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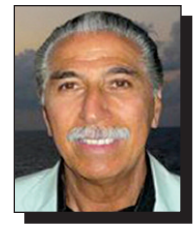
Jack Morgan, DPM


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The Art and Science of Dealing with Patients

Never underestimate the importance of doctor/patient interaction.

BY MARC HASPEL, DPM

It is the fundamental essence of the practice of podiatric medicine and surgery. It's something that never should be taken for granted, but often is overshadowed in the profession's quest to pursue clinical advancements. It encompasses a variety of experiences that are shared by nearly all podiatric physicians. It is, quite simply, the art and science of dealing with patients.

For the most part, of course, it is rewarding to be able to heal and improve the conditions presented by patients. There are times, however, when doctor/patient interaction can be difficult and frustrating—from handling anxious patients to discussin g dubious medical outcomes, from dealing with sometimes unpleasant billing issues to dealing with patients using cell phones in your office. The list of well-known "patient problems" is exhaustive, but we felt it would be beneficial to gather a panel of practice management experts to offer insight on a half-dozen of the most challenging issues.

Joining this month's round table panel:

Lynn Homisak is President of SOS Healthcare Management Solutions. She is an inductee in the *PM* Podiatry Hall of Fame. She is also an Editorial Advisor for *Podiatry Management Magazine* and is recognized nationwide as a speaker, writer, and expert in staff and human resource management.

Hal Ornstein, DPM is Chairman of the American Academy of Podiatric Practice Management and an inductee in the *PM* Podiatry Hall of Fame. He is a nationally known author and speaker and is in private practice in Howell, NJ.

Jack Morgan, DPM is vice president of the Los Angeles County Podiatric Medical Society, past president of ABPOPPM, a residency director for more than thirty years, and clinical professor at Western University, and has been in private practice for more than thirty-five years. He is a nationally known speaker.

Jon Purdy, DPM is in private practice in New Iberia, Louisiana. He is a trustee and fellow of the American Academy of Podiatric Practice Management.

Michael Robinson, DPM, JD is a graduate of Columbia University in NYC and of NYCPM. He is board certified by ABPS, ABPM, and ABQAURP; is past president of ABPM; founder of Sports Podiatry Resource in Brookline, MA; and an attorney licensed in Massachusetts.

Q ***PM:*** *What recommendations do you have for putting anxious patients at ease?*

Ornstein: Most patients who are anxious are afraid of the unknown and have probably been influenced by negative stories others have told them. The key is to clearly articulate that they seem anxious and to tell

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them you want to hear how they feel. By demonstrating that you are empathetic and delivering this with sincerity, you now have the trust of these patients. With this foundation of trust, you can let them know that their anxiety is normal and seen in most other patients on a regular basis. Be clear that what they are feeling is totally normal and let them know that when you are on the other side as a patient, you have felt similar anxiety in the past. Then ask, "What can my team, or I, do to make you feel better?"

In many situations it is effective to ask them if they want a team member to hold their hand during an injection or short procedure. Several studies have proven that touch establishes a better bond with the patient. While you're speaking with patients, in fact, keep your hands on their feet. Of course, when you leave the treatment room, some patients will ask your team member something like "it's really bad?" or "the doctor is just trying to make me feel better; the shot really hurts, doesn't it?" Therefore, it is important to spend time role-playing at office meetings so everyone knows what the best responses are to help put patients at ease.

Purdy: Any compassionate doctor is going to help ease patients' fears. It's always best to have patients as relaxed as possible prior to being placed in a treatment room. Doctors should pay attention to the surroundings in which they have placed their patients. For example, the reception area should feel comfortable and relaxing, and the staff should be welcoming and pleasant.

With all patients, a smile and eye contact goes a long way. I make sure to sit at eye-level when talking with patients. I first engage them to find out what they are anxious about. I inquire about previously painful experiences in other physicians' offices, frightening previous surgery recommendations they received, fear of needles, etc. I let patients know that my job as a physician is to diagnose and suggest treatment options, which gives the patients a sense of control. After establishing this relationship, persuasive language will help direct their decision-making toward what I feel is the best treatment course.

Several studies have proven that the power of touch establishes a better bond with the patient. —Ornstein

Doctors too often forget that their routine is anything but routine to nervous patients. I feel it is part of our Hippocratic Oath to develop the skills it takes to make our care as comfortable as possible. For instance, the treatment rooms should never contain exposed instruments and medical devices that may upset patients.

