

# Managing Office Staff Across the Generation Gap

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Contributing Writer

SAN DIEGO — A good office staff is essential for a thriving medical practice, and understanding generational differences is key to finding and keeping good employees, Dr. Larry Anderson said at the American Academy of Dermatology’s Academy 2006 conference.

Patient surveys show that roughly 70% of patients who change physicians do so because they feel in some way put off by office staff attitudes. “Unfortunately, the doctors seldom know this,” said Dr. Anderson, a dermatologist in private practice in Tyler, Tex. He stressed that two major demographic trends are converging in a way that will amplify the importance of finding good staffers at the same time as

it will become ever more difficult to do so. The U.S. labor force showed nearly flat growth in the late 1990s, and this hasn’t changed much in recent years. During this period the population of younger working people shrank by about 14%. That’s bad news for the 80 million Baby Boomers who will require increasing levels of services, medical or otherwise. Retirees are the fastest-growing segment of the population, but the 20-something workforce is the slowest-growing segment. “In the next decade, we’re expecting to see a 30% shortfall in younger workers, and this will persist for about 40 years,” Dr. Anderson explained.

“During this time our services will be needed more and more, and it will be harder for us to get and keep good employees.” The bottom line, said Dr. Anderson, is that dermatologists and all other physicians need to see their employees as an asset, not a liability, and they need to develop the sort of office culture and work environment that attracts and nurtures the best and the brightest.

In terms of employer-employee relations, dermatologists and other physicians are now facing what amounts to a significant generation gap. According to a recent AAD survey, 27% of all AAD members are 41-50 years old, and 29% are 51-60 years old. “More than 50% of all dermatologists are Boomers, with a mean age in their early 50s. Our employees, however, are in their 20s and 30s,” Dr. Anderson noted.

Although the attitudinal differences between the Baby Boomers, born between 1943 and 1964, and the so-called Generation X, born from the mid-1960s to the mid-1980s, may not be as great as the cultural divide between the Boomers and their Depression- and World War II-era parents, it can be much greater than people realize, especially when it

comes to matters of career and identity. In terms of work styles, the Gen-Xers tend to be highly independent. “Remember, these are the latchkey kids all grown up. When they were younger, their mothers gave them a list of things they needed to get done, and they learned how to do them on their own, in their own way.” They carry this general approach into their professional lives. They want to know what has to be done, why it must be done, and when they must deliver. Beyond that, they want to be left alone.

When managing Gen-X staffers, be aware that they are definitely not impressed by authority unless it is earned and backed by unquestionable competence. This generation has the “question authority” attitude in spades. Do not assume that just because you’re the doctor, your Gen-X staff will automatically submit to your vision of things. “With this generation, rules don’t count unless they have input and understand the rationale,” Dr. Anderson said. In managing Gen-Xers, it is best to give them guidelines, while at the same time letting them into the planning process and allowing them to figure out the implementation.

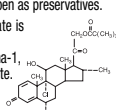
In Dr. Anderson’s experience, Gen-Xers are pretty practical. “They do understand the need for conformity, and they understand why the doctor is in charge at a medical office. But they expect fairness, balance, and inclusion.” He has found that team-based management works very well with Gen-X staffers, rather than top-down command and control strategies.

These generational inclinations are rough guidelines, Dr. Anderson stressed, and while they can give some insight, they are no substitute for getting to know the individual you are trying to hire. “Find out what each employee wants, and reward them accordingly,” he said.

## Tips for Keeping Gen-X Staffers Happy

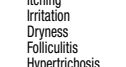
- Listen with full attention, speak respectfully, and praise good work often.
- Create an atmosphere in which it is okay to respectfully disagree, and remember that your Gen-X staffers will be far more responsive if you explain why you do things your way.
- Keep in mind that many Gen-Xers don’t have long attention spans, so make your communications and instructions concise and to the point.
- Gen-Xers are computer savvy, so whenever possible, put your communications, guidelines, and requests online or in electronic form.
- Gen-Xers are learning oriented, so conduct periodic learning inventories and ask them what they’re learning during the day-to-day operations of your office.
- Encourage your staffers to cultivate their lives outside the office.
- Encourage teamwork and help foster a familial atmosphere in your office.
- Whatever it is that you preach, make sure you’re practicing it.
- Lighten up and learn to be flexible.

