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Caring for an Unconscious Transgender Patient at the End of Life:

Ethical Considerations and Implications

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Abstract

Individuals who identify as transgender (trans) or other gender-diverse identities are highly marginalized populations within the United States health care system. Transgender individuals experience a broad range of health disparities leading to devastating health outcomes. Experiences with discrimination and biased care often result in a lack of trust in providers and reduced care seeking, yet providers frequently rely on communication with trans patients to build competence. Consequently, when a trans patient has restricted communication, whether due to biological or psychological reasons, their care can be further disrupted. The nursing code of ethics compels the provision of competent care to all patients, regardless of demographics or gender identity,

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including individuals with serious illness and injury. This article describes an approach to the provision of affirmative, trans-inclusive care in a palliative nursing context that integrates cultural humility and self-reflection into an established patient care framework. The approach is then applied to identify ethical dilemmas present in the case of a trans patient who arrived at a hospital in an unconscious state following serious injury. Nurses' use of the ethical approach when caring for seriously ill trans patients would represent important progress toward fostering a health care system that provides affirmative, trans-inclusive care.

Keywords

ethics; health services for transgender persons; nursing ethics; palliative care; transgender persons; unconsciousness

People who identify as transgender (trans) or another gender-diverse identity (ie, individuals whose gender identity varies from the culturally defined role that corresponds to their assigned sex at birth) are heavily marginalized groups in health and social care systems worldwide.[1] They experience health inequities associated with inappropriate or insufficient care and adverse outcomes across biological, psychological, social, and spiritual domains of well-being.[2,3] Despite the need for improvements in equitable care, there is limited scholarly evidence to inform primary palliative nursing care (PPNC) for this population. One area with notable gaps is the provision of PPNC for trans patients nearing the end of life, including their social support systems and caregivers.[4-6] This article presents an evidence-based approach to identifying ethical considerations when caring for a trans patient who arrives unconscious at a hospital. The article shares recommendations for how to promote PPNC that affirms a patient's gender identity (affirmative care) in settings that are open and accommodate trans individuals (trans-inclusive).[7,8]

Nurses are ethically obligated to deliver competent PPNC across settings and for all populations to “facilitate healing, alleviate suffering, and advocate” for patients with serious illness and injury.[9(p5),10] Primary palliative nursing care is holistic care registered nurses provide to patients with serious illness or injury.[11] Competent PPNC requires the provision of nursing care in collaboration and coordination with interdisciplinary teams and specialized palliative care providers.[11]

The provision of PPNC to patients with serious illness or injury requires knowing them through engagement in meaningful conversations that align the plan of care with their values, beliefs, and preferences.[10] Since the 1970s, Carper's patterns of *knowing* patients (empirics, ethics, esthetics, and personal), expanded by other scholars to include experience, intuition, unknowing, and sociopolitical,[12] have been considered synergistic with the nursing profession. Knowing a patient is a “uniquely personal type of knowledge, constructed of objective knowledge interfaced with the individual's awareness and subjective perspective on personal experience; it is a dynamic process and result of personal reflection and transformation.”[13(p1330)] Inherent to knowing a patient is the need to communicate with them, both as receiver and sender of information. When caring for seriously ill or injured patients in unconscious states, nurses lose the ability to receive verbal communication from

the patient about values, beliefs, and preferences, which for unconscious trans patients includes their gender identity, preferred pronouns, and name.

How does the nurse come to know the patient who is unconscious, uncommunicative, or otherwise silent? The skill to integrate the multiple ways of knowing is a holistic art of human caring and also a science.[14] All nurses are ethically compelled to engage in self-reflection and to identify their biases, constructs, and worldviews that may “other” or minoritize persons of vulnerable identities, thus causing them harm.[15] Ultimately, knowing another returns one to a shared humanity and the right of every human being to receive dignity, kindness, and compassion in the face of serious health-related suffering. This goal is easy to adopt in theory, but difficult to achieve in practice, at times because of conflicting demands.

