UNIT NO. 3

HANDLING DIFFERENT PERSONALITIES IN ACP CONVERSATIONS

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ABSTRACT

Documented advance care planning (ACP) discussions with patients enable doctors to have continuity and collaboration across all settings as patients move from one setting to another. These shared decision-making discussions generally consist of 3 steps: giving information; assisting patients to understand the options in the context of their situations; and helping these patients make informed decisions based on their individual preferences. Primary care physicians should take advantage of their position as healthcare providers to continue the care of the patient and the relationship they have with the patient by initiating ACP discussions. The National Medical Ethics Committee's recommendation in 2010 is that such discussions should be started as part of routine care in primary care and outpatient settings before individuals become acutely unwell. Important barriers that need to be overcome are negative encounters with different personalities who can present themselves as "difficult"— the angry patient, the anxious patient, the patient in collusion, and the patient in denial. In this paper are some guiding principles on how to carry out ACP discussions with such patients. There is also a need for doctors to recognise that as caregivers, they may be exhibiting blocking behaviours to ACP discussions that patients are trying to initiate. These should be avoided.

Keywords: Advance Care Planning; Primary Care Physicians; Tenet of Patient-centred Care; The Angry Patient; The Anxious Patient; The Patient in Collusion; The Patient in Denial; Blocking Behaviours

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INTRODUCTION

1. Advance Care Planning (ACP) as a Component of Care

In today's healthcare, it cannot be denied that the term "discharge" from a particular care setting can be replaced with continuity and collaboration across all settings.This has been made possible with Advance Care Planning establishing itself as an integralcomponent of medical practice.[1]

2. A Tenet of Patient-centred Care

As primary care physicians practice family medicine in a setting where longitudinal care across the life cycle takes place, they are well positioned to provide a tenet of patient–centred care. A tenet of patient-centred care, in this context, refers to the process of shared decision-making that generally consists of 3 steps: giving information to the patients on the options available; assisting the patient to understand the options by describing them in the context of his or her situation; and helping the patient to make informed decisions based on his or her preferences.[2]

3. Initiating ACP as Part of Routine Care

The primary care physician takes advantage of his position as a healthcare provider to continue the care for the patient and the relationship he has with the patient and his or her family to initiate ACP discussions.[3]

The Ministry of Health, Singapore, also sees the potential and the need for primary care physicians in Singapore to initiate ACP discussions in the community, as evidenced by, "Discussions should preferably be carried out in comfortable, unhurried surroundings. Ideally, ACP should be offered in the community, e.g. as part of routine healthcare in primary care and outpatient settings, before individuals become acutely unwell…".[4]

4. Barriers to ACP

Literature, in general, highlights the concerns that primary care physicians have in relation to initiating ACP discussions.[5] Some of these concerns are related to carrying out ACP discussions with different personalities.

Literature proposes a number of models that primary care physicians can use in their ACP discussions. The Transtheoretical Model (TTM) is a useful framework to help understand the process of ACP as a process of behaviour change.[6]

The TALK model is another framework that helps to facilitate best practices in ACP discussions.[7]

However, this segment of the article will highlight different personalities the primary care physician might encounter and share some tips on how to manage these personalities in order to build the ACP discussion. These tips are to complement the ACP framework that has been introduced earlier in article one.

PERSONALITIES DOCTORS MAY ENCOUNTER IN ACP CONVERSATIONS

1. The Angry Patient

A patient may be angry for various reasons. It could be guilt because he blames himself for not having taken better care of his health. The patient may be angry with the healthcare system for not treating him well. It could be self-directed anger for not having managed his life, career and personal relationships well. What is more prevalent is partially suppressed anger which is manifested through irritation, grumbling, brooding, bitterness,

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coldness, and so on. The patient may even feel angry with God for having "let" him or her down. The primary care physician will need to be aware of patients with an inability to contain anger due to psychological illnesses such as psychoses, alcoholism, and bipolar disorders. These patients may need treatment and ACP discussions should be carried out in consultation with their mental healthcare providers.[8]

