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Current transgenerational dynamics, a story lived from the sandwich generation.

Dinámica transgeneracional actual, una historia vivida desde la generación sándwich.

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Summary.

Medical training, along with technical knowledge, transmits a historical and cultural burden that links the practice of the profession with the idea of sacrifice. This work examines how the archetype of the martyred physician, reinforced by the hidden curriculum of medical training, contributes to normalizing demanding working conditions under the guise of vocation, and situates this phenomenon within a broader framework of learned helplessness. It also analyzes a generational divide between veteran physicians, trained in a sense of mystical obligation, and younger physicians who increasingly question this framework—briefly mentioning the concepts of "Salaried Hero" and "Infallible Savior Fallacy" to describe this dynamic. Furthermore, it incorporates recent evidence on identification with the aggressor, imposter syndrome, and a lack of pedagogical training among tutors, mechanisms that can perpetuate the gap between generations regardless of the age of the person experiencing them. It also emphasizes the fact that the current Competency-Based Training framework, despite declaring humanistic values, lacks effective mechanisms for teaching or assessing them. This work acknowledges and highlights the qualities that the younger generation brings to the profession and proposes that unacknowledged ignorance—both that of the veteran who has stopped questioning and that of the resident who needs to project confidence—is a common cause of friction. Finally, it concludes with a proposal for an alliance of mutual care between generations, developed from the author's situated reflections from her intermediate generational position.

Keywords: Transgenerational conflict; Medical burnout; Learned helplessness; Sandwich generation; Medical vocation; Job insecurity.

Resumen.

La formación médica transmite, junto al conocimiento técnico, una carga histórico-cultural que vincula el ejercicio de la profesión con la idea del sacrificio. Este trabajo examina cómo el arquetipo del médico-mártir, reforzado por el currículo oculto de la formación médica, contribuye a normalizar condiciones laborales exigentes bajo la apariencia de vocación, y sitúa este fenómeno dentro de un marco más amplio de indefensión aprendida. Se analiza también una ruptura generacional entre médicos veteranos, formados en la obligación mística, y médicos más jóvenes que cuestionan cada vez más ese marco —nombrándose brevemente los conceptos de «Héroe Asalariado» y «Falacia del Salvador Infalible» para describir esta dinámica—. Además se incorpora evidencia reciente sobre identificación con el agresor, síndrome del impostor y déficit de formación pedagógica en tutores, mecanismos que pueden perpetuar el distanciamiento entre generaciones con independencia de la edad de quien los sostiene. Enfatiza también el hecho de que el actual marco de Formación por Competencias, pese a declarar valores humanísticos, carece de

mecanismos reales para enseñarlos o evaluarlos. Este trabajo reconoce y subraya, las cualidades que la generación más joven aporta a la profesión, y propone que la ignorancia no reconocida —tanto la del veterano que ha dejado de cuestionarse como la del residente que necesita aparentar seguridad— es una causa común de fricción. Finalmente, concluye con una propuesta de alianza de cuidado mutuo entre generaciones, desarrollada a partir de la reflexión situada de la autora desde su posición generacional intermedia.

Palabras clave: Conflicto transgeneracional; Burnout médico; Indefensión aprendida; Generación sándwich; Vocación médica; Precariedad laboral.

Personal reflection

I write from a place of unease and a feeling of not being fully understood, which accompanies my generational position (Table 1), Generation X (born roughly between 1965 and 1980), often described as the "sandwich generation" or, as the Pew Research Center has called it, the "forgotten middle child" of medicine (1). We don't entirely share the silent endurance of the wounded healer embodied by our elders, but neither do we share the legitimate intolerance of normalized suffering held by our younger colleagues (2, 3). We inhabit an intermediate space, with its own form of suffering: that of feeling ignored by both extremes. I feel the need to name this intermediate void, hoping that naming it will be a first step toward its gradual disappearance.

Table 1. Generational framework used in this work, with its translation to the mysticism of medical sacrifice.