Source: Dr. Anderson

**Rx Only**  
**Cloderm** Cream, 0.1%  
(clocortolone pivalate)  
**FOR TOPICAL DERMATOLOGIC USE ONLY—NOT FOR OPTHALMIC, ORAL, OR INTRAVAGINAL USE. WARNING: KEEP OUT OF REACH OF CHILDREN**  
**DESCRIPTION:**  
Cloderm Cream 0.1% contains the medium potency topical corticosteroid, clocortolone pivalate, in a specially formulated water-washable emollient cream base consisting of purified water, white petrolatum, mineral oil, stearyl alcohol, polyoxyl 40 stearate, carbomer 934P, edetate disodium, sodium hydroxide, with methylparaben and propylparaben as preservatives.  
Chemically, clocortolone pivalate is 9-chloro-6 $\alpha$ -fluoro-11 $\beta$ , 21-dihydroxy-16 $\alpha$ -methylpregna-1, 4-diene-3, 20-dione 21-pivalate. Its structure is as follows:  
  
**CLINICAL PHARMACOLOGY:**  
Topical corticosteroids share anti-inflammatory, antipruritic and vasoconstrictive actions.  
The mechanism of anti-inflammatory activity of the topical corticosteroids is unclear. Various laboratory methods, including vasoconstrictor assays, are used to compare and predict potencies and/or clinical efficacies of the topical corticosteroids. There is some evidence to suggest that a recognizable correlation exists between vasoconstrictor potency and therapeutic efficacy in man.  
**Pharmacokinetics:** The extent of percutaneous absorption of topical corticosteroids is determined by many factors including the vehicle, the integrity of the epidermal barrier, and the use of occlusive dressings. Topical corticosteroids can be absorbed from normal intact skin. Inflammation and/or other disease processes in the skin increase percutaneous absorption. Occlusive dressings substantially increase the percutaneous absorption of topical corticosteroids. Thus, occlusive dressings may be a valuable therapeutic adjunct for treatment of resistant dermatoses. (See **DOSAGE AND ADMINISTRATION**).  
Once absorbed through the skin, topical corticosteroids are handled through pharmacokinetic pathways similar to systemically administered corticosteroids. Corticosteroids are bound to plasma proteins in varying degrees. Corticosteroids are metabolized primarily in the liver and are then excreted by the kidneys. Some of the topical corticosteroids and their metabolites are also excreted into the bile.  
**INDICATIONS AND USAGE:**  
Topical corticosteroids are indicated for the relief of the inflammatory and pruritic manifestations of corticosteroid-responsive dermatoses.  
**CONTRAINDICATIONS:**  
Topical corticosteroids are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation.  
**PRECAUTIONS:**  
**General:** Systemic absorption of topical corticosteroids has produced reversible hypothalamic-pituitary-adrenal (HPA) axis suppression, manifestations of Cushing's syndrome, hyperglycemia, and glucosuria in some patients.  
Conditions which augment systemic absorption include the application of the more potent steroids, use over large surface areas, prolonged use, and the addition of occlusive dressings.  
Therefore, patients receiving a large dose of a potent topical steroid applied to a large surface area or under an occlusive dressing should be evaluated periodically for evidence of HPA axis suppression by using the urinary free cortisol and ACTH stimulation tests. If HPA axis suppression is noted, an attempt should be made to withdraw the drug, to reduce the frequency of application, or to substitute a less potent steroid.  
Recovery of HPA axis function is generally prompt and complete upon discontinuation of the drug. Infrequently, signs and symptoms of steroid withdrawal may occur, requiring supplemental systemic corticosteroids.  
Children may absorb proportionally larger amounts of topical corticosteroids and thus be more susceptible to systemic toxicity. (See **PRECAUTIONS: Pediatric Use**).  
If irritation develops, topical corticosteroids should be discontinued and appropriate therapy instituted.  
In the presence of dermatological infections, the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.  
**Information for the Patient:** Patients using topical corticosteroids should receive the following information and instructions:  
1. This medication is to be used as directed by the physician. It is for external use only. Avoid contact with the eyes.  
2. Patients should be advised not to use this medication for any disorder other than for which it was prescribed.  
3. The treated skin area should not be bandaged or otherwise covered or wrapped as to be occlusive unless directed by the physician.  
4. Patients should report any signs of local adverse reactions especially under occlusive dressing.  
5. Parents of pediatric patients should be advised not to use tight-fitting diapers or plastic pants on a child being treated in the diaper area, as these garments may constitute occlusive dressings.  
**Laboratory Tests:** The following tests may be helpful in evaluating the HPA axis suppression:  
Urinary free cortisol test  
ACTH stimulation test  
**Carcinogenesis, Mutagenesis, and Impairment of Fertility:** Long-term animal studies have not been performed to evaluate the carcinogenic potential or the effect on fertility of topical corticosteroids.  
Studies to determine mutagenicity with prednisolone and hydrocortisone have revealed negative results.  
**Pregnancy Category C:** Corticosteroids are generally teratogenic in laboratory animals when administered systemically at relatively low dosage levels. The more potent corticosteroids have been shown to be teratogenic after dermal application in laboratory animals. There are no adequate and well-controlled studies in pregnant women on teratogenic effects from topically applied corticosteroids. Therefore, topical corticosteroids should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Drugs of this class should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.  
**Nursing Mothers:** It is not known whether topical administration of corticosteroids could result in sufficient systemic absorption to produce detectable quantities in breast milk. Systemically administered corticosteroids are secreted into breast milk in quantities not likely to have deleterious effect on the infant. Nevertheless, caution should be exercised when topical corticosteroids are administered to a nursing woman.  
**Pediatric Use:** Pediatric patients may demonstrate greater susceptibility to topical corticosteroid-induced HPA axis suppression and Cushing's syndrome than mature patients because of a larger skin surface area/body weight ratio.  
Hypothalamic-pituitary-adrenal (HPA) axis suppression, Cushing's syndrome, and intracranial hypertension have been reported in children receiving topical corticosteroids. Manifestations of adrenal suppression in children include linear growth retardation,

