

CHAPTER 1

SELF-AWARENESS AND COMMUNICATION

CHAPTER OBJECTIVES

1. Recognize and assess your attitudes, beliefs, and feelings about sexual orientation, gender identity, and gender expression/ gender presentation.
2. Recognize and assess your attitudes, beliefs, and feelings about the dying process and death.
3. Describe a three-step mitigation plan you can follow before each patient interaction to mitigate the power imbalance between patient and provider and prevent your attitudes and beliefs from having a negative impact on the care you provide.
4. List empathic and facilitating verbal and nonverbal behaviors you can use in delivering LGBTQ-inclusive care.
5. Explain how touch, humor, and self-disclosure can be either helpful or harmful to your relationship with a patient.

Key Terms: assumption, attitude, belief, CAMPERS, compassion, emotion, empathic behaviors, empathy, facilitating behaviors, humor, patient-centered, power imbalance, reflection, right to self-determination, self-awareness, self-disclosure, touch, unconscious bias

CHAPTER SUMMARY

Providing inclusive care to patients with chronic or life-limiting illnesses requires self-awareness — an awareness of one’s attitudes, beliefs, and emotions and the ways in which they shape interactions and patient care. For hospice and palliative care professionals, self-awareness should be an ongoing process rather than a static state of existence to strive toward. This chapter describes a seven-step process that hospice and palliative care professionals can follow to improve their ability to provide inclusive, nonjudgmental care when planning, engaging in, and reflecting on patient interactions. In addition, the chapter describes verbal and **nonverbal communication** techniques to facilitate LGBTQ-inclusive care.

SELF-AWARENESS

Being aware of your own **attitudes, beliefs, and emotions** and the ways in which they shape your interactions with patients and the care you provide is the first step toward providing inclusive care. This kind of insight entails **self-awareness** (Benbassat and Baomal 2005). For all health care professionals, including those in hospice and palliative care, self-awareness should be an ongoing process, not a static, ideal state of existence one strives toward. The following seven-step process can be used to improve your ability to provide inclusive, nonjudgmental care when you are planning, engaging in, and reflecting on a patient interaction. The mnemonic device for remembering the steps in this process is **CAMPERS**: clear purpose, attitudes and beliefs, mitigation plan, patient, emotions, reactions, and strategy.

STEP 1: KNOW YOUR CLEAR PURPOSE

As you approach an interaction with a patient, take a minute to think about the reason for that interaction. Every interaction has a purpose. Give conscious thought to identifying your *clear purpose* before the interaction, but keep in mind that your purpose may (and should) change during the interaction,

based on the needs of the patient. Whether you're a physician, an advanced practice registered nurse (APRN), a registered nurse (RN), social worker, counselor, or chaplain, your purpose for an interaction with a patient will generally fall into one or more of the following categories:

- Provide supportive **presence**
- Gather information
- Transmit information
- Clarify understanding of information
- Collaborate to create a plan
- Administer a medication or treatment

STEP 2: KNOW YOUR ATTITUDES AND BELIEFS

As you approach any interaction with a patient or client, think about your *attitudes and beliefs* in relation to that person. If you are going to be meeting a new patient for the first time, pay attention to any **assumptions** you might be making based on information on the intake form or referral sheet.

Does the first or last name of the patient lead you to make assumptions about the race, ethnicity, religion, or cultural traditions of the patient? If so, how do these assumptions lead you to draw other conclusions about the patient—for example, what their home may look like, what their socioeconomic status is, what amount of family support they have, and so on? Take a look at the patient's address. What assumptions do you make based on the patient's zip code, or whether the address includes an apartment number? When you look at the referring diagnosis, what thoughts pop into your head? For example, if the diagnosis is lung cancer, do you instantly wonder whether the patient was a smoker? What about a diagnosis of cirrhosis—do you find yourself wondering whether the patient has a history of alcohol abuse? Does a diagnosis of HIV/AIDS make you wonder whether the patient is gay?