The following is a blended case that arises predominantly from one individual and is augmented from the experiences of other patients, providers, nurses, and authors. Names and details were altered or removed to preserve the anonymity of the individual. Labels and pronouns are important to everyone given the fluidity of social constructions of gender (see Note on Terminology and Communication), so terms used here match the trans identity of the fictionalized subject but vary on the context and person using them.

THE CASE

Ashley arrived at the emergency department following a motor vehicle accident that resulted in a loss of consciousness and the need for mechanical ventilation. She was admitted to the intensive care unit in critical condition where medications were prescribed to sustain cardiopulmonary function and manage pain and sedation. A referral to specialty palliative care services was never ordered. On the unit, clinicians discussed with confusion that Ashley had male genitalia and wore makeup and nail polish. Paramedics reported that she was wearing “women's clothes” at the scene, which were removed while preparing her for transport to the hospital. The driver's license identified Ashley as a black man of 30 years.

Ashley's mother, her legal next of kin, received notification of the accident by the police and arrived at the hospital within a few hours. She was distraught and reported that she had not spoken with her son for several years, asserting that he had begun to hang out with “the wrong sort of people.” News of Ashley's accident spread among her friends, who arrived at the hospital soon after. However, Ashley's mother denied them access to the patient, calling them “sexual deviants.” The friends shared with the health care team that Ashley identified as a trans female and was part of a close-knit community. They also reported that she had ceased all interactions with her family several years before when they disowned her for identifying as female. The friends requested information about Ashley's status, but the team could not provide updates to her friends because the mother restricted release of Ashley's protected health information.

Several hours later, Ashley suffered a cardiac arrest requiring cardiopulmonary resuscitation. During the code, while surrounded by the code team, other team members, and several trainees assisting with the resuscitation efforts, the lead physician interjected, “What's up

with him wearing nail polish and make-up?" The team resuscitated Ashley, but she suffered several more cardiac arrests in the subsequent hours. With each arrest, the mother pleaded with the providers and nurses to do everything they could to save her son. She spoke of her desire for reconciliation with her son and the need for her son to reconcile with God. Ashley died of complications of the accident, having never shown outward signs of regaining consciousness. A nurse in the intensive care unit provided postmortem care, but Ashley's mother did not come to the bedside or let Ashley's friends see her. Grief counseling and bereavement services were offered to her mother, who declined. No services were offered to Ashley's friends. The health care team rounded about the case, but did not discuss concerns about the handling of Ashley's gender identity, future practices, or ways to support her friends. Outside of rounding, nurses who cared for Ashley shared with the specialty palliative care team their distress over the physician's comments, their frustration with the lack of a palliative care consult to support the team in caring for Ashley and assessing her preferences, and their apprehension of what they should say or do to address these concerns.

Ethical Foundations for Affirmative, Trans-Inclusive Care

Trans individuals experience extensive marginalization in their health care experiences that contributes to devastating health disparities.[16] Trans marginalization results from socially embedded stigma and prejudice toward minority gender identities enacted explicitly as discrimination and held implicitly as biased beliefs.[17] As exemplified by Ashley's story, implicit bias lies outside of conscious awareness, but informs how care is approached and delivered by health care professionals, presenting serious threats to the health and well-being of trans people from their nurses or providers (including gender-related discrimination, rejection, victimization, nonaffirmation or nondisclosure of gender identity, negative expectancies, a lack of community connectedness, and shame).[2,18-20] It emerges in what nurses say (content), how they engage with patients (process), and what they think, influencing their attitudes, assumptions, and intentions (perceptive).[21] There is often consistency between the words a nurse uses, the quality of his/her care, and the competence of his/her assumptions. Nurses have an imperative to become aware of their biases and formulate a plan to prevent them from adversely impacting the care they provide to patients, the core element of affirmative, trans-inclusive PPNC. As stated by Acquaviva,[4] having attitudes and beliefs that "make you cringe" is not inherently wrong; however, allowing these attitudes and beliefs to go unacknowledged and unregulated leads to unconscious biases that have detrimental impacts on the provision of care [4(p6)] An ethical approach to care involves both the reduction of explicit acts of discrimination and the adoption of a self-aware professional role that interrogates and reduces implicit bias.