The following guiding principles can be used to carry out ACP discussions with "angry patients":

- Listen with an open mind without interrupting. More often than not, patients have not had their grievances taken seriously. The very act of paying attention to them may itself help them to express their feelings freely and to contain their anger.[9]

- Find appropriate moments to empathise with them. While you may not agree with them, you could still say, "I can see how affected you are by this" or "I'm sorry that you had to deal with such a difficult time".[10]

- Look out for what's happening beneath that anger; is it unsuccessful treatment or a lack of treatment options that is causing the patient to be frightened of suffering and maybe even dying.[8]

- Allowing the patient to carry on with his catharsis means the conversation can drift away from ACP but it does help to moderate anger. Once the anger has been moderated, you can gently bring the patient back to the original topic of ACP.[8]

- Your body language and the way you speak must not appear confrontational (avoid staring and speak quietly). Don't take sides if the patient is unhappy with the medical team or with a family member because you have heard only one side. Neither should you support the other party even if you feel that what the patient says is not justifiable. This will only escalate the tension in the physician-patient relationship and the patient will lose trust in you.[10]

2. The Anxious Patient

The anxious patient is upset, nervous, distracted, uncomfortable, and will be in an emergency mode. To an anxious patient, the implications of his or her illness, the uncertainty of the future and thoughts of suffering and death become even more frightening. The anxious patient will benefit from a more realistic medical reassurance about what can be expected about his or her condition. The physician-patient relationship needs to be safe enough to address their fears and yet it needs to be set in a context where they do not feel out of control. As anxiety can be distressing it can also impair thinking. Thus, a more reflective approach towards ACP is recommended for patients with the use of relaxation and visualisation exercises.[8]

The following guiding principles can be used to carry out ACP discussions with "anxious patients":

- The manner you conduct the ACP discussion should give the patient a message that you are unfazed by his anxiety. You are helping to provide the patient with safe containment by maintaining stillness, unhurriedness, alert listening, and empathic interventions throughout the ACP discussion.[11]

- Patients with anxiety tend to see the world and likewise their health condition through disaster-tinted glasses. They will feel that symptoms cannot be managed; treatments will not work and that they will suffer before dying. Hence, during the ACP discussions, it might be helpful if you can assess their catastrophic assumptions and share insights to help them understand that their fears are not valid. Sharing successful stories of pain control and goals of management will be helpful.[11]

- Giving false reassurance will not be helpful even though family members might persuade you to give it. False reassurance will only result in more anxiety. ACP discussions need to incorporate honest feedback and answers.[8]

- Touch-based complementary techniques such as holding their hands at heightened moments of anxiety are recommended as literature suggests that these have a calming effect. However, in an Asian setting, such therapies, which include aromatherapy and a massage at appropriate junctures, might not be widely used.[12]

- ACP discussions may reveal anxiety related to guilt feelings. For example, a patient might say that he is being punished by God for his wrongdoings. Referring the patient to his religious leader will be a good recourse as religious or spiritual rituals and support can help to ease his anxiety.[13]

3. The Patient in Collusion

Collusion is defined as a secret or illegal cooperation or conspiracy in order to deceive others. In the context of ACP discussions, collusion is often related to a request from a significant other, usually a family member to withhold certain information from the patient. The information is usually related to the patient's diagnosis, informing the patient of the prognosis or transition of care from a curative to a palliative phase.[14] Research in Singapore[15] has shown that the act of collusion can be:

a. culturally based, where withholding of information is done in the belief that the well-being of the family comes first, and therefore the family will be the one to make decisions for the patient in the best interests of the patient; and

b. for the protection of the patient. Families prefer to keep the patient in the dark about his illness out of concern for the physical and psychological well-being of the patient.

One may argue on the need for "necessary collusion" during ACP discussions. This perspective does not advocate withholding of information but rather allowing the information to unfold as needed by the patient.[16] Generally,

collusion creates falsely based optimism which can be initially helpful but detrimental once the patient comes to know the truth. It also has the power to destroy trust in the patient-physician relationship.

