A Shopping Bag Full of Orthotics

In this type of scenario, you must be both careful and creative.

BY PAUL KESSELMAN, DPM

A disgruntled patient (new or established) presents to your office with a shopping bag full of foot orthotics. These patients are frustrated, often distrustful and may present with complicated issues. This common scenario can be a frequent occurrence in many podiatry offices. How you deal with these patients is the focus of this month's column.

Patients may migrate to you from other practices upon referral from another doctor or from one of your patients. Worse, this could be an established patient in your practice. Patients presenting with these issues often have multiple or complex pathologies, which may have not been properly addressed. Some simple examples that result in foot orthotic failures (and there are many) are lack of properly addressing a more proximal pathology, not identifying the primary biomechanical issue, improper shell durometer or posting for patient's age or activities, failure to add proper modifications, poor casting or patient positioning, etc. Other possibilities: the patient may have rejected the idea of an AFO, or the patient has had a failed surgery, or s/he has had a successful recent surgery requiring new orthotics.

There is, in fact, an endless list of reasons for foot orthotic failure. This column does not have the bandwidth to properly address all the possible modifications and simple repairs that could adequately address the patients' needs. Suffice to say, a thorough history; appropriate physical and thorough biomechanical examination must be performed prior to offering the patient any further remedies or treatments. It may be necessary to consult with another specialist (for example, a neurologist) or to order advanced imaging, if not already done, prior to determining the next steps.

Careful and Creative

Only after all the examinations and consultations are both properly performed and interpreted can one determine if some simple modifications to the existing foot orthotics may be sufficient. There is another C&C in podiatry which applies here. Be both "Careful and Creative" in making these initial corrections/modifications. These fixes may either be temporary—in which case they can be fashioned in your office using simple materials such as cork, felt, etc.—or they may require returning the device back to the laboratory. Don't bite off more than you can chew. Making modifications and corrections to only one pair of orthotics and making one modification at a time may be the prudent course to follow.

What you may charge for these services should be based on time and materials.

There is also the possibility that a new foot orthotic is needed. When this is the case, it's once again necessary to be careful and creative with the prescription and also empathetic with the patient. Limiting any guarantee that your plan will succeed is of paramount importance. Remember, these patients will likely be paying out of their own pocket for these services.

The next challenge may be that the patient requires an AFO if you have determined that foot orthotics are not the solution. How does one get the patient to commit to a lifestyle- changing AFO—one which may require a change in footwear, activity level, weight loss, physical activity modification and physical therapy etc.? These are not reimbursement questions, but nevertheless, challenges that every orthotic practitioner will need to address.

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These issues require practitioners to be empathetic and truthful with your patient. Show them models or videos of other patients or anatomical presentations so that they can better understand the challenges they face. Many patients may only need the AFO for a few months along with physical therapy and then gradually be successfully transitioned back to a custom fabricated foot orthotic. Others, such as patients with neurological issues or those with traumatic injuries, will no doubt require a perma-

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nent AFO. Be cautious about promises of restoration of their ability to either partially or fully resume their activities of daily living. Be careful about over-promising patients pre-injury or pre-pathology restoration. Being creative with the AFO design to adequately address both their physical and psychosocial needs are equally important.

Certainly, as part of the AFO selection process, patients need to be educated on what components are needed and why. This explanation must be geared to their level of understanding. Furthermore, showing examples of the device(s) intended for them is always a great way to "show and tell."

If the problem is unilateral, the other limb must be leveled off to avoid iatrogenic limb length discrepancy. This can be done by adding a lift (heel or full length) to the contralateral limb's foot orthotic.

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Surgical options often exist for many of those patients who fail custom foot orthotic therapy. Surgical alternatives have their own potential for success, complications or failure. Patients deserve to hear all alternative treatment options.

These cases can be extremely frustrating. Most national laboratories have a clinical consultant who will be happy to assist you with these challenging scenarios.

Calm communication in these cases is the key. Patients will feed off your enthusiasm or frustration. If you are frustrated, so will be your patient. If you are thoughtful, patient and creative, patients will often calm down and be less frustrated and more compliant. **PM**

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