A Theory-Based Approach to Ethical Care

Best practices for affirmative, trans-inclusive PPNC emerge from the related experiences of trans men and women who seek medical care when they are conscious and alert.[2,3,22] Individuals can intentionally choose when and how to reveal their gender identities to providers and nurses, if they feel safe and empowered to do so. Recommendations for the provision of ethical and affirmative trans-inclusive care have been provided within oncology[6] and hospice and palliative care.[4,5] They emphasize the central importance of assessing the gender identity of all patients during care encounters. Recommendations

should be expanded to consider the provision of affirmative PPNC to unconscious trans patients with serious illness or injury. The theory-based approach, presented below, integrates cultural humility and self-reflection into an established patient care framework to guide the provision of affirmative, trans-inclusive PPNC.

Cultural Humility as a Foundation for Change

Communication is paramount to the provision of quality care to patients and their support systems at the end of life.[23] Communication practices that promote the provision of affirmative, trans-inclusive PPNC reflect individual and organizational processes rooted in cultural humility. Cultural humility is a way of being—as opposed to a "way of doing"—that calls for (1) self-reflection and lifelong learning to make peace with differing beliefs; (2) patient- and family-focused interviewing that removes power imbalances in health care; and (3) community-based care and advocacy that nurtures sustained and mutually respectful partnerships between nurses and recipients of care.[24] Cultural humility provides a theoretical and practical basis for affirmative care and maintains particular attributes that advance health equity for trans patients, including openness, self-awareness, egolessness, supportive interactions, and commitment to both self-reflection and self-critique.[25,26] Active reflection on the part of all nurses regarding the development of cultural humility is imperative and creates fertile ground for the introduction of new interventions for marginalized groups and, ultimately, everyone.

The CAMPERS Framework for Affirmative, Trans-Inclusive Care

First formulated by Dr Kim Acquaviva[4] in 2017, the CAMPERS framework provides an important method to structure the provision of affirmative palliative and hospice care for LGBTQ+ (lesbian, gay, bisexual, trans, and queer and/or questioning) individuals. In the CAMPERS framework, palliative care nurses interact with each trans patient according to a standard approach that features important internal and external elements. Nurses should have a (C) clear purpose for the care interaction, an awareness of personal (A) attitudes and beliefs, a (M) mitigation plan to reduce the hierarchical distance between patient and nurse, an understanding of the (P) patient (including gender identity, preferred gender pronouns, sex assigned at birth, and preferred support system), a recognition of personal (E) emotions and (R) reactions (and how they might influence the provision of care), and a (S) strategy for reflection and future professional development of affirmative, trans-inclusive care.[4]

Thus, this framework draws upon cultural humility to promote growth-oriented self-knowledge and drive the plan of care. Reflective practice is critical to creating health care environments that foster emotional intelligence, caring interpersonal relationships, and quality health outcomes.[27] Self-knowledge requires forging authentic insight into one's attitudes, beliefs, and emotions and reflecting on how these elements influence patient and community interactions.[4] In addition, nurses should proactively identify implicit or unconscious biases by taking a self-assessment.[4] This emphasis on self-awareness within the CAMPERS' framework echoes Carper's personal knowing as a key component of the nursing profession.[28] Self-awareness is not solely an individualistic exercise of each nurse, but also yields creation and affirmation of "a shared set of values" that are "consistent with nursing's social mandate."[28(p6)] A formal approach to building self-awareness can assist

nurses to implement CAMPERS and ensure the provision of affirmative, trans-inclusive palliative nursing care.