Robinson: I also believe that the staff can help anxious patients by having a friendly, smiling presence and a cheerful helping attitude. In the treatment room, the doctor should have good eye contact and non-threatening body language, and should speak clearly, simply, and with a nurturing composure.

Morgan: The staff is very important. Putting anxious patients at ease requires caring staff members who are not rushed. First, patients should be made comfortable in the treatment chairs by having the chairs in the lowest positions. Staff members should engage the patients to verbalize that they are anxious, talk about it, and discuss the reasons for the anxiety. Next, staff members should relay that information to the doctor. Then, the compassionate, calm physician can enter, make visual contact with a gentle handshake, and begin the encounter interview. At that time, it can be appropriate for the doctor to discuss the fears causing the anxiety. This process may better be done sitting, with the patient and doctor each at eye level, although some doctors prefer standing in order to establish power and dominance. Once the anxiety has been identified and addressed, the doctor should try to move carefully and slowly to build confidence without triggering further anxiety.

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PM: *What is your policy towards patients using cell phones in your office during consultations or treatment?*

Morgan: In the reception room, cell phone use is permitted. If another person complains, then the patient is politely asked to complete the call in the hallway. I allow cell phones in the treatment room. If I enter a room to begin treatment and the patient is using the cell phone, I allow some time to complete the call. If they continue on the phone, I tell them I will return afterwards.

Homisak: I have a different angle on this. I recommend placing a sign in the reception area requesting that patients and visitors respect office policy by turning off all cell phones upon entering or stepping outside to make/take necessary calls, understanding that if they are not available when called to see the doctor, they may have to be rescheduled.

Purdy: We have a sign that says cell phones are to be turned off in the treatment area. If I walk into a treatment room and a patient is on the phone, I simply pause for a couple of seconds and give them a chance to hang up immediately. If they do not, I close the door and see another patient. The patient usually gets the point after that. For the patient who answers the phone during treatment, I stand up immediately and say, "I'll be back." I will see one or two patients, and then return. This extended period of time away usually conveys my feelings about patient's the rudeness and the disruption that s/he has caused.

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Ornstein: There seems to be so much discussion among physicians and team members on this issue, and it seems like such an easy issue to deal with. Many of our patients are parents, and receiving a call from their children is important. If their phone rings, I recommend giving them an opportunity to answer, letting them know that if it will take some time I will see the next patient and come back to them. If I walk into the treatment room and the patient is on the phone, I give them fifteen seconds to hang up, and if they do not, I let them know I will see the next patient and come back to them afterwards.

PM: *How do you approach patients who complain about the amount of your bill and who may refuse to pay?*

Robinson: My billing staff will explain our charges to patients. They will explain the differences between the amounts billed and the contractual obligations between our office and their insurance companies. Also, the staff will explain the patients' contractual obligations such as deductibles. Most patients will complain only because they have a high deductible, which they don't want to acknowledge.

Fortunately, our office has a very low percentage of those patients who don't meet their financial responsibilities. We send warning letters, make direct phone calls, create installment paying plans. I find that to be sufficient in the vast majority of the cases. The balances of those remaining cases are usually small amounts, which don't merit additional work or additional expenditures; however, those patients can't be seen again without first paying any balances due.

I believe that the tone which is set immediately upon entering the office, the quality of the paperwork which is given to patients to complete, such as information about our billing policies, requiring signatures, and initials on key areas, conveys a strong message. Put simply, I expect to be paid for my work, just like the lawyer, grocer, the electric, gas and every other service provider expects to be paid.

I take my work seriously, and I do my job conscientiously. I am helping them with their problems and I will

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be paid for my service. I don't let people play games in order to avoid their financial responsibilities.

Purdy: I try never to get involved with financial matters in the care of my patients. For patients with insurances that have high deductibles or co-insurances, my staff informs them of the specifics of their insurance policy. They then use exact wording to help them understand that their insurance plans require that we collect the unpaid portion of the charges that they have agreed to cover when they signed on to those particular plans.

For patients who are not happy about the amount of money they have to spend for any non-covered services, my staff will inform them that their particular insurance plan does not provide them with coverage for that particular item.

In any case, when patients are not happy and wish to address medical costs with me, I let them know that I am never willing to exclude an essential treatment which would compromise their care. When patients are serviced by my excellent staff, we have given them the best care we can provide. If they are still unhappy, there is not much more we can do for them.

