Editor’s Note: Encounters with “difficult” patients can be challenging and stressful to learners and even clinical teachers. In this month’s column, Heidi Pomm, PhD, and colleagues discuss a practical approach that teachers and learners can use to alleviate the stress in difficult patient encounters and better handle the patient’s needs.

I welcome your comments about this feature, which is also published on the STFM Web site at www.stfm.org. I also encourage all predoctoral directors to make copies of this feature and distribute it to their preceptors (with the appropriate Family Medicine citation). Send your submissions to williamh@bcm.tmc.edu. William Huang, MD, Baylor College of Medicine, Department of Family and Community Medicine, 3701 Kirby, Suite 600, Houston, TX 77098-3915. 713-798-6271. Fax: 713-798-7789. Submissions should be no longer than 3–4 double-spaced pages. References can be used but are not required. Count each table or figure as one page of text.

The CALMER Approach: Teaching Learners Six Steps to Serenity When Dealing With Difficult Patients

Heidi A. Pomm, PhD; Edward Shahady, MD; Raymond M. Pomm, MD

Teaching learners to handle encounters with “difficult” patients is not easy since these encounters may tax the coping resources of even the most skilled or experienced physician. Difficult patients include those who are “medically challenging, interpersonally difficult, psychiatrically ill, chronically medically ill, or lacking in social support.” Studies have found that they are older; have more acute, chronic, and psychosocial problems; take more medications; and more frequently are divorced or widowed and from a lower social class. Specific behaviors of patients that make the encounter difficult include their being overly dependent, demanding, manipulative, or noncompliant. One study found that family physicians rated approximately 30% of their 722 patient encounters as troubling.

However, the problems surrounding these encounters are often not solely due to the patient. Physicians must understand how their own attitudes and behavior may contribute. Reactions toward difficult patients can range from acquiescence and inward anger to more active scorn and disrespect. These negative reactions may result from these patients being “an uncomfortable reminder of the doctor’s inadequacy and impotence.” In addition, a physician’s failure to carefully listen, show empathy, or establish trust may result in an inadequate understanding of the patient’s history and issues.

The CALMER approach assists physicians in reducing the affective distress associated with interactions with problem patients. This approach combines elements from Prochaska and DiClemente’s “Stages of Change” model, Shahady’s “Rule of Five,” and Gillette’s “Practical Approach for Managing Problem Patients.” In addition, the CALMER model also incorporates strategies derived from cognitive-behavioral therapy.

Office-based teachers may find the CALMER approach to be a structured, easy-to-remember model that is especially helpful during encounters where the learner has difficulty dealing with a patient’s demands, feels frustrated with a particular patient, makes derogatory remarks about a patient, wants to transfer care of a patient to someone else, and is not interested in helping an individual patient and/or even the teacher has difficulty dealing with a patient.

The CALMER approach consists of six steps, several of which only take moments to complete: (1)
Catalyst for change, (2) Alter thoughts to change feelings, (3) Listen and then make a diagnosis, (4) Make an agreement, (5) Education and follow-up, and (6) Reach out and discuss feelings.

(1) Catalyst for Change

In this step (either before, during, or after an interaction with a difficult patient), physicians should remind themselves of what they can and cannot control about the situation. In most cases, the responsibility to change behavior lies with the patient. Physicians cannot control the patient’s behavior, but they can control their own reaction and try to be helpful by offering practical advice. After identifying the patient’s current stage in the “Stages of Change” model, the physician can serve as a catalyst for change by giving recommendations on how the patient can advance to the next stage of change and eventually overcome the problem.

(2) Alter Thoughts to Change Feelings

Cognitive-behavioral therapy posits that the only way individuals can control their reactions (feelings) is to alter their thoughts about the situation. Either before, during, or after the doctor-patient interaction, physicians should identify which feelings they are experiencing in response to the patient and then ask how these feelings might be affecting the physician-patient relationship and the management plan. Physicians should remind themselves not to take the patient’s behavior personally, since this is likely the patient’s way of responding and behaving in many areas of his/her life (not just in interactions with the physician). It is also suggested that the physician explore and understand possible underlying reasons or answers for the patient’s behavior (past abuse, poor finances, loneliness, etc.). Lastly, physicians should ask themselves, “What can I tell myself about this situation that will make me feel less (angry, distressed, etc.)?” In doing so, they are then able to alter or change their thoughts and therefore feel less distressed.