Moral Archaeology as a Mechanism of Ethical Self-awareness

In caring for a patient, nurses must develop the skill of recognizing ethical obligations as they arise with patients who are seriously ill or injured. According to Fiester,[29] the standard approach used in the clinical setting to identify moral obligations to patients is housed within the *principlist paradigm*. This paradigm comprises 4 ethical principles (autonomy, beneficence, justice, and nonmaleficence),[30] with each having corresponding fixed moral considerations. On a basic level, these principles reflect obligations to respect the patient's ability to make his/her own decisions, to act for the good of the patient, to spread the cost and benefits of care equally, and to do no harm to the patient. Although the principlist paradigm is effective at identifying moral issues at the foundation of health care, it also presents a risk that some nurses may fail to identify ethical obligations extending beyond these more basic concepts. Fiester[29(pp684–685)] writes, "It is not exhaustive of all of the moral considerations that arise in a clinical situation…the principlist paradigm is incomplete: it undertrains clinicians to recognize all of the obligations that exist in a particular case." She further likens the principlist paradigm to a metal detector, only capable of identifying certain items beneath the surface of the sand.

Moral archeology describes an intentional activity that identifies new moral obligations using the 4 general principles as an "archeological" guide rather than a limited template.[30] To demonstrate this point, Fiester[29] described 4 additional moral obligations: (1) *to express regret* when another is in pain, with efforts to validate the other and value their concerns; (2) *to apologize* for a wrong committed against someone, with efforts to describe the injury; (3) *to make amends* after harming someone, with efforts to reverse or compensate the person; and (4) *to repair trust* when a promise has not been kept, with efforts to restore the patient's trust and confidence or facilitate the transfer of care. Thus, the successful "nurse as moral archeologist" adopts an approach that identifies emerging ethical obligations, to the patient and to self, as they arise in the context of clinical challenges and ethical dilemmas, accepting accountability for the need to respond to these obligations and acting to address them. Having the courage to express regret, apologize, make amends, and repair trust is a bold effort in support of human-centered care. As Fiester[29] points out, such communications do not assume clinical or legal culpability or "wrongdoing"; rather, they acknowledge human suffering and, in that way, reaffirm humanity.

Thus, the proposed ethical approach for affirmative, trans-inclusive care calls for palliative nurses to develop skills of knowing their personal biases (cultural humility) and identifying ethical obligations as they arise (moral archeology), applying and enriching these skills through the systemic application of the CAMPERS framework to LGBTQ+ patient care. Through this proposed approach, nurses can capitalize on their self-knowledge and understanding of the patient to identify unwritten ethical obligations arising in the patient-nurse interaction and invoke an established approach to address them. This approach, which promotes better relationships with patients and navigation of the challenges in providing

competent, affirmative PPNC to unconscious trans patients, will guide our exploration of the ethical dilemmas arising for the patient and care team in our case.

ETHICAL DILEMMAS IN PERSPECTIVE

An ethical dilemma is a situation in which there is a difficult decision to be made between 2 choices where either option inherently involves an ethical transgression.[31] This case presents multiple ethical dilemmas pertaining to the care of a trans patient arriving unconscious. The authors maintain that using an informed approach in a closer analysis of seemingly conflicting obligations might lift the veil of uncertainty to reveal a clear, ethical, and mutually beneficial course of action. In the sections that follow, this article will describe ways for nurses to engage in both outward and inward behaviors to address complicated issues related to injurious language and communication; respect for Ashley's values, beliefs, and preferences; treatment of total pain; the provision of bereavement care; and the obligation to make amends.

Language and Communication

Exploring the case from the perspectives of the individuals present emphasizes that errors with communication lie at the core of the ethical dilemmas. Most notably, throughout her ordeal, Ashley's health care providers made comments about her appearance and identity in her presence. Team members who perceived this ethical dilemma have 2 potential responses: (1) they may speak up and confront the comments as biased, harmful, and unprofessional; or (2) they may say nothing despite recognizing the comments as harmful, assuming complicity in the behavior.

