

# Generation X: Implications for Faculty Recruitment and Development in Academic Health Centers

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## Abstract

Differences and tensions between the Baby Boom generation (born 1945–1962) and Generation X (born 1963–1981) have profound implications for the future of academic medicine. By and large, department heads and senior faculty are Boomers; today's residents and junior faculty are Generation X'ers. Looking at these issues in terms of the generations involved offers insights into a number of faculty development challenges, including inadequate and inexperienced mentoring, work–life conflicts, and low faculty morale. These insights suggest strategies for strengthening academic medicine's recruitment and reten-

tion of Generation X into faculty and leadership roles. These strategies include (1) improving career and academic advising by specific attention to mentoring "across differences"—for instance, broaching the subject of formative differences in background during the initial interaction; adopting a style that incorporates information-sharing with engagement in problem solving; offering frequent, frank feedback; and refraining from comparing today to the glories of yesterday; to support such improvements, medical schools should recognize and evaluate mentoring as a core academic responsibility; (2) retaining both

valued women and men in academic careers by having departments add temporal flexibility and create and legitimize less-than-full-time appointments; and (3) providing trainees and junior faculty with ready access to educational sessions designed to turn their "intellectual capital" into "academic career capital." Given the trends discussed in this article, such supports and adaptations are indicated to assure that academic health centers maintain traditions of excellence.

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**A**cademic medicine's long "buyer's market" with regard to faculty appears to be drawing to an end. Increasing job options for health care professionals are not translating into more candidates seeking faculty appointments.<sup>1</sup> And the historically large Baby Boomer generation will soon begin retiring, likely creating unprecedented numbers of vacancies in many areas. For instance, some investigators predict that in the near future, academic sections of general internal medicine will rarely be fully staffed and will require 30% more physicians than can be recruited.<sup>2</sup> These investigators believe their estimates are conservative and do not take into account lost productivity, the stress of covering inadequately staffed practices, and the impact this stress has on current faculty.

Competition for physicians is already heating up in many geographic and spe-

cialty areas. For example, Colorado is facing substantial shortages in radiology, neurosurgery, and heart surgery.<sup>3</sup> The Nevada State Medical Association blames a doctor shortage for an influx of unlicensed practitioners with phony degrees. The Council on Graduate Medical Education (COGME) is recommending that medical schools increase enrollments by 15%. Already the job market for specialty residents is considered excellent.<sup>4</sup> And new studies (for example, the report by Cain et al.<sup>5</sup>) are showing that over the course of their training, residents exhibit diminishing interest in joining the academic life.

Across the ocean, investigators in Britain are reporting "an impending crisis in medical manpower"<sup>6</sup> and that "medical graduates are reluctant to take on the demanding academic roles in favor of better paid consultant posts."<sup>7</sup> In part because of the current lack of incentives to take up or maintain an academic career, and deficient mentoring for aspiring academics, the British Medical Association and a range of international partners has initiated a large-scale project to examine the structure of academic medicine.<sup>8</sup>

Unpredictable environmental factors will influence the adequacy of the physician

supply and the level of interest of young physicians in academic careers. But clearly, academic health centers (AHCs) are dependent on Generation X to supply the next generation of educators and leaders. These roles will be even more demanding tomorrow than they are today. How might AHCs better position themselves to attract and retain the most highly skilled and committed members of this generation? We believe that looking at this question in terms of the characteristics of the generations involved helps to bring these challenges and opportunities into focus.

## Generational Consciousness

The term "generation" refers to a group that "came along at the same time," experiencing history from the perspective of the same phase of life; clearly, the era into which we're born shapes us. As life spans have increased, more generations are now alive simultaneously than ever before. And the accelerating pace of change means that a single generation can come of age in an entirely different milieu than the one on the previous generation did.