Generation	Approximate years of birth	General social traits	Relationship with medical mysticism
Baby Boomer	1946–1964	Post-war period, economic expansion, strong sense of institutional duty	He fully embodies the model of the "wounded healer"; he sustains the system out of mystical obligation.
Generation X	1965–1980	"Latchcock generation": more divorces, mothers entering the workforce	Sandwich generation: an intermediate position, often made invisible
Millennial (Generation Y)	1981–1996	The Great Recession of 2008 shatters the promise of stability: massive youth unemployment	First generation to openly name burnout
Generation Z	1997–2012	Culture of immediacy, hyperconnectivity	Explicit rejection of the mystique of sacrifice

Note: The cut-off years vary depending on the source; they are offered as a guideline and not as strict biological or psychological categories. The generational framework is a sociological approach that describes trends in a society; it does not define the character of the specific individuals who comprise it.

The hidden curriculum of medical training.

The "hidden curriculum" of medical training operates long before a student sees their first patient: it subtly penalizes personal boundaries and rewards submission. This pedagogy normalizes exploitative working conditions, excessively long shifts, and personal sacrifice under the guise of a sacred mission—a highly advantageous arrangement for healthcare systems, which thus outsource the true cost of care onto the health of the caregiver. Film and television reinforce this same message from outside the classroom, romanticizing burnout (as in popular series like *Grey's Anatomy* , *House* , *ER* , and *The Pitt, among others*).

Historical and literary figures such as Sophocles, Nietzsche, Foucault, Chekhov, and Zweig have addressed different facets of this phenomenon (4-8): from the wounded healer to pity as a form of emotional vampirism that binds the doctor to endless demands. Chekhov demonstrates that overwork does not produce better doctors, but rather apathetic and dehumanized professionals; Zweig, that misunderstood pity leads to disaster. University education and cultural propaganda contribute to instilling the belief that personal well-being is a form of criminal selfishness.

Learned helplessness and its mechanisms.

Within the medical profession, we can speak of learned helplessness: a systematic training that exploits this historical burden to neutralize resistance. When the system convinces doctors that mistreatment is a rite of passage, they stop fighting because they understand that suffering is part of their professional identity; residents learn that the "good doctor" endures inhuman workdays without complaint, and those who prioritize their mental health are labeled "insufficiently committed."

This phenomenon becomes normalized, and resistance remains minimal, through several mutually reinforcing mechanisms. The perverse use of "resilience" shifts the responsibility for burnout from structural conditions to the individual (1-3, 9, 10). The identity of a "special caste" distances the physician from the working class: while a pilot or factory worker will strike for their rest hours, the physician feels that demanding rights implies a loss of status. The social punishment of dissent isolates those who set boundaries: older generations use phrases like "in my day we worked twice as hard and never complained," and helplessness becomes collective. The validation of suffering transforms mistreatment into pride, and chronic exhaustion leaves the physician without the energy to question the system that consumes them. The result is fragmentation under a "every man for himself" mentality: those with the greatest leadership capacity are the first to leave the clinic.

The hidden side: identification with the aggressor and “imposter syndrome”.

Not all junior physicians respond to hierarchy with silent disengagement. Some respond with active aggression, driven by an almost compulsive need to prove they are better than their mentors. Sánchez M. et al., in a recent study based on interviews with medical students and residents, identified departmental hierarchical dynamics and, notably, insufficient supervision and teaching by tutors, along with arbitrary favoritism in on-call assignments, as the main causes of abuse of power (11). It is not hierarchy in the abstract that predicts mistreatment, but rather its combination with inadequate mentoring.

Psychoanalytic psychology offers a plausible mechanism to explain how this experience transforms into aggression toward one's own group. Krystal HL describes how "identification with the aggressor"—a defense mechanism by which someone subjected to hierarchical mistreatment unconsciously adopts the traits of the person who wielded that power over them—can explain much of the hazing culture that persists in medicine, even in generations that consciously reject the mystique of sacrifice (12). Under this interpretation, the aggressiveness of young doctors would not be evidence of a break with the old model, but rather one of its most persistent forms of continuity.

The person who exercises this deficient supervision does not necessarily belong to a specific generation: each generation, including the author's own Generation X, is composed of profoundly different individuals. The hierarchical training structure itself is a cause of generational distancing as real as, or even more real than, any difference in cultural values. There is also a more generous explanation than bad faith: many of the physicians who train residents have never received specific pedagogical training, as they are selected for their clinical excellence, not their teaching competence

(13). Knowing how to diagnose, decide, and act skillfully in medicine is not the same as knowing how to transmit how it is done; these are distinct competencies.

