

**Queering Baccalaureate Nursing Education in Canada: A Survey and
Qualitative Content Analysis of Curriculum and Policy Documents**

by
© Chris Shortall
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Memorial University of Newfoundland and Labrador
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Abstract

Lesbian Bisexual Gay Transgender Intersex and Queer (LBGTIQ, See: Appendix A) health and wellness data is largely ignored in policy domains. One way to redress the deleterious health effects of institutionalized cisgenderism and heterosexism is to train health professionals to be sensitive and knowledgeable about health and wellness issues that are known to greatly affect sexually and gender diverse people (aka: LBGTIQ). Studies have found that there is no standardization of sex and sexuality content in health professional education in North American universities. The present research focuses on the relative inclusion of sexuality and gender diversity health and wellness information in Canadian English language baccalaureate nursing curriculum and curricular policy. This research, informed by documented health and wellness experiences of LBGTIQ people, situated in the academic discipline of Applied Health Services Research, is a unique critical queer theoretical analysis of survey data and policy texts. The data for this research was collected from a nationwide survey of nursing school administrators in 2013, is scaffolded against LBGTIQ health and wellness literature, as well as nursing education policy. Surveys were returned from 17/76 institutions in Canada and the results show that LBGTIQ content in baccalaureate nursing curriculum in Canada is nominal, imperfect, and unregulated at best. Faculty were concerned about their own personal and professional ability to teach in the area of sexuality and gender diversity and less concerned with curricular policy advocacy in the area. After qualitative content analysis was performed on 52 educational policy documents in nursing, there revealed a need for inclusive policy development in the area of LBGTIQ subjectivities. The research found that while Canadian English language baccalaureate nursing curricular policy allows for an expanded notion of gender diversity that may give space to transgender people, queer, intersex, and other non-heteronormative notions of gender identity, it lacks clear position statements in the area of sexuality and gender diversity to be able to achieve inclusion in curriculum. The result is invisibility; haphazard inclusion; ill-defined policy with no directive from the national, provincial/territorial professional organizations. It was noted that the change in licensing exam might have affected the situation during the course of this research. Several recommendations are lobbied towards structuring LBGTIQ health and wellness curricular inclusion at the various levels of policy and pedagogy in baccalaureate nursing curriculum in Canada and a call for the nursing profession to pay attention to the political nature of policy.

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List of Abbreviations

ACNL	AIDS Committee of Newfoundland and Labrador
AFMC	Association of Faculties of Medicine of Canada
AGM	Annual General Meeting
APA	American Psychological Association
ARTC	Atlantic Regional Training Centre
B.Sc.	Bachelor of Science
B.Sc.N.	Bachelor of Science in Nursing
BC	British Columbia
BDMS	Bondage Dominance Masochism Sadism
BN	Bachelor of Nursing
CASN	Canadian Association of Schools of Nursing
CCRN	Canadian Council of Registered Nurse Regulators
CHA	Canada Health Act
CNA	Canadian Nurses Association
CRNBC	College of Registered Nurses of British Columbia
CRNE	Canadian Registered Nurse Exam
CRNNS	College of Registered Nurses of Nova Scotia
DSM	Diagnostic Statistical Manual
EBR	Evidence Based Research
FtM	Female to Male
GUYZ Project	Gay Urban Youth Zone Project
HIV/AIDS	Human Immuno-Deficiency Virus – Acquired Immune Deficiency Syndrome
HPV	Human Papillomavirus
HREA	Health Research Ethics Authority (MUN)
ICU	Intensive Care Unit
LBGT	Lesbian Bisexual Gay Trans
LBGTIQ	Lesbian, Bisexual, Gay, Trans, Intersex, Queer
LPN	Licensed Practical Nurse
MSM	Men who have Sex with Men
MtF	Male to Female
MUN	Memorial University of Newfoundland
NCLEX-RN	National Council Licensure Examination for Registered Nurses
NCSBN	National Council of State Boards of Nursing
PDF	Portable Document File
PHAC	Public Health Agency of Canada
PLA's	People Living with AIDS
PTSD	Post Traumatic Stress Disorder
RN	Registered Nurse
RNAO	Registered Nurse' Association of Ontario
RPN	Registered Practical Nurse

STI	Sexually Transmitted Infection
UK	United Kingdom
US or USA	United States of America
WSW	Women who have Sex with Women

For more definitions of sexuality and gender identity terms please refer to Appendix A

Chapter 1: Introduction

1.1 Research Aims and Objectives

This research is exploratory, investigational, and aims to give insight into the topics of sexuality and gender identity content in English language Canadian baccalaureate nursing curriculum and policy. As a masters thesis, this project was designed to identify a topic, develop a research question, design, implement, and report the project; however, this is only the bare minimal most basic part of the work. It may begin to lay the foundation for additional research and possibly a different future if there is uptake. This research queries Canadian baccalaureate nursing curriculum and policy for sexuality and gender diversity as Obedin-Maliver et al. (2011) investigated medical curriculum (see also: Coleman et al., 2013), Mulè (2006) analyzed social work curriculum policy, and most recently Lim, Johnson, and Eliason (2015) studied baccalaureate nursing curriculum in the United States (USA). In some ways this research also equates with the Canadian critical policy analyses of Mulè et al. (2009), Jackson et al. (2006), and Daley, (2006) while also highlighting important and readily available lesbian, bisexual, gay, transgender, intersex and queer (LBGTIQ) grey literature on health and wellness issues (see: section 2.3). It is research that has not heretofore been conducted regarding a population that is newly defined (see: Appendix A)

This thesis uses a survey (see: Appendix C) and critical discourse analysis to review Canadian baccalaureate nursing curriculum and policy. It is situated in the field of Applied Health Services Research. Its focus is on educational content and

curricular policy leading to the designation of registered nurse entry to practice for issues relevant to sexually and gender diverse people. It presents a synthesis of known health and wellness issues that affect LBGTIQ individuals, communities, and populations only recently synthesized (see: Section 2.3). It concurrently utilizes qualitative and quantitative analysis of nursing curriculum and curricular policy for relevant themes. It investigates if sexuality and gender diversity health and wellness information is being taught in nursing programs, and if not, why.

This research focuses on findings of what is currently being taught in English language baccalaureate nursing curriculum within an awareness of what could be taught, as well as the relevant Canadian curriculum policy framework. The findings highlight the possibility of heteronormativity, and cisgenderism in Canadian English language nursing pedagogy. This research does not posit any hard and fast solutions, nor does it fully investigate the rubric of teaching and learning or make assumptions for other health care professions outside of nursing. What follows is an academic understanding and narrative that will address the research question and provide insight into the divergent fields of queer theory (see: section 3.2), qualitative research methods (see section 3.1), and Canadian undergraduate nursing curriculum and curricular policy. This research sits at the intersection of several bodies of literature, first and foremost being LBGTIQ health and wellness issues that cut across micro/individual, meso and macro/structural issues. This thesis attempts to utilize accessible language and may be an advanced primer for anyone interested in the broad and complex field of sexuality and gender diversity. This thesis focuses

on systemic level of change rather than at the individual level of faculty teaching because a social psychological frame for including LBGTIQ health and wellness issues in curriculum results in a dead end of finger pointing at faculty members as problematic and a need for 'reproductive labour' with each individual. Pinar (1998) citing Seidman (1993) argues for a shift away from the preoccupation with self and representational characteristics (and postmodernism in queer theory) to a structural level analysis that embeds the self in institutional and cultural practices. It is from this stance that the present research is framed. The present research focus' not on the lived experiences of LBGTIQ people (the self and representational characteristics of identity politics) nor on the faculty members involved in delivering curriculum but on how established curriculum procedures and policy conveys sexuality and gendered subjectivities.

1.2 Research Question

What information on sexuality and gender diversity health and wellness exists in Canadian English language baccalaureate nursing programs and related policy? or - How do Canadian baccalaureate nursing programs and related policy conceptualize and teach information on sexuality and gender diversity health and wellness?

1.3 Research Objectives

1. Report on the queerness of Canadian baccalaureate English language nursing curriculum and curricular policy that is designed to prepare nurses for entry to practice relating it to available resources.

2. Survey administrators of English language nursing schools in Canada about baccalaureate entry to practice programs to identify how, if and where sexuality and gender diversity core competencies, and specific LBGTIQ health and wellness information exist in nursing curriculum, as well as to request curriculum examples.

3. Develop a comprehensive list of sexuality and gender diversity health and wellness issues, and available LBGTIQ curriculum and policy resources through a literature review of published documents, which would be both academic and community-based.

1.4 Applied Health Services Research

The thrust of Applied Health Services Research is to develop and utilize research for the betterment of health services. It has been shown that access to health services indeed reduce health inequalities, and usually the concluding arguments suggest educational initiatives to achieve appropriateness/betterment/effectiveness of health services (McKee, 2002). The current research defines Applied Health Services Research as the field of inquiry that examines quality, delivery, and outcomes of health care services to produce new knowledge about the effects of health services for individuals and populations

(Thaul, Lohr, and Tranquada, 1994). To these ends, an investigation of LGBTIQ health and wellness issues in curricular and policy documents would reveal knowledge about the quality of health care delivery for these peoples.

Applied Health Services Research became a burgeoning field in the 1960's when scientific information and policy deliberation were beginning to coalesce (Mykhalovskiy, 1999). "Health services research does not designate a specific discipline, but an area and program of empirical inquiry. [It] is not clinical research but research into the delivery of clinical services [...] Health services research is further distinguished by its highly applied character" (Mykhalovskiy, 1999, p. 30). It is an increasingly sophisticated field that ranges from health care management and health policy making, to applied clinical and population-based research. Applied Health Services Research utilizes all qualitative and quantitative methods across the board to ask questions of the healthcare system. It focuses on performance, quality, effectiveness and efficiency of health care services as they relate to health problems of individuals and populations, as well as health care systems (Mykhalovskiy, 1999). Mykhalovskiy (1999), goes on to identify that Applied Health Services Research addresses wide-ranging topics of structure, processes, and organization of health care services; their use and people's access to services; efficiency and effectiveness of health care services; the quality of healthcare services and its relationship to health status, and; the uses of medical knowledge. Lomas (1993) popularized the area of Applied Health Services Research, and while some disciplines are still not

catching on to its utility, the tenants of Applied Health Services Research are transferrable across all disciplines concerned with population health.

The difficulty of researching Applied Health Services Research is that it is a relatively new field that still goes unmentioned by many academics (see: Phillips, 2006). Without calling it as such, Spenceley, Reutter, and Allen (2006) assert that nurses' advocacy at the policy level is lacking. They state that nurses have been too insular and they have not gone to great lengths to affect client group advocacy in the health care policy domain (Spenceley, Reutter, and Allen, 2006). This identified weakness of the nursing discipline to engage with policy is partly why a student in a faculty of nursing did not conduct this research.

1.5 Positioning the Researcher

What follows may not actually give any background to the proposed research or inherently suggest or delineates any potential bias that I may harbour, but it is the beginning of an attempt to be reflexive in writing. Being reflexive is a qualitative research technique that attends to the problematic notion that scientific inquiry is objective and the researcher as a disengaged participant in the development of truth making. Reflexivity is a postmodern research notion that refutes that 'truth' is simply out there for the researcher to find and report on; it assumes that the researcher brings their own social location to the project. I am a queer, white, English-speaking male in my mid-thirties. I grew up middle class in St. John's, Newfoundland and resided here almost my entire life. One could say I am the gay

status quo, and if you didn't know my sexuality, I could pass as a completely average cisgendered person of unacknowledged white privilege. I completed an undergraduate degree (B.Sc.) in Psychology and Sociology at Acadia with Honours (2002) and when I returned to Newfoundland I undertook coursework in Social Work and was working towards a Masters degree in Sociology at MUN. I withdrew from that program to work nonprofit, on the Gay Urban Youth Zone (GUYZ) Project at the AIDS Committee of Newfoundland and Labrador, and subsequently worked as an AIDS educator for about two years prior to beginning the MUN ARTC Masters program in Applied Health Services Research.

I have always been interested in action research and social justice. While at Acadia, my thesis was a social psychology student evaluation of the campus-based computing environment, and I was heavily involved with the campus-based LBGT group. Upon returning to Newfoundland I was involved in a multitude of campus-based social justice organizations. It was during my time with the AIDS Committee that I passionately began exploring how heterosexism impacts people. I had been a queer activist and academic for about nine years but, at 27 years of age, while working on the education and outreach project for young gay men, someone asked me to name a LBGTIQ sensitive doctor. I didn't know anyone, I didn't have a doctor myself and I couldn't refer this person to anyone. I had also been employed as a Standardized Patient for the Medical School for a number of years, even working on developing and delivering a case for first-year students on communication skills and sexual identity. A confluence of factors influenced the decision to study this topic in

this way. My undergraduate degree in quantitative educational research, a supervisor who compelled me towards the current proposal and the release of studies investigating medical school curriculum were the main driving forces to develop this thesis as it is. I did not want something that was purely quantitative and the Obedin-Maliver et al. (2011) and Coleman et al. (2013) articles investigating medical school content were published while I was proposal writing. After several attempts in proposal writing under the direction of Dr. Diana Gustafson, my research topic shifted to qualitatively studying baccalaureate nursing education and related policy with regards to sexuality and gender diversity. The three year break between data collection and writing that unfolded due to family work obligations was also beneficial as Lim, Johnson, and Eliason (2015) published a comparable study that investigated baccalaureate nursing curriculum in the USA.

My position as a student of Applied Health Services Research rather than Nursing may have provided a challenge comprehending the areas of Nursing education policy and structure of Nursing education regulation as well as access to key curricular documents, however the outsider position as a queer, and a health researcher may have influenced the importance I place on the policy domain; an area known to be weak in nursing scholarly work.

1.6 Background Importance and Rationale

There is a gap in the literature around linking known LBGTIQ health and wellness issues to educational competencies in existing health care educational

policy. Lim, Johnson, and Eliason (2015) recently completed similar research in the USA focused on nursing educators' knowledge, ability and interest in teaching issues of sexuality and gender diversity. This research found that 75% of respondents cited the importance of reviewing curriculum to identify gaps in LGBT health. In Canada, the medical school equivalent (Obedin-Maliver et al., 2011) did not look at the structural framework for administering and regulating health care education. L'Heureux (2006) suggested that investigation is needed to assess the extent and quality of information being shared about sexuality and gender diversity health and wellness issues in health professional schools (p. 14). These excellent examples of similar research all seemed to have missed one or more component of the current research in Applied Health Services Research. In particular the critical content analysis of the policy domain. While adding greatly to the field of sexuality and gender diversity curriculum for health care providers in North America, these and other papers will be discussed later in the literature review.

Nursing scholarship was selected for analysis because it is the largest single identifiable health workforce population in the country. Canada's publicly-funded, not-for-profit healthcare system comprises a large workforce, mainly of nurses. In 2010, there were 268,512 registered nurses working in Canada, the single largest group of health care providers in the Canadian healthcare system (Canadian Nurses Association, 2012). They are also consistently rated as among the most trusted professionals in public opinion polls (Jones, 2005 as cited in Spenceley, Reutter and Allen, 2006). Nursing is perhaps the most important, overlooked, and

underappreciated, component of quality health care delivery in Canada (Storch, 2004).

Nursing curriculum, like any health professional curriculum, has a mandate to ensure graduates have competencies in patient-centered care, knowledge of particular health impacts, and an understanding of social determinants of health including cultural sensitivities. The recent change to standardize entry-level practice of nursing as Baccalaureate rather than diploma or certification, coupled with nursing shortages necessitates that graduates hit the ground running (Wolff, Pesut, and Regan, 2010). Wolff, Pesut, and Regan found that “education ought to prepare students for a variety of entry-level settings” (p. 189). As such, patient-centered care is an entry-level competency. Patient-centered care is the standpoint that orients care to be responsive to the humanistic idea of a person.

Nurses are taught, and teach themselves, methodologies for minimizing the emotional distress and embarrassment that their patients may experience. Disregard of such concerns and techniques... would reflect an uncaring attitude unbecoming to a member of the nursing profession, and [could] be an appropriate basis for disciplinary proceedings (Irvine, 2003, p. 179).

What follows next in the thesis is the presentation of information pertaining to health professional education, nursing curricular policy, and relevant LBGTIQ health and wellness issues in the literature review.

Chapter 2: Literature Review

The following section covers three divergent areas of literature: 1) health professional education pedagogy and policy, 2) LBGTIQ health and wellness issues, and 3) community identified core competencies and policy concerns. The literature reviews for these areas were conducted between 2010-2013 and again briefly in 2016. The literature was kept as focused as possible in the relevant areas however there appeared to be less information specifically about Canadian nursing education policy so the first broad area of literature was expanded to include health professions (primarily Canadian). These areas help identify the research as it lies within the structural processes and institutions rather than the individual, hermeneutic level. In the third chapter, Methodology, I will discuss queer theory as both a body of literature and a methodology. Discussing Queer Theory as solely a body of literature would potentially misrepresent it as something other than a worldview. Furthermore the area of LBGTIQ subjectivities was familiar to the author, the areas of Nursing Pedagogy and Applied Health Services Research, were not.

2.1 Health Professional Education, Pedagogy, and Policy

Nursing school curriculum in Canada is beginning to address the complexities of multiple social locations, without any standardized approach as the notions of cultural humility and cultural safety complicate already contested notions of cultural competence. First nations, multicultural/ethnic, and religious belief systems are

becoming to be acknowledged as teaching points, however Beagan (2000) studied Canadian health professional education and found that it aims to produce individuals who are intended to be relatively uniform in their attitudes, values, and future practice styles. Beagan suggests that institutional education of health professionals inoculates particular ways of being; Beagan found that Canadian universities encourage student physicians to believe that their own social location is not and should not be relevant during the patient interactions. While Beagan focuses on physicians, many of these Canadian institutions also have programs that educate nurses, and this type of standardized socialization can be said of most any educational program that is based on learning a particular and highly technical skill set.

Studies have found that there is a high degree of variability of sex and sexuality content in health professional education curriculum in North American universities (Barrett and McKay, 1998; Brondan and Paterson, 2011; Coleman et al. 2013; Colpitts and Gahagan, 2016; L'Heureux, 2006; Lim, Johnson, and Eliason, 2015; Malhorta et al., 2008; Mayer et al., 2008; Obedin-Maliver et al., 2011). These studies add that health care professional students lack accurate knowledge about important sexuality and gender diversity health issues (Coleman et al., 2013; Eliason, Dibble and DeJoseph, 2010; Gray et al., 1996; Rondahl, 2009; Rutter et al. 2008; Skelton and Matthews, 2001; Verdonk, Mans and Lagro-Janssen; 2006). So while these institutions are working to produce well-rounded and knowledgeable health care providers, it would appear that there is a lack of standardization in

sexuality health education in these programs and that these programs are ill-preparing health professionals to address the health and wellness issues of sexual and gender diverse as well as their own hidden assumptions on social location (Coleman et al., 2013).

Much pedagogy research focuses on the educator as site of influence, rather than the system, furthermore, outside of L'Heureux's community-based research, the studies referenced thus far have not investigated baccalaureate Nursing curriculum in Canada, a significant and noticeable gap in the literature. It was difficult to find relevant policy and pedagogy work in the area of queer health because it is such a new field, and sexual health pedagogy is not currently a favorable topic area of research.

As part of a larger research project L'Heureux (2006) *Environmental Scan* conducted telephone interviews with eleven English language schools of nursing in Canada:

- 2 BC Schools of Nursing
- 1 Northern School of Nursing
- 2 Prairies Schools of Nursing
- 3 Ontario Schools of Nursing
- 3 Atlantic School of Nursing
- 4 Quebec Schools of Nursing [not included in current research] (L'Heureux, p .6).

Interviews with these fifteen Canadian schools of nursing identified no mandatory course devoted entirely to LBGT health and wellness, often nonspecific content was included under the umbrella of diversity (L'Heureux, 2006, p. 6). LBGT health and wellness was not a primary focus in any institution but touched on

“several times in the single course”, “arises from student discussions only”, “material provided in the textbook”, “as part of a lecture in several courses”, “as a special topic in a 3rd year course”, “covered in one lecture”, “students are encouraged to reflect on LGBT issues”, “content is threaded through most if not all courses”, “part of the program's philosophy of inclusiveness, respect, and diversity”. L’Heureux (2006) presents a table that outlines in some cases the particular course and objectives, however, telephone respondents could not specify resources used in courses. “From the information provided through the telephone interviews it is difficult to assess the extent and quality of information being shared about LGBT health and access to care” (L’Heureux, 2006, p. 14). While comparisons cannot be made between exact institutions, ten years later, this research shows that there still appears to be no standard or consistency in LBGTIQ health and wellness content taught in Canadian schools of nursing.

L’Heureux (2006) found that most educational institutions expressed a desire to obtain resources; that there was coverage in some way or another without specifying resources or exact curricular content; and, there seemed to be a modest engagement with the LGBT community to exchange information, presentations, and student placements (p. 14). They reported the need for: 1) information/resources on issues of gender diversity and inclusive language, 2) research on access to care issues, and 3) training on how nursing students can approach the health history interview without immediately assuming heterosexuality (L’Heureux, p. 10). They

also requested consultation around the quality of resources being used in nursing programs.

Providing quality education is the responsibility of instructors, but it is the institutions and professional organizations that establish policies that dictate (in part) what is important to nursing practice, guiding these instructors and curriculum. “Currently shared accountability lies with provincial governments, regulatory bodies, educational institutions and healthcare organizations” (Wolff, Pesut, and Regan, 2010, p. 190). If a student passes their courses and subsequently graduates from an approved nursing program it is generally expected that they have acquired the proficiencies to pass the nursing exam and apply for licensure in their province/territory. It is not often questioned that the knowledge they may have acquired may not be 'good'. Beagan (2003) has taken this position of critiquing medical schools' ability to teach about social location and diversity, and Brennan et al. (2012) argue that there are weaknesses in Nursing curriculum with limited amounts of core sexuality and gender diversity content included. It must be noted that these critiques are rare within the profession.

Even the particulars of what is taught are potentially wrought with imbedded judgments (Wolff, Pesut, and Regan, 2010). Numerous theoretical and advocacy papers, as well as community-based research, have been written to redress this lack of attention paid to sexuality and gender diversity circulating in current health professional education, however, few have actually reviewed what content is in the curriculum (e.g. Bocking and Goldberg, 2006; Brennan et al., 2012; Brotman and

Ryan, 2001; Colpitts and Gahagan, 2016; Davis et al., 2000; Dunn, 2006; Fish, 2010; Israel and Tarver, 1997; Moser, 1999). Several authors have taken the approach of explaining how hegemonic ideologies are reproduced in educational training and suggest the negative impacts of it (Beagan, 2000; Eliason and Raheim, 2000; Grace and Hill, 2004; McGarry, Clarke, Cyr, and Landau, 2002; Noble, 2007). Scarce (1994) identified that even the published medical/scientific knowledge itself may be damning to particular subjectivities (see: Foucault 1975); discussing the medical condition Gay Bowel Syndrome (only renamed by the Canadian Association of Gastroenterologists in 2004 and the US Centers for Disease Control in 2005) Scarce highlights the ways in which social prejudices remain embedded in health-related discourses from the names of illnesses to the ways in which particular subjectivities are understood and communicated (chapter 1, Scarce, 1994). It would appear that the educational system and discourses used to discuss some particular issues take a long time to change, and critiques of it may be fraught with challenges.

Professionalism is touted as the main justification for initiating and including sexual and gender diversity content in health professional education.

Professional schools [and] continuing education programs [must] provide the training needed to improve the attitudes, knowledge, and skills of [health care providers] in caring for lesbian, bisexual, gay, transgendered people.... Without such training, sexual and gender minorities will continue to interact with a health care system that is unaware, insensitive, and unprepared to meet their needs (Mayer et al., 2008, p. 993-994).

Brennan et al. (2012) state that “faculty in schools of nursing need to incorporate content related to LBGTIQ needs across the curriculum to help eliminate

health care deficiencies and move toward the goal of health equity for all populations” (p. 103). Like the other authors mentioned above, they have suggested curricular reform without first identifying what is currently there in the curriculum. Other authors echo this statement and rationale for inclusion of LGBTIQ health and wellness issues and suggest health professional students should be taught to recognize inherent biases towards heterosexuality and cisgender/cissexual identity (see: Gray et al., 1996; Irwin, 2006; Manning, 2009). Sumara and Davis (1999) posit that interrupting heteronormative thinking in curriculum can also “create conditions for the human capacity for knowing and learning to become expanded” (p. 205); therefore it is not just professionalism at stake.

Of all the journal articles on the topic, Lim, Johnson, and Eliason (2015), is the one most relevant to the current research. These researchers surveyed 739 US nursing school administrative leaders, who returned up to 1231 completed surveys. They found that over 50% of respondents seldom to never taught the following topics in the last two years (12/13 topics):

- LGBT youth issues including bullying, suicide, homelessness ;
 - HIV/cancer screening and access to other early detection programs among LGBT people;
 - Approaches to HIV/STI risk reduction;
 - Obesity [management] among LGBT people;
 - Access to health insurance;
 - The need for referrals to appropriate social services;
 - The shortage of health providers knowledgeable and culturally competent in LGBT health;
 - High rates of tobacco, alcohol, and drug use among LGBT people;
 - Homophobia;
 - LGBT minority stress;
 - Prevalence of violence and hate crimes against LGBT people;
 - The need for LGBT health research;
- (Lim, Johnson, and Eliason, 2015, table 2, p. 147)

The authors go on to identify that the most frequently (~ 10%) taught topics were homophobia, and HIV/STI exposure among LGBT populations (indicating a limited and very specific discourse on what sexuality and gender diversity health and wellness entails). Seventy per cent of US nursing administrative leaders (n=1231) reported never or seldom reading about LGBT health related articles in professional journals, 80% indicated that their department never or only occasionally brought up LGBT health topics in faculty meetings, but 70% reported to be moderately or fully ready to teach LGBT topics (Lim, Johnson, and Eliason, 2015, p. 147). This suggests that despite their willingness, US nursing faculty are unprepared to teach on topics related to LBGTIQ health and wellness.