A number of sociologists and demographers have studied generational differences in depth.<sup>9,10</sup> Despite this readily

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available information, individuals tend not to see their own lives as part of an era. Just as fish do not discover water, a person tends to be unaware of the characteristics of his or her generation. This is particularly true of Baby Boomers (born 1945–1962). These members of the largest generation in U.S. history have been accused of acting as if they were *The Generation*.<sup>11</sup>

Generational differences are most easily illustrated by comparing the Silent Generation (born 1925–1944) with Generation X (born 1963–1981): The Silent Generation married early, considered television a luxury, and believed in the “Great Man” theory of leadership. By contrast, most members of Generation X had an extended adolescence and married later or remained single, consider technology a fact of life, and openly disdain hierarchy.

Differences are less stark between Generation X and Baby Boomers but still substantial:

*Generation X (1963–1981)*

- Work hard if balance allowed
- Expect many job searches
- Paying dues not relevant
- Self-sacrifice may have to be endured, occasionally
- Question authority

*Boomers (1945–1962)*

- Work hard out of loyalty
- Expect long-term job
- Pay dues
- Self-sacrifice is virtue
- Respect authority

Generation X is the first one in which both parents were likely to work outside the home. Also, parental divorce was twice as prevalent for children in this generation as it was for Boomer children.<sup>12</sup> In part because of these life experiences, Generation X’ers are seeking a greater sense of family and are less likely to put jobs before family, friends, or other interests. In their eyes, their parents suffer from “vacation deficit disorder.”

Many Generation X’ers also witnessed their parents reap downsizing in exchange for their loyalty to an organization. So Generation X’ers’ first loyalty tends to be to themselves rather than to any institution. While they may be deeply committed to

their work, they are less willing to sacrifice than their parents were, less fixated on titles and the corner office, and less likely to “delay gratification.”

By and large, department heads and senior faculty are Boomers; today’s residents and junior faculty are Generation X’ers. The subsequent Millennial Generation (1982–2000)<sup>13</sup> is now beginning to enter medical school; its characteristics are beyond the scope of this article, which focuses primarily on differences between the preceding two generations.

Certainly, no exact boundaries separate generations, and individuals do change as they mature. But if one steps back to see the “forest,” generational distinctions are readily apparent. Although AHCs operate within this rich and evolving social environment, administrative leaders have been slow to examine and address tensions between the generations. Yet the tensions are real. The perspective of many young physicians might be distilled as “Why are established faculty so defensive? They act as if the way things were for them was the best of all possible worlds. If they really cared about us, they’d be trying to make life easier instead of hanging on to the past. Or maybe this is really about validating their own sacrifices and protecting their own privileges.”

Recognizing the need to create high-performing work teams and to attract the best employees, many corporations have taken a proactive approach, asking, “How cross-generationally friendly are we?”<sup>14,15</sup> It is time for the academic health sciences to ask this question as well.

**Implications for Faculty Recruitment and Development**

A “generational lens” is useful for examining three interrelated components of effective faculty recruitment and development: mentoring relationships, work–life balance, and career and leadership development.

**Gaps in expectations about mentoring**

Mentoring has never been so important to individual career development in academic medicine or to institutional health. With the intensifying competition for external funding and often for access to support staff, to powerful mentors and to the richest opportunities, a young scientist’s or physician’s development of a

productive career depends to a greater degree than in the past on the ability to “hit the ground running.” Access to expert mentoring is required in order to accomplish this feat, that is, to acquire insights into the complexities of the organizational culture, to learn “the unwritten rules of the games” and to negotiate effectively for resources.<sup>16</sup> Institutions and departments that purposely assist their new members to acculturate improve productivity, stability, loyalty, and leadership capacity.<sup>17</sup>

The changing complexities of work and organizational structures are driving the search for new ways of facilitating and structuring mentoring relationships. The traditional one-on-one apprenticeship model assumed a relatively slow pace of change and of work, with the wise gray-hairs transferring their knowledge to their protégés over a period of years. With the speeded pace of change obliterating these luxuries, it is also clear that one mentor is not enough; trainees benefit from exposure to a variety of styles and options, the better to see what stimulates their own development.