This training responsibility does not fall solely on the tutor, but must be understood as shared among the physicians with whom the resident interacts. In other words, there is not a single training link but several, each conditioned by the pedagogical approach or its absence. Royal Decree 589/2022, which regulates the common transversal training for all healthcare specialties in Spain, explicitly includes among its competencies "commitment to the principles and values of the National Health System." The curriculum design itself illustrates this point: the Humanities do not resist the competency-based model because it excludes them, but because a framework focused on measurable and observable behaviors has a structural difficulty in determining qualities such as empathy or the ability to maintain a genuine training relationship.

This same insecurity can shift into a compensatory need to demonstrate dominance over more experienced colleagues. The "imposter phenomenon"—the persistent feeling of not knowing enough, despite objective evidence of one's competence—is extraordinarily prevalent among residents, and the confident self-presentation that many project can function as a strategic defense against this internal insecurity (14). Competitive aggression toward more experienced physicians would not stem from overconfidence, but rather from the need to mask the feeling of never being sufficiently up-to-date in a profession whose knowledge changes faster than humanly possible to assimilate.

It is worth asking, then, who is in a position to transmit these values. Teaching commitment and a sense of duty presupposes that the teacher holds them firmly enough to transmit them, and this work has already indicated that the erosion of the sense of duty in contemporary society may not be a trait exclusive to younger generations, but rather a broader social phenomenon that likely also affects those who should be educating. If this were the case, it would not be enough to simply include these values in the catalog of competencies: it would be necessary, first, to rebuild the very chain of transmission where generational erosion has weakened it.

The need for transgenerational reconciliation.

Today, a transgenerational reconciliation between two perspectives on this form of enslavement is urgently needed. The younger generation, raised in a culture of immediacy, encounters slow processes and delayed results in medicine; there is also a tendency to avoid conflict or physical suffering, which clashes with a hierarchical and exhausting system, explaining the increase in mental health-related absences and premature dropout rates (2, 3). Jonathan Haidt, a social psychologist, tells us that in the last two decades there has been a major shift in child-rearing practices, from a childhood based on free play to one familiarized with mobile phones, coupled with increasing physical overprotection, which may have reduced this generation's real opportunities to practice conflict and frustration tolerance. Another factor, already mentioned, is the erosion, within contemporary society, of the sense of duty, such that younger generations prioritize their individuality to a greater extent. This phenomenon does not arise in a vacuum: it originates, to a large extent, within the family unit itself (a social transformation of the last two decades: a sustained increase in separations and divorces since 1981 and a generational leap in women's entry into the labor market: 30% born in the 1940s and 75% in the 1970s), where social violence fueled by frustration—along with the progressive erosion of the maternal figure as a traditional axis of emotional containment and transmission of values—has left younger generations without the necessary emotional references to tolerate distress and adversity.[10] Without this early learning of frustration tolerance, the subsequent confrontation with a hierarchical and emotionally hostile medical system is even more devastating, and partly explains the intolerance—legitimate, but also painful for those around them—that young doctors display toward normalized suffering.

We experience this distancing with genuine sadness, because younger generations are indispensable to medicine for what they contribute and for what they question: questioning things is a necessary condition for sound thinking. They bring with them a natural familiarity with diagnostic and therapeutic innovation, greater speed of technological adaptation, and more recent updates to medical knowledge. Added to this is a relative absence of "expert bias": accumulated experience facilitates the rapid recognition of patterns, but also predisposes one to diagnostic fixation (15); the young physician, lacking this automatic repertoire, tends to be more attentive to the atypical. This relationship cannot afford to lose the habit of sharing, nor can it be stifled by the aggression that sometimes pervades it: nothing good comes of that path. Unrecognized ignorance is the great common cause of both extremes: both the veteran who frequently stops questioning and the young resident or specialist who needs to appear confident share the same difficulty in saying "I don't know" (Figure 1).

