As physician integration becomes more critical to healthcare organizations, generational differences among physicians can present stumbling blocks.

The difference in attitude and in value hierarchy among physicians of different generations is so great that older physicians and younger physicians often fail to communicate. Older physicians believe their younger colleagues have no work ethic, while younger doctors would suggest older physicians should “get a life.” But these obstacles can be removed through facilitated dialogue that builds trust and enhances mutual understanding.

Currently, most medical staffs comprise three generations of physicians: traditionalist, baby boomer and Generation X.

Traditionalist physicians were born before the end of World War II, and for them medicine is a vocational calling. Their profession and self-identity are one and the same and in their eyes are analogous to being a priest, rabbi or minister. Traditionalist physicians respect hierarchy; join civic, fraternal and professional organizations; are seldom computer literate; and would never imagine requesting reimbursement for being on call.

You have to get different generations communicating so they can appreciate what each seeks and why and identify what they hold in common.

Baby boomer physicians were generally born between 1945 and 1965. On the surface they appear to be a lot like traditionalists. However, they work with a different motivation: the acquisition of material wealth. That attitude is particularly present in the latter half of the baby boomer generation. Younger boomers are sometimes labeled the Jones generation, as in “keeping up with the Joneses.” For the boomer physician, failing to work generates feelings of guilt. Boomer physicians are loyal, don’t fear taking on debt, do not tend to accept statements of authority, are not joiners and are not as likely to sacrifice personal pleasures for the good of the group.

Generation X physicians are significantly different from traditionalists and baby boomers. For Generation X, managing time and balancing life are primary values. Being a physician is only part of their self-identity. They are equally vested in a life or lives outside of medical practice and for that reason often prefer shift work. Gen Xers are transactional and seek immediate stability, looking for what they get in return for hard work. They are disaffected by governance, lack trust in leadership, and are loyal to principles and not organizations.

Generation X physicians have many positive attributes. They are comfortable working with other professionals in a team-based approach to patient care. In addition, Xers are quite techno-savvy.

Generational Challenges

Trying to define a physician integration strategy with each generation in mind can be difficult. The physician community is a complex matrix of different groups. In addition to generational divides, there are differences related to gender, specialty, personality and in attitudes between physicians loyal to a single healthcare organization versus those who are “splitters.” While younger physicians are more willing to delegate and to work in teams, the primacy of individual physician autonomy remains the transcendent value in the physician community.

Nowhere is the tension among generations more evident than in efforts designed to recruit new physicians to
a community. As older, private practice physicians retire, there is a need to maintain critical mass to keep the practice viable. These physicians do not have the economic wherewithal to compete for younger talent. They are not in a position to provide income guarantees or meet the other expectations of physicians just leaving their residency or fellowship. More importantly, younger physicians predominantly prefer an employment relationship.

As healthcare organizations seek to meet their physician manpower needs by hiring those younger physicians, members of the medical staff who are in private practice perceive them as being in competition. Because newly recruited physicians can command significant reimbursement, it further angers older physicians who feel their many years of contributions to the community are not valued. In addition, a physician in private practice whose practice overhead exceeds 50 percent of its gross revenue must work twice as hard as the newly recruited physician just to achieve the same net income. You can appreciate their sense of anger and frustration and how it compromises attempts to integrate physicians across the generational divide.

In my view, the private practice of traditional, allopathic, fee-for-service medicine is nonviable. Physicians must seek to align with a source of capital, which, for most physicians, will be the community hospital or health system. This challenges the healthcare organization to develop a physician strategy designed to transform the physician community from an I to a We to a Us—a transition from autonomous individual to a group with a collective identity and ultimately with a sense of unity within the larger organization.

### Identifying Shared Interest

Given the differences that exist across the physician community, how do you best approach this challenge? What is it that will cause an individual to forgo self-interest for collective interest? For this to occur, an individual must believe he can get more of what he cares most about by working
Together with others than by working alone; therefore, you need to know what it is that people care most about. When you can put together in the same enterprise people who share the same primary interests, you can create the integration required to achieve those objectives.

Only through facilitated dialogue, where individuals feel listened to, can different generations within the physician community discover common ground.

How do you organize individuals of shared interest? You must begin by articulating the organizational vision. People accept and commit to a vision not because it is probable but because it is irresistible. You must be clear about what your vision is and why and explain your value hierarchy and the metrics that will define success. When those are clear, the individuals can decide for themselves if they want in or not.

By explicitly ranking the organization’s most important values an individual can appreciate how decisions will be made going forward. By managing these intangibles (articulating the organization’s vision and value hierarchy) you can begin to assemble like-minded individuals who are interdependent and vested in creating outcomes through which they find meaning and purpose.

In addition, you have to get different generations communicating so they can appreciate what each seeks and why and identify what they hold in common. Once this is accomplished, they can restructure work to accommodate each others’ needs in pursuit of their common interest.

The challenge in integrating physicians is there is no blueprint for success. In fact, a healthcare organization may have to create multiple business models to accommodate different sets of shared values.

But success stories do exist. The Mayo Clinic, Scott and White Healthcare, Geisinger Health System, some Veterans Affairs hospitals and some units of Kaiser Permanente come to mind as organizations that have found success integrating different physician generations.

Only through facilitated dialogue, where individuals feel listened to, can different generations within the physician community discover common ground. By attentively listening they can appreciate the perspectives and motives of others and thereby build trust and enhance mutual understanding. Through this process the participants will discover the creative solutions that can bridge their differences and allow them to interdependently work together to achieve shared objectives.

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