Assuring that trainees and young faculty are obtaining any career-advancing mentoring is becoming harder for AHCs. Perhaps most noticeably, the time available for informal education and for one-on-one exchanges with students has become scarcer as clinical care pressures have increased. Another limiting feature is the relative homogeneity of the senior faculty available as mentors compared with the ethnic and gender heterogeneity of trainees and young faculty. For instance, a survey of obstetrics–gynecology residents and fellows found that in their search for a mentor, many women and minorities encountered gender and racial discrimination; these negative experiences were a factor in discouraging their interest in academic careers.<sup>5</sup> Many other studies, in both the academic and corporate worlds, find that women and minorities gain less benefit from the mentor relationship than majority men do.<sup>18,19</sup>

But perhaps the greatest mentoring challenge of all has become generational differences. Seasoned faculties are expressing frustration that Generation X’ers appear to view mentoring as a right rather than a privilege. Moreover, Generation X’ers, less oriented toward institutional needs, expect their mentors to help

them achieve their own goals, leading some senior faculty to label them “self-centered.” Generation X’ers, without necessarily meaning disrespect, also tend to be more direct and outspoken than their parents, increasing the chances of their being seen as self-centered. A shift in locus of control is also apparent; they resent top-down management and are unlikely to follow directions “because I say so.” A chair of plastic surgery reports that when he tells residents to do something, they may question the order or simply not follow it; one told him “to chill out.”<sup>20</sup>

And many Generation X’ers reject the message that success means that “you gotta sacrifice” and “do what I did.” They may not necessarily regard “superstars” as admirable role models. Intent on creating a multifaceted life early on, Generation X’ers are looking for different models of career development and readily point out the shortcomings of the traditional model of single-minded focus on work.<sup>21</sup>

Thus, building productive mentoring relationships between these two generations is often challenging, and each generation tends to blame the other for the failures.

#### **Gaps in expectations about the “ideal worker”**

One of us (AJB) conducted a series of focus groups to assess the faculty development and gender climate at Duke University Medical Center.<sup>22</sup> One finding is that there exists a tendency for senior faculty to conclude that “they just don’t make ‘em like they used to” and to speak wistfully about the days before resident work-hours were limited. One senior faculty member commented that “young people need to work harder, and, frankly, I don’t think they want to.”<sup>23</sup> While senior members are labeling young people as “slackers” and “uncommitted to medicine,” junior members express a very different perspective. One said “a whole lot of docs at Duke look terrible [from overwork]. I want to say ‘lie down and I’ll come back in an hour.’” While such value judgments may stem from legitimate concerns about skill development or patient care coverage, on the one hand, and burnout on the other, such comments tend to alienate members of the other generation and to interfere with communication.

Desire for flexibility and work–life balance is apparent in both men and women students’ specialty choices. A study of obstetrics–gynecology fellows found that both men and women placed a high priority on “family responsibilities” in making career choices.<sup>5</sup> Among U.S. medical students, recent trends show an increase in residency applications for “controllable life” specialties (e.g., anesthesia, dermatology) and decreasing applicants for primary care.<sup>24</sup> Many young people believe that they cannot succeed at the expense of their family time and health and that “a fuller life outside of medicine makes us better doctors.”<sup>25</sup>

But messages that physicians should be “married to medicine” remain prevalent, e.g., doctors’ never needing extended or even episodic time away, especially during their 20s and 30s. Typically, tenure-track appointments allow less flexibility and individualizable options than faculty with young families require. “Constant decisions about which values to compromise” is a common complaint among such faculty and is certainly a disincentive to enter academic careers, where the pulls are in so many different directions.<sup>23</sup>

