

Training for future generations

The current trainees are the future workforce who are key to the sustainability of the NHS. However, different generations have different values and attitudes to work based on their life experiences. So what does this mean for educators? To ensure that trainees are engaged, we will need to embrace a new way of training and culture that respects the different generations and their values (Roberts et al, 2012).

What are the generations?

The year of birth defines the traits and values of a generation. Over a long period of time, these characteristics have been defined and categorised (Table 1).

When trying to communicate and perhaps more importantly teach and train these individuals, it is important to understand what makes them 'tick' and how, by tapping into this, we can provide a rich learning environment (Twenge, 2009). Trainees can, at times, appear more demanding than those of previous generations. How they receive information and even behave during training has important consequences. Just because someone is sitting at the back of a lecture hall using their mobile phone, trainers should not be judgemental and assume they are not listening. They are used to multi-tasking and taking information from different sources at the same time but still absorbing it.

Current picture

Traditionally education and training, especially in the early years of medical education, has been delivered through lectures mixed with tutorials or 'blended learning', a mixture of the two. This is efficient as one trainer can deliver a lot of information to a large number of people in

a short space of time. However, as time has progressed and technology becomes more important in all of our lives, newer forms of learning such as e-learning, simulation and webinars have become more prevalent. This has now moved on to even more modern forms such as flipped classroom, self-directed learning (Pettit et al, 2017) and gaming (Gorbanev et al, 2018). Interestingly, the evidence base for the latter is much more extensive than that for the traditional lecture (Hopkins et al, 2018). However, it could be argued that it is the mode of delivery rather than the actual educational theory that has changed (Evans et al, 2016). Content, relevance and feedback were important in the past and are as relevant today.

Why do we need to change?

There are a number of drivers for change: changing health-care needs and delivery, evolution of health-care systems, other health-care professionals and fundamentally the role of the physician. Technology is also driving change but it is important that we do not necessarily just use technology because it is there – it has to have value (Royal College of Physicians, 2018). Outpatient clinics via teleconference are now not unusual but becoming the norm. The use of apps to monitor patients' health care in their own homes is just the start of the revolution. Patients now come to consultations with

printouts from the internet – this changes doctor–patient interactions and requires the use of different and complex communication skills and styles.

What do we need to change?

The key tenets of training, relevance, content and feedback are still important. However, today's trainees want to know exactly why they are doing something and will question what many may consider 'standard' training activities. This is an opportunity rather than a threat: if the young doctors understand the deeper meaning behind a task, they can bring their energy and passion to it, which leads to greater satisfaction for both trainee and trainer and ultimately patient care. However, there needs to be a shift in the type and focus of training together with a shift in culture. Immediate gratification is one of the key characteristics of generation Y. Feeding this will increase motivation in an already motivated learner and lead to a more successful trainer–trainee interaction and ultimately better patient care. Giving feedback on performance after a procedure, ward round or consultation costs nothing and requires no technology (Eckleberry-Hunt and Tucciarone, 2011) but it is sadly lacking as part of everyday contact between the trainer and trainee in many settings.

The relevance of learning does require change and current trainees are driving this

Table 1. Characteristics of different generations

Name	Year of birth	Characteristics
Traditionalist	1928–44	Value authority and a top-down management approach, hard working, 'make do or do without'
Baby boomers	1945–64	Expect some degree of deference to their opinions, workaholics
Generation X	1965–79	Comfortable with authority, will work as hard as is needed, importance of work–life balance
Generation Y	1980–94	Respect must be earned, technologically savvy, goal- and achievement oriented
Generation Z	1995+	Many traits still to emerge. Digital natives, fast decision makers, highly connected

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change themselves. They know what excites them and how they wish to learn and if they can not get it via their trainers, many are now developing their own educational resources using social media including apps, videos, games and interactive podcasts and webinars. Harnessing this enthusiasm and desire to learn, linked to the current workplace, is an obvious recipe for success and improvement of medical education. No one size fits all and the use of different formats is to be encouraged and is indeed welcomed by the learners. This also accommodates different learning styles.

Perhaps the most crucial element is content. The capacity to store enough knowledge and have complete mastery of the technical skills required for the future delivery of medicine is almost impossible. Over 3000 references are added to Medline each month from 4000 journals. So is teaching facts still the backbone of learning, or is it knowledge acquisition, decision making or problem solving? When individuals want to know something, they look it up or find out about it (Hughes et al, 2009) – hence the YouTube revolution. Therefore the role of trainer will have to change from that of information provider to that of facilitator and enabler to support them in making decisions and crucially the right decisions.

Conclusions

Quality research in generational educational differences is often poor. These differences go much deeper than just training and are a useful concept when considering the workforce of the future and medical career decision making. A supportive network,

good role models and excellent teaching are valued above financial considerations by this generation (Scanlan et al, 2018) so there is a real opportunity to build on these values; understanding them may well be a route to improving medical recruitment and retention. The concept of training will continue but the mode of delivery and even more importantly what we teach will have to alter to meet the needs of the future workforce who will be working in a changing environment and will have a different view of the world. The role of the physician in the 21st century will continue to develop and training needs to adapt to meet these requirements.

To gain full commitment from our future doctors we must understand that future generations want the highest quality of both personal and professional life and will pursue opportunities to achieve these goals which will include quality of training. This will require a shift of culture in medical education but it is also a reflection of our current society. **BJHM**

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KEY POINTS

- The future workforce will have different values and culture.
- How and what we teach must move from the traditional teaching of facts through didactic lectures to knowledge acquisition using different forms which have a clear relevance.
- Content and most importantly feedback are important now and even more important in the future of training.
- Engaging with an already motivated learner will lead to a more successful trainer–trainee interaction and ultimately better patient care.

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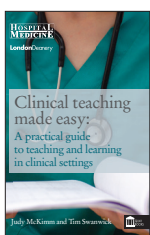
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