I think that it's always helpful to convey empathy over the costs of medical care, and that they may not like the plan they have chosen. I let them know my office is always willing to help explain the intricacies of the insurance world, and that there may be much better insurance plans out there for them.

Ornstein: In the ideal situation, the doctor should not be discussing financial matters with patients. This should be handled by a well versed staff member who can explain the details of patients' balances or the terms of their policies in a way that is empathetic, but allows them to understand that the contracts with insurance carriers dictate not only the allowed amounts for each covered service, but also the percentage or dollar amount that they are responsible to pay. Unfortunately, blame is often placed on the doctor for any "patient responsibility" due to lack of education on the part of the patients. This is why it is so important to have staff explain the amount owed in a matter-of-fact way, while also conveying to them the need to understand the terms of their policies. A doctor's patients should know that the doctor is on their side even though the balance owed is payable to the practice.

Homisak: I recommend taking a more proactive approach and addressing the issue of billing at the onset of the patients' visit. After they read, sign, and return the financial policy given to them, it is then handed back to them with the question, "Did you understand everything noted on our policy? Do you have any questions I can answer for you now?" This instantly attaches value to the policy and reinforces their financial responsibilities as opposed to it being just another piece of paper for them to sign. No one likes to get surprise bills, and most times, receiving them without knowing why is the very thing that precipitates their anger and displeasure.

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For those few patients who do still complain, it's usually not personal, but again due to a lack of understanding. They merely want an explanation. Rather than getting defensive, I recommend trying to work with them. Offering to find answers will help to put things in perspective. In instances where gathering facts will help to support why they were sent a statement, it's wise to offer to call the patients back. I recommend allowing the staff time to research the necessary details, while the patients have a chance to calm down. Remember, it is critical for staff to follow through or they will jeopardize not only their credibility, but also that of the practice. Finally, if one staff person is unable to help them, they should seek out someone else in the practice who is able to do so.

PM: *How do you approach patients who are disappointed because of poor surgical outcomes?*

Morgan: I believe that patients should be made aware before surgery that surgical correction never makes them normal. The doctor should make sure that the patients' levels of expectation are realistic for the procedures, outcomes, and their capabilities. Should any patient have a result that is less than optimal, it is advisable for the treating doctor to promptly make arrangements for second opinion consultations and continue to provide the best quality care.

Purdy: Unfortunately, I have had patients who have been disappointed because of poor outcomes. I feel I have averted further anger because I always talk about surgery as a last resort and tell them beforehand that they have to know what they're getting themselves into. With even the most simplistic surgery, such as a hammertoe procedure, I tell my patients about the potential complications and the ugly side of life in the recovery period.

The first thing I do when I have outcomes that are less than optimal is to let the patients identify them first. Oftentimes, we are more critical of our work than the patients are. When patients identify true post-operative problems, I validate their perceptions. I make sure they understand that I too am disappointed with any complications or shortfalls. I reassure them that I will do whatever possible to remedy the situation and convey my loyalty to their resolutions.

With any complication, it is es-

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sential to convey confidence and understanding of their worries. It is also a time to be concise in the direction of care and future considerations.

Robinson: I believe that the doctor should be able to identify potential patients who may easily become disappointed before commencing surgical treatments. Patients generally are not very disappointed with poor surgical outcomes if the doctors have properly given an informed consent. This includes the possibility of a poor outcome; stated in specific terms, poor outcome because of possibility of infection, poor skin or bone healing, lack of adherence to post-operative instructions, etc. If this is a common issue, however, those physicians should examine the circumstances, perhaps questioning the performance of the surgeries and management of post-operative periods while taking appropriate measures to correct the issues.

Homisak: I would also add that if staff members are approached by disgruntled patients, they should not take it upon themselves to try to respond directly to clinical outcomes; rather, politely inform those patients that the doctor will be in to answer their questions and warn the doctor before entering the treatment room.

PM: *What is your policy toward late and no-show patients?*

Homisak: It's not unrealistic to expect that there will be times when patients legitimately arrive late for appointments for myriad reasons. It's important, however, that staff does not give up the control of these types of situations to the patients, whereby they can take advantage. Whenever possible, first-time offenders should usually be worked into the schedule, but not without also being educated that in the future, without a pre-emptive call, they should expect to be rescheduled. Those patients who make a habit of arriving late for every appointment are automatically rescheduled, unless, of course, their condition requires immediate attention. Doctors should bear in mind that if they know their office always runs late, the patients will follow suit.