Another disincentive is the culture of “face time”—i.e., time physically present at work, which younger physicians experience as restrictive and outdated, preferring to be evaluated on accomplishments and productivity.<sup>26</sup>

#### **Gaps in expectations about faculty careers**

As is true of most jobs in an unstable, unpredictable economy, a faculty appointment is not what it used to be. A tenure-track position with substantial protected time and adequate support staff during the early years is now a rarity. Private practice and managed care positions are no bed of roses, but faculty appointments increasingly resemble these in terms of clinical load and may offer less flexibility and less remuneration. In many specialties, full-time faculty earn less than peers in private practice.<sup>27</sup> This differential is likely to represent a disincentive for many medical school graduates, especially those with high debt. (According to data from the 2004 Graduation Questionnaire of the Association of American Medical Colleges [AAMC], the median from private schools now exceeds \$140,000, and from public, \$105,000). The extraordinary time commitment

required to establish footing as an academic physician, whether as a clinical or basic scientist or as a medical educator, certainly advantages faculty without substantial debt and with the financial resources to hire household help. This feature is also a limitation to increasing the racial diversity of faculty, since disproportionately few underrepresented minorities share in these advantages.

Another difference now is that the top residents and fellows are not necessarily committed to academic careers. That steep climb toward the elusive “peak” of professor makes an HMO job look like “smooth sailing” by comparison. And many young physicians cannot see a clear, alternate path to success to the one modeled by senior faculty, whom they may not necessarily identify as role models.<sup>28</sup>

#### **Strategies for Generations to Work More Effectively Together**

These insights suggest strategies to assist members of the different generations to work together and to adapt practices to meet the needs of a changing workforce.

##### **Improving mentoring**

Mentoring represents the most tangible bridge to continuing the traditions of excellence that are now threatened by lack of funding for medical education, dysfunctional payment mechanisms, and other concerning trends. Bringing junior and senior members of the academy together in systematic ways assists junior members to navigate the complex academic environment more smoothly, to assimilate high professional norms, and to become excited about academic careers.

Clearly pivotal in assuring the provision of excellent mentoring, department chairs and division chiefs face increasing challenges in meeting these responsibilities. Now many chairs are under such pressure from their bosses to generate more clinical dollars that their financial concerns may supersede or conflict with their roles as mentors; they may no longer be able to advocate for protected academic time for their junior faculty. Other challenges facing many department heads with a direct bearing on provision of mentoring are increases in the numbers of faculty and trainees as well as in the pace of change and in productivity pressures. In response some department chairs are creating structures such as

mentoring programs that facilitate mentor–protégé pairings or mentoring “committees” assigned to each faculty are examples. Usually created with minimal resources, such programs can help to assure that trainees and faculty have access to career-advancing advice and critiques; in the long run, the programs are likely to enhance faculty productivity and retention.<sup>29</sup>

However, the potential of mentoring relationships and programs will not be realized unless senior members develop competencies in mentoring “across differences.” In mentoring Generation X’ers, the following techniques can help bridge differences:

- Begin the initial interaction with the protégé by having both individuals share information about their backgrounds and important influences, hence opening the door to a productive discussion of differences and preventing erroneous assumptions from arising.
- Create a clear picture of what needs to be accomplished and divide that into achievable goals. Seek the protégé’s reactions and opinions. Also, build-in milestones along the way; delayed gratification resonates poorly with Generation X’ers.
- Focus on outcomes. Generation X’ers tend to reject the notion of obligations and prefer to have “a piece of the action,” including input into the terms of any arrangement. So be clear about *what* needs to get done but leave some of the *how* to them.
- Use a participative rather than a top-down approach. A leadership style that incorporates teaching, information sharing, and engagement in problem solving is likely to be more successful than one that relies on authority or reference to “how it’s done around here.”
- If questions about the protégé’s commitment to the work arise, link the discussion to outcomes and performance. Offer illustrations linking effort to competency. Ask probing questions, such as—How would you define success in this situation? Will you feel competent? How will you make sure you develop the necessary expertise? To make the discussion as vivid and pertinent as possible, use immediate cases in the clinical care unit to illustrate how critical experience is in equipping a

clinician to competently accomplish complex patient care tasks.