2.2 LBGTIQ Health and Wellness from a Policy Perspective in a Federal Health System

In the federal system of Canada, the provision and regulation of healthcare is provincial while funding is national. The system allows for the nuanced variations of delivery for each province and particularities of the regions. The Canada Health Act (1985) is the policy basis for health care provision in Canada. While focusing on criteria and conditions for cash transfers, the Canada Health Act outlines a publically funded and insured health care system that positions health services as an entitled right to all citizens everywhere in the country. The Canada Health Act also is problematic in its outlining of health care priorities, goals and specifics of workforce preparation. The Canada Health Act has been critiqued using the notion of sexual

citizenship. Daley (2006) suggests that people of diverse sexual identities are invisible, ignored, and categorically denied in Canadian federal health policy. Daley further argues that universality and accessibility, foundational in the Canada Health Act, relies on the presupposition that people of diverse sexualities and genders already have rights and entitlements, while outlining research exemplifying how, in particular, gay men and lesbians, do not receive health care services on uniform terms and conditions. “The understanding of universality and accessibility in terms of monetary, biomedical and geographical resources fails to address the differentiated health care experiences of Canadians based on their social locations as gendered, racialized, and sexualized citizens” (Daley, 2006, p. 801). Daley asserts that while identity politics create social locations that implicate good/bad, insider/outsider versions of those positions, “the notion of sexual citizenship is about the extent to which a person's sexual [identity] status restricts [read: mediates] access to citizenship in terms of social, civil, and political rights” (p. 798). Many of the same federal health policies have also been critiqued due to their particular focus on individual behavioral interventions rather than structural (population level) approaches, again using a framework of sexual citizenship/social location (Colpitts and Gahagan, 2016; Jackson et al., 2006).

Whose Public Health: An Intersectional Approach to Sexual Orientation, Gender Identity and the Development of Public Health Goals for Canada (Jackson et al., 2006) critically examines Canada's contribution to the field of public health with a particular emphasis on the social determinants of health as they relate to people of

diverse genders and sexualities. Jackson et al. (2006) argue that conventional approaches to population health research (and policy) measure health disparities of 'minority groups' against the experiences of those in the general population (an unexamined norm of those in the dominant social position). The weaknesses of this framework thereby greatly affect people of different markers of social location (races, ethnicities, genders, classes, sexualities, ages, abilities, geography, etc.) due to their comparison to an unexamined norm compounded by an inability to comprehend the problems of multiple intersecting social locations. Similar to standard deviations from the mean, this is the notion that outliers are examined in relation to an uncriticized mode. Jackson et al. (2006) suggests that intersectional anti-oppressive analysis is the way to correct the lack of examination of the dominant social position prevalent in much Canadian public health research and policy. Intersectional Anti-Oppressive Analysis is not a new concept, Intersectionality was coined in 1989 by Kimberle Crenshaw and is used often by Social Work academics.

In light of this ignorance of LBGTIQ health and wellness issues, Mulè et al. (2009) argue that LBGT people's health and well-being issues need to be addressed through inclusive policy development. By way of critical analysis, Mulè et al. examine the extent to which gender identity and sexual orientation are recognized in Canadian health promotion policy. The authors suggest that addressing sexuality and gender identity health and wellness disparities must be foregrounded in a recognition of the diversities of social locations of sexuality and gender diverse

populations, but begin with the development of substantiated critical constructivist knowledge and structural analysis, leading to transformative practice. This thesis aims to add to the critical constructivist knowledge for nursing policy.

Smith (2006) further exposes a specific dominant social location in Canadian political economy by way of discussing the most common public policy issues raised by the LBGT movement in Canada: 1) freedom from discrimination, 2) relationship recognition/gay marriage, 3) hate crimes/hate speech, 4) sexual freedom and moral regulation¹, and 5) social policy (including health policy). Smith states, recognizing the complexity and lack of scholarship on queer health policy:

the health needs of bisexual citizens are not the same as the health needs of transsexual citizens. Hence, these policy areas pose a deeper challenge to conventional policy processed and policy analysis than the simple inclusion of LBGT citizens as an undigested group, defined by sexual orientation... (Smith, 2006, p. 15).

After discussing similar challenges with feminist inclusive policy development in Canada, Smith (2006) concludes that sexual and gender diverse citizens and their voluntary organizations are not formally or routinely consulted during engagement exercises and their interests are not systematically included in all areas of policy analysis. Mulè et al. (2009) also concluded that it is extremely important for educational institutions to take on the work of inclusive policy development, but does not outline how or what that would look like. In the discussion section of Lim, Johnson, and Eliason (2015) the authors note that the Association of American Medical Colleges has issued clear recommendations for

¹ Justice Minister Wilson-Raybould tabled a bill changing the age of consent for anal

including LGBT relevant content for medical schools and medical educators, but the equivalent American National League for Nursing, and the American Association of Colleges of Nursing do not have such initiatives (p. 150). It is unknown what the Canadian nursing associations have in the way of recommendations for including LBGTIQ relevant content for nursing schools and nursing educators, but it is clear in the literature that inclusive policy development must include representation from the target populations and have buy in from professional organizations who will use the policies.

One of the greatest threats to the appropriate inclusion of sexual and gender diverse health and wellness issues into policy directives is the purported lack of scientific information about the topics. Existing population health research is cited as problematic because many surveys do not ask adequate questions about sexuality and gender diversity; consequently, non-heterosexual and alternatively-gendered people are either overlooked or ignored (Jackson et al., 2006 p. 27; see also Colpitts and Gahagan, 2016). However, Jackson et al. go on to state:

Extensive international literature reviews have revealed that the physical and mental health of LBGTIQ people is significantly affected by discrimination... The [well-documented] health effects... has also resulted in their reduced access to quality health care and [subsequently] under-utilization of health services (Jackson et al., 2006, p. 4).

What this quote indicates is that while there are research gaps, like any and every important research area, there are also numerous authors expressing a growing concern that sexual orientation and gender identity are not being paid particularly close attention (see: Banks, 2001; Banks, 2003; Canadian Rainbow

Health Coalition, 2006; Coalition for Lesbian and Gay Rights Ontario, 1997; Coleman et al., 2013; Makadon et al., 2008; Namaste, 2000; Shankle, 2006). A lack of action on the available information of sexual orientation and gender identity health and wellness information is usually cited as a need for more evidence informed research.

The available literature investigating LBGTIQ health and wellness is often written from the patient's perspective rather than any other framework. This credible phenomenological epidemiological information available about sexually and gender diverse subjectivities is rarely synthesized, but there is more than enough available information if someone were interested in seeking it out and compiling it (see: Auger, 2003; Banks; 2001; Banks, 2003; Brotman, Ryan, Collins et al., 2007; Dean et al., 2000; Makadon et al., 2008; Sinding, Barnoff and Grassau, 2004). Like the recent tactic of female White House staffers called 'amplification'; information needs to be reiterated as a consistent message, each time it is reiterated, it gains more ground². With the thrust of Applied Health Services Research, there is a need for systems-level analysis of LBGTIQ health and wellness concerns because despite the depth and breadth of phenomenological individual level health research and its sometimes incongruent methodologies and results, thus far LBGTIQ health and wellness concerns have ultimately failed to take hold at the policy level.

There are some very real and many perceived structural barriers to inclusion of new or previously ignored information in the domain of healthcare policymaking.

² Retrieved March, 23, 2017, from
https://www.washingtonpost.com/news/powerpost/wp/2016/09/13/white-house-women-are-now-in-the-room-where-it-happens/?utm_term=.1ced50861093

Spenceley, Reutter, and Allen (2006) identify some challenges to uptake that nursing has faced with regards to policy work stating that “the individually focused view has had the effect of limiting our [nursing’s] assessment of the root causes of injustices or inequalities, leading us to pursue short-term, one-off solutions to the individually experienced effects of systemic problems” (p. 183). Almost as if channeling Daley (2006), Jackson et al. (2006), and Smith (2006), Spenceley, Reutter, and Allen (2006) go on to assert that policy advocacy is political and is intended to improve individual and population health by influencing system-level decisions, but that there is not an extensive body of literature on policy work in nursing and that nursing is virtually invisible in terms of policy influence (p. 184). Spenceley, Reutter, and Allen (2006) go on to suggest that nursing education has done little to equip nurses to engage in policy advocacy, and that there is a tendency to be inwardly focused in nursing inquiry, yet nurses are uniquely positioned to significantly contribute to policy discussions in the vein of applied health services research.

At the time of writing this thesis, the literature usually directs any curriculum changes at the individual level of educator, or front line practice nurse. The available literature does not appear to adequately address the structural framework for nursing education. Knowledge translation is imperative. Any 'higher level' policy-based analysis of curriculum it was identified must take into account the regulatory bodies which are tasked to set standards regarding educational competencies and standards.

Registered nursing is a self-regulated profession in Canada. Through provincial and territorial legislation, nursing regulatory bodies are

accountable for public protection by ensuring registered nurses are safe, competent, compassionate, and ethical practitioners. Regulatory bodies achieve this mandate through a variety of regulatory activities such as registration and licensure, professional conduct review, setting standards governing nursing practice and education, describing the scope of registered nursing practice, and identifying competencies required for entry-level registered nurse practice (Canadian Council of Registered Nurse Regulators (CCRNRR) 2012, p. 5).

2.3 LBGTIQ Health and Wellness Issues

Diverse sexual and gendered individuals addressed in the current research are recognized as a social location and a cultural group by World Health Organization standards and Canadian Human Rights legislation. Recently they have come to be identified as *sexual citizens*, as described above, but this is also problematic because sexuality in sexual citizenship fails to include gender diversity (see: Daley, 2006). Smith (2006) further articulates that transgender issues do not equate with bisexual issues; the sexually and gendered diverse are therefore a community of communities. These extremely diverse people, comprise a sometimes identifiable, mostly invisible 'minority' group that could better be understood as a swarm or a cluster than a cultural group. Unlike other groupings based on religious beliefs/practices, biology, or geographic location, the sexual and gendered diverse are a fluid populace that everyone may at some point be labeled as or participate in. Their group membership has no fixed boundaries or in group membership to define them.

Sexual orientation is a protected characteristic under human rights legislation in every jurisdiction in Canada, yet sexuality remains an under-

acknowledged characteristic in many instances (of life) and only encompasses half of the current research area. Representing the other half of the research area, gender diversity has only been written into the human rights legislation in the Northwest Territories and there are more struggles regarding gender identity rights emerging in Canada daily³. Understood and defined in increasingly fine-tuned academic discussions concentrating on characteristics such as: behaviours, identity, preference/attraction, presentation/expression, cultural norms, community organizing, rights as well as health; the sexuality and gender diverse are everywhere, multiplying, and no two are the same [see: Appendix A]. Thankfully, improved societal acceptance and recognition of sexually and gender diverse people has resulted in less direct and outright violence; however, the prejudice and oppression now appear more subtle and embedded. Characterized by a lack of knowledge and little recognition about non-heterosexual and alternative sexed/gendered people, heterosexism and transphobia exists (Shelton and Delgado-Romero, 2011). Further complicating matters on this sensitive topic, is the trend in scientific literature for non-heterosexual and transgender people to be generally understood in relation to normative constructs of sexuality and gender (see: Bornstein, 1998; Katz, 2007; Mattilda, 2006). LGBTIQ people are in fact an ever-increasing range of people who for various reasons do not fit heteronormative ideas

³ Justice Minister Wilson-Raybould tabled a bill changing the Criminal Code and the Human Rights Act to include gender identity and gender expression. Retrieved March 23, 2017, from <http://www.cbc.ca/news/politics/transgender-bill-trudeau-government-1.3585522>

of sexuality and gender diversity (Jagose, 1996; Katz, 2007; Mattilda, 2006; Noble, 2007).

Boehmer (2002) suggests that historically people of diverse sexualities and genders have not been identified as a population with specific health and wellness concerns outside of a framework of sexual deviance or sexually transmitted diseases. While this is beginning to change as rights are being gained in the area of relationship recognition and freedom from discrimination, medical discourses are still being critiqued for framing sexuality simplistically as a matter of STIs/HIV and contraception/pregnancy, ignoring a range of other factors (Coleman et al., 2013; Dean et al., 2000; Makadon et al., 2008; Steinauer et al., 2009). Intersectionality would suggest that all social determinants of health affect and compound the issues faced by sexual and gendered diverse peoples (See: Dean et al., 2000; Jackson et al., 2006; Makadon et al., 2008). The removal of homosexuality as a mental illness (1987) from the American Psychological Association's *Diagnostic and Statistical Manual* and the current renaming of gender identity disorder as 'gender dysphoria' indicates profound changes in the ideological understanding of LBGTIQ people (APA, 2013).

Outside of the noted exclusion as sexual citizens [read: heterosexism and oppression as a cultural group], the problems on an individual level are characterized more often by what is termed micro-aggressions; "communications of prejudice and discrimination expressed through seemingly meaningless and unharmful tactics" (Shelton and Delgado-Romero, 2011, p. 210). Primarily used in

race theory, microaggressions are often delivered by well-meaning and well-intentioned individuals who are unaware of the unconscious biases that they hold (Shelton and Delgado-Romero, 2011). Assumptions of having an opposite-sex partner or a biological match to a particular gender presentation are primary sites for microaggressions that affect the health care that sexually and gender diverse people receive (see: Brotman et al., 2007; Harbin, Beagan, and Goldberg, 2012; Kitzinger, 2005; Mathieson, Bailey, and Gurevich, 2002). These assumptions (and the communicated microaggressions) convey insensitivities and lack of knowledge about the social location and lived realities of individuals that are non-heterosexual and non-cis-gendered. Morrison and Dinkel (2012) state that there needs to be a distinction made between heterosexism and homophobia “because heterosexism does not require an overtly homophobic attitude on the part of the individual, the well-meaning nurse could be alienating patients unintentionally”(p. 129); thus keeping with Shelton and Delgado-Romero (2011) notion of micro-aggressions. The injury to the well-being of sexually and gender diverse people comes with the regularity and accumulation of these small injustices, insensitivities, and ignorance that end up promoting an unwelcoming environment, devaluing and, ever so slightly discriminating against sexually and gender diverse individuals. Morrison and Dinkel (2012) outlined antecedents (such as societal hegemony) and consequences (impacts on sexually and gender diverse people) by way of concept analysis in health care.

The simple fact is that some sexual and gender diverse people may be treated by caregivers who are unaware or insensitive to their health care needs (Aguinaldo, 2008; Bonivicini and Perlin, 2002; Fish, 2006; Harbin, Beagan, and Goldberg, 2012; Hinchliff, Gott, and Galena, 2005; Moser, 1999). Compounding assumptions and insensitivities of health care providers can (and do) perpetuate existent health and wellness issues of sexual and gender diverse people, in some cases causing adverse health consequences, the least of which is delays in seeking care (See: Dreyer, 2007; Harbin, Beagan, and Goldberg, 2012; Meyer et al., 2008). Due to a lack of relevant, up to date, and sensitive information circulating in the workforce of the existing healthcare domain, sexual and gender diverse people are at increased risk of near misses. They face insensitivities in health care services due to personal, social and cultural prejudices, and have interrelated compounded social determinants of health consequences (Banks, 2003; Dean et al., 2000; Fish, 2006; Irwin, 2006; Johnson, Mimiaga, and Bradford, 2008). Situations arise where the (in)visibility of sexuality and gender identity force sexual and gender diverse people to avoid seeking care, receive inappropriate care, or face prejudices when seeking care (Brotman et al., 2007; Harbin, Beagan, and Goldberg, 2012; Irwin, 2006; Kitinger, 2005; Neville and Henrikson, 2006). The literature is replete with these accounts and discourses. A synthesized list of relevant, researched and researchable, health and wellness concerns facing sexual and gender diverse people is presented below as Table 1. It is non-exhaustive and the health issues are presented in no particular order but give

an idea of the complex network of health issues facing sexually and gender diverse individuals (mostly accredited to Dean et al., 2000).

Table 1: Known LBGTIQ Health and Wellness Issues

Sexual Health
<ul style="list-style-type: none"> • HIV/AIDS- compounded by high risk behaviour and sensation seeking • Hepatitis A and B vaccination for gay men • Enteritis (giardia, amoeba) • HPV • Bacterial Vaginosis • Trichomoniasis • Cancers of the sexual organs • Polycystic ovary syndrome • Chlamydia gonorrhea syphilis (oral as well) • Inequalities in the cost and availability of insertable condoms • Access to PreP - and provider's knowledge of Pre-exposure prophylaxis • Genital reassignment surgery • Inequities in the availability of vaginal pap smears to trans men and rectal pap smears to cismen • Sexual abuse • Pregnancy and Family planning issues related to sperm donations from gay and MSM • Risk reduction education is necessary • Preference for community level education • Numbers of sexual partners • Erectile dysfunction • Risks associated with public sex • Risks associated with BDSM and other fetishistic sexual activities
Cultural Factors
<ul style="list-style-type: none"> • Body Culture such as eating disorders, body dissatisfaction in gay men, obesity, bulimia, anorexia • Socialization through bars- resulting in problematic drug, alcohol and tobacco use • Nulliparity- breast cancer • Blood and plasma donor regulations limit gay and MSM's contributions • Parenting issues such as insemination, fertility challenges, mental health concerns, fear of loss of children, hostility in school settings, non-biological status challenges, assumed heterosexuality, women suggested birth control regardless of need

- Gender polarity in dominant culture- conflicts for trans and intersex persons
- Lack of role models
- Changing notions of relationships and relationship recognition
- Systemic ambivalence, persistent discrimination, or ignorance resulting in self censorship

Disclosure/ concealed identity

- Coming out and coming to terms is a process
- Psychological adjustment, depression, anxiety, suicide may persist during process of self discovery
- Conflicts with family of origin, possibilities of lack of social support
- internalized homophobia
- Physical / economic location affect ability to come out
- Structural, personal, geographic and sometimes cultural barriers in accessing sensitive care services
- Failure to disclose resulting in incomplete medical history (eg. Concealed risks, sexually related complications, social factors)
- Reluctance to seek preventative care (worsened for gay men who already have reduced health care use)
- Delayed medical treatment
- Medical and intake forms insensitive to LBGTIQ people and diverse families
- Insensitive examination techniques
- Concealed identities can lead to differential diagnosis, treatments, and preventative recommendations that are misguided

Prejudice/ Discrimination

- Provider biases, lack of sensitivity, judgemental attitudes, communication difficulties (microaggressions)
- Harassment, hostility, discrimination in everyday life including employment, housing, child custody
- Limited access to care or insurance coverage
- Ageism
- Lack of public entitlements for next of kin/partner (visitation, power of attorney, health proxy, authorized decision making)
- Pathologizing of gender-variant behaviour
- Direct physical violence
- Lack of reporting to authorities and inability to fight back due to systemic and internalized oppressions
- These issues are compounded if ethnic, racial, religious, or language minority

Mental Health

- Existence of reparative therapy
- DSM diagnostic requirement for people of diverse gender identities
- Treatments that rely on group therapy can be vulnerable to discrimination
- Anxiety and suicide ideation higher in LBGT populations, but studies are often inconclusive
- Individuals may lack the skills or self efficacy to interact with healthcare providers, authorities, and others to disclose
- Pressures of being unable to meet social expectations
- Isolation and internalization of negative attitudes
- Increased risk of mental distress leading to increased substance use
- Increased sexual risks due to low self esteem, or maladjustment
- Need for more and better research in the area of mental health
- Bipolar and major depressive disorders, sense of hopelessness and suicidal tendencies, internalized homophobia

Transgender, Intersex

- Possibility of difficulty securing work, shelter, and other basic services while transitioning
- Difficulties finding or being able to use (without harassment) appropriate bathrooms
- Microaggressions regarding use of chosen pronouns
- Public misconceptions that gender identity and sexual orientation are conflated
- Lack of community supportive social networks, prone to social isolation
- Access to hormones, and hormone management is not commonly known among health care providers
- Issues seeking birth control options for people presenting as male
- Aesthetic surgeries are not covered under most provincial health plans
- Passing/disclosure
- Voice training and other socialization processes are difficult to access
- Reproductive health such as hysterectomies and annual pap smears resulting in higher instances of cervical cancer in trans men
- Examples of health impacts of particular activities such as long term effects of chest binding
- Barriers to reaching appropriate supportive medical care (often not covered by CHA insured services)
- Genital reassignment surgery is a contested topic that may not be the end goal for all and for those that do require it, there is continual hoop jumping
- Mental health issues of adjustment disorders, anxiety disorders, PTSD, depression, possibly resulting in self harm, suicide, sex work, substance abuse
- Health risks associated with acquiring and administering 'black market' hormones and silicone injections

- All other issues already mentioned in these tables

Care Services

- Paramedics, Emergency rooms, ICU, police, may not be aware or sensitive to issues of sexuality, same-sex behaviours, and cisgender identities
- Seniors homes and nursing homes often times do not accommodate same-sex partnerships and may be insensitive/unaware of how to care for transgender peoples
- Failure of insurance to cover relevant healthcare procedures for trans people
- Police untrained in how to deal with same-sex partner violence
- Domestic violence shelters, rape crisis centres and medical personnel can be unfamiliar with the psychological and physical effects on male and trans victims
- Physical examinations can be rough or overly cautious and may miss relevant details if unaware of sexual or gendered diversity
- Care providers may lack repertoire of appropriate questions, or be unaware of the necessity of a complete social/sexual history
- Rectal pap smears are important for MSM to detect HPV
- HPV vaccine is only available for free to teen women
- Existing drug and alcohol treatment programs may not be geared to sexual and gender diverse people who may be common participants
- Numerous social services are not equipped to understand or provide tailored services to the complex issues facing sexual and gender diverse clients
- Coping and social support services, beneficial pro-social peer support services ameliorate negative social stressors; solidarity, cohesiveness, group approval, even relationships can have these effects- these services are often underfunded, volunteer, and may not be available outside larger centres

Physical Effects

- Ulcers and other intestinal disorders related to stress
- Heart disease
- Obesity and or eating disorders
- Chemical dependency and substance use- tobacco high rates and increased rates of tobacco related health issues; leading to cardiovascular issues and the full range of effects of tobacco use
- HIV/AIDS-AIDS related non-hodgkin's lymphoma, Kaposi's sarcoma
- Safer sex, increased risks for STI due to condom fatigue
- Cancer - more research is needed but, high risk of breast cancer, less frequent gynaecological screening and therefore cancers are identified later with worse prognosis, Kaposi's sarcoma in gay and bisexual men, anal cancer

- Violence - probably the most frequent victims of hate crime across all settings, attacker frequently unknown; youth are particularly vulnerable; sometimes not reported as such for fear of additional harassment; often times more violent and physical than other attacks on other populations; intimate partner violence is perceived to be lower in lesbians; lack of data on same-sex partner violence
- Possible self harm
- Homelessness - youth are sometimes evicted from the family home when coming out or caught engaging in same-sex behaviour, also leave home for fear, or perceived danger
- STIs - stigma related to infection, gay men face higher prevalence of urethritis, proctitis, pharyngitis, prostatitis, hep A and B, syphilis, gonorrhea, Chlamydia, herpes, genital warts, and HIV infection; may be higher reported due to regular testing practices; coinfection with HIV increases chances of illness; WSW do not have any illnesses that are higher prevalence than heterosexual populations and may be less common; herpes and HPV are 'rampant'; yeast infections, candidiasis and bacterial vaginosis are sometimes reported higher frequency

Particular issues for particular populations

- People in crisis
 - Youth- Safe learning environments in K-12 schools including non-discrimination policies, prevention of physical violence and creating non-hostile environments.
 - Elderly – social support, advocacy
 - PLA's – drug and alcohol use counteract effects of medicine and may pose health risks
 - Addicts – methodologically flawed, recruitment from bars or failure to ask sexual orientation; heavy drinking, binge drinking as a coping mechanism (mostly in men); little research into substance use in women, marijuana and cocaine, smoking, poppers, hallucinogens and illicit drugs overall are higher in gay men than the general population; may exhibit potential consequences of chronic pharmacological manipulation of neurotransmitters, and drug use may be linked to unsafe sexual behaviours; higher rates in LBGT youth than the normal population;
 - Sexual assault victims- gay men may be at an elevated risk for sexual abuse and assault; one study suggests that lesbians choose sexual orientation based on experience with sexual assault; sometimes exhibiting the characteristics of sexual assault, it is common for gay men to acclimatize to violence and accept it as part of normal sexuality; higher rates persist in jails and prisons; related to coping mechanisms such as internalized homophobia, substance abuse, need for mental health services, suicide ideation, and risk taking behaviour;
 - People of colour
-

- LBGT youth are overrepresented in the homelessness populations
 - Intersection of religious and ethnic diversity underappreciated within LBGT community
 - Community and scientific research studies are not always cognizant of sexuality and gender diversity and therefore these populations are often an invisible population or an ad hoc addendum
 - Trans people – diagnosis as gender dysphoria is a clinical diagnosis and thus reinforces normative gender standards; diagnosis is ill defined and may be used inappropriately; trans may easily be confused as sexuality and trans people face increased risk of harassment
-

2.4 Community Identified Core Competencies

Part of the research of this thesis was to compile a variety of educational resources, curriculum, core competencies that are reported in the literature to be difficult to locate. As evidence-based information presented above is apparently esoteric, it would follow that educational curriculum and relevant teachables designed by sexual and gender diverse peoples for educating the populace would be even more obscure and rarefied. What follows in Appendix B is a curated list of useful curricular resources identified by the researcher. The list is by no means complete, and there are many resources available for people interested in searching them out.

Chapter 3: Methodology

This study uses multiple qualitative methods. To address the question “what information on sexuality and gender diversity health and wellness exists in Canadian English baccalaureate Nursing programs and related policy” the research is comprised of a survey, the development of a resource list, and qualitative content analysis of nursing standards and policy documents. It uses primarily qualitative research methods and queer theory to develop a broad overview of an under-investigated area. The following section outlines the philosophical approach to the methods of analysis.