There is nothing wrong with having any of these thoughts. Human beings sort information based on patterns,

prior experiences, and learned social norms. These prejudices (prejudices) are instinctual, even though they are often inaccurate:

We categorize, make assumptions, interpret, and infer from within a viewpoint we routinely use to advance our personal ends and desires. We are, in a word, naturally prejudiced in our favor. We reflexively and spontaneously gravitate to the slant on things that makes it easiest to gratify our desires and justify doing so, including the desire to be correct. We naturally shrink at the thought of being wrong, and conversely, delight in the thought of being right, and so often resist the attempts of others to “correct” us, especially when this involves beliefs that are fundamental and part of our personal identity. . . . When people act in accordance with the injunctions and taboos of the group to which they belong they naturally feel righteous. . . . Group norms are typically articulated in the language of morality and a socialized person inwardly experiences some sense of shame or guilt in violating a social taboo, and anger or moral outrage at others who do so. In other words, what commonly seems to be the inner voice of conscience is often nothing more than the internalized voice of social authority, the voice of our parents, our teachers, and other “superiors” speaking within us. (Paul and Adamson 1993)

When you find yourself wondering whether a patient “did something” to cause their illness, you are hearing what Paul and Adamson call the “internalized voice of social authority.” You are subconsciously trying to make sense of the patient’s illness by sorting the patient into the category of “other”—a category of taboo breakers from whom you feel comfortably distant, or perhaps uncomfortably close. When you subconsciously view a patient’s illness through a lens of taboo and punishment, you may feel safe from experiencing a similar fate or fearful that a similar fate might befall you. In reality, of course, no one is “safe” from experiencing a life-limiting ill-

ness: nonsmokers get lung cancer, heterosexual people get HIV/AIDS, and nondrinkers get cirrhosis. The challenge for all of us as health care professionals and human beings is to become aware of our instinctual prejudgments and then counteract their ability to influence our decisions and behaviors.

If you are going to be seeing a patient you have met before, pay attention to your attitudes and beliefs about the patient. Do you find yourself dreading the visit because the patient is a hoarder or the house seems uncomfortably dirty to you? If the patient is wealthy and lives in a beautiful home, do you find yourself looking forward to that visit a little more than you look forward to others? Do you have more positive feelings about visits to a patient who is gay than visits to a patient who is straight (or vice versa)? Ask yourself the following questions, and be honest with yourself:

- Which patient do you feel more **compassion** for: a patient with lung cancer who smoked or a patient with lung cancer who never smoked?
- Which patient would you rather spend time visiting: a homeless patient who lives under a bridge or a patient who lives in a luxury high-rise apartment?
- Which patient would be harder for you to relate to: an evangelical Christian or a devout Muslim?
- Which patient would you rather have assigned to you: a gay man with rectal cancer or a heterosexual (“straight”) woman with rectal cancer?
- Do you believe homosexuality is a sin?
- If you believe in heaven and hell, do you believe gay, lesbian, bisexual, and transgender people go to hell after they die?
- Do you feel as though it’s “normal” for older people to die but not younger people?

An important part of this step is becoming more aware of your attitudes and beliefs about dying and death. Ask yourself these questions:

- How do you define a “good” death?
- When patients choose to go to the hospital to die because they don’t want to die at home, do you silently think to yourself that this is a bad decision?
- What are your thoughts about the use of artificial nutrition and hydration at the end of life?
- When family members of a patient who is likely days from death insist that the patient be given artificial nutrition and hydration after you have clearly explained the risks, do you think to yourself that they are making the wrong decision and that they’re “in denial”?
- When a palliative care patient decides not to pursue potentially life-extending or curative treatment, do you think to yourself that the patient has “given up”?
- When a patient has adult children who live nearby, work full-time, and say they cannot help with the patient’s care, do you find yourself viewing those adult children negatively?