- Give conscientious feedback. Whereas Boomers tend not to seek feedback, and expect substantial documentation to support the feedback they receive, Generation X’ers tend to look for and appreciate frequent, frank feedback.
- Money and advancement are not the only rewards Generation X’ers value, so also offer thanks, professional development opportunities, new electronic equipment, time off, and extra flexibility. Even a simple awards program, e.g., a video store coupon or a laminated button for “resident of the month,” can build good will and *esprit d’corps*.
- Encourage the protégé to mentor others. If the protégé takes the mentoring relationship for granted and underestimates the time and patience involved, encourage the protégé to become a mentor herself or himself.
- Refrain from comparing today to the glories of yesterday.

Crucial for recruiting and shaping the next generation of educators and leaders is having a core of faculty who are enthusiastic and passionate about their work and who invest their time in their colleagues from the next generation. Since mentoring is a critical professional activity requiring great commitment and competency, medical schools should recognize and evaluate mentoring as a core academic responsibility. For instance, students can rate residents and faculty on such indicators as “provides timely feedback that both challenges and supports me,” “demonstrates respectful attitudes,” and “inspires me as a role model.” On their annual review, senior faculty might name their protégés, and trainees and junior faculty, their mentors and role models. Promotions committees might count not only first authorships but also last authorships when the person’s protégés are first authors. Mentor-of-the-year awards might include in their criteria the modeling of integration of personal and professional lives.

Schools and departments that have created mentoring programs should assess their effectiveness from both the protégés’ and mentors’ perspectives<sup>30</sup> and align these programs with other institutional efforts to optimize their value. Whatever frameworks help senior faculty to effectively share the gifts of their expertise and

supports mutually respectful dialogues deserve consideration.

### Redefining the “ideal worker”

Most young physicians are hard workers but do not fit the traditional “ideal worker” profile because they have daily responsibilities outside the workplace. As a leading surgery residency program director writes: “Are there changes in what medical students expect from their careers and life in general? Yes, but this does not necessarily reflect a decline in commitment. We can attract or repel them, and we must choose which we wish to do.”<sup>31</sup>

Individuals with many multilayered commitments will not build careers in the linear fashion of yesterday’s and today’s “giants.” Career trajectories are now more likely to undulate and include more plateaus and spirals.<sup>32</sup> Compared with eras when a healthy life span was shorter, young persons now may have several careers over five or more decades. This longer life expectancy means more than a simple addition of years at the end; it encourages new ways of thinking about health, balance, and energy management. Naturally, then, young people question the requirement to push so very hard early in their careers at the expense of nutrition, exercise, family, and other interests. Rather than “slacking off,” Generation X’ers may actually be extending their productive professional lives.

To retain both women and men in academic careers, two norms in particular deserve reevaluation. First is “face time” at work. Commonly taken as evidence of commitment to the profession, unrestricted availability to work actually rewards neglect of family and personal life. When possible, de-emphasizing time at the hospital as an indicator of effort and focusing instead on productivity-based measures of effort and on meeting learning objectives make more sense. However problematic resident work hour restrictions have been, these requirements are stimulating innovations, such as the identification of the clinical activities that are most educationally useful.<sup>33,34</sup>

More problematic is the unavoidable congruence of career-building and child-bearing years. By adhering to an inflexible career trajectory that requires the greatest time commitment in the same years that young families need the most

attention, academic medicine forces unnecessary “either/or” choices between work and family.<sup>35</sup> To be sure, assuring equity for faculty without family responsibilities, funding benefits, and assuring patient care coverage are challenges. But dualistic thinking has interfered with creative problem-solving here. Each department and institution ought to be exploring and evaluating methods of adding flexibility and of legitimizing less-than-full-time options.<sup>36</sup> Part-time practice has been shown to be satisfying not only for physicians but also for their patients.<sup>37</sup>

In addition to less-than-full-time options, other strategies to recruit and retain Generation X’ers include job sharing, greater access to technology, and unpaid leave for personal reasons.<sup>38</sup> In a field as demanding as medicine, why not make it easier for young physicians to integrate their personal and professional lives, especially with so many decades of practice potentially ahead of them?