3.1 Qualitative Text Based Methodologies: Document (Content) Analysis AKA Critical Discourse Analysis

Citing Derrida, Prior (2003, p.4) states “in most social scientific work, documents are placed at the margins of consideration. They are viewed as mere props for the real human action that takes place in and through talk and behaviour”. Documents are important social products constructed in accordance with rules that extend beyond time and space. They express a structure, are nestled within a specific discourse, and their presence in the world depends on a collective organized action. Furthermore, the absence of a record denotes a failure, a lack of concern, planning, foresight and, organization (Prior, 2003). It is true that the production of any document requires a coordinated effort of a number of individuals (not just the author) and that documents are written in certain traditions or styles, and, in the

case of many constitutional documents delimit particular ways of being. For example, Prior suggests, only the charter or an equally legal text can define an organization such as a university and provide the necessary condition for its existence. So the analysis of legislative-type documents becomes of central import. Prior goes on to state that “dismantling documents is not an easy task, but it is a worthwhile one, not least because every document is packed tight with assumptions and concepts and ideas that reflect on the agents who produced the document, and its intended recipients, as much as upon the people and events reported upon”(p. 48).

Document analysis is the qualitative analysis of textual data to identify prominent themes in written materials, and subsequently reveal patterns among those themes (Polit and Tatano Beck, 2008). Document analysis is a type of methodology that many researchers do without giving it credit; uncredited document analysis is often referred to as the literature review, while the ‘real’ data collection is completed through a survey, interview, or focus group. There is real importance in document analysis as a methodology, as shown in the expansion of the Cochrane library and other databases used in Applied Health Services Research, for their ability to synthesize vast quantities of textual information.

A form of content analysis, document analysis is a research technique for making replicable and valid inferences from data to their context (Krippendorff, 1980, p. 21). Document analysis as a methodology is becoming widely used in health research for its flexibility and appropriateness in addressing complex qualitative

research questions (Burla et al., 2008). Elo and Kyngas (2007) state that this methodology is commonly used in nursing studies despite a lack of publishing on the analysis process. Similar to other variations on this qualitative method, content analysis, thematic analysis, discourse analysis and document analysis, all function in the same way to reveal information about something (see: Braun and Clarke, 2006). Document analysis as a method involves identifying textual data as units of analysis, coding and naming them according to the content they represent, and then grouping coded material into conceptual categories (Polit and Tatano Beck, 2008). In Krippendorff's understanding of the methodology, symbolic communication is generally about a phenomena other than those directly observed, i.e. discourse. Documents are important in the analysis of any social phenomena because they have longevity and can be used to generate assertions that are both generalizable and specific (see Krippendorff).

Discourse analysis has been used to investigate doctor-patient encounters, for example (see: Harbin, Beagan, and Goldberg, 2012; Kitzinger, 2005; Sinding, Barnoff, and Grassau, 2004). The analysis of discourses focuses on how these communicative patterns are constructed and co-constructed, shaped and reshaped, in the interactions of everyday life and, how these communicative patterns reflect and create social realities of life (i.e. hegemony). Take the example of HIV/AIDS, initially socially understood and derogatorily labeled a gay man's disease, Gay Related Immunodeficiency Syndrome, until epidemiologist Don Francis and a team of US public health practitioners uncovered that it was not simply affecting only gay

men (Shilts, 1987). Subsequently, authors have also analyzed the public discourses surrounding HIV/AIDS (see: Donovan, 1997; Goldstein 2004). Discourse analysis is being used more frequently in the growing area of policy analysis, and while a variety of theoretical frameworks are being utilized within the methodology, document analysis looks at the words within and between texts for comparison and subsequently identifies how issues are conceptualized.

Lent and Bishop, in *Developing a Gender Issues Perspective in Medical Education* (1998), explored a variety of text-based sources of information as a subset of a larger project on integrating women's health issues into undergraduate medical curriculum. In an attempt to make the idea of 'gender issues' more concrete the authors investigated how women and men were portrayed in textbooks and education resources, clinical experiences, problems-based learning cases, and examination objectives (Lent and Bishop). The authors have no description of methods, but situate their project as an extension of the work of the Canadian Medical Association's Gender Issues Committee to review the Medical Council of Canada's licensing examination objectives. They simply said they looked for omissions or incomplete attention, unequal description; highlighting appropriate representation, and discussed with colleagues regarding important themes, male and female health problems, and social context (Lent and Bishop). In 1998, gender issues equated broadly but specifically to women's health, now this dated journal article highlights the epistemology of reviewing medical pedagogy and its lack of attention to the method of content analysis. While overlooking transgender issues,

the article did report that “sexual orientation has an impact on health care” and “that educational materials should use gender neutral language wherever appropriate but should identify the sex of the patient or the physician whenever educationally relevant” (Lent and Bishop, p. 341-342).

In another study, Mulè (2006) used content analysis to investigate sexual orientation issues in Canadian, UK, and USA Social Work policy (in particular ethics and curriculum standards). Mulè’s critical investigation into Social Work curricula policy via the profession’s Codes of Ethics found that sexual orientation is haphazardly included in curriculum standards and accreditation documents in Canada, the US, and the UK. Mulè states that “sexual orientation is included in Canadian human rights legislation and the Social Work professional Code of Ethics ... yet current and proposed curriculum standards lack the comprehensiveness required to adequately address the issues of these populations...” (Mulè, p. 618). While Mulè presents a very good article outlining what is and what could be regarding the inclusion of sexual orientation issues in social work ethics and curriculum policy, he does not include gender identity and does not present a great detail of information on how to conduct content analysis.

Pinto et al. (2012) analyzed public health policy documents for two Canadian provinces to look at how 'equity' was conceptualized. The research team used a constant comparative method to discover dominant social and structural processes (i.e. discourse) surrounding the concept of 'equity'. The authors engaged positioning in the research; “In order to remain open to various conceptions... team members

shared their own views on equity and how this influenced their reading of the documents” (Pinto et al., p. 3). Memos were kept and the documents were read, reread, and coded in three stages to reach higher levels of abstraction and gain an in-depth understanding of the usage of the term 'equity' in the public health policy documents. Pinto et al. first checked for mentions, definitions, and usage of the words under analysis, then looked for proxy terms, and finally looked at the intersection of all of the related concepts identified to begin to develop codes. Coding categories in Pinto et al. were explored to gain an understanding of how the concept of equality is used in public health documents. After the analysis of the coding categories, Pinto et al. pulled together a grounded understanding of the concept of 'equity', and found that it is not always conceptualized in the same way in the public health documents analyzed.

Pennycook (2001) suggests that these types of critical discourse analyses focus on the content rather than the structure of texts and ultimately have to do with the ways ideologies are (re)produced through discourse. Like all document (content) analysis, critical discourse analysis is a systematic way of analyzing text, but critical discourse analysis focuses more specifically on the political and social import of the text to denaturalize the ideologies embedded in them. The tradition of discourse analysis stems back to the 1950's but, gained popularity with the early work of Michel Foucault. Critical Discourse Analysis does not limit its analysis to specific styles of text or talk (eg. syntax, grammar, and punctuation), but systematically relates these to the sociopolitical context. Critical Discourse Analysis

gives insight into the ways which micro and macro contexts are linked together; and as Rogers et al. (2005) finds, it often identifies unintended consequences of educational decisions, policies, and social practices.

Critical Discourse Analysis hinges on the ability to produce insights into the way language reproduces (or resists) social and political inequality, power abuse or domination. The sociolinguistic term 'discourse' lies within the domain of language that is characteristic of unified common assumptions, and communicative patterns. Furthermore, "a discourse, as a ready-made way of thinking, can rule out alternative ways of thinking and hence preserve a particular distribution of power" (Abercrombie, Hill, and Turner, 1988, p. 71). It highlights the subtleties of power and privilege and depicts the ways in which ideas are reinforced and made to become hegemonic.

Sociological attention concentrates on the social function of discourses, most importantly on their ability to close off possibilities. Within a discourse there are literally some things that cannot be said or [written]. This means that discourses may have an effect similar to that of ideology. That is, a discourse, as a ready-made way of thinking, can rule out alternative ways of thinking and hence preserve a particular distribution of power (Abercrombie, Hill, and Turner, p. 71).

So in this sense discourse is the production, utilization and impact, of our communicative systems and their ability to shape our lived experience; as Strega (2005) states "rather than describing reality, language constructs and constitutes reality insofar as we can apprehend, understand, and describe events and experiences through the words, language, and discourses that are

available to us” (p. 217). Critical discourse analysis produces insights into the ways language reproduces (or resists) social and political inequality, power abuse or domination. What we assume to be background knowledge or common sense, in fact, are always ideological representations. The goal of critical discourse analysis is to make these ideological systems and representations transparent and to show how they relate to the broader social order (Pennycook, 2001, p. 81).

In critical discourse analysis the researcher positions one’s self within a framework (or standpoint) with which to analyze selections of speech, written, or sometimes visual, texts. Rogers et al. (2005) found that in educational research there is a tendency to miss or misrepresent the connection between the linguistic details of interaction and the social practices (p. 386); thus suggesting that when discourse analysis is used in educational research it usually fails to fully examine the ideological system and the ways language reproduces (or resists) social and political inequality, power abuse or domination. Further complicating the application of the methodology of critical discourse analysis to pedagogy, curriculum is sometimes difficult to review due to the sheer quantity of documents used in pedagogy, compounded by the existence of hidden curriculum, and the numbers of individuals and organizations that are involved in curriculum development, renewal, and implementation. To circumvent this, people have either studied available textbooks on the market (Camase, 2009) or reviewed course descriptions available in the public sphere (Gustafson and Reitmanova, 2012). Hong and Hodge (2009) used a

rigorous qualitative approach and provided thorough, replicable, trustworthy, research in their study of the concept of social justice in social work syllabi. The current research uses critical discourse analysis to investigate how Canadian English language baccalaureate Nursing programs and related policy conceptualize and teach information on sexuality and gender diversity health and wellness.

3.2 Queer Theory

Queering, as the title of this thesis suggests, is the performance of inquiry into the socio-cultural norms of gender and sexuality that connotes making strange and challenging normative common assumptions (Sullivan, 2007). Postmodern anti-oppressive theorist Chrys Ingraham (2005) suggests “thinking straight... prevents us from seeing the widely variant social/sexual world. By shifting away from the heterosexual imaginary and not thinking straight, we are able to see that gender and sexuality are historically variable and constantly changing over the lifespan”(p. 312). Berlant and Warner (1998), and the new field of Queer Theory hopes to challenge systems, the notion of a coherent self, and social society, while infusing raw eroticism into everybody’s everyday life. This fresh radical philosophy of sexuality and gendered critical inquiry forms the hermeneutic basis to this research.

Queer Theory rejects assimilationist approaches that seek to standardize LBGTIQ lives and it refutes the notion of an individual's' singular identity based on the concept of sexuality or gender (de Lauretis, 1991; Wilchins, 2004). The new lens of Queer Theory disrupts the margins by focusing on differences in identity and is a

rejection of homogenizing and mainstream identities (Sullivan, 2007). Queering refutes the foundational (yet liminal) position of heterosexuality by seeking to expose the normalization and invisibility of heterosexuality (Sullivan, 2007; Warner, 1993). To trouble or Queer as the title suggests, is the act of critical investigation and deconstructionism, specifically dealing with sexuality and gender. In this way, queer theory has been of utility in its analysis of cultural texts (i.e. movies, novels, cultural moments) focusing on non-assimilationism and highlighting the unstable assumed representations involved in sexuality and gendered binaries. It has only had the most basic applications to health and educational policy at an academic level. It is still a developing field that is contested within and outside of its own discipline.

While Queer Theory has been critiqued for its lack of attention to the institutional and material contexts of discursive power (Seidman, 2003, as cited in Valocchi, 2005); educational theorist Kevin Kumashiro (2002) writes that it can be used to critique and understand pedagogy, and it is perhaps at its best but underutilized in its application to the educational context. Sumara and Davis (1999) state that queer theory “does not ask that the pedagogy become sexualized, but that it is excavated and interpreted to show the way that it is already heterosexualized” (p. 192).

We are not interested in promoting queer curriculum theory as a theory about queers but, rather, are interested in showing how all educators ought to become interested in the complex relationships among the various ways in which sexualities are organized and identified and in the many ways in which knowledge is produced and represented (Sumara and Davis, 1999, p. 203).

Adrienne Rich's (1980) text *Compulsory Heterosexuality* demonstrates the important role of deconstructionism in queer theory and highlights deconstructionism's ability to examine supposedly natural and neutralized gender and sexuality norms, thus exposing the powerful effects of language. Deconstructionism is a semiotic (philosophical) term that denotes the exploration and articulation of concepts to reveal dominant social hegemonies; it is the critical reading of words and metalanguage to highlight the uninterrupted reliance on unstable signifiers. As Fish states in the text *Heterosexism in Health Care* (2006) "Heterosexism refers to the privileging of heterosexuality over homosexuality and its assumed normality. The term [heterosexism and heteronormativity] seeks to draw attention to the ways that heterosexuality is inscribed in institutions, cultural practices and everyday interactions" (p. 7). Heteronormativity is heterosexual culture's ability to interpret itself as society, defining homosexuality and gender bending as abnormal, it is problematic because it forces everyone to pass as a coherent identity, a static body, or an otherwise cognizant, intentional, and foundational collection of activities (Atkinson and DePalma, 2008; Gray et al., 1996; Ingraham, 2005; Sullivan, 2007; Wilchins, 2004).

According to Sullivan (2007) and Warner (1993), there is a need to refute the dominant position of heterosexism [and cisgenderism] in society by exposing the seeming normalness and unspoken taken-for-grantedness of heterosexuality [and cisgenderism] and understanding how these notions are circulating in society. Queer theory cannot be dissected from postmodernism; a philosophical tradition that

claims social reality cannot be described or explained with certainty or in authoritarian terms (Moosa-Mitha, 2005). However, queer theory has moved from a strictly postmodern theory to an anti-oppressive theory. The concept of hegemony is important here because it accounts for the various and complex ways that power operates to shape and construct reality (Kincheloe and McLaren, 2003). Despite queer theory's current limitations in targeting structural institutions like education, Valocchi (2005), suggest that most current work in the area of queer theory does not fully capture all the tenets of queer theory, and therefore Valocchi poses the question "how can we incorporate an analysis of discursive power that operates subtly but pervasively into a discussion of gender and sexual power inequality that still recognizes the material and political impact of social institutions?" (p. 757). This thesis attempts to 'level up' queer theory and frames the sexual and gendered critique squarely on social institutions and processes themselves, rather than the individuals performing those institutional activities.

3.3 Steps to Ensuring Rigor, Credibility, Trustworthiness, Dependability, Confirmability, and Congruence

Koch and Harrington (1998) suggest that reflexivity be addressed within any discussion of the rigour of a qualitative study. They propose a critical awareness that goes beyond self-critique and personal quest, and suggest 'positioning' as an approach to rigour that is richer than reflexivity. Koch and Harrington do not propose a definition or strategy on how to position, however Code (1991) suggests

that positionality explicitly resists taking any one position as referent, but is understood to “analyze, assess, assume accountability for the positions one occupies, while engaging in critical dialogue with, or resistance against, occupants of other positions, in cognizance of their political implications”(p. 180). In this way, Code suggests that positions are at once loci for the active construction of meaning... and foci for socio-political change (p. 180). Positioning is also elaborated by Thorne (2008), “reveals something of the motivation and bias of the researcher and become a fixed point against which it becomes possible to determine whether data collection and analysis are either informed or skewed by these earliest conceptions”(p. 69). Thorne goes on to assert that it reflects the researcher’s integrity in the sense that they have located themselves within the particular research project and that it is important to surface, acknowledge, and reflect upon what ideas are held. “In general, if ideas, thoughts, perspectives, or personal experiences are going to influence the angle of vision that [the researcher] is taking into a study, it is always best to confess them and ensure that [they] are appropriately managed and accounted for” (Thorne, p. 72). As the reader is aware, the researcher’s position was outlined in the introduction of this thesis.

Trustworthiness is often a term employed to describe the reliability and validity of qualitative research (Polit and Tatano-Beck, 2008). While the quantitative terms reliability, rigour, and validity have been critiqued on the basis of inappropriate epistemological and ontological assumptions, research integrity is necessary and must be congruent with specific philosophical underpinnings to

support the research (Whittemore, Chase, and Mandle, 2001). Some authors have developed standards for establishing and assessing trustworthiness in qualitative research. Lincoln and Guba (1985) are the most predominantly cited qualitative source for a framework on trustworthiness, however Whittemore, Chase, and Mandle (2001) synthesized ten prominent systems to develop a set of criteria that included Lincoln and Guba's framework. Whittemore, Chase, and Mandle (2001) propose four primary criteria (credibility, authenticity, criticality, and integrity) and six secondary criteria (explicitness, vividness, creativity, thoroughness, congruence, and sensitivity) that are essential to all qualitative research. They state that "findings subsequently need to be written with an explicit articulation of the emphasized criteria, and the specific techniques employed, so that consumers of the research can critique findings in a meaningful way" (Whittemore, Chase, and Mandle, p. 533). Presenting twenty-nine specific techniques that demonstrate the trustworthiness of the design, the validity of data generation, the solidity of the analysis and the presentation of findings, Whittemore, Chase, and Mandle suggest that quality in research is dependent on honest and forthright investigations. I draw on many of these techniques to help articulate the transparency of the research (i.e. justification of sample, articulating data collection decisions, keeping an audit trail, and using exact quotes to support analysis), however as with most qualitative research, issues of rigor, credibility, trustworthiness, dependability, confirmability, and congruence are dialogical between the reader/audience and the author's work. The steps described previously in the work of Pinto et al. (2012) will be followed.

Chapter 4: Methods of Analysis

4.1 Ethics

Ethical approval/clearance was sought from the Health Research Ethics Authority at Memorial University of Newfoundland. Expedited review was granted February 2013 (HREA Reference Number 13.026: See Appendix C). Ethical approval was also granted from one other participating Canadian university, as access to their faculty or staff was contingent upon obtaining such approval, in accordance with their organizational policies.

4.2 Survey Data Source

The survey tool developed for the current research was built on the work of Obedin-Maliver et al. (2011), however, it was modified to take into account the survey's recognized limitations, and included areas covered better by Sherry, Whilde, and Patton (2005). Obedin-Maliver et al. surveyed 176 medical schools in Canada and the USA and had a 75% response rate, however, Obedin-Maliver et al. reported on medical school curriculum in Canada; and despite its topic areas Sherry et al's survey is an adaptation from a multicultural survey for psychotherapists, and therefore could be misleading when applied to researching sexuality and gender diversity curriculum content in nursing. The study by Lim, Johnson, and Eliason (2015) collected similar data from the USA in the same year but was not published until after data for the current thesis was collected. Obedin-Maliver et al. and the research team at Stanford University was contacted to request use of their survey

questions. The research team at Stanford University permitted the use of similar questions for this research; the researcher offered to supply them with an electronic copy of the published master's thesis in return.

The survey for this study was developed by the researcher, and then reviewed by the thesis committee. It was then put online at LimeSurvey.com and pilot tested by one member of the thesis committee for speed, ease of navigation, and any possible sources of miscommunication. The total number of questions was limited to 24 questions with open comment boxes to allow the participant to supply more information at their choosing. There was no demographic information needed other than the name of the responding institution, which was removed prior to analysis. The survey included questions about the licensing exam, any available professional development and faculty development, the clinical internships/practicum/placements, the availability of independent student projects, specific questions about how history taking is taught, if scenarios are used, and whether or not a variety of sexuality and gender diversity health concerns are addressed anywhere in the curriculum. Respondents were also asked if sexual health information had been removed from curriculum over the years, and what they believe to be the main sexuality and gender diversity issues that should be included in the future. Finally, a question allowed participants to include curriculum resources. The survey was intended to be completed by the department head or a designate, someone who is generally familiar with the entire curriculum and its development.

Online surveys allow flexibility of time and space; they also enter data directly into a computer format that is ready for analysis, therefore saving research time and money. This study used a cross sectional non-probability survey design as the main design feature. It was administered online to a purposive sample of nursing administrative leaders (or their delegates) in Canada. Cross-sectional studies are simple in design and are aimed at finding out the prevalence of a phenomenon, problem, attitude or issue by taking a snapshot or cross-section of the population. This obtains an overall picture as it stands at the time of the study. These studies usually involve one contact with the study population and are relatively cheap to undertake.

The open source survey-building tool Limesurvey.org is hosted in Germany and unlike Survey Monkey, it is exempt from the US Patriot Act. Data entered into the survey on Limesurvey saves directly into a spreadsheet and notifies the researcher with an email when an entry has been logged. The data from the Excel compatible spreadsheet must be downloaded to the researcher's computer when the data collection is complete. Failure to download the data set results in the loss of data. Once the survey is closed the data is deleted from Limesurvey, it is the researcher's responsibility to download and securely save the spreadsheet prior to closing the survey. This function includes all data as well as particular questions. The entire data set was saved to the researcher's password protected hard drive on March 6, 2014.

The full survey is attached as Appendix C. Using a modification of existing surveys adds to the ability to situate this research alongside other research in the area and may be used for generalizability of results.

4.3 Survey Selection and Inclusion Criteria

A complete list of eligible universities was derived from those listed on the Canadian Association of Schools of Nursing (CASN) website in 2012. French language programs were removed from the list of universities due to a language barrier of the investigator. This resulted in 65 universities being eligible for participation. There were an additional 11 institutions included with non CASN accredited English language baccalaureate nursing programs identified through online research of institutions in Canada.

All 76 chief administration positions with available email addresses sourced online were contacted in September 2012. The institutions identified and contacted were a combination of CASN accredited and CASN non-accredited English language baccalaureate nursing programs in Canada. They were initially contacted via email September 17, 2012 with an introductory invitation letter titled *Masters Student requests support for Canada-wide research in Nursing* (Appendix C). The department heads, deans, faculty chair, or an appropriate surrogate were contacted to ask if they would be interested in the topic generally, to assess its relevance, and inform them that in the future a formal request for participation would be forthcoming. These contacts were then used to populate the list of possible respondents. This invitation

letter of support was sent in advance of the research to gauge interest and verify email addresses.

4.4 Survey Participants

While the Canadian Association of Schools of Nursing (CASN) accredits programs rather than institutions, there are also institutions in Canada offering baccalaureate nursing programs not accredited by CASN. In 2012, 65 institutions were identified by the researcher with CASN accredited English language baccalaureate nursing programs. CASN reports 135 university programs, 94 accredited in total, including French (CASN, November, 2015). A methodologically similar study by Goodwin (2005) cited that there were only 35 institutions offering baccalaureate nursing programs in Canada in 2003-2004. While there are difficulties in identifying the total number of potential respondents, depending on how the definitions of programs are arranged, there were an additional 11 institutions with English language non-CASN accredited baccalaureate nursing programs that were contacted for participation.

These institutions offer a variety of program formats, including collaborative programs with multiple institutions responsible for one degree. Nine institutions in British Columbia at the time of data collection were part of a collaborative educational program that offers degrees in the Canadian north.

Of the total 76 institutions known to be involved with English language baccalaureate nursing programs in Canada, 65 of these were contacted for

participation in the study. The initial invitation letter of support revealed that 11 institutions were not eligible (did not offer a baccalaureate degree in nursing), not interested, or did not have valid contact information. The 65 institutions identified and contacted were a combination of CASN accredited and non-accredited English language baccalaureate nursing programs. Only one respondent from the initial invitation letter self-selected to not participate.

Of the email addresses that were valid and those that were updated, the first call for participation went out on February 19th, 2013 after receiving ethics approval. A second request was sent out March 11, 2013, and the third and final request went out May 8, 2013. The survey was closed March 6, 2014. Each time a request was sent out a few more respondents completed the survey and in total 17 institutions responded to the call.

4.5 Survey Method

A few of these institutions had multiple responses, in total, there were 24 surveys received, for the institutions that had multiple entries, yes no response comments were averaged and the written comments were kept in the study. In cases where multiple responses were received from a single institution the multiple responses reaffirmed a single response to add to the credibility of the data despite the small sample size.

Data was cleaned for totally incomplete entries, and then the data was preserved in its most complete manifestation and each quantitative question was

graphed or tabulated. The individual analysis of each question means that there is no single total number of responses, because no question was forced response (after the initial identifier of responding university). This leads to variability in the total number of responses for each question and particular analysis issues, but this methodological choice places heavier emphasis on the distinction between yes, no, and don't know/didn't answer categories than on the quantity of each category.

The written textual information of the comments sections of the survey was captured into a single document. The question was included to keep the comments organized until later data synthesis required comments to be grouped categorically. Without using interrater reliability, the entire document of comments was read three times to ensure understanding of the richness of the statements. The comments were then highlighted and annotated in paper and on computer versions to make notes on emerging themes. After initial highlighting, comments were annotated as to what was being said in the text and how the participant understood and responded to the question. The synthesized results include selected comments verbatim. The full list of comments is attached as Appendix F.

4.6 Document Analysis Data Source

All the known Canadian English language nursing associations at the provincial/territorial and national levels were identified by way of Internet searching and their websites were searched multiple times for nursing standards documents, educational policy documents, entry to practice competencies, and

standards for practice of Registered Nurses (RNs). These professional organizations were also searched for policy statements, position statements, competency frameworks, and any document outside of their AGM reports that could have relevance to the current study. In total there were 52 documents read. The documents were downloaded and saved to the personal computer of the researcher and the citations were entered into a spreadsheet. A thorough reading of the initial documents for 'sexuality' and 'gender identity' apprised the researcher of the intended meaning and standardized usage for these words for nursing.

4.7 Document Analysis Sample, Selection and Inclusion Criteria

Nursing, like most healthcare professions, falls under provincial/territorial jurisdiction. While there are steps to standardize nationally (and across North America), each province or territory has its own collection of documents related to entry-to-practice competencies, practice standards, scope of practice for RNs, and educational approval processes. All provinces and territories outside of Quebec were reviewed for the above-mentioned documents as they related to what and how baccalaureate nursing students are taught. As a self-regulated profession, the *Code of Ethics* (CNA, 2008), supplemented by various (national and provincial/territorial) policy documents guide the regulation, practice, and educating of its members. “Through provincial and territorial legislation, nursing regulatory bodies are accountable for public protection by ensuring registered nurses are safe, competent and ethical practitioners” (College of Nurses of Ontario, 2008, p. 1). The documents

obtained for analysis were all available in the public sphere. The full list of documents is compiled in Appendix D. The websites of each of the provincial/territorial regulatory bodies was searched for these documents on multiple occasions. When an updated version of the document was found, it was re-analyzed and replaced in the list with updated information. These documents seem to be updated on approximately a 5-10 year cycle. Numerous policy documents were reviewed and not discussed in the results section because they had no direct correlation to education, and the assertions may have seemed too forced; extensive time and energy went into searching the CNA website, the provincial/territorial associations and reading a lot of documents to find out that they were not really relevant to curriculum, but nursing practice.