(3) Listen and Then Make a Diagnosis

As a result of a physician’s negative response to a difficult patient encounter, he/she may not accurately hear what the patient is trying to verbally or nonverbally communicate. This can lead to severe errors in diagnosis. By engaging in the first two steps described above, the physician will be better equipped to truly hear what patients are trying to communicate. This will improve the likelihood of making more-accurate diagnoses and will lead to better working relationships with patients.

(4) Make an Agreement

This step is focused solely on making an agreement with the patient to continue the doctor-patient relationship. The physician might say to the patient, “So, after all we have discussed, it is my understanding that you would like to continue to see me, and we have agreed that we will work together to keep you as healthy as possible. Is that your understanding too?” It is important to confirm that the patient understands and agrees with the proposal.

In addition, if the patient has insight into the problem behavior, the physician might say, “We have agreed to work on this problem (specify exactly what the problem is) together. Is that your understanding as well?” This step helps both the physician and the patient increase their awareness that they are making a conscious choice to continue their relationship and work on the patient’s concerns, which in turn increases perceived control for both parties.

(5) Education and Follow-up

After the doctor and the patient agree to continue their relationship and work together, how they will accomplish this needs to be addressed as specifically as possible. Physicians should temporarily let go of their own agenda (even though they feel it is more appropriate) and give a “doable” recommendation tailored to where the patient is in the “Stages of Change” model. For example, for a patient contemplating whether to quit smoking, the physician may prescribe homework such as: “Over the next 2 weeks, I’d like for you to write down your feelings right before you reach for a cigarette. Think about the ‘pros’ and ‘cons’ of picking up that cigarette without judging yourself on the choice you ultimately made.”

### Table 1

<table>
<thead>
<tr>
<th>Stages of Change</th>
<th>Description</th>
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<tbody>
<tr>
<td>Precontemplation</td>
<td>Patient denies or minimizes problem</td>
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<tr>
<td>Contemplation</td>
<td>Patient acknowledges problem but not ready to change</td>
</tr>
<tr>
<td>Preparation/determination</td>
<td>Patient commits to time and plan for resolving the problem</td>
</tr>
<tr>
<td>Action</td>
<td>Patient makes daily efforts to overcome problem</td>
</tr>
<tr>
<td>Maintenance</td>
<td>Patient has overcome problem for at least 6 months but must remain vigilant</td>
</tr>
<tr>
<td>Relapse</td>
<td>Patient has gone back to problem behavior</td>
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mately make. We’ll talk about your experience with this homework assignment when I see you back in 2 weeks. Is that okay?” Similarly, the physician can encourage a patient in the precontemplation stage to begin thinking about the issue at hand. The physician and patient should agree on the “homework assignment” and the time frame in which it is to be completed.

(6) Reach Out and Discuss Your Feelings

It is commonly believed that most doctors are “islands” and are generally reluctant to ask for help. Yet, as stated earlier, even the most skilled and competent of physicians will at times feel great distress following an interaction with a difficult patient. After engaging in the preceding steps, it is suggested that physicians ask themselves, “How do I now feel about this patient and his/her behaviors?” It is also important for physicians to identify how they will care for themselves the next time a patient elicits these types of feelings. Discussing these feelings and the difficulty of the experience with a trusted colleague or friend can be of great assistance since a wealth of research attests to the beneficial effects of social support. When dealing with difficult patients, physicians do not have to feel alone.

Although numerous articles have been published on difficult doctor-patient interactions, only a few models have been proposed to help physicians decrease the distress frequently associated with these interactions. The CALMER approach incorporates six steps that physicians can utilize to feel more in control and less distressed during these types of patient encounters. By taking the time to guide learners through the individual steps of this approach, the office-based teacher may increase learners’ self-efficacy in handling difficult patient encounters since the CALMER approach focuses on what learners can control (their own reactions) and less on what they ultimately cannot control (the patient’s behavior). A CALMER learner results in a more serene learner, who is better able to care for patients in need.

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REFERENCES