### Enhancing faculty career and leadership development

Packed to overflowing, undergraduate and graduate medical curricula have made little room for the increasingly critical subject of strategic career management. Given the complexities of career building in medicine, trainees can use assistance in turning their “intellectual capital” and technical abilities into “career capital.” Students and residents deserve easy access to educational sessions in such areas as designing an effective curriculum vitae and resume, effectively introducing themselves and discussing their work, setting and achieving professional goals, deciphering the “unwritten rules” of advancement, managing energy and time, obtaining mentoring, and expanding their professional networks.

Faculty development programs are also needed to facilitate proactive career management and to prevent career dead-ends and derailings, but few schools offer their faculty a rich and accessible selection of these resources.<sup>39</sup> Although such programs cost much less than replacing faculty, they tend to be underfunded. The costs of recruiting and training faculty are estimated at over 1.5 times the first year’s salary (and this estimate does not include costs associated with having the position vacant, e.g., lost referrals, overload on other faculty).<sup>40</sup>

Perhaps even more important to most faculty than continuing opportunities to build skills is the faculty member’s relationship with her or his department head. Studies within AHCs have found trust in and communication with the division head to be most predictive of faculty satisfaction.<sup>41</sup> These studies also find that administrators are often unaware of low faculty morale. Apparently, rather than adopting a forward-looking approach to the challenges of faculty development, department chairs often ignore problems with faculty turnover and stalled careers. Evaluating department heads on their faculty development skills and offering them supportive tools to build these capacities are essential. Also periodic surveys of faculty satisfaction and career development experiences are advisable because faculty concerns are usually amenable to successful intervention.

Updated mechanisms of faculty management are clearly needed, including covenants of accountability and reward systems that reflect both societal needs and the values of younger physicians.<sup>42</sup> Given the pace of change in the environment, it is advisable to periodically examine all institutional motivators and reward systems.<sup>43</sup>

Given the extraordinary demands of administrative leadership roles in medicine, AHCs should also actively nurture the development of their leaders, upon whom our profession (and thus the health of our society) will depend. It’s risky to assume that the “cream” will continue to “rise to the top,” ready and skilled for tomorrow’s demanding leadership roles. Some AHCs have created internal leadership development programs to facilitate the acquisition of management and leadership skills.<sup>44</sup> Some also assist the development of up-and-coming and existing administrative leaders by paying for executive coaching. Individualized coaching can help professionals make the best use of their talents and experience, provide insights into blind spots, leverage failures, and provide a framework for analyses of opportunities and relationships.<sup>45</sup>

### The Challenge

An academic institution’s faculty is its greatest asset. Thus the recruitment and preparation of the next generation of first-rate faculty ought to be of great con-

cern to all who are invested in medicine. Certainly, workforce trends are notoriously difficult to predict. Even if medicine does not experience a fall-off in excellent candidates for academic careers, the changing demographics and conditions we have described here necessitate a variety of adaptations and innovations.