Thinking about these questions — and answering them honestly, even if the answers make you cringe a bit — will help you become more aware of your attitudes and beliefs. Without this self-awareness, you run the risk that an **unconscious bias** will play a detrimental role in your care of patients — an unconscious bias that can lead you to develop “stories” to fit your bias. For example, your bias could lead you to become judgmental and assume that a person living in subsidized housing is uneducated or living in an unsafe environment.

STEP 3: KNOW YOUR MITIGATION PLAN

The term *mitigation plan* is used in the business world to describe an aspect of risk management: “Mitigation plans eliminate the exposure of a business to risk, lessen the impact of a threat, or reduce the frequency or severity of risks. In order for mitigation to be effective, the risks must be identified ahead of time and a plan devised[,] ready for implementation[,] before or when the risk occurs” (Sandilands n.d.).

PROVIDER PERSPECTIVE

I worked as a social worker in hospice in South Dakota in the '90s and have such fond memories of the men [with HIV/AIDS] we worked with at the end of life, and their partners/families. While it was tragic and very sad to lose such a young, vibrant group of men, they taught me so much in my time with them. Those men taught me that quality of life is defined only by the person going through the illness. I saw a young man that we all felt had no quality of life due to his blindness, chronic diarrhea, pain, nausea, and [other] intractable symptoms but he, at his young age, saw being alive to be with his mother one more day as an acceptable quality of life for him. These men taught me the strength and bond of a homosexual relationship and what excellent caregivers men are to each other. At that time, there was no legal or binding arrangement for their relationships, but I witnessed unbelievable commitment to each other and a resiliency that was not always present in the heterosexual population that we served. I learned the value of humor in coping with very difficult times.

I think the most valuable lesson that I learned in my work with those gay men was other people's ability to adapt and overcome their apprehensions in working with this population. Parents who were not always comfortable with their sons' homosexuality were almost always able to allow love to overcome any barrier they had, and they provided wonderful, supportive care at the end of their sons' lives. I [have] worked with nurses who would refuse to take a homosexual patient with AIDS. One nurse overcame her apprehension and became the nurse to care for all the men on our caseload with AIDS. She grew to love serving her "boys" and became the greatest advocate for these

men, their partners, and their families at the end of their lives. As treatment of AIDS changed, we began decreasing our hospice caseload of patients with AIDS and sometimes even discharged people with AIDS—a happy end to a very tragic time.

—LYNNE HUNTER, MSW

In the context of the CAMPERS self-awareness process, the term refers to the actions you plan to take to prevent the attitudes and beliefs identified in step 2 from having an impact on your interactions with a patient.

Your mitigation plan should also include actions you will take to minimize the **power imbalance** between you and the patient. A power imbalance exists when one person in a relationship has more authority, expertise, or access to resources than the other person. Patients receiving palliative care or hospice care are in a vulnerable position because they may be dependent on the health care professional for meeting some of their most basic human needs, such as relieving their pain, helping them perform their activities of daily living, and easing their emotional and spiritual distress.

Some of the phrases used by health care professionals exemplify the existence of this power imbalance. The terms *noncompliant*, *nonadherent*, and *in denial* are probably the best examples. These terms connote that a patient has failed to comply with, adhere to, or accept the care plan developed by a health care professional—and they imply that the patient’s role in the relationship between provider and patient is to follow orders. But what does terminology like this say about our respect for a patient’s **right to self-determination**? “Non-compliance” and “non-adherence” do not describe patients’ failures—instead, they reflect our inability as health care professionals to help patients set goals they are motivated and able to achieve. The phrase “in denial” similarly reflects our

inability as health care professionals to meet patients where they are and understand their perspective on their situation.

While most hospice and palliative care professionals have abandoned the use of terms like noncompliant in favor of more **patient-centered** terminology, there is still much work to be done at the individual level to mitigate the effects of attitudes and beliefs on the care provided. Your mitigation plan does not need to be complex. In fact, the best mitigation plans are so simple that they can be easily remembered and quickly implemented in less than a minute, before each interaction with a patient.