The following guiding principles[14] can be used to deal with collusion from family members or significant others:

- Focus on the feelings of the family members and empathise with them.
  This must be very difficult for all of you. Can you tell me how you feel right now?

- Clarify the reasons and identify any concerns for requesting to withhold information.
  I understand that you do not want me to talk about the diagnosis (or prognosis) to the patient. What is it that you think will happen if we do have this conversation?

- Do not challenge but support them.
  I can appreciate why this might be a concern for you.

- Educate them on the "costs" of withholding information, such as negative impact on trust in relationships and the hindered preparations for what is inevitable in relation to the patient's health.

- Explore if the patient had asked about his health condition previously and propose that the patient might already have some awareness on his condition.

- Ask for permission to assess the patient's current knowledge and desire for further information. Assure family members any unwanted information will not be given but a date will be set should patient request more information.

- Negotiate a plan.

4. The Patient in Denial

When conducting ACP discussions, it is not uncommon to encounter patients who are in denial with regards to their health condition. While denial often compromises the patient's ability to be fully informed on his situation, research has shown that denial also has helped to reduce psychological morbidity by acting as a coping mechanism. Denial is said to gradually help a person to accept his health condition at his or her own time. Therefore, denial is usually short lived and it is important to explore the extent of the denial to establish if it is indeed going to be an actual barrier before proceeding with the ACP discussion.[14]

The following guiding principles[14] can be used to carry out ACP discussions with patients in denial:

- Assess that the denial is not absolute, which will provide a "window" to discuss the health condition more realistically and to explore the patient's perspective.
  Have you ever considered that things might not happen the way you expect them to? How do you see your illness in the future?

- Challenge any inconsistencies.
  You said your condition is not serious and yet you have been hospitalised several times recently with stays in the ICU too.

- Ask a hypothetical question to explore goals.
  Have you ever thought about what might happen if things do not go as you wish? It would be good to have a plan that prepares you for the worst because that makes it easier to focus on what you hope for most.

- Propose seeking a second opinion if the patient will not accept the futility of a particular treatment.
  Sometimes it would be good to seek a second opinion from another experienced professional when we have challenging issues to consider. Would you like me to arrange for one?

RECOGNISING BLOCKING BEHAVIOURS

The primary care physician is set to meet many different types of patients in the course of conducting ACP discussions. Some patients may be easy to manage while some can be more challenging. The fear of making mistakes and causing distress to the patient and family can burden the primary care physician to get the ACP discussions right. However, in his wish to get it right, the primary care physician may inadvertently block potential open dialogues by his perceived "right" responses. Thus, it is important for the primary care physician to be aware of some of these blocking behaviours in conducting ACP discussions with all types of personalities.[17]
An example of a blocking behaviour:

Patient: *I'm worried about starting dialysis. I have heard that it can be a painful experience with poor outcomes.*
Physician: *Everyone reacts differently to starting dialysis. And the outcomes will not be the same for everyone. However, the pain should be manageable.*

In the above scenario, the patient expresses concerns about starting dialysis. The primary care physician attempts to reassure the patient and probably hopes the patient will feel better. However, the primary care physician's response may serve to act as a block to further exploration and discussion of the patient's specific concerns and feelings. Table 1.0 shows some examples of blocking behaviours that should be recognised and avoided.

CONCLUSIONS

As Joanne Lynn, MD, says, "Advance care planning is about planning for the 'what ifs' that may occur across the entire lifespan".[8] Given their longstanding and trusted relationships with their patients, primary care physicians are probably best placed to conduct timely ACP discussions. There is a need for primary care physicians to understand the barriers to doing ACP discussions and there is sufficient evidence to show that