No-show patients should always be called when they fail to keep their appointments, and their reasons should be documented in their chart notes. I've been in many practices that charge a fee for no-shows. The purpose of this policy is not to get more money out of the patients; rather, its purpose is to help them understand that the time set aside for them should be respected. If done properly, this policy is extremely effective, but can falter when the patients are kept waiting once they arrive.

If new patients fail to present for three consecutive appointments, these patients should not be allowed to schedule future appointments.—Ornstein

Ornstein: These kinds of policies should be made very clear in writing at the initial visit (included in the intake documentation as part of the practice's financial policy and signed as understood by the patients). Such policies should include verbiage such as "patients who present more than fifteen minutes beyond their set appointment time shall be subject to rescheduling" and "twenty-four hour cancellation is required, with few exceptions, in order to avoid a 'no show fee' of $50." Some practices even post these policies in their reception areas, while others tend to avoid these types of pejorative signage. Obviously, patients who actually present to the office and sign their intake forms and financial policy forms should have no problem with these policies. It is advisable to have staff relay to new no-show patients who call to reschedule that such policies exist. If new patients fail to present for three consecutive appointments, these patients should not be allowed to schedule future appointments. In the case of patients with diabetes or patients referred by primary care physicians, the referring physicians should be made aware of the no-show situations.

Purdy: The caveat here is that all situations are different. As physicians, we need to follow the advice of our malpractice carriers and our healthcare attorneys on the proper procedures for any patient dismissal in which we engage.

We are all human beings and we forget, or have circumstances that cause us to be late. Our patients, however, know we have a policy concerning chronic forgetfulness. When patients are late, we sympathize and let them know we will work them into the schedule. They are informed whether or not the wait will be extended. This gives them the option of waiting or reappointing.

We do not have a no-show charge, but rather, we institute a "three strikes" policy with no-show patients. After a third no-show, they will no longer be able to schedule an appointment. These patients will have to come to the office and wait to be worked into the schedule, which may have them waiting an extended period of time. We leave it as our option to reinstate future appointments for continued compliant behavior.

Of course, if we are in the mid-treatment phase of any significant medical condition, we are obligated to follow through with treatment regardless of the no-show history, or go through the proper patient dismissal procedures if needed.

Morgan: Habitual no-show patients or those who are habitually late must be addressed because their behavior affects other scheduled patients. We tell those patients to call the day they wish to be seen and have transportation. They are told that hopefully the doctor can see them sometime on that day.

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PM: *How do you deal with disruptive children in your practice?*

Robinson: That doesn't happen frequently, but I will have my staff tell parents to stop whatever disruptive action is happening in the reception area. What is bothersome is when parents bring children into the treatment room who are preventing the patient from being attentive to the treatment and findings—obviously this is counter-productive to the patient's own interests. Rarely, if parents are not controlling their children, I will intervene by telling them to sit while I talk to the parents.

Ornstein: I recommend being honest with those patients and make it all about the other patients in your office. I try to explain that many patients are already very anxious about being at a doctor's office, and that their own children's behavior can add fuel to this anxiety. I let patients know that their children can easily get hurt with the instruments in the office as well as other items in the treatment room. Also, I reinforce that their own care is very important and there is a lot of important information to give them, so they need to concentrate on listening to all that is said. If the situation worsens, I let those patients know that other patients are complaining, and that everyone being treated in the office deserves respect.

Purdy: Disruptive children will always be a part of practice. As long as these children are not disrupting an exam and/or are not a safety risk, it's all a matter of having patience and tolerance. If, however, the children are causing a safety concern, then that's different. I leave the room and see other patients so that the parents can talk with the disruptive children. If that behavior continues to be disruptive, I pleasantly inform the parents that rescheduling is in order when there is a better time to come with another adult, or alone.

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Homisak: Many offices can curtail children's interruptions by creating a small "children's corner" or providing children's items such as books, toys, and puzzles to keep them occupied. We used to give them crayons and coloring books, until some of them decided to draw on our walls. Yet, if they promise to be good, we always rewarded them with stickers or picking a toy from the toy chest. Most children are very entertained by simple things, like blowing up a non-latex surgical glove, drawing a face on it, and letting them take it home.