The following mitigation plan consists of three concrete steps—three questions and answers that, if you repeat them to yourself each time you meet with a patient, will help you mitigate the power imbalance between patient and provider and prevent your attitudes and beliefs from having a negative impact on the care you provide. I have used “I” statements so you can imagine how the plan could be used in your own practice.

- **Who is the story about?** The story is about the patient. What I believe and my own attitudes have nothing to do with the patient’s story.
- **Who should be writing the story?** I am not writing this story. The patient should be the one writing the story. The patient is the author of the story throughout this illness and for the remainder of the patient’s life.
- **What is my role?** My job is simply to give the patient the behind-the-scenes support needed to write the story. I won’t try to tell the patient what to write or cast myself as a central character.

STEP 4: KNOW THE PATIENT

At this point, you have identified the purpose for your interaction with the patient, taken a look at your own attitudes, beliefs, and assumptions, and implemented a plan for miti-

gating both the patient-provider power differential and the impact of your attitudes and beliefs on the care you are going to provide. The fourth step in the self-awareness process is to know the *patient*. Knowing the patient goes beyond simply knowing their diagnosis and prognosis—you need to get to know who the patient is as a person and what is most important to them. The following list of questions can be asked when you first meet a patient, after a brief period of rapport-building conversation:

- What name do you use?
- What sex were you assigned at birth?
- What gender do you identify as now?
- What gender pronouns do you use? (e.g., he/him, she/her, them/their, ze/zir)
- What prompted your decision to seek palliative care or hospice care?
- Whom do you consider to be your “family”?
- To whom do you turn for support?
- What do you know about your diagnosis? Prognosis?
- What are your short-term and longer-term goals for your life? For your care?

While several of these questions are standard components of a palliative care or hospice admission visit, the three questions about sex, gender, and gender pronouns may be unfamiliar to you. *These questions should be asked of all patients—not just those you think may be transgender.* The questions are discussed in greater depth in Chapter 2.

STEP 5: KNOW YOUR EMOTIONS

The fifth step in the self-awareness process is to learn to recognize your *emotions*. I still remember one of the first deaths I witnessed as a new social worker. Shortly after the patient took his last breath, I felt my eyes well up with tears and a lump form in my throat. When I glanced over at the patient’s

PROVIDER PERSPECTIVE

I think a really good place to start in caring for the LGBT community is to get on the same page with patients and clients about language (i.e., personal pronouns, words for “partner,” etc.). If you don’t know, ask! It’s OK to show that you don’t know, because asking shows you care to get it right. Once you are informed, either directly or indirectly, it’s so important to apply what you’ve learned about the language that people prefer. I once was involved with a situation where a hospice professional, Mr. A., gave a report referring to the male partner of a male patient as his “wife.” That seemed unusual to the rest of us on the team because the male partner had clearly identified himself as the patient’s husband in his interactions with us. When I asked Mr. A. about it, he said he was told by the male partner to refer to him as the patient’s wife. When we sought clarification from the patient’s husband about his preferred language, he reiterated that he is the patient’s husband. The patient’s husband reported that when he told Mr. A. that he was the patient’s husband, Mr. A. continued to question it and didn’t seem to “get it.” The patient’s husband finally [gave up and] told Mr. A., “Just think of me as [the patient’s] wife.” As a community, let’s not be dense—let’s ask for patient and family preferences and let’s honor them!

—VICKI QUINTANA, RN, BSN

wife, though, her eyes were dry and I thought she looked almost bored. I felt a flicker of disapproval. I had *just* met the man and I was tearful. The word “cold” popped into my mind, followed by a cheek-burning sense of shame that in a split

second I had unconsciously imposed my idea of what grief looks like onto her. Recognizing my emotions made it possible for me to move past them and focus on the emotions of the patient's wife. I sat with her and reminded myself that I needed to meet her where she was. Recognizing my emotions made it possible for me to put my feelings aside so that I could focus on the feelings that really mattered—those of the patient and his family.