The AAMC’s Faculty and Leadership Development Office and Group on Educational Affairs can provide numerous examples of promising institutional improvements. For instance, the University of Pittsburgh School of Medicine has appointed an assistant vice chancellor for academic career development; this office provides a full spectrum of career development resources for its health science professionals including postdoctoral students. Duke University School of Medicine has created the position of associate dean for women in medicine and science (and named one of us—AJB—to fill it) and a new Office of Grant Support to improve faculty facility and efficiency with the grant application process. The University of California, San Francisco, School of Medicine’s Academy of Medical Educators includes a mentoring program for junior faculty built around peer observation of teaching and offered as a service rather than as a remedial undertaking.<sup>46</sup> Many schools in the United States and Canada are creating such innovative faculty development programs. If their designers are able to evaluate their successes in meeting objectives, the community will learn a great deal from these innovations, particularly if cost–benefit data can also be generated.

In this article we have presented a number of strategies for updating faculty development, mentoring, and personnel practices. If put into action, these updates will help attract and nurture the next generation of academic physicians and scientists upon which our AHCs and society depends.

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### References

- 1 Holmes DE, Lindeman LM (eds). *Proceedings 9th Congress of Health Professions Education: Faculty shortages across the health professions*. Washington, DC: Association of Academic Health Centers, 2003.