Consider the physician's comments about Ashley's physical appearance during the code and the subsequent silence by the other health care team members present. Because Ashley was unconscious, the team had no way of knowing what she perceived or understood in the environment. Evidence on covert consciousness indicates that awareness during unresponsiveness can range from no perception to good awareness of events in the room,[32] and such awareness can be traumatic for patients. The consequences of comprehension could have been devastating for Ashley. Such comments act to reinforce the bias, lack of advocacy, and risks of traumatic experiences for trans patients within health care systems. Similarly, had they heard of the comments, Ashley's friends would have received confirmation that health care settings are psychologically and emotionally unsafe places for trans individuals, even at their death.

Ashley's mother would also have reacted negatively to the disrespectful content of the comments. However, Ashley's mother—who in one moment was grieving the loss of the son she knew, the daughter she never knew, and the estranged child with whom she wanted reconciliation—could have viewed an act of compassion and inclusivity, such as affirmative pronoun use, as disrespectful and immoral.

For some team members, the physician's comments may have implicitly or explicitly encouraged their own biased beliefs and discriminative actions toward trans patients. For others, as noted within the case, the comments were viewed as unprofessional,

offensive, and harmful. These comments represent a violation of cultural humility and moral archeology's respect for the patient. Directly confronting the physician could have disrupted the provision of emergent care; however, the nurses who did not address these comments while caring for Ashley or during rounding experienced persistent internal conflict and moral distress. Remaining silent resulted in a self-perception by these nurses that they had committed violations of their own professional ethics codes. These comments set an expectation for the norms of the health care setting and unit culture for the trainees who were assisting with the code that limit the practice of cultural humility, abdicate ethical responsibility, and propagate the bias that drives trans health disparities.

Values, Beliefs, and Preferences

Another ethical dilemma stems from the obligation to respect the values, beliefs, and preferences of a patient. Ashley was unconscious, and her mother was the authorized medical decision maker and next of kin. There was no documentation of advance directives or her values, beliefs, or preferences within the medical record. Specialty palliative care services could have helped the team, but a consult was never ordered. The health care team was legally required to follow the wishes of Ashley's mother and to meet her expectations in this time of great loss, yet they also had a competing ethical obligation to provide the patient with affirmative, trans-inclusive care, which was in direct conflict with her mother's wishes.

Total Pain: A Holistic Imperative

The imperative for nurses to acknowledge total pain spans myriad domains: physical, cognitive, emotional, spiritual, social, and existential. Ashley's physical trauma from the accident, mechanical ventilation, and cardiopulmonary resuscitation were sources of physical pain.[33] Pharmacologic and nonpharmacologic interventions were employed to address the physical elements of Ashley's pain, but assessment for existential or spiritual pain was indicated and might have contributed comfort and succor to her at the end of her life. The prevention of access to friends and potential partners may have represented substantive unaddressed social pain for Ashley.

Bereavement

Both Ashley's mother and friends experienced emotional pain due to acute grief (mother) and acute and disenfranchised grief (friends). Grief can manifest as physical, emotional, and spiritual pain and distress.[34] The nurses and other members of the health care team needed to provide bereavement care and referral to additional resources for both the mother and friends, such as the hospital chaplain, specialty palliative care, grief counselors, or local support groups and bereavement programs.[35] Failure by the entire health care team to provide immediate acknowledgement of the loss and access to support services likely predisposed all parties to experience more intense grief.[35] Although bereavement services were offered to her mother, Ashley's friends were left without resources and support.

Obligation to Make Amends

Comments made about Ashley generated negative events that affected several nurses, particularly as they fostered moral distress and residue. Moral distress is “an experience

where a moral decision has been made about what to do in an ethically challenging situation, but the desired action cannot be carried out."[36(p1)] "Moral residue is often experienced as pain that is lasting, powerful, and felt deeply, and it may remain after values and ideals have been compromised."[36(p5)] Moral distress is prevalent in nursing and is associated with unsupportive health care systems, poor leadership, bullying, incompetent colleagues, and poor care practices.[37] The ethical obligation to make amends arises in this case to self, to the patient, and to the team.