As hospice and palliative care professionals, it can be difficult for us to acknowledge experiencing socially undesirable emotions. How often have you heard a patient, family member, friend, or neighbor say that you're an "angel" or a "saint" for the work that you do? It can be tough to reconcile the way that others see you (and the way you want to be seen) with the gritty emotions you experience working with patients and families. The fastest way to shed this sense of cognitive dissonance is to accept the fact you are not and cannot be a saint or an angel. You are a mortal human being doing incredibly challenging work to make the lives of patients and families better during illness, death, and bereavement. Feeling frustration or disgust or annoyance with patients doesn't mean you're a "bad" health care professional—it means you are human. Your task is to do whatever you can to recognize those feelings when you experience them and then make a conscious choice not to let them get in the way of your ability to provide the best care possible to patients.

STEP 6: KNOW YOUR REACTIONS

The sixth step in the self-awareness process, know your *reactions*, is closely intertwined with step 5. When you feel annoyance, do you convey that reaction to others in your facial expressions, body language, and tone of voice? Do you furrow your brow or maybe wrinkle your nose? What about when you feel frustrated with someone? Your goal in step 6 is to gain a better understanding of how your reactions become visible to others so you can make a conscious effort to avoid

communicating those personal feelings to patients. One of the medical students I taught years ago would twirl her hair with her finger and bounce her foot up and down, dangling her shoe from her toes, when she was feeling a lack of confidence during an interaction with a patient. Once she was aware of both what she was feeling and her reaction to it, she was able to stop bouncing her foot and playing with her hair and begin projecting more confidence. Another medical student would register shock or surprise by widening her eyes and raising her eyebrows. She worked hard to control her facial expressions and is now a skilled practitioner with a rock-solid yet compassionate poker face.

If you are not sure how you show your emotions, ask your partner or spouse, family members, or friends. Ask them how they can tell when you are annoyed, frustrated, angry, disapproving, or impatient. The insights you glean will help you put this step into practice, so that when you are interacting with a patient and you recognize that you're experiencing an emotion you would rather not make visible to them, you can make a conscious effort to control your "tells"—the physical reactions, like pursed lips, furrowed brows, or crossed arms, that reveal your feelings.

STEP 7: KNOW YOUR STRATEGY

The last step in the self-awareness process is know your *strategy*. This step involves taking time for a brief period of review after an interaction with a patient, in order to develop a strategy for communicating more effectively in future interactions. Think about what went well in your interaction and what did not. Were you surprised by any of the thoughts or emotions you experienced during the interaction? How did those emotions make themselves visible to the patient? Were you able to support the patient's role as the author of their own story, or did you find yourself trying to take control of that story at times? Whose goals and needs were met during the interaction—the patient's, yours, both? Based on how the

interaction went, consider what you would do differently or better in your next patient interaction, and devise a strategy for carrying this out in the future.

COMMUNICATION

The CAMPERS process—clear purpose, attitudes and beliefs, mitigation plan, patient, emotions, reactions, and strategy—when paired with good communication skills, will help you provide inclusive, nonjudgmental care. Communicating with patients and their families is central to your work as a hospice or palliative care professional. APRNs, RNs, physicians, chaplains, social workers, and counselors learn communication skills in school, with each discipline putting a unique spin on the communication techniques that are taught. Because the focus of this book is on the skills hospice and palliative professionals need to deliver LGBTQ-inclusive care, I will not be covering basic communication skills. Instead, this book will highlight communication techniques and other verbal and nonverbal approaches that facilitate LGBTQ-inclusive care.

Empathic behaviors are the things you say (verbal) or do (nonverbal) to convey to patients that you care about them and are committed to understanding their perspective or experience, and **facilitating behaviors** are the things you say or do to foster open communication (AAHPM 2009). Table 1.1 summarizes the behaviors.

