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Correspondence: Letter to the Editor

Surgical leadership in the time of significant generational diversity

Dear Sir,

We read with interest the matter put forth for debate by Money et al.[1] and published in The Surgeon. A brilliant account of the inherent differences between three generations of surgeons was given: baby boomers born between 1945 and 1964; generation X born between 1965 and 1980; and the succeeding generation Y that accounts for most of the current surgical trainees.

Money et al.[1] pointed out that the majority of current surgical leaders belong to the baby boomer era. Undoubtedly, their life philosophies, work ethic, sources of motivation and expectations differ significantly from generations X and Y. These factors impact on the way the generations interact and may create a disconnect between leaders and the surgeons in the later generational groups. It is difficult for an individual to lead a group of persons they cannot identify with. But the conundrum is deepened by three additional factors that we would like to point out.

First, consider the progress in surgery that has occurred over the past two decades. There has been a surge in the complexity of advanced laparoscopy and robotics. Many of the current surgical leaders in the baby boomer era would have had little exposure to these technologies during their training. Yet, they are expected to support and encourage procedures that they themselves may not be able to perform and may not fully understand. The rapid change we have witnessed in surgical practice only widens the gap that exists due to generational differences.

Secondly, many current surgical leaders – at least in Caribbean practice – possess no formal training in leadership roles.[2] Therefore, the emotional intelligence skills defined by Goleman[3] may be under-developed, further widening the existing gap between surgical leaders and the younger generation surgeons that they should be leading. In this circumstance, administrative powers may be used to erect barriers and marginalize younger generation X and Y surgeons, fueling their outward migration from the healthcare systems.[4]

Thirdly, unlike other specialties, the surgical leader must accept that they will become outdated far more rapidly than their predecessors or contemporaries in other fields. For example, the young laparoscopist from Generation X who trained as recently as the 1990s, would have already lost ground unless they mastered advanced techniques such as single incision laparoscopic surgery (SILS). On top of that, they may be required to support their juniors who, in a short time, may be able to do things that even the young leader cannot do. This is a serious challenge to the psyche of even the most mature surgical leader. Therefore, humility[2] and charisma power (influence through personal character)[5] are indispensable qualities of the modern surgical leaders – again very different to the philosophies of earlier generations.

We believe that there are two lessons to take away from these scenarios.

Firstly, it should be mandatory for the next generation of leaders in generation X and Y to possess formal managerial training. Educators should also consider formally integrating management training into post-graduate surgical training courses for future generations.

Secondly, we firmly believe that surgical leaders should be in touch with the ideas and philosophies of those they lead. We should identify those generation X and Y surgeons with an interest in management and leadership so that they can be shunted into formal training courses. Without this, they will not be prepared for their future roles.

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