The bigger issue is letting patients know that staff are not babysitters, so while they may tend to those new patients who come in for the first time with their misbehaved or disruptive children, it needs to be explained to them that while staff would love to spend time with their children, there have certain tasks that need their attention. It should be then that they are informed that, for future appointments, they need to please either bring someone with them to keep an eye on their children while they are receiving treatment or make other arrangements for their children during their appointment time. I recall having misbehaved children climb on furniture and cause all kinds of chaos. Parents need to be told that those actions are totally unacceptable. Aside from it being dangerous for the children, it poses a serious risk-management concern for the practice.

Habitual no-show patients or those who are habitually late must be addressed because their behavior affects other scheduled patients.—Morgan

PM: *How do you handle non-compliant patients?*

Robinson: First, I carefully elicit the complete nature of the non-compliance and document it. Then, I review those patients' conditions, the findings, and the treatments that were advised and their current conditions based on the treatments done or not done. This process is just stating the facts first so that we are all in agreement and then using whatever seems to be the approach that they need to be encouraged to help themselves get better.

Purdy: Sometimes, the most important thing we can do as doctors is to take off the gloves and put the charts down. Step one in this situation is to find out why those patients are non-compliant. The answers can range from "I'm too busy," to "I didn't think it would work." Those responses give me a starting place to help realign these patients with their problems, and solve them. If these patients are unsure about their treatment courses, I am never too egotistical to suggest they consider second opinions. I tell them that they should remain with whoever they are most comfortable.

Of course, this is much different from patients with significant mental or other types of issues who either have no understanding of their actions or do not care enough to ensure successful treatments. When dealing with these types of patients, I engage them in a very serious and straight-

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forward dialogue that is well-documented. I initiate against-medical-advice forms for them to sign, which shows an acknowledgment of their unwillingness to comply with my care. I may ask them to consider treatment elsewhere if they cannot comply with my requests. Sometimes, after having this talk, they choose not to return. We make multiple attempts to contact them by phone and mail for continued care, and we document all of our actions. For those who continue to show unwillingness to comply, I start the process of termination while carrying out continued availability and treatment though the separations process.

Ornstein: Non-compliant patients are not the type of patients doctors want filling their schedules. In these situations, it is of the utmost importance that doctors have well-established protocols in place and make it very clear to those patients that their following the prescribed treatment plan is essential to the improvement of their conditions. This can be demonstrated by verbal and written instructions for condition-specific treatments as well as the ability of the podiatric physicians to be confident in their approach to instruct. If, upon follow-up visits, the staff evaluates the patients to find that the conditions are not improving or are worsening, specific questions should be asked regarding the following of instructions about such things as icing or stretching, for example. The answers to these questions will quickly identify non-compliance and should be documented as much as possible in the electronic health record. No practitioner enjoys dealing with this type of patient, but fortunately, if the doctors and staff are equipped with the right tools, these situations should be rare in practice.

Morgan: I find that this most commonly occurs in patients with diabetes. If a doctor's instructions are beyond patients' capabilities to perform or follow, then re-assessment is necessary to determine how the treatments should be provided. When I have patients with diabetes ulceration who cannot stay off their feet, I will place them into rehabilitation or special facilities, where I am more comfortable that instructions will be followed. Of course, I recommend strong documentation and notification to other family members of non-compliance and the risks.

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PM: *Can you provide an instance where you succeeded in "turning around" a difficult patient situation?*

Homisak: I recall a patient being very angry at having to wait a long time to be seen. She waited in the reception room for thirty minutes and was brought back to the treatment room where she waited another forty-five minutes. Evidently feeling neglected, she put her shoes back on and headed towards the door. I knew that, in addition to her leaving, she would eventually tell others about her experience, so I took it upon myself to accept the blame by saying I had misdirected the doctor and persuaded her to give us another chance. I escorted her back to the room, made sure the doctor came right in, and twenty minutes later her visit was complete. On her way out, I apologized again, handed her a ten-dollar Starbucks gift card for her inconvenience, and told her to have a cup of coffee on us. That simple and inexpensive gesture made her smile. She even scheduled her next appointment before leaving. In addition, for her next visit, we made sure to reserve the first appointment in the afternoon to avoid a potential recurrence of the problem. As she left, she turned and thanked me for all I did. The trust was restored, and it was the most satisfying patient "thank you" I think I ever received.