The nursing standards documents for practicing nurses were also reviewed because several of them indicated that the standards were used to evaluate nursing programs and ensure that graduates can achieve professional practice standards. The documents stated that nursing education programs utilize these standards and foundational competencies to guide curriculum development.

Nursing education programs must ensure that students practice learning experiences/clinical hours, reflect national and jurisdictional standards and prepare graduates to achieve the competencies. Canadian Council of Registered Nurse Regulators (CCRNRR) 2012, p. 7

There were several national documents identified on the CNA and the Canadian Association of Schools of Nursing (CASN) which were also retained for

analysis and are included in Appendix D. There were a total of 52 documents collected and analyzed.

Each provincial/territorial nursing association's website was scanned for documents relating to educational program policies, entry level competencies, standards for practice/requisite skills and abilities for RNs, and any documents that specifically addressed sexuality and/or gender diversity. Other information considered relevant was printed off and kept for comparison or further investigation. The analysis also included the CASN and CNA websites.

Initial scans revealed gaps, indicating that the initial collection of documents was incomplete. After compiling the list of relevant documents, websites were further scanned to identify documents in particular areas, or deeper searching of provincial/territorial association's websites to retrieve particular documents in the areas of educational program policies, entry level competencies, standards for practice/requisite skills and abilities for RNs. This snowball sampling was achieved via Internet searching available documents online; it was only necessary once to contact the website administrator to request a document available in the public sphere.

Provincial/territorial nursing association continuing competency documents were initially collected, but removed from analysis as the focus is on baccalaureate educational programs leading to entry to practice competencies, and initial reading of these documents did not reveal references to baccalaureate education or entry-to-practice requirements. Quebec nursing associations were not included due to the

language barrier of the researcher. The subsequent understanding that developed from the analysis of these texts allowed for a unique understanding of the survey results.

4.8 Document Analysis Method

Scanning documents in PDF format is increasingly easy. Especially when looking for a particular word or part of a word. The find function on the PDF viewer was used to search for any word that included 'sex' and or 'gender'. If these revealed no hits then documents were searched more broadly for words like 'person', and 'client' to try to identify relevant areas. Documents were also searched for truncated words like 'cultur', 'divers', 'vulnerab'. Leaving these words truncated allowed for the linguistic extensions to be searched in the find feature of the PDF reader. For example: 'Cultur' returned 'culture', 'cultural' and 'culturally'. Segments of the documents were cut and pasted for analysis of meaning. A traditional qualitative content analysis computer program, such as Nvivo, was not used for this analysis. Programs like this are tailored towards larger and more complex sets of data. It is possible that use of such software may have produced more detailed complex relationships between texts in a shorter time, but this is not definite.

The documents were read for the broad inclusion of sexuality and gender diversity. Anything that could be construed as important or relevant to notions of sexuality and gender diversity were noted in analysis. From there connections within the documents were made to identify the usage of the terms under analysis,

and then connections between documents were made. The terms under analysis started with:

- ***Sexual Orientation / Sexuality***
- *Coming Out*
- ***Gender*** / *Gender Expression*
- *Sex Reassignment Therapy*
- *Intersex and 'Disorders of Sex Development'*
- *Transitioning (e.g. Male-to-Female, or Female-to-Male)*
- *Sexual Health*
- ***Safer Sex***
- ***Sexually Transmitted Infections*** and or *HIV/AIDS*
- *Barriers to accessing medical care for diverse sexualities and gender identities*
- *Problematic alcohol, tobacco, and drug use*
- *Chronic diseases relevant to people of diverse sexualities and gender identities*
- *Mental health*
- *Body image*
- *Unhealthy relationships/partner violence*
- ***Culture/cultural / Diversity***
- *Parenting/insemination*

The bolded words were found to be included in at least one document and other words which arose from analysis were: person/client, and vulnerability.

Qualitative Content Analysis of these educational policy documents

proceeded in a stepwise fashion, with multiple readings and rereadings of the texts. The reiterative process of thought processing and repetitive returning to the texts and survey results, like stepwise regression in statistics, is a form of forward selection, building up the theory, with the recognition of supporting examples. A kernel of an idea was noticed, and then the documents were read with that in mind to see if it could be fleshed out. If, not then the idea was dropped and another idea was pursued. This process is fundamentally similar to statistical analysis, as theory testing is built in stepwise regression analysis. Therefore, the same criticisms are relevant, such as data dredging, oversimplification of models/theory, a higher frequency and importance of seemingly correlated elements. The quantitative data of the survey helps guide and flesh out the theories arising from the qualitative critical analysis, as laid out in the chapters on results and conclusions.

After initial organization of the textual data, analysis began using Elo and Kyngas' (2007) combined inductive and deductive approach. Elo and Kyngas' combined inductive and deductive approach involves developing analysis matrices and coding according to content (rather than open coding), while comparing to earlier studies as a way of hypothesis testing. This broad framework was used because, Elo and Kyngas suggest, the inductive approach is to be used if there is little or no previous knowledge of the topic (i.e. nursing education and core competencies), while the deductive approach is to be used if there is a great deal of previous knowledge on the topic (i.e. sexuality and gender diversity health and wellness issues). Textual data was read and coded in nursing for the categories

identified in the LBGTIQ health and wellness literature; textual data that had similar themes were aggregated, and when the data was grouped into categories, there were comparisons drawn to existing literature in the field. This process leads to abstraction of themes emerging in the data and allowed for a grounded theoretical understanding of the discourses of sexual orientation and gender identity in Canadian baccalaureate nursing curriculum and policy.

The first step of content analysis of the curriculum policy documents was to describe the relationships between texts, interactions and/or social practices (Rogers et al. 2005, p. 371). The articulation of relationships between these texts outlines a structure of nursing curricular policy in Canada as well as identifies what may be defined as core competencies in the profession. The second goal of content analysis is to interpret the configuration of discourse practices (Rogers et al. p. 371). This second dimension looks at the process of production, interpretation distribution and consumption of texts and “is concerned with how people interpret and reproduce or transform texts” (Rogers et al. p. 371). The third goal is to “use the description and interpretation to offer an explanation of why and how social practices are constituted, changed, and transformed the way they are.... The third dimension, sociocultural practice, is concerned with issues of power – power being a construct that is realized through interdiscursivity and hegemony” (Rogers et al. p. 371). This highly complex and challenging style of discourse analysis was attempted in the following pages, by linking the findings in nursing curricular policy surrounding the inclusion of sexuality and gender diversity in the texts where the

result is an attempt to argue that notions of heteronormativity and cisgenderism exist in nursing curricular policy.

While the main focus of this research is on the inclusion of notions of sexuality and gender diversity in baccalaureate nursing curriculum and policy, it begs the questions 'what does it mean when notions of sexuality and gender diversity are/are not present'. From this understanding of the research, it moves the study from simple content analysis (counting whether or not codes are present in the text) to critical discourse analysis. This allows for richer analysis of the how the notions of sexuality and gender diversity are circulating in baccalaureate nursing curriculum. In this way, the analysis allows for the second goal of critical discourse analysis (stated above).

Chapter 5: Results / Discussion

5.1 Response Rate

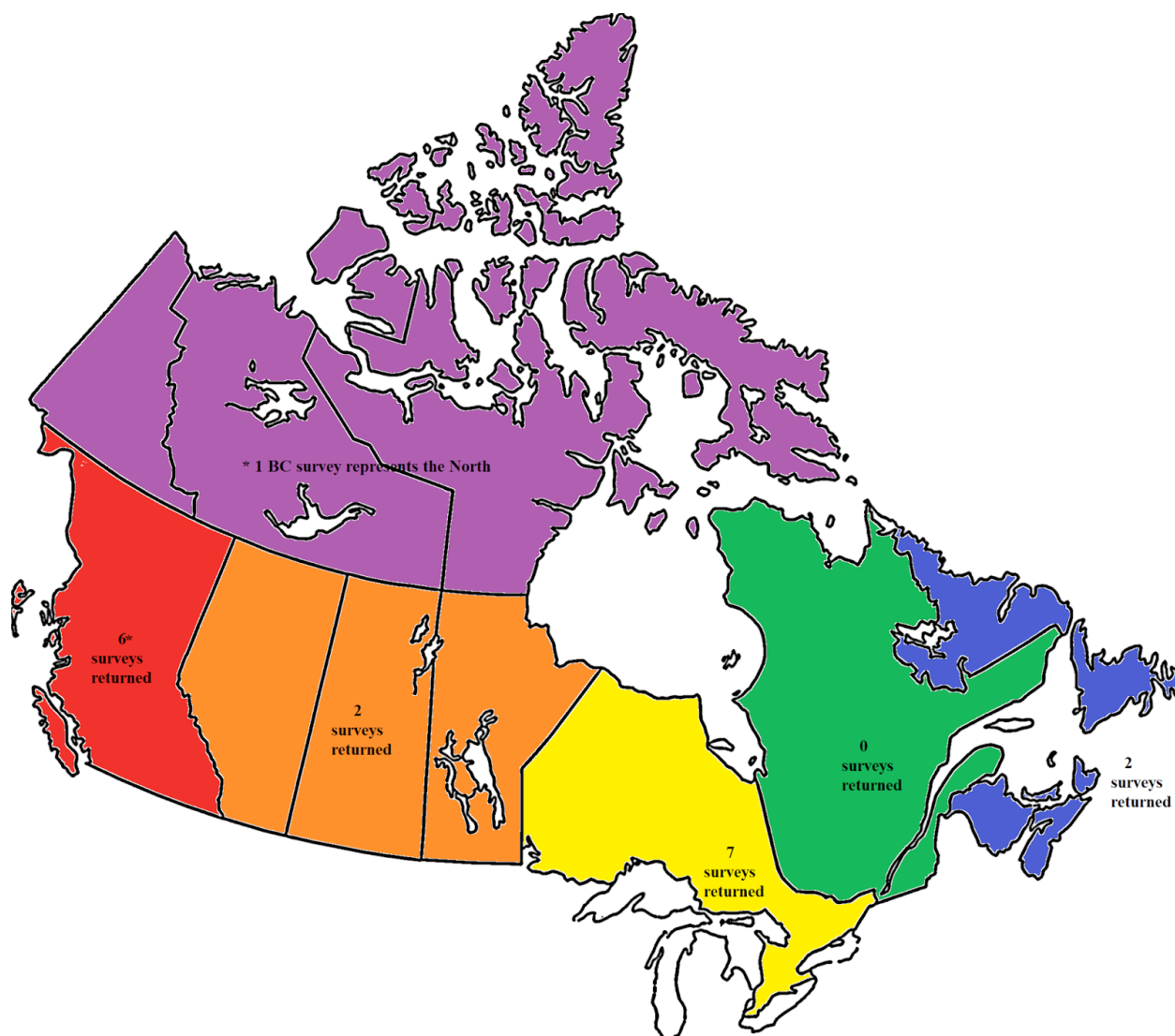
While the online survey was left open for one full calendar year, the date stamps on the entries indicate that the self-report surveys were filled out immediately following dissemination of the invitation emails. The overall response rate was 26%. This is low in comparison to other studies, as a similar Canadian baccalaureate nursing educational survey in 2005 required mailing paper copies and had only five more returned surveys, but reported an 83% response rate (Goodwin, 2005). This research had 24 respondents whereas Goodwin had 29 respondents. Goodwin only counted the total population of eligible institutions as 35, whereas the current research counted the total population as 76 institutions. Three institutions engaged with the researcher to discuss the survey, my credentials as a student, and/or to request additional ethics clearances before considering involvement. These institutions were happy to participate, but after the back and forth emails, and completion of various letters of intent and ethics clearances, and these institutions internally forwarding the survey to other faculty, these three institutions did not end up participating. Only one institution refused to participate based on the doctrine as a faith based institution, while this is normally not a point to address in a survey, refusal to participate based on a doctrine of faith is a significant incident in the current research.

A comparable US based email survey (albeit with National Nursing Association support) received 1231 surveys from 739 institutions offering

baccalaureate nursing programs in the USA when available online for only two months (Lim, Johnson, and Eliason, 2015). While the response rate for the current survey is low by any standards, completed surveys arrived from across Canada and there was no region that was not included, so the institutional analysis could at least hint at issues arising at the provincial/territorial level. While only 17 institutions are reported on in the following pages, a total of 24 usable surveys were received, including extensive comments from respondents. Three institutions provided multiple surveys. The multiple responses from institutions was used to verify responses, provide additional insight, and in the case of a disagreement internally for that institution, show that there are even deeper issues at play in this area of pedagogy. In qualitative research the focus is on the richness of data not on the quantity of data points.

The map below indicates the geographic distribution of the sample.

Figure 1: Geographic Distribution of Survey Responses



As Figure: 1 shows there is representation from English language Baccalaureate nursing programs from across Canada. A chi square reveals that observed frequencies from BC were higher than expected and in the Prairies, lower than expected. This indicates that while response rates were low, the survey responses are slightly weighted. BC institutions reported more frequently than they should have and the Prairies responded less frequently.

Table 2: Observed and Expected Frequencies of Survey Responses

# of Response	Observed #/17	Expected #/75
BC 6/17	.35	.23
Prairies 2/16	.12	.21
Ontario 7/33	.41	.44
Quebec 0/1	0	.01
Atlantic 2/8	.12	.11

Other provinces appear on par with observed and expected frequencies of responses. The researcher uses .05 as a p-value cut off for evidence in hypothesis testing. The only provinces which had differences greater than .05 were BC and the Prairies, indicating that the number of responses from these geographic regions were different than would be expected, and the table values also indicate that the responses in this thesis are weighted slightly towards BC and Ontario respondents.

Of the 17 institutions responding:

7 reported part time BN programs

15 reported having full time BN programs

5 reported fast track programs

12 reported collaborative programs

8 reported post RN programs

Other programs available were post LPN, post RPN, and conversions.

After these simple demographics, the survey presented 23 questions with multiple choice, yes/no, and open dialogue boxes (full survey see: Appendix C). All of the respondents' comments are presented in Appendix F while selected comments are included in text to highlight the situation about inclusion of sexuality and gender diversity content.

5.2 Curriculum Inclusion

Respondents were given the option to upload documents: 'can you provide curriculum materials, syllabus, reading lists, powerpoint slides, handouts, lecture notes, in the area of sexuality and gender identity?' None were received. This is similar to L'Heureux (2006) who could not access any resources being used for educating students in health professional education. Some respondents explained that course materials *may be shared at a later date*, or expressed reservation at sharing course materials that were *not their intellectual property*. Without being able to access and investigate these resources directly the survey relies on respondents' opinion about what is included in the curriculum and where. This is not necessarily a downfall of the research as similar research in the area often relies on opinion and survey responses rather than any analysis of actual educational resources.

Table 3: Topics Covered in Curriculum

Question	Yes	No	Don't Know
Is there a clinical placement, internship or practicum dealing with LGBT issues?	6	9	2
Are students able to undertake independent projects on LGBT issues?	11	2	4
Are students taught to obtain information about same-sex relations?	14	3	0
Are students taught the difference between behaviour and identity with regards to sexual orientation?	8	5	4
Are students taught the difference between identity and presentation with regards to gender?	9	5	3
Are there scenarios regarding sexuality and or gender identity?	10	4	3
Are there scenarios with LGBT families?	15	1	1
Are students taught oppression exists for LGBT people?	13	0	4
Are students taught to demonstrate sensitivity and respect for diversity in sexual orientation and/or gender identity?	16	1	0

Based on their responses to the survey, a majority of the institutions appear to feature at least one required or elective course that includes at least some content in the area of sexuality and gender diversity. The table above suggests a basic overview of LBGTIQ curricular inclusion and if taken at face value the results look good, and encouraging. One type of survey response bias appears to be avoided in this survey, as the respondents in the above table neither completely agreed nor completely disagreed with any question; because there is variability in the raw counts of responses the survey does not appear to be affected by acquiescence bias, it would seem that the responses are an honest portrayal of areas of LBGTIQ inclusion rather than a tendency towards extremism in responses. It was found that regardless of specific course content, resources such as the library, student clubs, other academic departments and, institutional policy for inclusion are available for

those who wish to seek such information about LBGTIQ subjectivities and their health and wellness concerns independently. Respondents' comments are included throughout the results section in italics and state:

There are several journals in the library related to sexual orientation and gender identity.

[Our institution offers] many workshops, seminars, and presentations on supporting/being supported as LGBT person open to faculty and students.

Information available through student services, but sessions are not mandatory.

Not in Nursing but in other faculties, Anthropology, Psychology, Health and Aging.

Not in Nursing. In Social Work maybe.

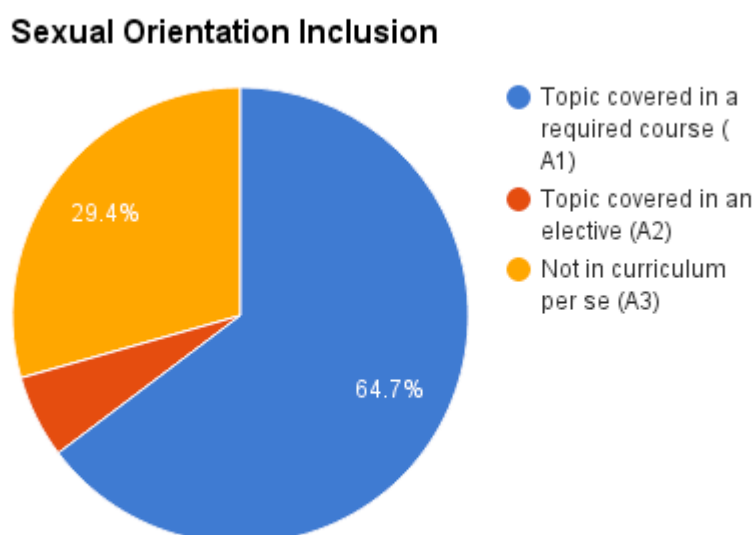
Students in their final third year have opportunity to work in AN URBAN NEIGHBOURHOOD where they may work with transgendered pts. Students may work with homosexual clients in clinical sites and/or community settings.

Students who express an interest may complete projects if specific faculty agree. This largely depends on faculty comfort and knowledge re: the appropriateness of student's expressed interest.

Most institutions appear to offer at least one course albeit an elective which may or may not include some relevant LBGTIQ health and wellness information, but overall the university environment is conducive to inclusion. It therefore appears that LBGTIQ health and wellness issues are not formally structured throughout the curriculum and content location and particularities vary depending on the instructor.

In order to get a clearer picture of what types of sexuality and gender diversity content is included in curriculum the survey asked if 16 specific topics relevant to LBGTIQ people were included. These 16 topics are presented in the following pie charts. The survey asked if 16 relevant areas of known LBGTIQ health and wellness information was required in the curriculum or presented as electives. The following pie charts are presented as visual representations alongside selected survey comments to elucidate the responses concerning whether or not particular relevant health and wellness concerns facing LBGTIQ people were included in existing curriculum.

Figure 2: Sexual Orientation Inclusion



To clarify, the degree to which the content on sexual orientation is covered is left to the course instructor as the course is an introductory course to Health and Healing.

We currently use the chapter on sexuality from Potter and Perry as required reading for our students in first semester.

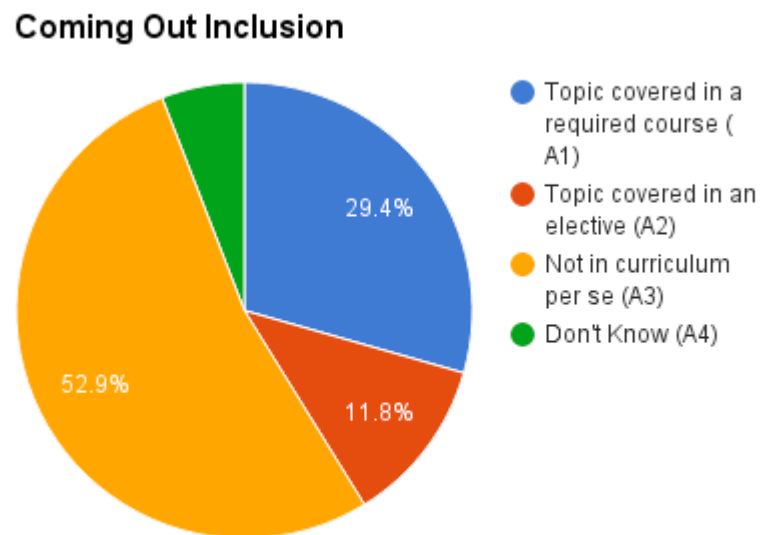
We offer an elective in Sexuality.

Included in at least 2 courses in curricula - e.g., explored through a learning package with same-sex male couple in one course, lecture provided to students in course re: sexual orientation and health promotion.

The focus/week on sexuality is prescribed in the curricular content.

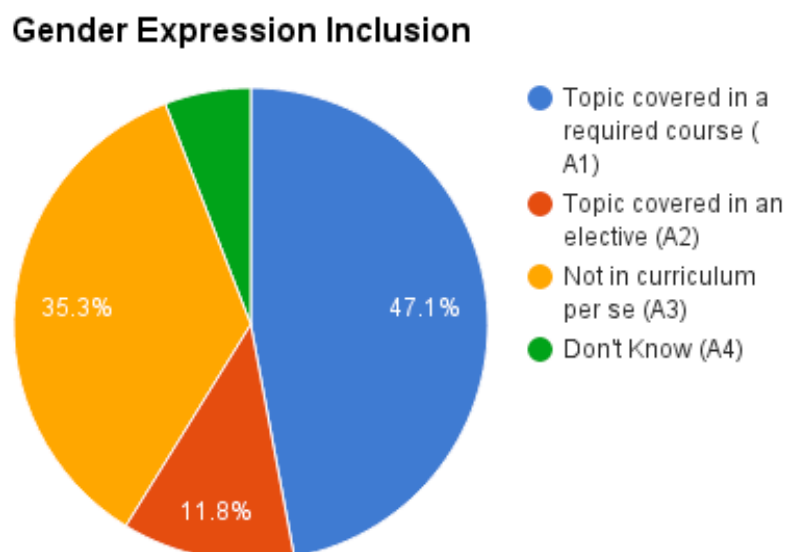
It is more generic than specific sensitivity and respect for LGBT people.

I know that nursing generally is behind in this regard. There is another study here in uncovering why this might be. It was not very long ago that it was make clear to me I was not to disclose my sexual orientation to patients. Why, when it is perfectly fine for patients to ask and receive information about children and husbands [read: ability and desire to reproduce and opposite sex monogamous partner]?

Figure 3: Coming Out Inclusion

There are films, documentaries etc that professors have access to that outline oppression, educate re: adolescent coming out.

[...] our library has the video/documentary which I use in class it's a bit dated, "The Canadian Closet".

Figure 4: Gender Expression Inclusion

The current text used in [Year 1 Course], Fundamentals of Nursing (Potter and Perry) currently discuss gender identity in their Sexuality chapter.

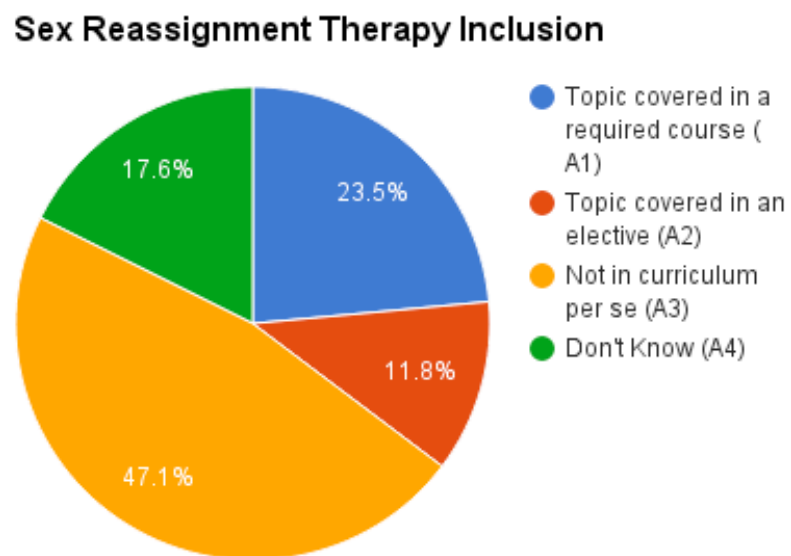
Yes a clear discussion of the difference between sexual identity and gender identity is discussed.

Unless it is done informally, gender identity and presentation is not formally in the curriculum.

I must confess that we do not discuss identity and presentation in any great depth.

Not generally in the nursing core courses, although there are several courses that list gender identity as a topic that may be included in courses. It is my experience that faculty covers this topic in a variety of ways and for those who are more knowledgeable it is covered in more depth. I don't feel that general faculty have a great understanding of the differences between identity and presentation.