The behaviors listed in table 1.1 can convey **empathy** and facilitate open communication, but if carried out clumsily or insincerely, some of these behaviors can be detrimental to forming a relationship with a patient, especially when it comes to being LGBTQ-inclusive. Three behaviors in particular are open to misuse by well-meaning professionals: **self-disclosure, touch, and humor.**

SELF-DISCLOSURE

Disclosing information about yourself can convey empathy and openness, but the disclosure should be made to meet

TABLE 1.1 EMPATHIC AND FACILITATING BEHAVIORS

	VERBAL	NONVERBAL
Empathic	silence listening affirmation self-disclosure	touch open posture facial expression
Facilitating	naming normalization reflection humor	eye contact head nodding/shaking eye-level approach

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the needs of the patient, not those of the health care professional (you). If you self-identify as lesbian, gay, bisexual, transgender, gender nonconforming, queer, and/or questioning, you may find yourself wanting to share this fact with the LGBTQ patients you work with. Before you do, think about your rationale for disclosing this information. Would you be doing it because you want the patient to like you? Trust you? Feel understood by you? Are there other ways you could accomplish those goals more effectively? The same questions hold true for heterosexual hospice and palliative care professionals. If you self-identify as heterosexual and you find yourself wanting to mention your other-gender significant other or spouse during a conversation with a patient, think carefully about your rationale for doing so. Why do you want to disclose your heterosexuality? Whose needs are you meeting— yours or the patient’s? Self-disclosure is neither good nor bad. Use it with intentionality to maximize its potential benefits.

There are ways other than verbal self-disclosure to show that you are committed to providing nonjudgmental care to LGBTQ individuals and their families. Some providers wear

a rainbow “ally” lapel pin as a way to signal to patients and families that they are committed to LGBTQ-inclusive care.

AUTHOR’S NOTE

Over the years I’ve been asked many times why lesbian, gay, and bisexual people feel the need to “tell people about their sex lives” by coming out to others. Rather than answer the question directly, I like to respond by asking the questioner to try the following exercise. If you are heterosexual and currently in a relationship with a person of the other gender, keep track of how many times you make reference to this person (either by name or by such terms as boyfriend, girlfriend, husband, wife) in your conversations with colleagues, friends, neighbors, and family members this week. At the end of the week, reflect on why you felt the need to share your heterosexuality with so many people.

This exercise never fails to leave people surprised by how often heterosexuality is casually disclosed in everyday conversations. Mentioning your sexual orientation to others isn’t telling people about your sex life; it is sharing a part of who you are as a person.

TOUCH

When touch is a part of care delivery—for example, when a nurse puts lotion on a patient’s dry skin or a chaplain holds hands with a patient in prayer—it can be a powerful tool for conveying a sense of caring and compassion. When touch is used during a conversation between a professional and a patient, however, it can be awkward. Does putting a hand on a patient’s knee make potentially difficult news easier to hear, or does it just make us as professionals think we are doing something to lessen the patient’s pain? As a social worker and as a patient, I view touch as something that needs to be invited. I do not want my health care providers to pat me on the knee or rub my back, and I don’t do those things to patients I work with. Touch may even be physically or emo-

tionally painful for a patient, so refrain from touching without a patient's invitation and consent. Each patient you work with will have different preferences in terms of touch; it is important to be cognizant of that.

Hugging is particularly tricky territory. A patient who has a history of sexual abuse, for example, may feel triggered by a forced or unexpected embrace. The power differential between the hospice and palliative care professional and the patient may make it difficult for the patient to refuse a hug initiated by a care provider. Talk with all of your patients about touch and ask them about their desire for and level of comfort with hugs from you. This may seem like a small thing, but the importance of respecting patients' physical and emotional boundaries cannot be overstated.

HUMOR

Like touch, humor is a behavior that should be used carefully and with an awareness of the needs and preferences of each patient. A joking comment that seems lighthearted to you may seem callous to a patient or family member. A patient with a chronic or life-limiting illness—especially a patient in physical pain—may not appreciate your attempts at humor. This is not to say that there is no place for laughter in hospice or palliative care—on the contrary, laughter has many physiological and psychological benefits (Mayo Foundation for Medical Education and Research n.d.b).