- 2 Linzer MD, Rosenberg M, McMurray JE, et al. Respecting the lifecycle: rational workforce planning for a section of general internal medicine. *Am J Med.* 2002;113:443–8.
- 3 Scanlon B. Proposal irks doctors. *Rocky Mountain News* 2004 Feb 3.
- 4 Sheehan M. Survey sheds light on residents' views. *Resid Staff Physician.* 2003;21(Summer suppl):1, 21.
- 5 Cain J, Schulkin J, Parisi V, et al. Effects of perceptions and mentorship on pursuing a career in academic medicine in obstetrics and gynecology. *Acad Med.* 2001;76:628–34.
- 6 Gray S, Alexander K, Eaton J Equal Opportunity for all? Trends in flexible training 1995-2001. *Med Teach.* 2004;26:256–9.
- 7 Scallan S. Education and the working patterns of junior doctors in the UK: a review of the literature. *Med Educ.* 2003;37:907–12.
- 8 Tugwell P. Campaign to revitalise academic medicine kicks off. *BMJ.* 2004;328:597.
- 9 Howe N, Strauss W. *Generations.* New York: Random House, 1998.
- 10 Lancaster L, Stillman D. *When Generations Collide.* New York: HarperCollins, 2002.
- 11 Queenan J. *Balsamic Dreams: A Short But Self-Important History of the Baby Boomer.* New York: Picador, 2002.
- 12 Romanelli F, Ryan M. A survey of attitudes and beliefs of Generation X pharmacy students. *Am J Pharm Educ.* 2003;67(1):72–7.
- 13 Howe N, Strauss W. *Millennials Rising: The Next Great Generation.* New York: Vintage, 2000.
- 14 Karp H, Fuller C, Sirias B. *Bridging the Boomer Xer Gap: Creating Authentic Teams for High Performance at Work.* Palo Alto, CA: Davies-Black, 2002.
- 15 Zemke R, Raines C, Filipczak B. *Generations at Work: Managing the Clash of Veterans, Boomers, Xers and Nexters in Your Workplace.* New York City: AMACOM, 2000.
- 16 Carr P, Bickel J, Inui T (eds). *Taking Root in a Forest Clearing: A Resource Guide for Medical Faculty,* Boston: Boston University School of Medicine, 2004.
- 17 Zachary L. *The Mentor's Guide: Facilitating Effective Learning Relationships.* San Francisco: Jossey-Bass, 2000.
- 18 Bickel J, Wara D, Atkinson BF, et al. Increasing Women's Leadership in Academic Medicine: Report of the AAMC Project Implementation Committee. *Acad Med.* 2002;77:1043–61.
- 19 Valian V. *Why So Slow: The Advancement of Women.* Cambridge MA: MIT Press, 1998.
- 20 Stauffer D. *Motivating across generations.* Harvard Management Update. 2003;March: 4-7.
- 21 O'Neill E. *Shaping America's health care professions: how the health sector will respond to Generation X.* *West J Med.* 2002;176:139–41.
- 22 Brown AJ, Swinyard W, Ogle J. Women in academic medicine: a report of focus groups and questionnaires, with conjoint analysis. *J Womens Health.* 2003;12:999–1008.
- 23 Brown AJ. A report of 17 focus groups exploring the climate for professional development for women and men at Duke University Medical Center [unpublished].
- 24 Dorsey ER, Jarjoura D, Rutecki GW. Influence of controllable lifestyle on recent trends in specialty choice. *JAMA.* 2003;290:1173–8.
- 25 Mackay B. Residents strive to raise public awareness of their role. *CMAJ.* 2003;168:1030.
- 26 Morahan P, Bickel J. Capitalizing on women's intellectual capital. *Acad Med.* 2002;77:110–2.
- 27 *Physician Compensation and Production Survey.* Chicago: Medical Group Management Association, 2003.
- 28 Kenny NP, Mann KV, MacLeod H. Role modeling in physicians' professional formation. *Acad Med.* 2003;78:1203–10.
- 29 Benson C, Morahan PS, Sachdeva AJ, Richman RI. Effective faculty preceptoring and mentoring during reorganization of an academic medical center. *Med Teach.* 2002;24:550–7.
- 30 Castiglioni A, Bellini LM, Shea JA. Program directors' views of the importance and prevalence of mentoring in internal medicine residencies. *J Gen Intern Med.* 2004;19:779–82.
- 31 Meyer AA, Weiner TM. The generation gap: perspectives of a program director. *Arch Surg.* 2002;137:268–70.
- 32 Hirsch G. *Strategic Career Management for the 21st Century Physician.* Chicago: American Medical Association, 2000.
- 33 Wilson MC. In pursuit of optimal duty hours and resident experiences. *J Gen Intern Med.* 2004;19:97–8.
- 34 Hoff TH, Pohl H, Bartfield J. Creating a learning environment to produce competent residents. *Acad Med.* 2004;79:487–91.
- 35 Williams J. *Unbending Gender: Why Family and Work Conflict and What to Do About it.* New York: Oxford University Press, 2000.
- 36 Froom J, Bickel J. Medical school policies for part-time faculty committed to full professional effort. *Acad Med.* 1996;71:91–6.
- 37 Parkerton PH, Wagner EH, Smith DG, Straley HL. Effect of part-time practice on patient outcome. *J Gen Intern Med.* 2003;18:717–24.
- 38 Shields MC, Shields MT. Working with Generation X physicians. *Physician Exec.* 2003;29:14–8.
- 39 Morahan PS, Gold J, Bickel J. Status of faculty affairs and faculty development offices in U.S. medical schools. *Acad Med.* 2002;77:398–401.
- 40 Wenger D. Conducting a cost-benefit analysis of faculty development programs. *Acad Physician Scientist.* 2003;May/June:1, 6-7.
- 41 Demmy TL, Kivlahan C, Stone TT. Physicians' perceptions of institutional and leadership factors influencing their job satisfaction at one academic medical center. *Acad Med.* 2002;77:1235–40.
- 42 Griner PF, Blumenthal D. New bottles for vintage wines: the changing management of medical school faculty. *Acad Med.* 1998;73:719–24.
- 43 Aschenbrener CA. The future is in the present: the impact of generations. *J Am Coll Dent.* 1998;65(1):22–8.
- 44 Morahan PS, Kasperbauer D, McDade S, et al. Training future leaders of academic medicine: internal programs at three academic medical centers. *Acad Med.* 1998;73:1159–68.
- 45 Fitzgerald C, Berger JG (eds). *Executive Coaching: Practices and Perspectives.* Palo Alto, CA: Davies-Black, 2002.
- 46 Irby DM, Cooke M, Lowenstein D, et al. The academy movement: a structural approach to reinvigorating the educational mission. *Acad Med.* 2004;79:1729–36.