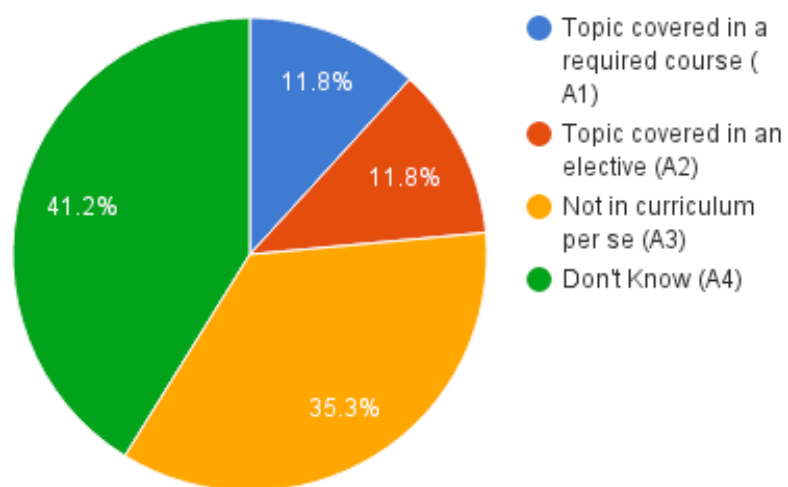
Figure 5: Sex Reassignment Therapy Inclusion



There were no comments attributed to this question or topic area

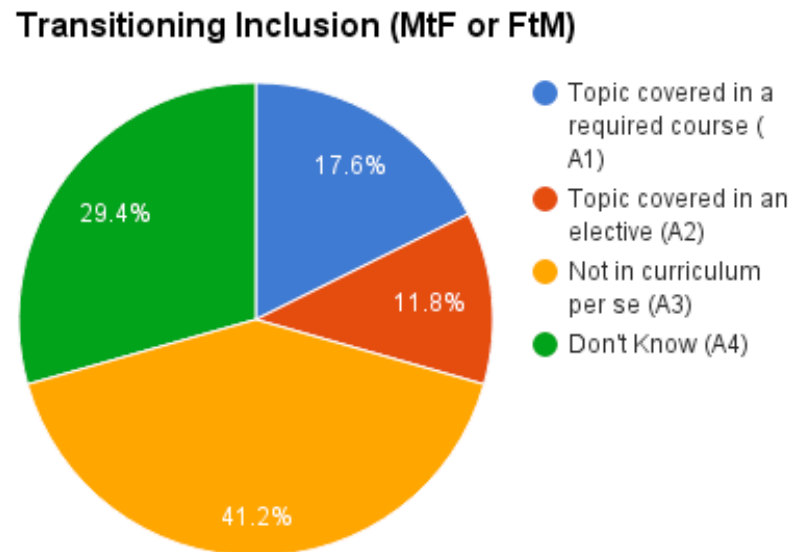
Figure 6: Intersex and 'Disorders of Sex Development' Inclusions

**Intersex and "Disorders of Sex Development"
Inclusion**



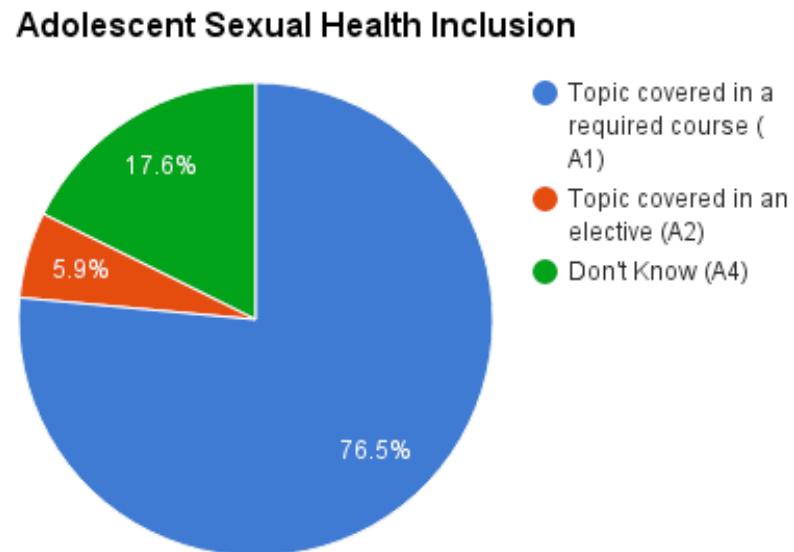
There were no comments attributed to this question or topic area

Figure 7: Transitioning (MtF or FtM) Inclusion

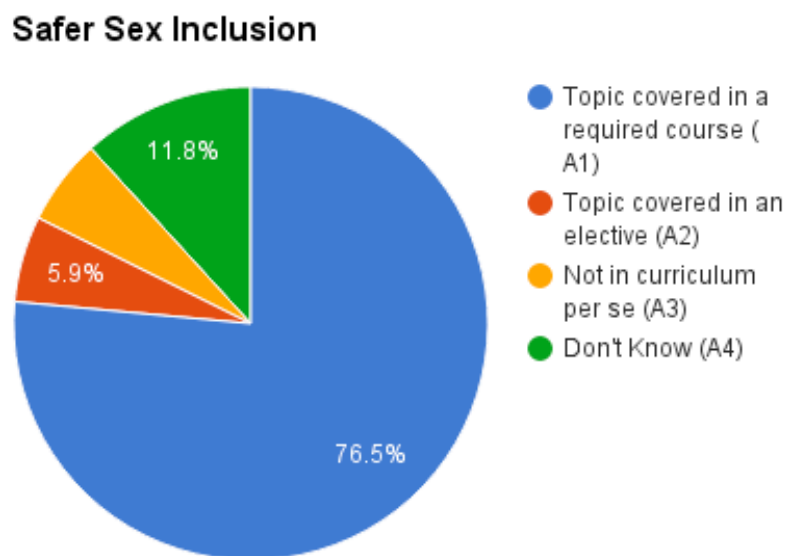


[There is a] faculty member interested in [researching] the process that individual youth who are transgendering experience.

Figure 8: Adolescent Sexual Health Inclusion



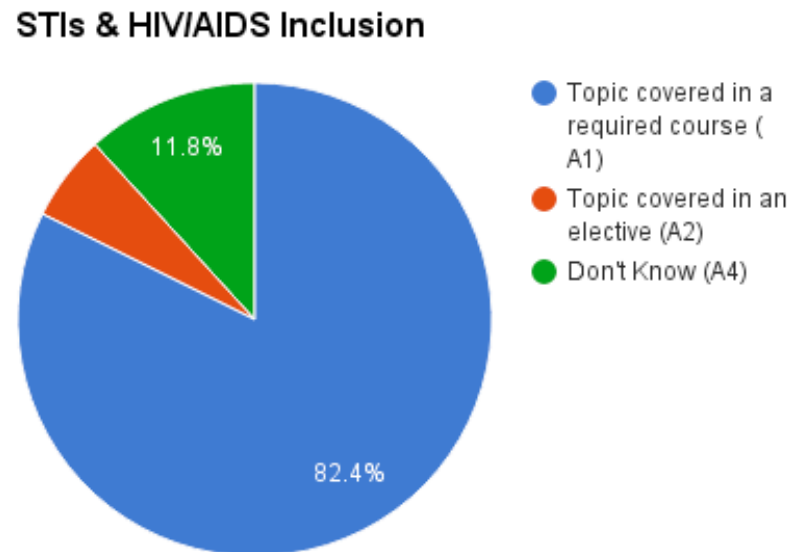
I think sexual orientation is covered quite well in the context of bullying and children/adolescence, and I am not sure if the same applies to gender identity.

Figure 9: Safer Sex Inclusion

Interviewing clients in taking a sexual health history or wherever it might be appropriate to include this in the nurse-client interaction.

I introduce lectures on "taking a health history" with how we limit others' self expression, i.e. a space for "marital status" and the gay/lesbian/ trans client says "What are my options?" They usually laugh but it gets them thinking.

Figure 10: STIs and HIV/AIDS Inclusion



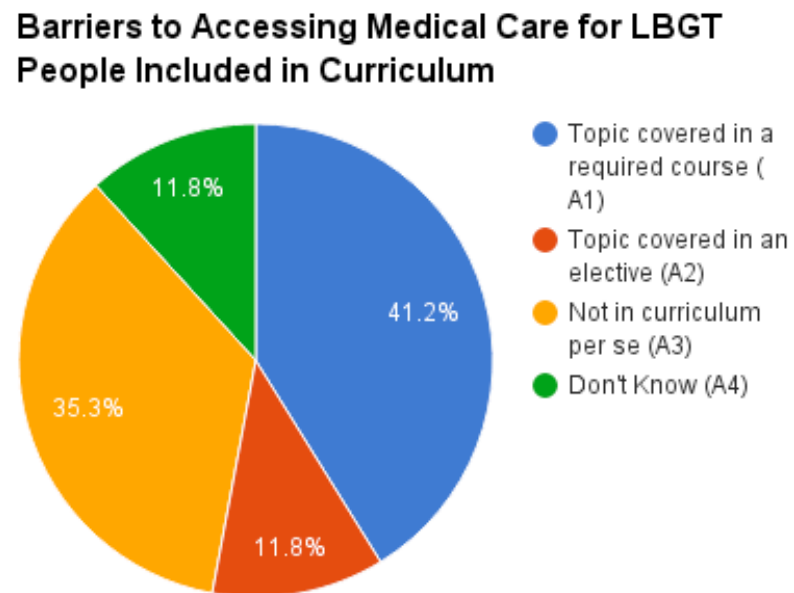
In the social determinants of health courses and when students use specific scenarios for their learning, the difference between [sexual] behaviour and identity are embedded in the content.

Not specifically. If the difference between behaviour and identity is included it is up to individual faculty and is not specifically included in our curriculum.

Students in the BScN program are not generally taught this however they may take an elective course that does provide the difference between behaviour and identity and opportunity for practice.

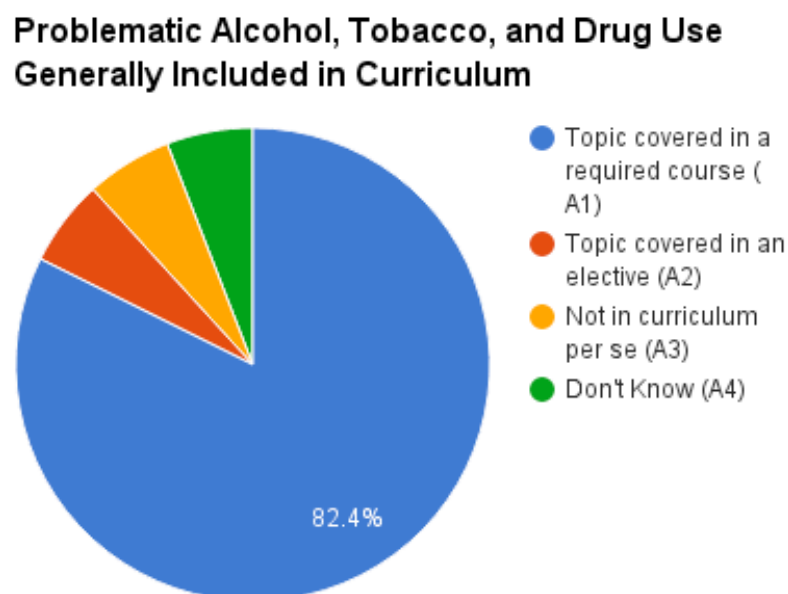
In an independent study course.

Figure 11: Barriers to Accessing Medical Care for LGBT People Inclusion



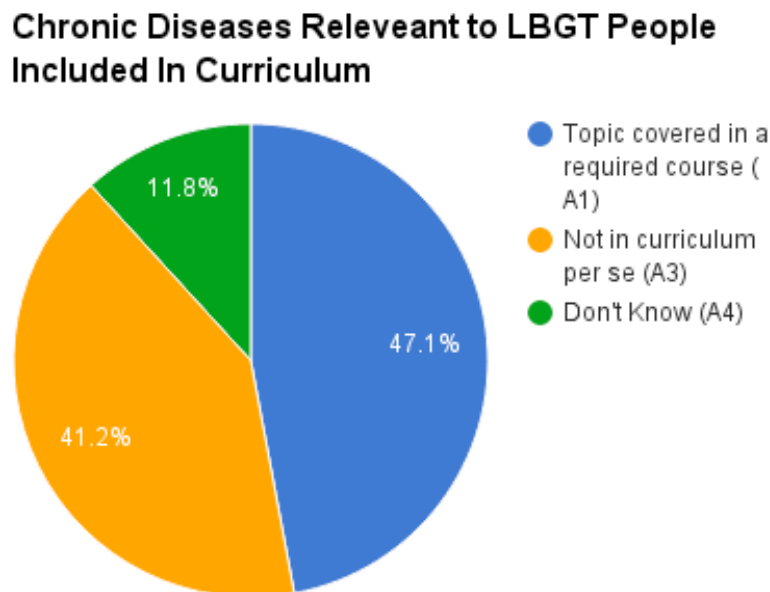
We speak of heterosexism, definitions of what homophobia etc mean, how it impacts nursing care in institutions, at the bedside, through attitudes and values and how it puts patients at risk.

Figure 12: Problematic Alcohol, Tobacco, and Drug Use Generally Included in Curriculum



This and other questions were intentionally worded as ‘generally’ under the assumption that specific evidence from LBGTIQ communities would not be commonly known. These ‘general’ questions were designed to identify if these topics that are known to have adverse health effects on LBGTIQ populations are being taught. In this case, most English baccalaureate nursing curriculum in Canada includes topics on addictions and substance use. The research probed as to whether or not more content on these topic areas should be included in the curriculum, which is presented later in this chapter in Table 4.

Figure 13: Chronic Diseases Relevant to LGBT People Included in the Curriculum

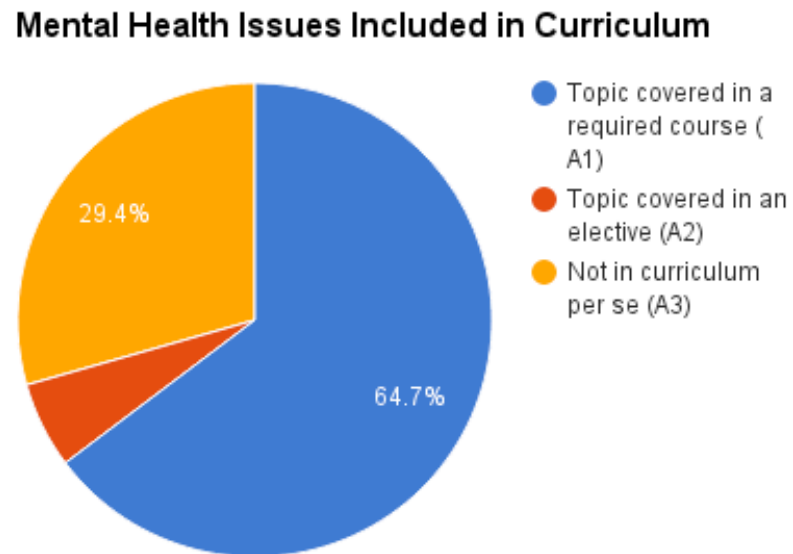


There are likely others, but I know of one [case/scenario] in an acute care nursing course where one of the partners in a same-sex relationship is hospitalized and has surgery.

We have an example/scenario where a middle aged adult First Nations male undergoing bowel resection for cancer who is palliative is homosexual and is hoping to marry his partner.

This split is quite interesting because equal parts say that chronic diseases relevant to LBGTIQ people are included in a required course and not in the curriculum at all. This results shows great disparities between institutions in Canada

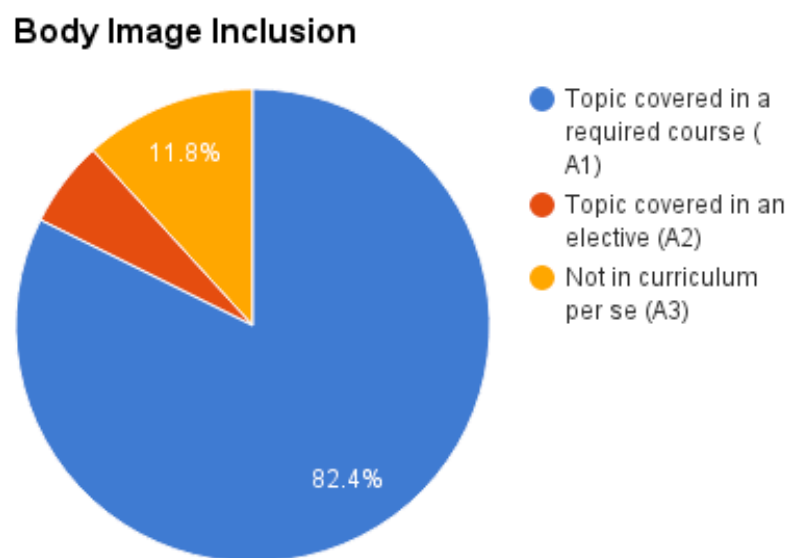
Figure 14: Mental Health Issues Included in Curriculum



Oppression and discrimination are mental health issues as indicated in Table 1, presented in the literature review; faculty reported including oppression discussions as current news as part of large lecture presentations, group discussions and even:

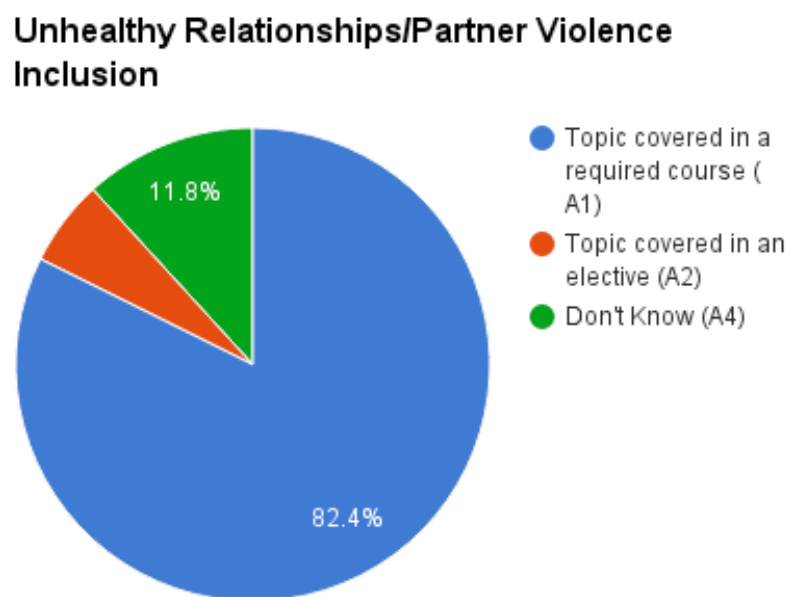
students who share [Oppression] as their lived experience!

Figure 15: Body Image Inclusion



There were no comments attributed to this question or topic area

Figure 16: Unhealthy Relationship / Partner Violence Inclusion



While this question did not allow for related comments there were some general comments that can be loosely attributed to this topic area and its general inclusion in curriculum.

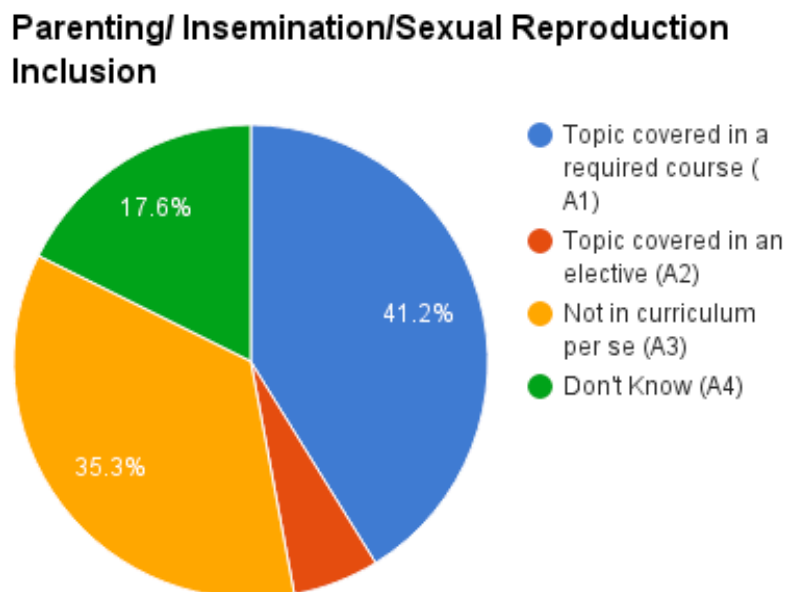
We do discuss how the traditional family has changed/is changing but I don't believe we currently have any scenarios that highlight this piece.

We teach students to use gender non-specific terms like "partner" or "family member".

There is an obviously an attempt to avoid heteronormativity in the nursing curriculum however it is not possible in the current research to identify if same sex partner examples are used when discussing teaching on unhealthy

relationships/partner violence.

Figure 17: Parenting / Insemination / Sexual and Reproductive Health
Inclusion Generally



*Minimally and again depends on the faculty teaching a course.
Certainly non-traditional families are included and may or may not
include same-sex parents but not in any depth (in my opinion).*

As these pie charts illustrate, certain topics enjoy widespread coverage in curriculum, whereas other topic areas do not. It would seem that issues related to gender diversity, queer and trans life experiences are almost completely neglected to be taught. It would seem a rarity if a student had a discussion about transitioning, and even more rare to learn about intersex and 'disorders of sex development'. The

pie charts and related comments also show that outside of the occasional exemplar, issues faced by LGBTIQ people are not framed as such. By including these probing questions in general areas that are non specific to diverse sexual and gendered identities, such as body image, mental health issues, access to healthcare, partner violence, addictions, adolescent sexual health, we can see that respondents are aware of the curriculum and are responding with knowledge of the curriculum at their institution. LGBTIQ people's' health and wellness issues are used minimally as teaching material and sometimes inappropriately.

The survey also asked what needed more or less coverage in the curriculum.

Table 4: Respondents Opinion of Topics for Inclusion

	Needs More Coverage in Curriculum	Needs Less Coverage in Curriculum	No Answer
Sexual Orientation	7	0	10
Coming Out	7	0	10
Gender Expression	4	0	13
Sex Reassignment Therapy	4	0	13
Intersex and 'Disorders of Sex Development'	3	0	14
Transitioning (MtF FtM)	5	0	12
Adolescent Sexual Health	5	0	12
Safer Sex	2	0	15
STIs HIV/AIDS	2	0	15
Barriers to Accessing Medical Care for Particular Populations	4	0	13
Problematic Alcohol, Tobacco and Drug Use	1	0	16
Chronic Diseases relevant to LGBT people	3	0	14
Mental Health of LGBT people	6	0	11
Body Image Generally	4	0	13
Unhealthy Relationships/Partner Violence Generally	3	0	14

Parenting/ Insemination/ Sexual Reproduction	3	0	14
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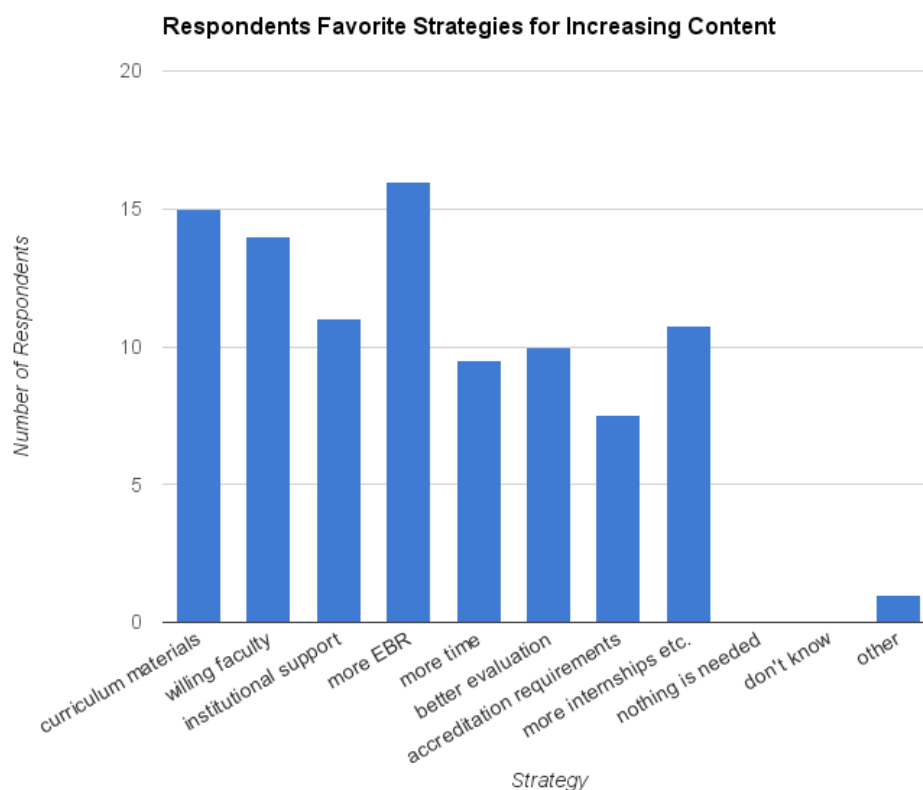
Interestingly, the majority of respondents choose not to answer, rather than to indicate if something needed more or less attention in the current curriculum. As indicated earlier, acquiescence bias- the response bias whereby respondents have a tendency to agree, there is also the social desirability bias whereby participants under report or deny undesirable traits - in this case removing relevant LGBTIQ content from the curriculum. One possible interpretation of this response pattern is that respondents may have chosen no answer rather than respond with an opinion that might seem ethically unfavourable. While there are a number of complicating factors in these questions (there was no option to indicate happiness with current teaching levels), another possible read is that a low response rate attributed to responder attrition, however that is not a valid point because questions placed after this question in the survey were responded to highly and the survey only included 24 questions in total. It could possibly be understood that they don't want less, they just want better improved content for existing curriculum in the face of limited curriculum hours and pressures for content. In particular, the areas which they would like more curricular content are sexual orientation (n=7), coming out (n=7), and, mental health of LGBT people (n=6). While areas that don't seem to need much additional attention are safer sex (n=2), STI's HIV/AIDS (n=2), and problematic alcohol tobacco and drug use (n=1).

The mid range responses (3, 4, 5) are all the health and wellness issues based in a humanistic perspective. These are the particulars of the known health and

wellness issues that can be used to inform evidence based practice, they are the relevant facts that support a queer understanding of sexuality and gender based nursing education, unfortunately due to low response rates these cannot be investigated in more depth. But it could be said that the areas that they had some familiarity and comfort with were rated higher than others (see sexual orientation versus sex reassignment therapy and intersex 'disorders of sex development'. Comments on these questions did not result in more insight into what LBGTIQ health and wellness issues are included in nursing curriculum even with prompting on topics as geriatric care, health insurance policies, medical decision making and visitation rights for LBGTIQ people, the only supplied comment which addressed a particular topic was: *[We teach] ethics related to [sexuality and gender identity]*.

In another question faculty responded with strategies for increasing content.

Figure 18: Strategies for Increasing LBGTIQ curricular content



A 'select all that apply' question revealed that the least favoured option for increasing curricular content in the area of sexuality and gender identity was 'changes to accreditation requirements'. This is the only recommendation that could offer standardization of sexuality and gender identity content across the country. It could be interpreted/read that respondents are not thinking of the global picture, but primarily of themselves and their specific situations. With less than half of the respondents recognizing the possibility of systemic integration of LBGTIQ content in nursing curriculum, it seems that they see inclusion of LBGTIQ issues as a problem, but not as a systemic problem. The desire for 'more evidence based research' and

'more curriculum materials' are indicative of faculty's lack of time, effort, and energy for searching out the available information, a lack of direction on what is appropriate and relevant information, and inadequate knowledge on how to include such LBGTIQ information in the existing curriculum.