The blindness of fear: a shared rigidity

novel Blindness (1995), José Saramago describes a society that discovers that true blindness—moral, empathetic—already existed before the contagion (16). Borrowing this image, it can be argued that veterans and young doctors suffer from two mirror-like blindnesses, both born of fear. The veteran cannot see the system as abusive without undermining the meaning of their own sacrifice: their blindness is a retrospective rigidity that protects the coherence of an entire life. The young doctor cannot see the veteran as an ally without risking repeating their fate, and responds with an evasive rigidity: disconnection as a way of avoiding confronting a conflict they perceive as insoluble. Both “see, but do not see”—and this shared blindness is what prevents the alliance of mutual care that this work proposes.

From the total institution to self-exploitation

The contemporary philosopher Byung-Chul Han, in critical dialogue with Foucault, argues that the disciplinary society has given way to a "performance society," in which the subject is no longer subjected from the outside, but rather self-exploits under the illusion of freedom (17): a foreman is no longer needed when the subject has internalized the demand to the point of experiencing it as their own choice. The contemporary doctor fits this description perfectly: the total institution no longer needs walls; it is enough for the doctor to believe that their sacrifice is free. In a later work, Han expands on this idea by analyzing how violence itself has mutated in contemporary society: from visible to invisible, from frontal to viral, from physical to psychological, from negative to positive, retreating into very deep spaces until it seems to have disappeared.

I propose two concepts here. The “Salaried Hero” suggests that the physician has sold their health, time, and clinical judgment to the highest bidder—the public or private system—to maintain an image of superiority, for which the system itself pays them less than their worth. The “Infallible Savior Fallacy” is the belief that if the physician stops, the patient will die or the system will collapse: a distortion that prevents them from recognizing themselves as a replaceable part, making it easier for the system to “rent” and exploit them.