The sense of failure felt by some of the nurses represents moral distress linked to the ethical obligation to "right the wrong" that had been enacted on Ashley. Within Ashley's case, the nurses' moral distress may have stemmed from (1) the perception that the physician's comment reflected biased care and (2) fears of the adverse ramifications of speaking up. Many strategies have been proposed to mitigate moral distress and bolster ethical capacity.[36] Reflective practice, guidance on ethical care and fostering a growth mindset, and adequate use of nurse self-care practices can mitigate moral distress.[36] Staying silent about the ethical dilemma led to moral distress and lingering moral residue that would require time and honest reflection to understand, without making progress toward a more trans-inclusive health care system.

NURSING IMPLICATIONS

These dilemmas illustrate how nursing practice could have been different in Ashley's care and promoted the provision of affirmative, trans-inclusive PPNC. Although the considerations below would not have prevented Ashley's death, they would have substantially improved the experiences for everyone involved, including Ashley, her mother, her friends, and members of the health care team. These implications provide a compelling rationale for the adoption and implementation of the ethical approach presented above.

Language and Communication

As discussed, the core of the ethical dilemmas within Ashley's case focuses on errors with communication. What if the language had been different? What if the team members in the room had communicated in a manner that was respectful and had honored Ashley's gender identity, as recommended by cultural humility? What if those present had challenged the physician and addressed the offensive comments? Although Ashley's death seems inevitable because of her injuries, a different atmosphere might have resulted in more dignity for her at death. The team had a clear and compelling ethical obligation to honor the dignity of the human being in their care and speak about her respectfully.

There was a need to address the comments to bring attention to the explicit and implicit biases underlying the comments. Nurses who used the CAMPERS approach and thus were aware of their biases and consciously engaged in corrective actions could have enhanced the provision of affirmative, trans-inclusive PPNC for Ashley by providing her with a respectful and safe environment. Whether the comments had been challenged in the moment or during the subsequent debriefing rounds, nurses on the care team had a second obligation to address inappropriate comments to promote the growth of ethical practice for the whole interdisciplinary team. These uncomfortable conversations can be guided by the proposed

ethical approach. First, nurses could have a clear purpose for the conversation in which the comments are addressed. The conversation could invoke cultural humility and awareness of personal attitudes and beliefs about the nature of the comments and reactions to them. When confronting the comments, nurses could provide support and a plan to promote collaboration and respectful communication between all team members. Inherent within the comments was a lack of understanding of the patient, which would require exploration and selfreflection. Following a group ethical violation, the whole team requires an opportunity to engage in reflection and to explore individual- and system-level opportunities for growth and development.

Values, Beliefs, and Preferences

Despite following their legal obligations by adhering to the decisions of the next of kin, the health care team missed key opportunities to learn more about Ashley's values, beliefs, and preferences, which could have informed the provision of affirmative, trans-inclusive palliative and end-of-life care. Ashley's friends attempted to convey what they knew of her wishes, but were not given entrée into care by Ashley's mother or the interdisciplinary team. While the members of the health care team could not legally provide the friends with access to Ashley, they could enlist other members of the care team, such as specialty palliative care, social workers, or chaplains, to speak with Ashley's mother. Collectively, the team could have advocated for Ashley by talking with her mother to identify mechanisms by which she would allow Ashley's friends to share their knowledge of her values, beliefs, and preferences. With her mom's permission, the team could have identified who among Ashley's friends should be trusted to provide this information and used what they learned about Ashley to guide the plan of care.