Despite the fact that respondents (eg. department heads, deans, faculty chair, or an otherwise chief administration position) generally desire faculty willing to teach in the area of sexuality and gender diversity, the only comments for this question were:

Need a conscious instructor capable to teach this topic as if not exposed and aware to the issues they would not be adequately prepared to identify their own heterosexism.

I believe more evidence-based research on this piece is needed, as it will then provide the knowledge needed to teach this piece more competently.

Respondents were asked 'has sexual health content been removed from the curriculum?' Sixteen respondents said no. One respondent from Atlantic Canada said yes. Specific quotes reveal that *content has not been removed as it barely exists, or, only faculty who are comfortable or knowledgeable include sexuality content.*

This offers insight into the depth the situation, it may not be LBGTIQ experiences alone, but sexuality as a whole is lacking or inadequate in the curriculum; *likely is a topic that should be covered, though not sure where and how.* However, it has to be noted that *curriculum is constantly being updated;* and in some institutions *some [sexual health content] is covered in the health assessment course* while in other institutions *I don't know if [sexual health content] was ever included.*

But there is the hope in that one institution that stated *sexual health is woven into all 4 years in many courses from Pathology to Health and Healing streams.*

The written responses overall give a feeling of low to moderate relevant inclusion and raises questions on the quality of the content that is included. In another question respondents were asked, to offer the five most important issues they feel need to be taught. This question was framed towards the end of the survey so as to elicit the most thought out responses. The 78 responses to this question were synthesized into four themes. 1) Relational practice, how to create a safe space; 2) Addressing heterosexism and personal phobias; 3) Celebrating diversity; and 4) Evidence relating to specific health issues of the at risk populations. Each theme/area was equally complex with well rounded with highlights of rich comments (Full responses and coding categories see: Appendix: E).

5.3 Curricular Resources

Ability to teach in the area of sexuality and gender diversity depends on the availability of curricular resources and teaching materials to the faculty, in conjunction with the particular knowledge level and interest of the professors. None of the respondents could offer examples of curricular resources that they use in class. There were references to a section of one textbook and other resources, but respondents chose not to share them. Respondents obviously are requesting evidence informed curricular resources as per Figure 18, above. Curricular resources could entail anything from textbooks, course readings, handouts, to

PowerPoint presentations and videos; anything that is a teaching material that allows the faculty to present and transmit information to students. The survey asked 'are there curricular resources and/or teaching materials regarding sexuality and gender identity available to you (online at your library or otherwise)?' Fifteen respondents said yes, two said 'don't know', however very few offered mention of curricular resources in their faculty. Two respondents again said that resources were available in Social Work, and in the institution's library.

We've electronically made materials available to our students enrolled in the Nursing Elective course.

New media clips used in our theory class, we have one in which gender identity is in flux - the individual is struggling with this question and we have two others in which it is clear, in one of these sexual identity is not a main feature of the scenario and in the other it is core information.

Our Problem Based Teaching Strategy is used for nursing theory courses that would include some of this content. Tutors have guides to follow but no actual lesson plan. Students teach content to their group and tutors facilitate discussion and application.

5.4 Curricular Development and Pedagogy

Who determines what is included in curriculum is a complex topic - pedagogy areas are often developed by overarching bodies which dictate content streams and then committees at each institution develop broad course outlines and learning objectives, and then it is left up to the instructor to develop particular content; it is also bottom up in that faculty seek committee approval and representatives from institutions sit at the educational policy table to debate if particular curriculum meet

the requirements existing content streams. So it was important that the survey included questions about whether or not 'is it left up to the course instructor to determine content on sexuality and or gender identity for any course?' The results indicate that in the area of sexuality and gender identity content there is limited requirements for curriculum inclusion in the existing content streams and that it is the instructor who ultimately takes lead on including LBGTIQ content. Twelve institutions responded yes it is at the instructor's discretion to determine content in this area, whereas three institutions reported no and two said don't know. The respondents supplied answers that address the complexity of including LBGTIQ content, but overall it appears to be at the discretion of the instructor with little to no requirements from the institution or curriculum accreditation.

Course instructor will initiate idea but will need to present to our curriculum group for approval and support to move content changes forward, we have this content in some of our courses.

[We do] not specifically have a clinical placement/internship. Students are encouraged to address sexual orientation and/or gender ID issues in their practices generally and to recognize the importance of these topics in all areas of health.

As this is a collaborative program, I am not entirely sure of what aspect of [LBGTIQ curriculum content] is covered at our partnered institution and to what degree.

We wish the curriculum included this information as a REQUIREMENT rather than an elective, however, we have a set curriculum to follow. Even still, we can integrate this into practice and into some of the theory courses, but some faculty aren't comfortable with it for some reason.

Not in courses where content is required objective. Otherwise, faculty are encouraged to create opportunities to explore topic where appropriate.

As faculty and with curricular design I think we can do a better job threading sexuality and gender issues throughout the program.

5.5 Teaching Relational Practice

The survey asked two questions about ability to teach and examine students on: 1) the impact of personal values and assumptions and, 2) practicing with non-judgmental attitudes. It was identified in the course of writing the results that these are core competencies in relational practice. Relational practice is the “understanding of patient’s health care needs within complicated contexts [...] it is the essential core of nursing practice [...] it focuses on how personal, interpersonal and social factors shape patient’ [health and wellness] [...] it is a respectful and reflexive approach to enquire into patient’s lived experiences and health care needs; the skilled action of respectful compassionate, and authentically interested enquiry” (Zou, 2016, p .9).

There were plenty of comments when respondents were asked generally about ability to teach and examine: 1) the impact of personal values and assumptions and, 2) practicing with non-judgmental attitudes. All institutions responded with comments that indicated teaching in the area of non-judgmental attitudes and the impacts of personal values and assumptions was definitely in the curriculum and offered specific mention of how and where students are taught to practice with non-judgmental attitudes. This type of awareness of own social location and inoculation of relational practice seems to be very well developed in

nursing and is a touchstone of its philosophical underpinnings. Without reiterating each and every comment, a variety of teaching and learning opportunities fell into the following groups: 1) direct observation of clinical practice, 2) role play, 3) case studies, 4) simulation, 5) role modeling, 6) lecture, 7) group discussions, 8) course presentations, 9) assignments and papers, 10) theory courses, 11) self reflection and narrative reflection assignments, 12) self tests, 13) interviewing skills, 14) readings, and 15) instructor feedback. The responses articulating teaching of relational practice sometimes went into great length suggesting that teaching the impact of personal values and assumptions and, non-judgmental attitudes is a source of pride or questioning ability to teach and examine relational practice is a perceived threat.

"Foremost in our professionalism content"

"This is a progressive part of our learning outcomes that have to be met each semester"

"Standards for nursing practice and expectations are reinforced throughout the curriculum"

"Faculty work hard to include teachings about non-judgmental attitudes"

"Our university as a whole emphasizes non-judgmental attitudes and inclusive language for all populations"

"We have a very diverse student population so concepts related to all diversity are inherent in the classroom and also part of the course content in most cases"

"Yes, we endeavour to teach and model embracing diversity (not only tolerating, which implicitly invokes dominant perspective). Faculty use a variety of approaches to promote student awareness, comfort and competence with diversity, vulnerability, marginalization"

“We introduce the need to validate information and to not make judgments or assumptions about patients/families/populations right away in the program. We discuss perspectives throughout the program and encourage students to be open to other perspectives”

“Many courses include issues of diversity and respect but it’s up to the individual instructor what to emphasize”.

Only two institutions recognized that they might not be teaching and evaluating relational practice well enough:

“We know that we need to do better and are looking at new ways to do this that thread the non-judgmental attitudes from the first year all the way through the program”

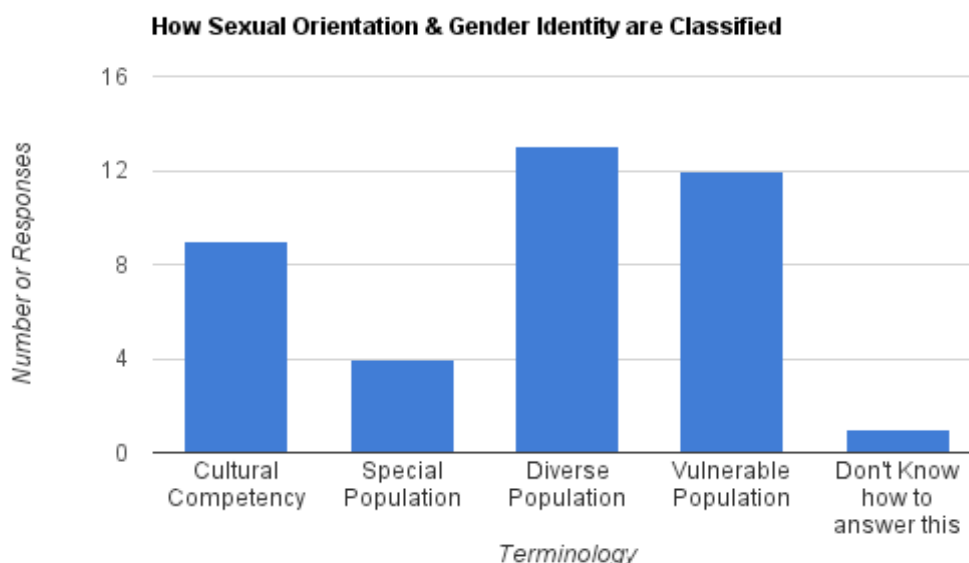
One responded stated that they felt that they taught relational practice “very poorly in my opinion, I teach 4th year students who still think their personal beliefs and values have no impact on their practice”. But otherwise the general attitude was positive:

We recognize that our own personal values and opinions most definitely influence interactions we would have with clients. That’s why it’s so important in our language, posture and attitude to convey a sense of inclusiveness and value in diverse populations of people.

Yes [we teach] sensitivity and respect for LBGT people and the depth of this teaching varies according to faculty.

In order to contextualize and elucidate these responses about relational practice, it is important to understand how language is used within nursing curriculum to discuss sexuality and gender identity with follow up questions. To begin, we need to know the language that is used to discuss sexuality and gender diversity outside of the limited notion of sexual health.

Figure 19: How Sexual Orientation and Gender Identity Issues are Conceptualized



This question allowed respondents to make multiple selections, so it would seem that the most used conceptual categories for beginning to understand the depth and breadth of sexuality and gender diversity and the health and wellness issues that these populations face are understood conceptually as ‘Diverse Populations’ and ‘Vulnerable Populations’. From the related open dialogue box the following observations were made:

Depends on faculty teaching course and more likely [teaching in the area] would include diverse sexual orientation and less likely includes gender identity.

Through their cultural competency and holistic understanding of the client, students are taught to be sensitive to the needs of the individual client.

One of our program abilities is professional identity and ethics and we have outcomes threaded throughout the program speaking to diversity of culture, gender, religion, age, etc. [note: sexuality is not listed in this mention of diversity]

This is integrated in a first year course on Health and Healing which examines this concept across the lifespan and within a diverse population.

The figure above and these comments indicate that sexuality and gender diversity are less likely to be considered a 'special population', but this is probably due to the term 'special population' not being used very often in the literature. Cultural competency is found frequently in the literature, but it often related to issues of race and ethnicity, which is outside of the scope of the current research. 'Diverse populations' is a term that implies distinct and unlike elements, whereas vulnerable populations connote a power imbalance and susceptibility to harm. The notions of cultural humility and cultural safety are relevant here as they recognize the position of outsider recognizing their own position in relation to others. While the argument can be made for sexuality and gender diversity issues as a cultural group, and therefore cultural competency, this argument is hinged on a population group bound by at least one common identifiable characteristic. As indicated previously in the discussion of queer theory, a singular common identifiable characteristic does not and should not define sexuality and gender diversity. Like the respondents indicated, the most appropriate term would be 'diverse' or 'vulnerable population' depending on the context of the discussion. The curious component of the written open dialogue box is that teachings are less likely to include gender identity, and that 'this concept' is understood as a singular issue rather than a whole network of issues.

5.6 Faculty Professional Development

Considering that individual instructors are responsible for introducing specific content into the curriculum, it is important to consider what professional development resources are available to support faculty in this process. With the primary focus on the individual instructors as identified as the key site for existing curriculum inclusion, it leads to the question if there are faculty development opportunities available in the areas of sexuality and gender identity; five responded yes, ten responded no, and two said that they were not aware of faculty development opportunities. While continuing professional development is necessary in the profession of nursing to achieve registration annually, very few places specify what content is required for practicing nurses, let alone teaching faculty. It became apparent that continuing professional development in nursing is a self directed activity. So there does not seem to be any requirements at the national level regarding the specific areas of continuing professional development. The comments indicated this is such:

Not specifically, however, faculty are welcome to conduct continuing education on their own. Often guest speakers come to the university to present on this topic and faculty are welcome to attend if they are interested.

To date I am not currently aware of any structured PD sessions that address this piece.

I think it would be useful. I'd love to be part of an initiative to do that.

Not yet but there are plans for faculty development in this area.

So while faculty requested more systemic support, it is apparent there is very little geared towards the faculty professional development in the area of understanding and being able to teach sexuality and gender diversity content. Only 5/17 institutions indicated that there are professional development opportunities available for faculty in the areas of sexuality and gender diversity. Some of the responses not included in the above section (full comments see: Appendix F) appear to have missed the thrust of the question, stating that the institution as a whole has policies regarding safe spaces and inclusion, and other faculties in the university are dealing with it but that it's not specific to nursing. There seems to be a knowledge gap whereby there are limited opportunities to learn more about LBGTIQ subjectivities and the health and wellness concerns for practicing faculty.

One indicator of faculty willingness to improve the quality of content could be whether or not faculty are conducting or interested in conducting research in topics related to sexuality and gender diversity. For this question, ten institutions reported 'yes', there were faculty interested in or already conducting research on sexuality and gender identity related issues. Seven institutions responded 'no' or 'don't know'. The survey responses indicated that some faculty are conducting research on topics related to sexuality and gender diversity, and that others would like to, provided funding were made available.

Two of us have developed and conducted an upper division nursing elective course dealing with Sexuality and Health Promotion across the Lifespan which covers these topics extensively.

Yes this is a topic that I am interested in as faculty. I teach a Human Sexuality course and this content is included in the course. Guest

lecturers are often invited to share personal perspectives re: sexual orientation and/or gender ID topics.

Depending on the grants received.

This comment alludes to the pressure for faculty to receive grants and also highlights strategic directions in funded research, in particular how funding for certain research areas creates vacuums in other research areas. This is notoriously prevalent in the area the arts and social sciences versus the laboratory sciences and other disciplines as was highlighted in the Jackson et al. article (2006).

5.7 Licensing Exams

In Nursing, as in Medicine, the licensing exam is a controlled document. Access is guarded for the protection of the examination process. Without access to the licensing exam (which has subsequently changed to the North American standardized NCLEX-RN) the first question of the survey was 'are you aware if the licensing exam in your region contains questions about sexuality and gender identity?' The survey was structured in this way to get the respondents immediately thinking about the curriculum as a whole while considering the broad issues of sexuality and gender diversity as well as the requisite core competencies and learning objectives. Four institutions reported yes, they were all from the same province, they were aware of the licensing exam and it's requirement to contain questions dealing with sexuality and gender diversity issues. Two institutions responded no, one from Ontario and one from BC, and 11 institutions reported don't know. So this leads to several conclusions: 1) faculty are unaware of whether or not

the licensing exam in their region contains questions about sexuality and gender diversity, 2) the content of licensing exam in each region differs, 3) the question was worded improperly and respondents didn't know how to answer. However, within the province of Ontario, four respondents said yes, one said no and one said don't know. This leads to the possible understanding that not all nursing faculty administrators are aware of the content areas of the provincial licensing exam. Ontario was the only province where responders that could identify that the Canadian Registered Nurse Examination (CRNE) may have content related to sexuality and gender diversity. The written comments revealed:

Faculty have developed and included learning modules about gender and health in social determinants, concept courses and as discussion topics in other course such as professional practice. The provincial nursing association includes scenario based questions in the CRNE which include gender and sexual identity as a context for answering questions about practice and health teaching.

As the CRNE is undergoing changes, I am not sure if the new NCLEX-RN will contain this content.

I don't believe it does.

The faculty who responded are generally not aware of what sexuality and gender diversity content is included in the CRNE and moreso, with changes to the licensing exam proposed at the time of data collection (subsequently taken into effect at the time of write up) more uncertainty could ensue.

5.8 Synthesis of Education Pedagogy and Policy Documents Overview

This study included critical discourse analysis of 52 nursing professional association documents. Six of the provincial/territorial licensing organizations had documents designed to guide the *regulation and CASN approval of educational programs leading to nursing entry to practice* that were focused towards the educational institution as a whole, and not included in further analysis as there was nothing compelling in these documents in terms of LBGTIQ health and wellness inclusion in curriculum. Most provincial/territorial licensing organizations had documents outlining *requisite skills and abilities* such as the ability to hear, range of motion, and other employee physical traits, they were also not included in further analysis. Fortunately, the Canadian Council of Registered Nurse Regulators (2012) document was reiterated almost verbatim in 11 provincial/ territorial entry to practice documents so these entry to practice documents authored by provincial/territorial licensing organizations are not discussed individually (Full list of documents under analysis see: Appendix D). The following pages will focus on 14 national documents and relevant position statements.

The CNA *Code of Ethics* (2008), like other health care providers' codes of ethics (see: Mulè, 2006), outlines ethical responsibilities and primary values which guide nurse's professional relationships with clients. Because it is a foundational text it is referenced in most subsequent document analyzed, the *Code of Ethics* (2008) refers to education, as part of its definition of nursing practice (p. 7) and there is considerable emphasis on the relational practice.

While the *Code of Ethics* (2008) abstractly influences educational policy there are other documents more closely knit to educational policy. The Canadian Association of Schools of Nursing (CASN) *National Nursing Education Framework: Baccalaureate* (2015) articulates a consensus-based framework for core expectations of baccalaureate nursing education programs designed to prepare generalist nurses (p. 4). A generalist entry-level nurse is someone able to care for people of all diversities. This document is important because the CASN accredits programs and recently CASN changed the entry-level requirements for nursing to baccalaureate (CASN, 2011).

The CASN *Accreditation Program Standards* (2014) delineate what educational institutions in Canada must abide by to offer approved educational programs leading to degrees in nursing. The *Accreditation Program Standards* is broken down into two sections, 1) the standards for the educational unit and 2) the standards for the program. There are some things in the educational unit that may be linked to the current topic, but these standards refer more specifically to what a university is. The standards for the educational programs indicate that syllabi, student assignments, exams, papers, clinical performance reports, evaluation rubrics and course evaluations are scrutinized as part of accreditation (CASN, 2014). Please note that the survey respondents did not provide any of these materials citing it was not their intellectual property.

The next important document is the Canadian Council of Registered Nurse Regulators (CCRNRR) *Competencies in the Context of Entry-Level Registered Nurse*

Practice (2012). Identifying entry-level knowledge skills and abilities that graduates must require to enter nursing practice, these competencies are understood to be gained through a baccalaureate nursing education, and these specific competencies were identified to be reiterated in the 11 English language provincial/territorial nursing organizations that license RNs. A peculiarity of the current research is that between the time of data collection (2013), and the time of results writing (2016) there were two fundamental shifts in the education and examination of entry-level nurses in Canada in 2015. Entry-level requirements for the designation of RN were changed to a baccalaureate degree requirement for entry-level nursing (CASN, 2015), removing diploma based options. The second major shift was the discontinuation of the Canadian Registered Nurse Exam (CRNE) in 2014, and the institution of the North American standardized exam called the NCLEX-RN. The first Canadian nursing school graduates faced with the new exam were tested in January 2015 (CCRN, 2015).

Upon realization of the change to the NCLEX-RN, qualitative content analysis of the National Council of State Boards of Nursing (USA) document *Test Plan for the National Council Licensure Examination for Registered Nurses* NCLEX-RN (NCSBN, April 2016) was added to the following synthesis. This was the only non-Canadian authored document considered for review.

After these five integral documents regarding educational policy, there were an additional 12 position statements policy statements and practice guidelines reviewed.

5.8.1 CNA *Code of Ethics: Centennial Edition (2008)*. With the overall thrust of education implicated throughout the *Code of Ethics*, the PDF was searched for the terms ‘education’, ‘professional development’; the following citation was relevant:

Code G 9. Nurses share their knowledge and provide feedback, mentorship and guidance for the professional development of nursing students, novice nurses, and to other health-care team members. See Code of Ethics Appendix D (p. 19).

The subsequent Appendix D referenced by the Code of Ethics states [among other things] that *all nurses endeavour to provide nursing students with appropriate guidance for the development of nursing competence* (page 50).

When investigating the particulars of sexual orientation and gender diversity, the following was identified:

Code F 1. When providing care nurses do not discriminate on the basis of [...] gender, sexual orientation [...] (p. 17).

Definition of Diversity: *includes the terms sexual orientation and gender.*
(p.24)

Diversity in populations is cited as *a challenge and opportunity* (p.32).

Competency is cited as the *integrated knowledge skills judgment and attributes required of a registered nurse to practice safely and ethically in a designated role and setting* (p. 23).

While there were only two mentions of sexual orientation, ‘person’ was mentioned 116 times addressing the following relevant topics: disclosure of personal health information, respect and dignity of the person, relational practice,

client centered care, client advocacy, ethical conduct with client interactions, and nondiscrimination. These two citations are the only specific mentions of 'sexual orientation' and 'gender', and the mention of 'gender' is singular. The *Code of Ethics* does not include any of the words 'identity', 'presentation', 'binary', 'trans'. The mention of 'gender' singular is apparently in keeping with outdated notions of 'gender' equaling 'women' and presents a normative limited construct that reinforces 'gender' as a binary, therefore heteronormative (see: earlier critique of Lent and Bishop, 1998). The document was further analyzed and, interestingly it identified the definition of 'family' as people who provide family support, *whether or not there is a biological relationship* [italics added], identified by the person receiving care (p.25). This is a very good example of how health care policies affect people of diverse sexual orientations. This definition of family is under the rubric of 'family of choice' (see: Appendix A), a concept that allows non-biological same-sex partners to act as caregivers to each other and offspring. It also allows for intimate kinship networks to be recognized within the circle of care. This is the exact type of embedded discourse that opens the possibilities of not thinking straight (Ingraham, 2005) and envisions a social reality that is not heteronormative. While the *Code of Ethics* (2008) presents 'gender' as singular and normatively constrictive, it's definition of 'family' is inclusive.

5.8.2 CASN National Nursing Education Framework: Baccalaureate (2015a). The CASN "national guidelines integrate professional and academic

expectations... and offer schools direction in developing, reviewing, evaluating or modifying nursing programs and curricula” (p. 4). CASN regulates and reviews programs leading to the baccalaureate nursing (and related) designations. Like in medicine, schools of nursing are reviewed and regulated against an established accreditation framework. CASN, the creators of this document (or at least the publishers) are the administrative group who approves and is responsible for accreditation. So, with this, they set the broad framework and standards for program approval. This framework, developed collaboratively by the CASN promotes excellence in nursing education.

Unlike the *Code of Ethics* (2008) the *CASN National Nursing Education Framework: Baccalaureate* (2015a) document uses the term ‘client’ rather than ‘person’ and specifies client as an individual, family, group, community, or population (p. 14). *Domain 1: Knowledge* (p. 8) requires foundational knowledge of primary care and the determinants of health in relation to health disparities of diverse clients and vulnerable populations, which, if using the notions from the literature presumably includes people of diverse sexual orientations and genders, as this document does not include any mention of the term ‘sex*’ or ‘gender’, nor has a glossary to define any possibly ambiguous terms.

The only two mentions of client populations that are apparent in the *CASN National Nursing Education Framework: Baccalaureate* (2015a) are the terms ‘diverse clients’ (which is used throughout) and ‘vulnerable populations’. Outside of these, which hopefully are intended to include all genders and sexual orientations,

there is mention of relevancy in three other domains. More specifically *Domain 3: Nursing Practice* requires baccalaureate nursing programs to prepare the student to demonstrate holistic and comprehensive assessment of diverse clients, plan, and provide competent ethical, safe, and compassionate nursing care (CASN, 2015a, Component 3.1, p. 10).

Domain 4: Communication and Collaboration states that programs prepare students to communicate and collaborate effectively with clients....; specifically, *the ability to self-monitor one's beliefs, values, assumptions, and recognize their impact on interpersonal relationships with clients...* [italics added] (CASN, 2015a, Component 4.2, p. 11). Presumably, nursing scholarship would frame this as relational practice.

Domain 6: Leadership states that programs prepare students to coordinate and influence change within the context of nursing; more specifically, the program prepares the student to demonstrate the ability to advocate for change to address issues of social justice, health equity, and other disparities affecting the health of clients (CASN, 2015a, Component 6.5, p. 13). As identified by Spenceley, Reutter, and Allen (2006), nursing has not done a very good job of being able to engage in policy advocacy. The CASN *National Nursing Education Framework: Baccalaureate* (2015a) is echoed by all provincial/territorial nursing regulatory associations. This suggests a significant shift towards standardization in the area of educational requirements, foundational knowledge, and entry-level competencies for nursing.

5.8.3 CASN Accreditation Program Standards (2014). The CASN

Accreditation Program Standards (2014) outlines that educational programs must be rooted in excellence in nursing education that capture the current and emergent trends, prepares students to address complex health issues, provides them with foundational knowledge in humanities, sciences, social sciences, and “provides learning experiences related to primary health care, health promotion, prevention, curative supportive, rehabilitative, and end-of-life care, across the lifespan of individuals, families, groups, communities, and populations” (p. 23).

Accreditation sets for the overarching quality dimensions, standards, descriptors, and key elements against which nursing programs and their institutional units are assessed while also incorporating flexibility regarding the organizational structure and curriculum. This flexibility enables programs to be autonomous in their academic perspectives and responsive to their particular regional, social, professional, and institutional contexts (CASN, 2014).