There are different ways to use humor, including laughing at oneself, laughing at the other person, laughing at a situation, and laughing at someone other than the two people interacting. Within the context of your relationship with a patient, it is wise to avoid laughing at the patient or laughing at someone else. This kind of humor runs the risk of being interpreted as mean-spirited and hurtful. Laughing at the absurdity of a situation is safer territory, especially if the patient initiates the laughter.

AUTHOR'S NOTE

When I was twenty-six, I was finishing up my dissertation proposal at my childhood home in Texas while caring for my mom, who was dying of ovarian cancer. The morning of the day she died, friends and family members were gathered around her on her bed, telling funny stories and sharing memories. She was minimally responsive—it was clear to all of us that she would die within hours. Suddenly she smiled slightly and said, “You know, I’m not dead yet.” Our laughter at her parting joke ended up sweetening all our tears. Had a hospice professional cracked the joke, saying, “You know, she’s not dead yet,” it wouldn’t have been funny at all—it would have come across as cruel. Remember that humor relies on context as much as content.

KEY POINTS TO REMEMBER

- CAMPERS is a seven-step process you can use to improve your ability to provide inclusive, nonjudgmental care when you are planning, engaging in, and reflecting on a patient interaction. The letters in the mnemonic device stand for: clear purpose, attitudes and beliefs, mitigation plan, patient, emotions, reactions, and strategy.
- Every interaction with a patient should have a clear purpose. Give conscious thought to your purpose before an interaction, but keep in mind that your purpose may (and should) change based on the needs of the patient during the interaction.
- As you approach an interaction with a patient, take a minute to think about your attitudes and beliefs in relation to that patient. Become aware of any prejudgments so that you can counteract the ability of those judgments to influence your decisions and behaviors.
- Review your mitigation plan before each patient interaction as a reminder to mitigate the power imbalance between patient and provider and prevent your attitudes

and beliefs from having a negative impact on the care you provide.

- Get to know who the patient is as a person and what is most important to the patient.
- Recognize your own emotions during your interactions with patients and make a conscious choice not to let them get in the way of your ability to provide the best care possible.
- Avoid making your emotional reactions visible when interacting with a patient. When you recognize that you are experiencing an emotion you would rather not communicate, make a conscious effort to control your “tells” (e.g., pursed lips, furrowed brows, crossed arms).
- Engage in a brief period of review after each interaction with a patient so that you can develop a strategy for communicating more effectively in the future.

DISCUSSION QUESTIONS

1. Why is it important to recognize and assess your attitudes, beliefs, and feelings about sexual orientation, gender identity, and gender expression or gender presentation in order to provide LGBTQ-inclusive care? Can you provide LGBTQ-inclusive care *without* this self-awareness? Why or why not?
2. Growing up, what messages did you hear regarding sexual orientation, gender identity, and gender expression or gender presentation? How did these messages shape the attitudes, beliefs, and feelings you have today?
3. Imagine you have been asked to care for an LGBTQ patient. Describe how you would use the CAMPERS self-awareness process before, during, and after your first interaction with the patient.
4. Describe how you might use verbal and nonverbal techniques to convey empathy and facilitate communication with a patient who seems reluctant to talk openly with you.

5. Imagine that you are meeting with a new patient recently diagnosed with the same rare, life-threatening illness that your close friend had, who was treated and cured. The patient is sobbing and you want to offer some comfort. Give examples of how touch, humor, and self-disclosure might be used *inappropriately* in this scenario.

CHAPTER ACTIVITY

Use the CAMPERS self-awareness process before, during, and after an interaction with a patient (either a real interaction or one simulated via role playing). Immediately afterward, write down what you were thinking and feeling during each step in the process. Did any of your thoughts or feelings surprise you? If you used the CAMPERS process for your work with all patients, do you think it would decrease the impact of unconscious bias on the care you deliver? Why or why not?