Total Pain: A Holistic Imperative

Palliative nurses have an ethical obligation to provide holistic care to patients, which includes assessing and intervening in the multifactorial elements of pain.[38,39] Nurses could enhance the provision of PPNC by working within their full scope of practice to respond to Ashley's need for holistic pain management. Concurrently, team members, such as social workers or chaplains, could be consulted to implement interventions targeted toward other elements of pain, such as psychological or spiritual, and to aid in the soothing of potential social pains due to isolation from loved ones. Specialty palliative care could assist the team in addressing multiple aspects of Ashley's care, especially when it was clear she would die. Responding to a patient's total pain requires a coordinated team approach.

Bereavement

The provision of bereavement care for family and friends of patients who have died is an imperative in PPNC. Nurses knew and should have acknowledged that multiple individuals experienced a loss, not just the legal next of kin. LGBTQ+ partner bereavement is complicated when health care teams deny partners access to the bedside of a dying patient, when sometimes estranged biological families are given preference and support disproportionately over the patient's chosen family, and when society and the health care system express their lack of acceptance of the relationship.[40] Systemic barriers do not absolve nurses of ethical obligations. The nurses caring for Ashley needed to

provide unbiased palliative and end-of-life care by supporting both her biological and chosen families in acknowledging their loss without partiality and connecting them with bereavement services.

Obligation to Make Amends

Although the team members in the case are unable to apologize to Ashley, her family, and her friends for their ethical errors, they could still make amends in other ways. By using the proposed ethical approach, engaging in continuous self-reflection, integrating cultural humility into care, and seeking opportunities to learn more and grow, the nurses who cared for Ashley would be taking incremental steps toward making amends. Doing this requires the health care team to acknowledge the mistakes they made in Ashley's care, to engage in culturally humble reflection, and to develop a new strategy that integrates a better awareness of their own beliefs, emotions, and reactions. Intentionally seeking to make amends for prior ethical lapses promotes the provision of affirmative care to all trans patients who will receive care in the future and may help reduce their hesitance to seek care based on past negative experiences. Nurses can take targeted steps to change the overall culture of their health care systems to enhance the provision of affirmative, trans-inclusive PPNC.

CONCLUSION

In this article, the authors presented the case of Ashley, a trans woman who arrived to an emergency department unconscious after an accident. The case raised several ethical dilemmas, and in response, the authors proposed an ethical approach to meeting these challenges. Integrating cultural humility, moral archeology, and the CAMPERS framework, the approach fosters the development of the skills and self-awareness needed to provide affirmative, trans-inclusive PPNC. When applied to Ashley's story, this approach identified key ethical issues that went unaddressed, holding promise to change the culture and practices of palliative nurses and avoid similar injustices in the future. As Ashley's story demonstrated, palliative nurses have an ethical obligation to provide care that meets patients where they are, including at their moments of highest need, while satisfying professional and humanistic codes of ethical practice. The approach described above can help with this complicated task.

NOTE ON TERMINOLOGY AND COMMUNICATION

Provider and nurse communication can cause significant harm to patients, so communication skills lie at the foundation of affirmative, trans-inclusive care interactions.[4] The language used by providers and nurses can carry substantive bias that reinforces stigmatization of and discrimination

against trans patients. The moment that communication is used to define an “other” represents the critical moment that precludes authentic understanding, for example, knowing the patient and providing ethical care. Using targeted language that labels patients' gender without their disclosure implicitly invokes a hierarchical relationship that disempowers the receiver.

The authors of this article recognize that the labels of trans, transgender, gender diverse, and others are potentially powerful tools for marginalization and affirm the right of all people to choose descriptors for their gender identity. They acknowledge that the terms used in this article may not reflect all gender-diverse individuals, nor do they depict a norm for non-*cis* gender identities. To facilitate communication in this article, the decision was made to use the umbrella term of trans to represent, without reducing, the complexity of the pluralistic identities encapsulated within the construct of gender, setting our strongest focus on those "whose gender differs from the one they were assigned at birth."[22(p468)] For further discussion, the reader may refer to Campbell and Catlett,[22] who present a summary of key terms pertaining to gender identity in a prior case article published in the *Journal of Hospice and Palliative Nursing*.

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