As stated previously, CASN approves educational programs but as part of this accreditation, CASN regulates the educational unit. Six of the provincial/territorial licensing organizations had documents designed to assist and delineate criteria of CASN approval of educational units. Without being prescriptive, the CASN *Accreditation Program Standards* (2014) allows for a quality improvement approach to curriculum renewal, however this document did not include the terms ‘sex’ or ‘gender’ at all, and the only mention of diversity was related to the institutions’ ability to provide evidence that they attend to inclusion and diversity. Moreso, this document does not have a glossary or appendix to define terms so a further scan of ‘person’, ‘individual’, ‘client’ identified that the “curriculum prepares students to

address complex health issues that affect clients in a variety of settings” (program framework, element 5, p. 23). It also refers to client-centered care in knowledge-based practice framework, (standard statement, p. 25). There appears to be a consistent message to prepare nursing students to work with all client populations in all settings in all stages of life.

As an outsider of nursing scholarship, the relative importance of the CASN *Accreditation Program Standards* (2014) may be inflated in this research. As an outsider I don’t know which particular educational policy documents have more or less influence on pedagogy. While the CASN *Accreditation Program Standards* (2014) states that “learners receive education that is progressive [read: built upon] and knowledge based, while developing personally and professionally” (p. 22); very few of the survey respondents indicated that sexuality and gender diversity health and wellness information was built sequentially [threaded] into the curriculum and the ones that did show it was included at their institution suggested it may not be done well. The survey responses suggest that only parts of relevant sexuality and gender diversity health and wellness information presented in the known LBGTIQ health issues (Table 1) are taught; therefore the responding institutions do not meet the accreditation requirement *Professional Growth*, key element 8 whereby “the program provides opportunities for students to develop theoretical and practical knowledge of relational practice, cultural safety, and social and political advocacy” (CASN, 2014, p. 26).

5.8.4 CCRNR *Competencies in the Context of Entry-Level Registered Nurse*

Practice (2012). Since nursing practice regulation in Canada is provincial in scope and not national, there is quite a bit of interplay between the regulatory environments. There appears to be a gap in the policy discourse. There do not seem to be specific guidelines for what a nurse is to be taught in the area of sexuality and or gender identity. There are broad national program accreditation standards (CASN), and many national and provincial/territorial entry to practice competencies; there are national frameworks for practice (CNA), and there *were* national examination guidelines, but it would appear that there are no standardized or even delineated notions of what is to be taught, like a consensus statement for a particular area. CASN and the newly formed, Canadian Council of Registered Nurse Regulators are working towards standardization, the Canadian Council of Registered Nurse Regulators states:

From a regulatory perspective, the entry-level competencies serve the primary purpose of nursing education program approval by describing the competencies required for entry-level registered nurses to provide safe, competent, compassionate, and ethical nursing care in a variety of practice settings. The competencies also serve as a guide for curriculum development and for public and employer awareness of the practice expectations of entry-level registered nurses (CCRNR, 2012, p. 5).

This is a new beginning to the standardization of nursing education regulation in Canada as the workforce mobility requirements of the Federal Agreement on Internal Trade requires increased standardization between provinces since 1995. The development of the Canadian Council of Registered Nurse

Regulators (CCNR) document the *Competencies in the Context of Entry-Level Registered Nurse Practice* (2012) had involvement from all English language nursing professional associations (that registers nurses) in Canada except the Yukon (Quebec was excluded). It had buy-in from 10/11 of these English language organizations as well as the Canadian Nurses Association with the aims to meet the requirements of the 1995 Federal Agreement on Internal Trade. In the assumptions section at the beginning of the report, the CCNR outline that entry-level registered nurses are prepared as generalists to enter into practice safely, competently, compassionately, and ethically:

- In situations of health and illness
 - With people of all genders and across the lifespan
 - With the following possible recipients of care: individuals, families, groups, communities and populations
 - Across diverse practice settings
- (CCNR, 2012, p. 6).

The preface of the CCNR *Competencies in the Context of Entry-Level Registered Nurse Practice* (2012) outlines that these competencies are fundamental to competent ethical nursing practice and it specifically states that nurses must have and apply population health knowledge, such as the health disparities and inequities of vulnerable populations (e.g., sexual orientation, persons with disabilities, ethnic minorities, poor, homeless, racial minorities, language minorities)... to achieve positive health outcomes. (CCNR, 2012, Item 36, p. 13).

These two sections (the assumptions section and Item 36) of the CCNR report were copied into the *Competencies of Entry Level Registered Nurses* documents of each of the eleven provincial/territorial regulatory organizations

under investigation, reiterating the generalist entry-level competencies for RN's in all English jurisdictions in Canada. Due to each provincially mandated nursing association's liberty to slightly alter guiding documents due to suit the needs of their regulatory specifics, there are slight variations in these documents (CNA, 2015, p. 3).

It is interesting to note that while sexual orientation is mentioned as a particular type of knowledge that is required to be known, the same document specifies that nurses must be competently able to give care to people of 'all genders', not just men and women, not both genders, but 'all genders', as a fundamental assumption in the preamble to the listed competencies. The CCRNR and *all* provincial/territorial competencies of entry-level registered nurses documents further state that nurses accept and provide care for all clients, regardless of gender, age, health status, lifestyle, beliefs, and health practices (CCRNR, 2012, Item 82, p. 17). The CCRNR and *all* provincial/territorial competencies of entry-level registered nurses documents further iterate the term 'all genders' in its definition of the term generalist (CCRNR, p. 21); reinforcing and reiterating the initial assumption that references 'all genders'.

This mention of 'all' genders is quite important, and required of all nursing graduates. As a generalist the CCRNR states that all nurses must be prepared to practice safely, competently, compassionately, and ethically, and in situations of health and illness, with people of all genders, across the lifespan, in a variety of settings, with individuals, families, groups, communities, and populations (CCRNR, p.21). Linguistically, using 'all genders' as terminology indicates a very complex

meaning of gender that operates outside of a binary and fixed singular definition. The first use of this term in the preamble places it as assumed knowledge while the placement in the definition of an entry-level generalist implies that the seemingly common unquestioned knowledge (read: assumption) encompasses expressions and identifications beyond the familiar woman/man binary (read: all genders) is integral to all nursing professions (read: generalist). Thus it implies an unexplained everyday knowledge of the depth and breadth of gender studies topics so normal, natural and pervasive among health professional students, that it simply exists and does not need any further clarification, discussion or elaboration.

In contradiction to the centrality of this unexplored everyday knowledge that competent entry-level RN practitioners are required to exhibit, the survey responses above illuminate that gender diversity and sexuality knowledge is far from a developed component in the curriculum. Less than 50% of respondents reported *gender expression* in the required curriculum (Figure 4), less than 24% reported including *sex reassignment therapy* in required curriculum (Figure 5), less than 12% reported *Intersex* in the required curriculum (Figure 6), less than 18% reported *transitioning* in the required curriculum (Figure 7). This was reiterated whereby respondents reported they don't do a very good job teaching the difference between gender identity and gender presentation. Furthermore, it was identified that 9/17 institutions or 53% of students are possibly taught the difference between identity and presentation with regards to gender - albeit admittedly not well, and often as an elective (Table 3).

So while this assumed baseline knowledge is fundamental in the texts that help guide and direct core competencies, it would appear that half of Canadian baccalaureate nursing students are possibly not taught sexuality and gender identity content, and the quality of the content appears curious. It is unknown if they are examined on the concept of 'all genders'. Furthermore, less than 5/17 or 29% of senior administrative faculty responsible for responding for their institution saw the need for increasing gender diversity content (Table 4).

5.8.5 National Council of State Boards of Nursing (USA) *Test Plan for the National Council Licensure Examination for Registered Nurses NCLEX-RN*

(NCSBN, April 2016). The only non-Canadian document under analysis, did not include any mention of sex, gender, vulnerability, or diversity, however it did include 'lifestyle choices', aging process, and developmental stages and transitions, all under the rubric of 'health promotion and maintenance', which are concepts examined by the exam. It also included requirements to examine 'psychosocial integrity' including topics of:

- Abuse/Neglect
- Family Dynamics
- Chemical and Other Dependencies/ Substance Use Disorder
- Mental Health Concept
- Coping Mechanisms
- Stress Management
- Cultural Awareness/Cultural Influences on Health
- Support Systems

The vagueness of this document makes it difficult to integrate completely, however the National Council of State Boards of Nursing (USA) *Test Plan for the*

National Council Licensure Examination for Registered Nurses NCLEX-RN (NCSBN, April 2016) uses the terms 'lifestyle choices' and 'culture' without an associated glossary. As it appears on the surface to rely on the main concepts of the *Code of Ethics* (2008), it also has a different slant to terminology than what is commonly used in the Canadian healthcare tradition, and the impact of this document should be investigated thoroughly. For example.

The following processes are fundamental to the practice of nursing and are integrated throughout the Client Needs categories and subcategories:

Nursing Process – a scientific, clinical reasoning approach to client care that includes assessment, analysis, planning, implementation and evaluation.

Caring – interaction of the nurse and client in an atmosphere of mutual respect and trust. In this collaborative environment, the nurse provides encouragement, hope, support and compassion to help achieve desired outcomes.

Communication and Documentation – verbal and nonverbal interactions between the nurse and the client, the client's significant others and the other members of the health care team. Events and activities associated with client care are recorded in written and/or electronic records that demonstrate adherence to the standards of practice and accountability in the provision of care.

Teaching/Learning – facilitation of the acquisition of knowledge, skills and attitudes promoting a change in behavior.

Culture and Spirituality – interaction of the nurse and the client (individual, family or group, including significant others and population) which recognizes and considers the client-reported, self-identified, unique and individual preferences to client care, the applicable standard of care and legal instructions (NCSBN, April 2016, p. 5).

Exactly how these concepts are translated into examination questions cannot be fully integrated into the analysis due to the vagueness of this document and the researchers position as outsider. It would be very beneficial but outside of this masters thesis to track the changes in population health/health promotion language

used in nursing in the face of a standardized North American testing originating in the USA.

5.8.6 Related Policy Statements and Practice Guidelines. There is a real ignorance towards the inclusion of sexuality and gender diversity in nursing as exemplified by the Canadian Nurses Association position statement *Promoting Cultural Competence in Nursing (2010)*. This document is particularly troublesome within queer critical discourse analysis. The 2004 version of this CNA document included sexual orientation and gender in its definition of culture. The 2010 version removed these concepts from the rubric of cultural competence. This deletion could suggest that ‘culture’ does not include sexuality and gender; the deletion could also indicate the potential of clarification of terms and delineation of concepts whereby sexual orientation and gender identity are written into another more specific position statement; and/or the deletion could also mean that the omission of sex and gender was unintentionally overlooked, therefore promoting heteronormativity and cisgenderism in nursing. It is difficult to ascertain from the available data if the effacing of these types of identity from the notion of culture and cultural competency was intended, as it is included in the terminology of culture in more than one other national curricular policy document. Ideally, it is indicative of the future development of another position statement that addresses sexuality and gender diversity as ‘diverse populations’ and/or ‘vulnerable populations’ rather than ‘cultural competency’ as these appear to be the adequate terms to discuss issues of

sexuality and gender, from the survey results. The effacing of these words from one type of document and supplanting them into another type of document would make complete sense, however, there is currently no position statement of the CNA, CASN, that specifically address 'sexuality' and 'gender identity'. Regardless of the explanation, the removal of these terms without an adequate additional document renders these identities invisible.

The College of Registered Nurses of Nova Scotia *Position Statement: Promoting Culturally Competent Care* (2016), articulates gender and sexual orientation in its definition of diversity, stating that "Educators must also recognize and address explicit professional, theoretical and cultural biases in curriculum content" (CRNNS, 2016, p. 2). The College of Nurses of Ontario, *Practice Guideline: Culturally Sensitive Care* (2009) takes a more artistic understanding of culture but yet still recognizes that gender and sexual orientation affect people's culture.

The only position statement of all the documents reviewed that specifically and thoroughly addressed 'sexual orientation' and 'gender identity' was issued by a non-license granting professional organization. The Registered Nurses' Association of Ontario position statement on *Sexual Orientation and Gender Identity* (2007) states that "*Genderism is the belief that the binary construction of gender, in which there are only two genders (female and male), is the most natural, normal, and preferred gender identity. This assumption that all people must conform to society's gender norms does not include or allow people to be intersex, transgender, transsexual, or genderqueer*" [italics added]. This 2007 position statement was the only of it's

kind found during the research and in the hierarchy of professional organizations the RNAO position statement should be as pervasive as the *Code of Ethics* (2008). While this progressive document combats institutional heteronormativity, the research and the other documents analyzed thus far do not share the same insight.

The CNA and the Canadian Federation of Nurses Unions *Joint Position Statement on Workplace Violence and Bullying* (2015) could very well have been written to include sexual orientation and the other protected human rights classifications, but it does not. Curiously, even the CNA position statement on *Health and Human Rights* (2011), fails to mention any particular identity classifications. CASN *Mental Health and Addictions Entry to Practice Competencies Framework* (2015) outlines that a “trauma informed approach ... recognizes... the negative effects of.... discrimination (CASN 2015, p. 16). This document recognizes that mental health issues affect ‘all genders’, and it would presumably include all sexual orientations although it is not mentioned. The CASN *Mental Health and Addictions Entry to Practice Competencies Framework* (2015) represents an opportunity to frame some of the discrimination effects based on sexual orientation and gender identity (see Table 1) as mental health and addictions entry to practice competencies, if the profession is willing to acknowledge the topic area of this thesis.

The College and Association of Registered Nurses of Alberta - produced a *Position Statement on Vulnerability* (2005). This take on healthy public policy is very beneficial when put into practice. Taking a definition of vulnerability that iterates: open to attack, susceptible to physical wounds (etc) and then linking vulnerability to

the social determinants of health, makes this a well-worded argument that recognizes the complexity of vulnerability and situates it within population health and health promotion frameworks. The downfall of this 2005 document is that gender is not mentioned, only the social determinants of health term of 'biological and genetic makeup/endowment'. Even though it only passively recognizes sexual orientation, sex, and does not include the 'all genders' notions, this document could be reworded slightly and adopted by the CNA as a nationalized position statement to guide nursing. It was found that there is also some degree of unstandardized reporting of the social determinants of health pervasive across health policy communities. Some nursing educational policy documents indicate 10 determinants, some indicate 14 determinants, and the wording of these determinants varies on the citation. This masters thesis takes 12 social determinants of health at its core.

The CNA *Position Statement: Social Determinants of Health* (2013) in keeping with the current research states that "rather than focusing on the individual, attention must be paid to the structures and processes that maintain power and privilege for some and marginalization for others" (CNA 2013 p. 3). It addresses vulnerable populations, health inequities, and how social determinants of health affect access to care, CNA *Position Statement: Social Determinants of Health* (2013) recognizes the need for prioritizing social determinants of health and states that nursing has a professional and ethical responsibility to actively engage with developing, implementing, and educating in health public policy. This framework needs to be upheld in the face of changing to the NCLEX-RN.

The CASN *Entry-to-Practice Public Health Nursing Competencies for Undergraduate Nursing Education* (2014a) uses a PHAC definition of culturally-relevant (and culturally appropriate) care that specifically includes all genders and sexual orientations (CASN 2014a, p. 12) and the framework for inclusion of gender identity and sexual orientation content would arise as a public health competency in curriculum. This document, unlike the CNA position statement *Promoting Cultural Competence in Nursing* (2010) discussed above, does indeed include sexual and gender diversity in its definition of culture (see: CASN 2014a). It is unhelpful as a profession to have conflicting or incommensurate policy discourses circulating.

One particular asset of the federal structure of nursing regulation is that provincial/territorial and national organizations have the ability to produce position statements or develop practice competencies in particular areas to assist practicing nurses. This may, if translated (read: uptake, applied, integrated) appropriately, assist faculty in developing curriculum. This practice has been useful in medicine; in Nursing, I may simply have not been able to identify many of these documents, other than the College of Registered Nurses of British Columbia *Competencies for Certified Practice: Reproductive Health – Sexually Transmitted Infections* (2014). These types of documents are useful frameworks for articulating the complexities of dealing with particular issues and do so in a effective way. What is good about the *Competencies for Certified Practice: Reproductive Health – Sexually Transmitted Infections* (CRNBC, 2014) is that it takes into account such knowledge as: 1) socio-economic determinants of health as it pertains to clients' STI risk, 2) trauma informed

care/practice 3) available and accessible resources /services for affected populations; as well as demonstration of attitudes that: 1) respects clients' choices, beliefs and values 2) demonstrates self-awareness of own beliefs, values, and practice limitations, 3) demonstrates sensitivity regarding impact of STI diagnoses; infectious disease surveillance, reporting, and partner notification (CRNBC, 2014).

This was the only specific competency in the area of LBGTIQ health and wellness that was located in the research, and it is limited to sexual health. Another useful document produced by the College of Registered Nurses of Nova Scotia, while not geared to effecting curriculum, *Change of Sex Designation on Birth Certificates: Questions and Answers for RNs and NPs* (2016), clearly outlines how practicing nurses are to cope with one topic of gender identity. These valuable and specific types of documents do not appear in all provinces and are not readily available at the national level. There is a gap in available knowledge in nursing policy documents related to the health and wellness issues faced by people of diverse sexuality and gender identities.

Chapter 6: Conclusions and Recommendations

The present research focuses on the articulation and relative inclusion of sexuality and gender diversity health and wellness information in Canadian English language baccalaureate nursing curriculum and curricular policy. This research, informed by documented health and wellness experiences of LBGTIQ people, situated in the academic discipline of Applied Health Services Research, and is a unique critical queer theoretical analysis of survey data and relevant policy texts. The data was collected from a nationwide survey of nursing school administrators in 2013, is scaffolded against LBGTIQ health and wellness literature, as well as nursing education policy.

6.1 Contribution to the Literature

Studies have found that there is no standardization of sex and sexuality content in curriculum in North American health professional schools (Coleman et al., 2013; L'Heureux, 2006; Lim, Johnson, and Eliason, 2015; Mayer et al., 2008; Obedin-Maliver et al., 2011). This research found the same, but also highlighted at least one reason why there is no standardization of content in Canadian English nursing curriculum; a lack of articulate policy in the area. The current research had not heretofore been conducted on baccalaureate nursing education in Canada and had not been done with a focus on education policy. L'Heureux's community-based research was part of a much larger project and the findings are limited and easy to miss. Medical schools have been covered extensively (see: Coleman et al., 2013; Obedin-Maliver et al., 2011), and in the USA at the same time as this research was

being conducted, Lim, Johnson, and Eliason was conducting analogous research in their country with less focus on the policy domain. This research sits alongside those studies but goes one step further by scaffolding the survey results against critical content analysis of curricular policy standards like Mulè (2006) did with Social Work. Where Mulè found rationale for unstandardized sexual orientation curriculum in social work, he did not conduct surveys to identify the depth of the situation. This research is exploratory in the context of Canadian baccalaureate nursing education. I draw attention to the ways heterosexism and cisgenderism are inscribed in the institution of health education policy and deconstruct the system of pedagogy to interrupt the notions of sexuality and gender identity. This research sets the stage for future research in the area, finding that in part, the lack of standardization of sexuality and gender diversity content in nursing education in Canada is due to the lack of clear and definitive policy at the provincial/territorial and national levels. This area of research is a relatively new academic area and because of that, care has been taken to use this thesis to outline parameters for future research. Each of the sections of the results chapter outline a little bit more information on how the complex and messy policy in nursing fails to educate on LBGTIQ issues and the sections that follow hopefully identify ways that nursing education can move forward.

6.2 Key Finding: Implications for Nursing

Lim, Johnson, and Eliason (2015) found that despite reporting severe knowledge limitations and lack of institutional support, most USA nursing faculty felt comfortable and able to teach on LBGTIQ health and wellness topics. In Canada the respondents indicated they want more knowledge and support, their written comments indicate that they do not feel comfortable teaching LBGTIQ health and wellness. They reported self-awareness about not being able to teach sexuality and gender identity issues well enough and not having enough institutional support to be able to teach extensively in the area of LBGTIQ health and wellness, therefore it may be avoided in curriculum. Responding faculty also cited the need for more access to curricular resources, and evidence-based research, however, they listed these as being available in their library, and this research also compiled an entire appendix of educational modules readily available in the public sphere. It would seem that there is little uptake of this information.

While the first step towards the inclusion of coherent relevant sexuality and gender diversity information is the recognition of the need for awareness of LBGTIQ health and wellness content, without proper delineation of key concepts in sexuality and gender diversity rubric, the intention may fall short or be misguided. It needs to be lead by stakeholders in nursing who have the professional duty to advocate and engage in policy work. It was found that guiding policy documents for nursing education were not consistent in their terminology of 'culture', 'diversity' and 'social determinants of health', leading to a lack of consistent inclusion of the terms 'sexual

orientation' and 'gender'. The apparent lack of importance for LGBTIQ health and wellness issues in Canadian English language baccalaureate nursing education is further reiterated in the reported haphazard availability of clinical placements and the relegation of this type of content to elective courses. This high degree of variability made it difficult to draw consistent conclusions across educational institutions other than recognition that faculty need support and professional development opportunities (to standardize educational content within and across institutions), and that nationwide there is high variability in programs and therefore by extension, a graduating workforce that is by not consistently adequately trained to work in areas of LGBTIQ health and wellness. By way of critical discourse analysis, the end result is the invisibility, cast off, and willfully ignored subjectivities of populations known to be facing adverse health concerns.

The USA survey by Lim, Johnson, and Eliason, 2015, identified barriers and facilitators to integrating LGBT health topics in the curriculum into four levels: 1) at the curriculum, 2) faculty, 3) institutional policy, and 4) stakeholders/community outreach levels. They report that:

- LGBT health should be incorporated into curriculum with similar topics (eg. obesity dialogue mentions LGBT issues)
- LGBT topics should be promoted as social justice, vulnerability issues, or cultural competence in the curriculum
- Limited space in the curriculum and limited classroom time has to be taken into account
- There is limited guidance on how to appropriately integrate LGBT topics
- Faculty need development sessions on LGBT topics and guidance on integrating topics into curriculum
- Faculty may have limited knowledge of LGBT topics and may oppose or be uncomfortable teaching on LGBT topics
- There needs to incorporation of LGBT topic in the NCLEX-RN exam
- LGBT topics are not required for accreditation

- There should be collaborations with LGBT community agencies when planning curriculum and discussions regarding curriculum need to include LGBT organizations. (Lim, Johnson, and Eliason, 2015, table 4, p. 149).

The current research arrived at many of the same conclusions. Faculty are more comfortable and more likely to teach on: 1) sensitivity and respect for people generally, 2) safer sex, 3) LGBT families, 4) how to obtain same-sex sexual health information when conducting a sexual health assessment, 5) adolescent sexual health, 6) HIV/AIDS and STI information. They would like to know how to address heterosexism and create safe spaces in the classroom, as well as how to talk about LBGTIQ people and their health and wellness issues outside of a discourse on safer sex/HIV. They generally felt unaware of how to articulate the particulars of LBGTIQ social location and health and wellness issues. In Canadian English language nursing, clinical placements are not frequently available to address LBGTIQ health; sex reassignment therapy, intersex and 'disorders of sex development', and transitioning, are probably not included in most baccalaureate nursing curriculum. Furthermore, from written comments many nursing administrators referred to this collection of health and wellness topics as a singular issue, and there does not appear to be a single required or elective class or teaching stream dedicated to sexuality and gender diversity issues. Content that does exist on average appears to be a small component of a course, in many cases as an elective course, whereby the teaching faculty may choose to include content relevant to the health and well-being of LBGTIQ clients. Lim, Johnson, and Eliason found that over 50% of USA respondents seldom-to-never taught health and wellbeing topics relevant to LBGTIQ

people (Lim, Johnson, and Eliason, 2015, table 2, p. 147). This research supports the research of Lim, Johnson, and Eliason in finding that topics relevant to LGBTIQ health and wellness were seldom taught and if and when it was, it was often at the discretion of the instructor.

CASN still holds the authority to approve or deny institutional and program accreditation. CASN is the only identified legislative body with this authority. While respondents reported requiring LGBTIQ content as part of the accreditation standards as the least beneficial way to affect curriculum, the researcher identified this as one of the most beneficial ways to consistently ensure the inclusion of LGBTIQ subjectivities in nursing curriculum. Nursing as a profession has a tendency to be inward looking and has not had a very large presence in policy advocacy (Spenceley, Reutter, and Allen, 2006). The findings of the survey hint at this as well; when asked if changing the accreditation requirements would be an efficient means of ensuring more and better inclusion, less than half respondents agreed, they strongly preferred to build their own personal knowledge on the matter rather than affect systemic change. However if that is an effect means of ensuring appropriate content in curriculum it should be noted. Curriculum is not developed in a vacuum, it is developed and approved by a committee within the institution whose external review process examines the information that guides the learning objectives and ultimately accreditation. CASN does not include any documents outlining gender diversity in program accreditation standards, while they do have one mention of sexual orientation, on the ground in the classrooms, transitioning is apparently not

required curricular content in approximately 83% of the Canadian English language baccalaureate nursing curriculum (Figure: 7), and sexual orientation is notably haphazardly addressed in curriculum. The responding institutions appear to have a university environment that is conducive to inclusion and may have an elective that includes some relevant LBGTIQ content, so the failure for more consistent inclusion is due to a lack of structural requirement from administration at the provincial and national level. The schools then, in conjunction with the, teaching faculty, the curriculum committees, the accreditation/examination committees/legislative bodies, all need to be on the same page when it comes to sexuality and gender diversity.

The problem of appropriate inclusion of LBGTIQ health and wellness content from this research is systematic. It's not just one of implementation, but also sustainability. In 2004 the Canadian Rainbow Health Coalition based in Saskatoon received 2.3 million dollars over two years from the Primary Health Care Transition Fund of the Public Health Agency of Canada to investigate and make LBGTIQ health and wellness information available for health care providers and educators. They did good work towards those ends and the Canadian Rainbow Health Coalition (2006) final report shows that strides were made. However, ten years later, the organization is disbanded and the influential director Gens Hellquist has passed away. This should not have stopped the momentum of their KT work, and if faculty personal development was the most beneficial way to affect curricular change then why hasn't the work of the Canadian Rainbow Health Coalition radically

transformed nursing education. Relying on slow research uptake within the academic educational system at the level of individual teaching faculty, on the basis of each individual instructors self-realization and actualization to recognize the importance of a queer lens leading to implementing changes in their own pedagogical practice seems risky, expensive, and highly laborious.