delayed weight gain, low plasma cortisol levels, and absence of response to ACTH stimulation. Manifestations of intracranial hypertension include bulging fontanelles, headaches, and bilateral papilledema.  
Administration of topical corticosteroids to children should be limited to the least amount compatible with an effective therapeutic regimen. Chronic corticosteroid therapy may interfere with the growth and development of children.  
**ADVERSE REACTIONS:**  
The following local adverse reactions are reported infrequently with topical corticosteroids, but may occur more frequently with the use of occlusive dressings. These reactions are listed in an approximate decreasing order of occurrence:  
Burning  
Itching  
Irritation  
Dryness  
Folliculitis  
Hypertrichosis  
Acneiform eruptions  
Hypopigmentation  
Perioral dermatitis  
Allergic contact dermatitis  
Maceration of the skin  
Secondary infection  
Skin atrophy  
Striae  
Milium

**OVERDOSAGE:**  
Typically applied corticosteroids can be absorbed in sufficient amounts to produce systemic effects (see **PRECAUTIONS**).  
**DOSAGE AND ADMINISTRATION:**  
Apply Cloderm (clocortolone pivalate) Cream 0.1% sparingly to the affected areas three times a day and rub in gently.  
Occlusive dressings may be used for the management of psoriasis or recalcitrant conditions.  
If an infection develops, the use of occlusive dressings should be discontinued and appropriate antimicrobial therapy instituted.  
**HOW SUPPLIED:**  
Cloderm (clocortolone pivalate) Cream 0.1% is supplied in 15 gram, 45 gram and 90 gram tubes.  
Store Cloderm Cream between 15° and 30° C (59° and 86° F). Avoid freezing.  
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