).
17. Lukianoff G, Haidt J. The Coddling of the American Mind. The Atlantic. Hayley Romery: 2015.
18. Available at: http://www.acgme.org/What-We-Do/Accreditation/Duty-Hours (captured 04/12/16).
19. Available at: https://www.acgme.org/Portals/0/PDFs/Resident_Duty_Hours_and_Related_Topics[1].pdf (captured 08/08/16, page 10).
20. Salovey P, Mayer JD. Emotional intelligence. *Imagin Cogn Pers*. 1990; 9: 185–211.
21. Weng HC. Does the physician's emotional intelligence matter? *Health Care Manage Rev*. 2008; 33: 280–288.
22. McKinley SK, Petrusa ER, Fiedeldey-Van DC, et al. A multi-institutional study of the emotional intelligence of resident physicians. *Am J Surg*. 2015; 209: 26–33.
23. Lin DT, Liebert CA, Tran J, et al. Emotional intelligence as a predictor of resident well-being. *J Am Coll Surg*. 2016;223: 352–358.
24. Heller N. *The Big Uneasy*. The New Yorker. Conde Naste: 2016.