Table 1: Blocking Behaviours

Behaviour	Example
Overt blocking: complete change of topic	Pt: I have been worried about what the future might hold. PCP: I wanted to talk to you today about pain.
Distancing strategies: change of time frame, person, removal of emotion	Pt: I was anxious about being ill. PCP: And how does your wife feel? (change of person) PCP: Are you anxious now? (change of time frame) PCP: How long were you ill for? (removal of emotion)
Premature reassurance	Pt: I'm worried about starting the treatment. PCP: You'll be fine…
Giving advice; attempting to problem solve. While offering some "solutions" to problems raised may be required at some stage during ACP discussion, it is important not to do this before all of the patient's concerns have been elicited and prioritised	Pt: I'm worried about what this pain might mean and feel anxious about the future. PCP: So I will prescribe some pain killers and I will ask the social worker to arrange some financial benefits advice…
Asking closed questions that generally lead to a yes or no type answer means that patients are unable to elaborate	PCP: "Did you sleep well last night?" instead of "How well did you sleep last night?"
Asking leading questions suggesting a desired response within the question	PCP: You don't have any pain, do you?
While discussion of treatment may be appropriate, introducing this too early before the impact of a serious diagnosis has been allowed to sink in may inhibit the patient from bringing up concerns	PCP: Well, I'm sorry to say the investigations have shown that you might have heart failure. However, this can be managed with some procedures and medication.
Minimising	PCP: You say you're worried but I've seen many more patients cope even without the support your family has given you.
Normalising—this may serve to undermine the patient's situation/distress	PCP: Many people in your situation feel anxious. The addition of "Tell me how it feels for you" would encourage further disclosure and generate greater insight of the patent's perspective.
Asking physical questions While it is important to undertake a thorough physical assessment, it is also important to pick up on the cue offered by the patient — for example, what is it that is "worrying" about the pain?	Pt: I have a pain that I am worried about. PCP: Can you describe the pain to me?
"Passing the buck"	Pt: Since I am single and staying alone, can you tell me what support services I can receive should my condition deteriorate in future? PCP: It's not my role; you will have to speak with a social worker.

Asking multiple questions leading to confusion and uncertainty within the patient as to which question he should answer	PCP: You say you would like to work as long as possible; how will you feel if your medical condition does not allow you to work next year; what would your plans be then and how will your children come in to support you?
Jollying along	Pt: You mean I will have to take medication for my diabetes for the rest of my life? PCP: Come on; please don't worry about your diabetes; it is still in the early stages and you don't want to spend your time worrying about it when you can enjoy life!
Defending	Pt: You told me that you will arrange for another scan before conducting the ACP discussion. PCP: We are all so busy and it's difficult to get everything right all of the time.

Source: Handbook of Palliative Care (Faull)

communication skills are vital for conducting ACP discussions.[19] As primary care physicians will encounter different patient personalities, communication skills become crucial for them to open up communication channels with the patients, their caregivers and other healthcare professionals.[20] Communication skills in ACP discussions involve "active listening", which is listening to what is really being said, to pick up the spoken and unspoken clues about what the patient wants to discuss and understand where the patient is at in his unique personal journey.[21] The National Medical Ethics Committee's recommendation in 2010 is that such discussions should be started as part of routine care in primary care and outpatient settings before individuals become acutely unwell. This article has therefore attempted to share skills that will aid inconducting ACP discussions with some of the different personalities in a helpful and empathetic way.

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LEARNING POINTS

- **Documented advance care planning (ACP) discussions with patients enable doctors to have continuity and collaboration across all settings as patients move from one setting to another.**
- **ACP discussions generally consist of 3 steps: giving information; assisting patients to understand the options in the context of their situations; and helping these patients make informed decisions based on their individual preferences.**
- **Primary care physicians should take advantage of their position as healthcare providers to continue the care of the patient and the relationship they have with the patient by initiating ACP discussions.**
- **The National Medical Ethics Committee's recommendation in 2010 is that such discussions should be started as part of routine care in primary care and outpatient settings before individuals become acutely unwell.**
- **Negative personalities — the angry patient, the anxious patient, the patient in collusion, and the patient in denial — may be encountered and guidelines are available to continue the conversations.**
- **Attending physicians should also recognise that they may be exhibiting blocking behaviours to ACP discussions that patients are trying to initiate, and avoid these.**