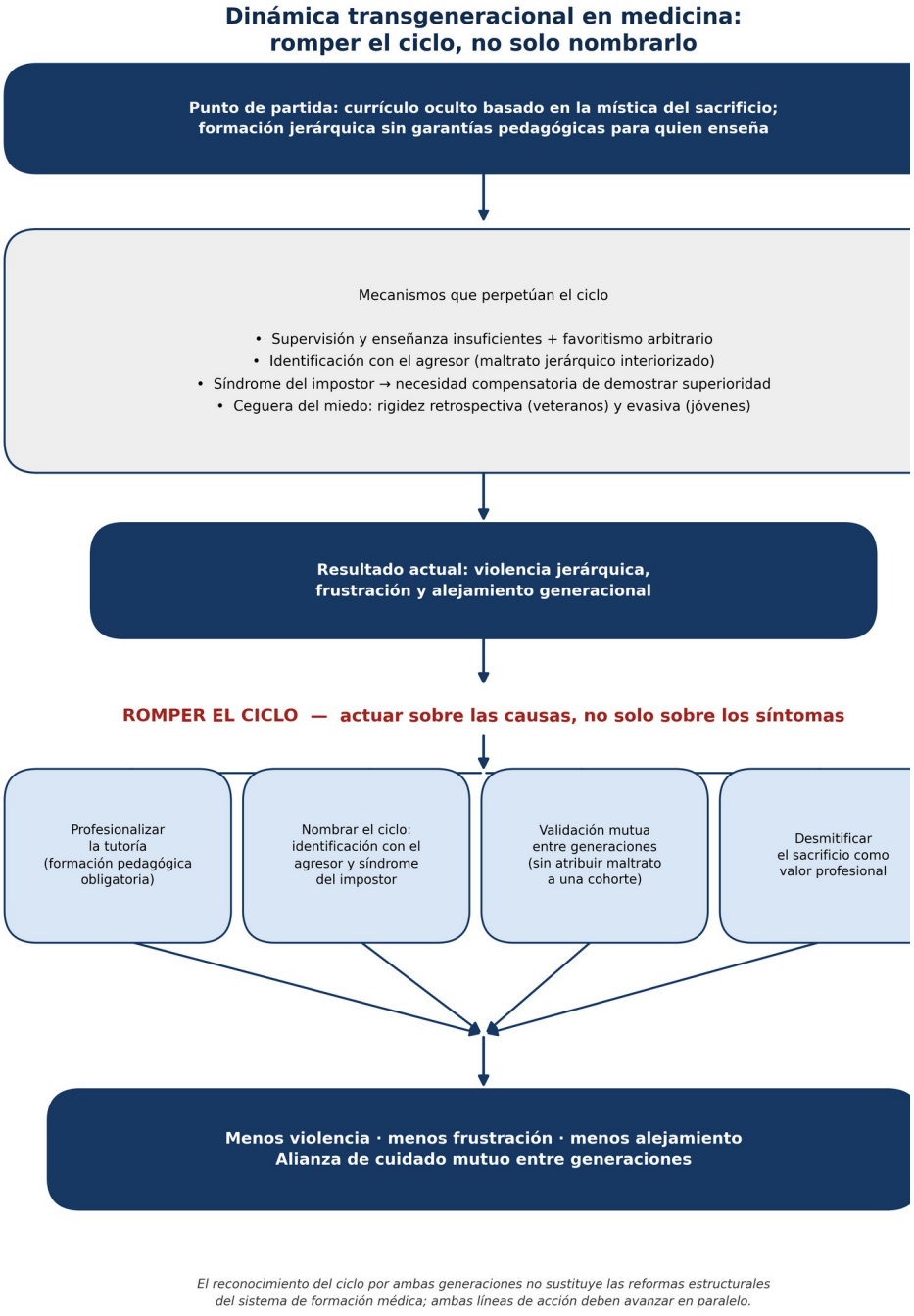

Figure 1. Transgenerational dynamics in the medical education.

Towards an alliance of mutual care

It's not a matter of one generation demanding change while the other resigns itself to the status quo; we are all—veterans and young doctors alike—exhausted by a system of endless shifts. The gap lies not in the desire for improvement, but in memory: those of us who have been here longer have sustained the system by sacrificing our health and families, while young doctors enter a model that is already unsustainable. A young doctor's breakdown should not be interpreted as a lack of respect for their mentors, but as an echo of the same exhaustion that veterans have endured for decades: the Wounded Caregiver and the Wage-Earning Hero are two sides of the same coin of victimhood.

For this alliance to be genuine, we must confront a contradiction that affects us all: the system not only exploits us with excessive working hours, but also seduces us with the idea that sacrifice deserves a reward attainable only through that same excess. As long as we continue to validate our value through overwork, we will continue to fuel the engine that is destroying us. This diagnosis is reflected in the recent wave of national medical strikes in Spain in 2026 (18, 19).

Every human community rests on a framework of shared beliefs: convictions that no one needs to justify because everyone takes them for granted, and which therefore sustain institutions and sacrifices for generations. Medicine has lived this way: the mystique of sacrifice has been that common belief, invisible in its very self-evidence. But general beliefs don't die suddenly; they are exhausted from within while the institutions that depended on them continue to stand by inertia, now devoid of the faith that sustained them. The transgenerational conflict described here can be interpreted as a symptom that the old belief can no longer bear the weight of the profession alone, and that the one that will replace it has not yet been born. The task of this work is not to lament the loss of the old faith, but to actively participate in building the one that comes after.

Conclusions

- The medical profession has historically been built on values such as vocation, commitment, responsibility, and dedication to the patient. However, when these values are taken to extremes, they can contribute to normalizing excessive working hours, disregarding personal limits, and accepting exhaustion as an inevitable part—and even as proof of merit —of professional identity.

- The infographic offers a transgenerational interpretation of this phenomenon. Baby Boomers, Generation X, Millennials, and Generation Z have experienced different professional contexts and, therefore, interpret concepts such as sacrifice, authority, resilience, well-being, and work-life balance differently. The so-called hidden curriculum can transmit and reproduce these norms beyond what institutions formally teach.

- The proposal is not about pitting generations against each other or replacing one set of values with another. It's about making visible what each generation has learned to consider normal. Recognizing shared exhaustion, acknowledging what each group cannot express or question, and creating spaces for dialogue can transform generational conflict into an opportunity for mutual learning.

- The ultimate goal is to move from a culture based on individual sacrifice towards an intergenerational alliance of care, in which caring for the patient and caring for those who practice medicine cease to be understood as opposing goals.

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