We used to give children crayons and coloring books, until some of them decided to draw on our walls. —Homisak

Morgan: I frequently see patients who have been treated in other places before coming to see me. One example I can remember was an injured worker who explained to me that he had presented himself at an industrial clinic with a foot trauma that required initial immobilization, but instead was provided with four weeks of physical therapy. I believe that the real goal at these clinics is to yield maximal financial return, then eventually send the patient out to a specialist for further treatment. Once I had the opportunity to spend extensive time with this patient, I was able to explain to him the nature of his injury and what was necessary to improve his condition. I was able to provide definitive treatment that immediately provided relief. In this case, I used immobilization. He was in awe that something positive had occurred and was dismayed about how long it took to get into my office.

Ornstein: Upon checking in, a new patient was handed his intake paperwork and was asked for his picture identification and insurance card. He complained about presenting his picture identification. The

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front desk assistant assured the patient that this was a policy of the practice adopted to protect the identity of patients. He mumbled under his breath, sat down, and proceeded to fill out his paperwork. Upon approaching the desk again, and handing over his identification, the assistant thanked him, and then asked for his $20 co-payment. Once again, he did not comply and stated, "I'm good for it, bill me." The assistant did not know what to do and passed the situation along to the back office assistant who would be evaluating the patient next.

Once the patient was taken back and positioned in the chair, the back office assistant politely introduced herself, and began to ask a few questions about the present condition as well as medical and medication histories, during which time the patient seemed to become increasingly annoyed. What the patient didn't know was that the assistant evaluating him was also the office manager, and she was determined to make a point to the patient about following policies as well as respecting the other members of her staff.

In the occupation section of the intake form, the patient had entered "salesperson." This was acknowledged to the patient, and the following conversation ensued.

Assistant: "I see here that you are in sales. That's interesting, how long have you worked in the field?"

Patient: "Over twenty years, I suppose; time flies."

Assistant: "So, can I ask a question, then?"

Patient: "I guess," responding somewhat still annoyed.

Assistant: "When you have a client who wants to buy something from you, do you expect to be paid then or simply take their word that they are "good for it"?

Suddenly the patient's demeanor changed, and the office manager knew that she had struck a nerve. She then went on to explain that the staff is trained to collect co-payments, as per the policy put in place by insurance carriers, at the time of the visit, in order to avoid chasing after monies owed. The patient not only apologized to that office manager, but also to the front desk assistant. Upon checking out, he willingly paid his co-payment.

We do not have a no-show charge, but rather, we institute a "three strikes" policy with no-show patients.
—Purdy

Purdy: I remember one patient who came to see me, and throughout his entire visit, continually interjected about his concern with medical costs. In his particular case, I was unsure as to the success he would achieve from prefabricated orthotic devices that would be an out-of-pocket cost to him. Because of my uncertainty, I offered him a trial period. If he found it worked well, we decided that he would pay for the inserts on his next visit. The next visit he told me that the inserts worked great. At the front desk, he was informed of the cost of the orthotics, after the successful trial period. He became very angry and insisted that I had given him those devices.

I had the staff place him back in the room. I was certain that our previous communications had been crystal clear, and that he had left with an understanding of the deal we had made. My initial thought was that I wasn't going to give in after I had made an exception for him in the first place and provided a successful treatment. However, I remained calm. The only thing that would come out of my giving this patient a piece of my mind would be an afternoon of agitation and an even more incensed patient. What I decided to do was blame myself for not adhering to my protocols. I entered the room and told the patient I misspoke, and because of that, there would be no charge for the orthotics.

Difficult patients are only as difficult as physicians and staff permit them to be.
—Ornstein

Yet, this man had no intention of being diplomatic. He continued to carry on and demonstrated an unwillingness to even let me speak. I just sat for one minute and listened to him rant. Once he knew he had put across his message, I followed with a moderate, non-confrontational tone of apology and expressed my willingness to give him what he wanted. Obviously expecting an argument, he was completely disarmed with nothing else to say. He ended up telling me he was sorry and would pay for the devices as originally intended. Naturally, I still declined his offer.

That was about four years ago, about forty subsequent treatments ago, and he has been the most appreciative patient ever since.

Ornstein: Here's a final word of advice. Difficult patients are only as difficult as physicians and staff permit them to be. I recommend getting creative when dealing with these situations, training the staff to do the same, and not letting one bad seed ruin an entire day. **PM**

Dr. Haspel is senior editor of this magazine and past-president of the New Jersey Podiatric Medical Society. He is a member of the American Academy of Podiatric Practice Management.