Nursing education policy is an exceedingly complex field with a large number of curricular demands for content. With recent changes to the examination format to standardize it across the entirety of North America using the NCLEX-RN, the guiding documents and format of the NCLEX-RN are currently US-based and therefore Canada has lost some of its unique authority to tailor health care education and training to the particularities of its regions and populations. Furthermore, the CASN and the CNA who held authority regarding the development of nursing philosophy have become involved in another new organization tasked with the mandate; the CCRNR. These particular changes that happened during the research process may prove to benefit the area of nursing education, but they presented a challenge in the current research due to my position as outsider and the overall applicability of the study. With significant changes to the legislative environment there could be opportunities to uptake information found in this research.

The *Code of Ethics* (2008) situates education, social justice 'work', direct patient care, and knowledge sharing as fundamental integral components of nursing practice. As indicated by survey participants, faculty do not have much knowledge in the area of sexuality health and wellness issues outside of sexual health/STIs and

even less knowledge and ability to educate on gender diversity issues. This point is further supported by Lim, Johnson, and Eliason (2015) who found that American nursing faculty, despite having a willingness to teach on the topics, do not have a good knowledge base in the areas of sexual orientation and gender identity. Mulè (2006) found similarities in UK and Canadian Social Work code of ethics whereby inconsistencies between professional ethical expectations and adequate training standards fail to provide a coherent framework to appropriately address sexuality [and gender identity] diverse populations in social work education. The *Code of Ethics* (2008) is due for a revision. The provincial/territorial standards and practice documents appear to be updated on a 5-10 year cycle, and it has been eight years since the 2008 centennial edition of the *Code of Ethics*. Clear and concise, well-worded, alignment of professional ethical expectations and provincial/territorial educational standards is needed to move forward (see: Mulè 2006). Nursing is at a crossroads as it takes on the standardized NCLEX-RN and it is clear that there is a need for more nationwide consensus building on particular terminology. Failure to engage in activities to standardize and include a focus on LBGTIQ subjectivities will result in more students inadequately prepared to address issues of sexuality and gender identity and reflect a negligence of nursing to meet the ethical requirements of its profession.

While all registering professional associations require entry-level nurses to be able to enter into practice safely, competently, compassionately, and ethically with people of all genders and across the lifespan, it would seem that entry level

nurses may not be required to be educated in any issues related to transgender or genderqueer health and wellness. Similarly, the licensing regulatory associations who have written the notion of foundational knowledge of 'all genders across the lifespan' into their required entry to practice competencies do not seem to have a solid understanding of the complexities of trans and genderqueer issues across the lifespan. The reference to 'all genders' without a solid foundation anywhere in any of the available documents to explain exactly what all genders entails is genderism, supporting the belief that gender is binary and fixed.

6.3 Queer Analysis Summary

I started this research with a belief that there would be a limited amount of inclusion and relatively no explicit articulation of LBGTIQ subjectivities in Canadian English language baccalaureate nursing curriculum, signifying an unacknowledged and uninterrupted culture of heteronormativity and cisgenderism. I assumed that the discourses in nursing were rendering sexuality and gender diversity invisible for all intents and purposes and furthermore promoting heterosexuality in its wake. My identification as a queer and health researcher motivated my work while the topic of nursing education and policy was unknown, interesting, challenge. These reflections on my position and the work presented in these pages can only be verified or critiqued by the reader on the merits of the research presented. I was not alone in the assumption of heteronormativity and cisgenderism because anytime I mentioned my research to nurse educators, recent nursing graduates, or nursing

students, they said “you mean nothing?” I acknowledged this viewpoint as part of the research process (as standard in qualitative research) and proceeded to test it during the research process.

After reading more and more methodology texts in the area concurrently with my first and second read through of the survey responses, it became apparent that the agent (instructor and/or administrator) had a vital role to play in how curriculum and curricular policy are performed. Curriculum is not simply static but discursively reproduced. This concurrent reflexive practice of analysis revealed the situation less critically. In the results presented I focus on not their individual inabilities, insecurities, of faults (as others have, see: Lim, Johnson, and Eliason 2015), but on the system that has neglected to recognize and steer a response to a pressing contemporary phenomena.

The policy documents analyzed partially allude to the inclusion of LBGTIQ subjectivities, but do so haphazardly and incomprehensibly. They also indicate severe variation and a lack of consensus of what is meant by 'culture', 'genders', and 'sexuality'. The various policy documents analyzed are not consistent or mutually reinforcing in the area of LBGTIQ subjectivities. Legislating inclusion of ill-defined topics in curriculum is difficult as professors are targeted for so much professional development due to their work on the front lines, but there is a noticeable lack of institutional support at many of the responding universities and colleges, and the professional associations in each province have not mandated sexuality and gender diversity content as relevant. Furthermore, CASN is still working out the ability to

enforce particular information, as baccalaureate-nursing degrees are still being granted without accreditation. Perhaps the recent changes to the exam, and standardization between Canada and the USA might become the guidepost for what is taught, and then perhaps the best target to infiltrate.

By saying that sexual health equates to the broad complexity of sexuality and gender diversity health and wellness issues reduces the subjectivities of diverse sexually and gendered bodies to merely sex acts which can be made safer. It was apparent that there is a lot of safer sex content in baccalaureate nursing curriculum. A sexual health framework renders lesbians invisible because they are at such low risk for STIs/HIV and it fails to comprehend that gendered bodies are more than just genitals. Conversely, a mental health framework denies the existence of heterosexual men and women, and a sexuality framework (such as gay and lesbian studies and feminisms) denies the existence of the gender diverse. By equating sexuality and gender diverse subjectivities to LBGTIQ mental health issues risks medicalizing their version of life events and, while there was a desire by survey respondents to learn more about the mental health of LBGTIQ people, I should hope it was not a pathologizing thrust. These ways in which sexuality and gender diversity are rendered in the educational context either respect the dignity for the client; a fundamental tenet of the *Code of Ethics* (2008), or convey a baseline assumption that LBGTIQ subjectivities are not important or too complex.

Recognizing the use of potentially problematic terms 'minority', 'vulnerability', and the pedagogical practices such as teaching on 'coming out', safer

sex, while skipping over the really hard to handle topics of gender diversity are the subtle ways that the nursing profession conveys an understanding of LGBTIQ people. Pascoe (2007) analyzes how high schools are socializing institutions that have hidden curriculum surrounding heteronormativity and using the same theoretical understanding, the present look at nursing curriculum as a socializing institution is important to the subjectivities of LGBTIQ people. If we continue to represent LGBTIQ people as a minority group, they are minority to what? If LGBTIQ people have to come out, why don't heterosexuals have to come out? If we don't talk about adolescent gender identity and medical options for transitioning, then are we teaching compulsory heterosexuality and cisgenderism? These are the difficult considerations that nursing curriculum needs to reflect on to become queer and inclusive. The research above briefly highlights the ways that schools of nursing institutionally promote heterosexism and cisgenderism. The ways that nursing curriculum define what is normal, acceptable, expected, and delimit the richness of human experience is the way that our society as a whole continues to neglect a recognition of diversity. To explain, Jackson et al. (2006) argue that conventional approaches to population health research (and policy) measure health disparities of 'minority groups' against the experiences of those in the general population (an unexamined norm of those in the dominant social position). The weaknesses of this framework thereby greatly affect people of different markers of social location (races, ethnicities, genders, classes, sexualities, ages, abilities, geography, etc.) due to their comparison to an unexamined norm compounded by an inability to

comprehend the problems of multiple intersecting social locations. As a standardized patient, I taught Medical school students not to use value judgments such as ‘good’, when conducting sexual health palpitations because it might be construed as sexual. However, the alternative normal, in the context of sexuality and gender diversity is potentially more problematic.

While the *Code of Ethics* (2008) helped inform the provincial/territorial *standards for practice for RNs* in each province (discussed above) the *Code of Ethics* only states gender singular, not *all genders* pluralized. Whereas the provincial/territorial standards and practice documents investigated interpret gender as multiple, this indicates a need for the revision of the *Code of Ethics* (2008) to align with the provincial/territorial standards and practice documents on the issue of singular versus multiplicity of gender. Also, ‘families’, as identified in the *Code of Ethics* (2008) will need to be grandfathered into the provincial/territorial standards and practice documents to ensure consistency. The definitions of ‘diverse’ and ‘vulnerable populations’ are further not operationalized in many documents and this lack of specificity does not benefit nor hinder the suggestion that heterosexism and transphobia are embedded in nursing curriculum.

Despite a broad understanding of family that allows for non-biological family of choice, the *Code of Ethics* (2008) upholds a constricting normative understanding of the gender binary, and lacks a defined discussion of sexual orientation. This discourse is not shared, or reiterated in the CCRNR (2012) whereby ‘all genders’ is the assumed baseline, hopefully allowing for a complex and unbinding, non-

normative definition of gender that includes genderqueer, and all the identities outlined in Appendix A. As stated earlier in the methodology: “What we assume to be background knowledge or common sense, in fact, are always ideological representations... the goal of critical discourse analysis is to make these ideological systems and representations transparent and to show how they relate to the broader social order” (Pennycook, 2001, p. 81). The CCRNR jurisdictional document (2012) presupposes ‘all genders’ but does not and is not followed up in any other document regarding this complex diversity and discussion of gender. This offhanded mention would/could be overlooked but it has become ingrained in provincially mandated regulatory associations and educational policy documents, yet is not operationalized as what ‘all genders’ means, leaving hope (and work) for trans and queer rights. A contemporary reading of the notion ‘all genders’ until supporting documentation becomes available, currently means both genders. It would seem that nowhere in the research survey responses or document analysis was transgender, genderqueer, intersex, or anything gender creative considered in nursing policy since the 2007 RNAO document. The CCRNR definition of ‘all genders’, until further articulation is made public, would appear to be the entrenched heteronormative male female binary definition (see: critique of Lent and Bishop, 1998). Furthermore, as Prior (2003) states the absence of a record denotes a failure, a lack of concern, planning, foresight, and organization.

Terminology in the area of queer theory is exceedingly important as this research proposes. The use of inappropriate/non-preferred pronoun for trans

people can result in microaggressions that convey a lack of acceptance, using the right terminology for the situation is a perilous task. For this research, I somewhat intentionally conflated the terminology in the survey, more of happenstance than anything, the terms gender identity, gender diversity, trans, queer, are all used somewhat interchangeably as is their components in the LBGTIQ spectrum. Similarly, the terms sexuality, sexual orientation, sexual diversity, queer, lesbian, gay, bisexual, are all conflated in this research. This is partly the result of my own personal deepening understandings of the appropriate use of these terms but it is also indicative of the situation in healthcare for those outside of the intimate knowledge and application of queer theory. This heuristic was also iterated in the respondents written comments who understood LBGTIQ health and wellness issues as a singular issue. Using the terms interchangeably went theretofore unnoticed because of a lack of knowledge in the area. A point worth highlighting because if the research conflates terms and it goes unnoticed, then what does it mean for the research participants, who see LBGTIQ health and wellness issues as a singular issue.

6.4 Strengths and Limitations

6.4.1 Overall. As an enfranchised, educated, white, middle-class cis male, I am in the privileged position of being able to engage in a rights struggle to advocate for systemic changes to the Canadian health care system that, in theory, may benefit people experiencing a wide range of health and wellness issues. This thesis has

possible implications for addressing barriers to equitable, inclusive, respectful health care, for people of diverse sexualities and gender identities. It may not be immediate, and it may never happen, but operating from my privileged position as a masters student, the preceding pages lay out a situation facing our healthcare system, and then after conducting research in the area, lays out some recommendations for systemic change. Change that if acknowledged, may reverberate to the everyday societal interactions of future generations of queers in Canada.

As of 2016, there were limited other findings on LGBTIQ health and wellness content in Canadian baccalaureate nursing curriculum from a policy perspective. The development of this research project, including the methodology and area of study, contribute to the congruence of the research. The explicit framing within queer theory helps position the research while the agreement between method, methodology, and data analyzed helped build the study's credibility. This research essentially serves two functions: it is utilitarian in its aim to provide information to the reader through knowledge diffusion (Lomas, 1993) and it is theoretical in its attempt to describe and represent scholarly analysis on discourse of possible heteronormativity and cisgenderism in Canadian baccalaureate nursing education. As a masters thesis, this project was designed to identify a topic, develop a research question, design implement and report on the project; however, this is only the bare minimal most basic part of the work. In the area of Applied Health Services Research, the big issues surround knowledge synthesis, knowledge translations, and

implementation to practice (Lomas, 1993). Research is everywhere and the simple diffusion such as sending it out to the participants is only the first step. There is a great need for dissemination in the way of journal articles, conference presentations, and other means of ensuring that its diffusion is targeted before even the real work of uptake. I can only email the final thesis to every school of nursing in Canada, every nurses' union, every legislating body and every other organization that may have an interest in the hopes that they may use this research in their own knowledge building. There is a great need for more knowledge translation in the area, but a more suitable knowledge broker would be people within the field of nursing.

6.4.2 The study design. The research developed or achieved rigor through explicit articulation of the process and method of data collection, synthesis, and analysis. Furthermore, memoing and an audit trail was conducted as the research progressed. The analysis was as close as possible to the original data and used the American Psychological Association (APA) established guidelines for *Avoiding Heterosexual Bias in Language* (APA, 1991). Memoing was very important to this research. As was the three year break between data collection and results writing. As the research evolved organically several times, until the point of data collection, and then was shelved for three years while the researcher undertook other activities it coincided with other research of a similar stream to become published. This allowed for more comparisons to the literature and also gave myself the researcher more insight into the issues.

Analysis and results writing began simultaneously with a surface level look at the texts, and raw counts of numbers in the survey responses. The analysis of educational policy documents, entry-level competencies, as well as of the RN standards, proceeded quickly due to the limited number of references to the words identified apriori.

The survey did not ask size of graduating classes or number of faculty teaching specialized content in sexuality. It was deemed not necessary to collect identifying information of the respondents such as age, ethnicity, gender, sexual orientation, however an oversight could be made for not asking respondents number of years teaching, highest academic degree, employment status (full time/part time/adjunct), and position/title/responsibilities within curriculum development/administration/delivery. This information is available from the CASN report *Registered Nurse Education in Canada Statistics: 2013-2014* (2015); it would be nice to know a bit more about the respondents in these areas in hindsight. From the CASN (2015) report the representativeness of the data cannot be fully obtained because the CASN report findings include French language programs as well as English language programs, and addresses diploma, masters, doctoral, and nurse practitioner programs, above and beyond the scope of the current research (CASN, 2015). CASN also does not ask about part time programs.

6.4.3 Responses and document selection. Initially, this research included an analysis of course titles and descriptions available online in the public sphere.

This was included to be able to increase the reliability of the findings and support/double check responses against courses, and provide another level of analysis of the discourses used to frame LBGTIQ inclusion. However, with 76 institutions under analysis, each with 4 years of courses, the task would have taken too long, produced too much data to sift through and, was found to possibly yield too little information. The task of collecting and recording course titles and descriptions for each course at each institution was accomplished for three provinces but discontinued as it became clear that access to anything other than course names and numbers and an institutionally approved one liner course descriptions would not be a fruitful use of research time. Future research from a pedagogical standpoint could include investigation such as course descriptions, as has been done with cultural diversity (see: Gustafson, and Reitmanova, 2010).

This research asked survey participants to supply any relevant curricular resources such as lecture notes, textbook titles, handouts, powerpoint slides, and other relevant teaching materials. These were not shared and therefore future research instituted by CASN who has the authority to request curricular documents could look into the LBGTIQ content in existing curriculum resources such as examinations, lecture notes, student assignments and teaching materials as part of the annual accreditation review. The original research also proposed investigating required textbooks (like: Camase, 2009); this became unmanageable for a student from a different faculty with no knowledge of nursing curriculum, and exceedingly time-consuming, and was subsequently removed as a research activity early in the

process. It is not without its merit, however, it may be better conducted as a Ph.D. thesis in education or nursing. This aspect of the research could be expanded on in the future.

Furthermore, there is no outsider access to the restricted document NCLEX-RN. At the time of the study (2013), CASN was undergoing a major review and revision of the accreditation program. CASN's accreditation program standards were subject to stakeholder consultation. Changes were made to the values of the CASN accreditation program and to the CASN standards along with some key elements and their interpretations. This may have affected the survey responses, in conjunction with the NCLEX-RN exam coming into effect. As the exam is now a North American standardized controlled exam, outsider access is not possible. This presented a weakness to the study as an investigation of the NCLEX-RN for LBGTIQ health and wellness issues is necessary. I would urge the people who have access to development, implementation, and evaluation of the NCLEX-RN exam to consider the ways in which anti-oppressive discourses are (or are not) present. Lim, Johnson, and Eliason (2015) identified that the NCLEX-RN exam does not require content on sexuality and gender identity. CASN/CCRN should ensure that sexuality and gender diversity content is a component under review of this exam by ensuring it is in their accreditation standards. Without LBGTIQ inclusion in the NCLEX-RN exam, there may be a loophole in requiring North American baccalaureate nursing programs to properly educate and train students in the areas of sexuality and gender diversity health and wellness.

A struggle of this research was identifying the target population as institutions that offer a baccalaureate nursing programs. Oddly enough the established CASN process of accrediting programs and not institutions makes it somewhat difficult to quantify the exact numbers of institutions that offer a baccalaureate nursing programs in Canada. Every year CASN accreditation approves or denies programs, yet there are still unaccredited programs offered at institutions graduating students with baccalaureate nursing degrees. This annual accreditation process is one of the contributing factors to the problematic of researching curriculum as an outsider.

This research gathered information from 17 institutions across Canada; there was enormous variation in responses. Some institutions reported including little to nothing while at least one institution appears to include a great deal of relevant, up to date information structured consistently throughout the curriculum. Even within any particular institution there appeared to be high variability of content used to educate baccalaureate nursing students on LBGTIQ health and wellness issues. This research, and the issues around sampling and response rate were not difficult to address, and may have in some cases increased the confirmability and congruence of the results. While 17 institutions responded overall, three institutions provided multiple surveys, thus allowing for internal checks on those institutions responses otherwise known as confirming and congruency.

6.5 Directions for Future Action and Research

The thrust of these recommendations rely on the ethical/moral courage of nurse administrators and educators to act on this knowledge translation/policy advocacy work. As the *Code of Ethics* (2008) outlines nurses have a responsibility to engage in social justice work to promote the socially determined health and wellbeing of disadvantaged populations. Without the nursing communities uptake of this matter LBGTIQ will continue to be second-rate citizens.

6.5.1 Nationally. An environmental scan of nursing professional associations at the provincial/territorial and federal level could be undertaken to identify 'key components and educational requirements to achieve a basic level of competency for working with diversity in sexuality and gender identity'.

While the present research did not include the legal and regulatory environment, a further investigation could situate the current research within the human rights and legislative regulations. Alternatively lawsuits or human rights complaints could achieve the same outcome.

Internationally it is known that the NLCEX-RN does not have any sexuality and gender identity content, this research and the related content area of LBGTIQ health and wellness could be levied to argue for the need to include such content areas.

At the time of writing this the CNA did not have a position statement on vulnerability or diversity, or any position statement which specifically addresses sexual orientation/sexuality/gender identity/gender diversity and moreso had

actually removed those words between the 2006 and 2010 versions of a position statement (see: CNA, *Position Statement: Promoting Culturally Competent Care, 2010*). It is recommended that the CNA adopt and revise the RNAO position statement *Respecting Sexual Orientation and Gender Identity* (2007) to rectify this gap in policy, and then CASN take steps to develop entry to practice competencies regarding vulnerability/diversity and in particular, all genders and other anti-oppressive discourses such as, heteronormativity, cultural diversity, cisgenderism, ableism, etc. As it is made very clear in the supporting documentation for the development, delivery, accreditation, and entry to practice competencies for nurses in Canada nurses need to be competent as general practitioners to care for “all genders” across the lifespan and have a knowledge base that encompasses sexuality/sexual orientation. The lack of clear positionality about sexuality and gender diversity from the top down (non-specificity, invisibility) communicates that it is not a relevant topic that does not require immediate attention.

There appeared to be a disconnect between educators’ knowledge, and the language of governing documents from professional associations on the topic of sexuality and gender diversity. A possible way to redress this lack of standardization would be to have sexuality and gender diversity be the theme for a future CASN and CNA conferences. This would position the issues of LBGTIQ people as an important topic and perhaps a national working group would come forward to begin to tackle the issues of getting LBGTIQ content into curriculum. This approach has been used by the AFMC who have developed a resource group on *Equity, Diversity, and Gender*.

As leadership in policy and social justice is a core competency in all Canadian nursing jurisdictions it would be advisable for national and provincial/territorial organizations to provide some framework for teaching faculty and future instructors in the area of sexuality and gender diversity. While this recommendation did not come directly from the surveyed administrators of schools of nursing, it was apparent that faculty are concerned with their own self-development over the topics, and they are simply thinking of their own personal self-development in the face of a new health care population diversity concern, otherwise known as 'a new topic facing the health of Canadians'. Failure to lead nursing faculty towards integrating evidence-informed knowledge and inclusion of best practices in curriculum amounts to a failure of relevant social justice competency and an ignorance of the necessary policy work on behalf of the nursing profession. A simple knowledge translation plan in the area of inclusion of sexuality and gender diversity in nursing curriculum would be beneficial.

6.5.2 Provincial. Each provincial/territorial nursing organization should have at least one generic position statement, practice standard, or practice guideline in the area of sexual orientation and gender identity. Some of these organizations already have numerous position statements or papers. It would be beneficial to be proactive, rather than reactive in the case of sexuality and gender diversity. In particular, the College of Registered Nurses of Nova Scotia *Q & A on Change of Sex*

Designation is an excellent exemplar, as is the RANO position statement *Respecting Sexual Orientation and Gender Identity*; these should be adopted nationally.

In conjunction with policy development, there should be continuing competency professional development sessions made available surrounding the pressing issue of ability to teach (transmit relevant knowledge) and integrate evidence-based research on issues of sexuality and gender health and wellness. Failure to do this will result in more and more nursing students failing to receive training in what is identified as core competencies.

6.5.3 Institutional. Each institution should sign partnerships with ASOs and or sexual health centres (Planned Parenthood) to allow for student internships and placements.

Faculties of Schools of Nursing should write sexuality and gender diversity health and wellness into their identified objectives/outcomes for teaching. This would allow CASN to consider it a point of inclusion in the requirements for accreditation (*Standard of Teaching and Learning*, CASN 2014, pp. 16-17).

Faculties of Schools of Nursing should form curriculum committees to identify spaces to infuse LBGTIQ health and wellness information into existing curriculum. A suggestion that does not rely on simple exemplars such as 'coming out' or 'sexual health' but is built on an understanding of the whole individual as sexually and / or gendered diverse and their experiences of any of the health issues mentioned in the preceding table of known LBGTIQ health and wellness issues.

Critical Content Analysis of every course outline and required textbook for gender and sexuality content could be useful - an assets and opportunities map could help identify how and where, as well as what content would fit into existing curriculum constraints of topic/ content areas, and timelines, without overburden.

While no respondents addressed the complexities of developing and presenting cases, I helped develop and administer a 'coming out' case for teaching medical school as a gay cis male youth, and it would be excellent if health care students received a standardized patient experience whereby a masculine presenting trans-identified pre-operational FtM is seeking a pap smear. While most responding English language baccalaureate schools of nursing reported teaching on domestic violence/unhealthy relationships, none indicated that they use examples that address same-sex, bisexual, transgender intersex or queer relationships. This is an easy adaptation that could help teach and train about non-judgemental attitudes, relational practice, and addressing possible heterosexism, cisgenderism, and personal phobias.

Individual teaching faculty can use, integrate, and share best practices such as: not using gendered pronouns, conveying the idea that nurses must assume all potential clients are not heterosexual or gender binary, and the specific example from one nursing administrator: *I introduce lectures on "taking a health history" with how we limit others' self expression, i.e. a space for "marital status" and the gay/ lesbian/ trans client says "What are my options?" They usually laugh but it gets them thinking.* The sharing of best practices can be done formally at a national conference

or by way of a national working group or informally in collegial interactions. This step in knowledge mobilization is a critical component in fully integrating an innovative curriculum and can have the effect of faculty professional development.

We have an example/scenario where a middle-aged adult First Nations male undergoing bowel resection for cancer who is palliative is homosexual and is hoping to marry his partner. This comment reflects an excellent approach to embedded content that could be adopted by faculty. In this scenario, the nurse-student learns the richness of the individual while figuring out how to deal with the specific health issue. This scenario exemplifies the intertwined nature of particular health diagnoses with the lived experiences of those people; it shows how health is social. There should be more use of non-normative individuals as standard examples in all aspects of nursing curriculum. The only critique of this scenario is that the First Nations person may identify as Two-Spirit rather than homosexual.

Students who share [Oppression] as their lived experience! shows a potentially highly contentious use of student experience in the classroom. This use of student examples in the classroom as teaching points is analogous to teaching about the effects of sexual assault by relying on students to supply their own lived experiences as the primary teaching aide. It is not acceptable to teach about sexual assault by relying on survivors to relive the experience, why should it be acceptable for LBGTIQ people to have to continually reiterate the vividness of the experience of discrimination and oppression and therefore further perpetuate their position as a vulnerable, and elucidate the inequalities of a heteronormative society, for the

benefit of those who have never and will never experience that position? While talking about experiences of oppression in the classroom is excellent and should be encouraged because it allows people to bring forth their own experiences and provides a form of coping/therapy, reliance on individual's personal accounts should not be used as a main teaching aide.

No comments were cited to elucidate the inclusion of body image in 83% of the English language baccalaureate nursing curriculums in Canada however like other opportunities for embedded examples the following scenarios come to mind. A person struggling with body image issues such as a gay male who works out too much and is taking performance enhancing drugs, and therefore reinforces the dominant societal image of heterosexuality and hyper-masculinity; or a youth who presents with social isolation and dissociative tendencies could be struggling with issues of body image stemming from gender identity dysphoria.

6.6 Final Words

Nursing needs to overcome it's policy paralysis as discussed by Spenceley, Reutter, and Allen (2006) and focus on systems level approaches to nursing education reform such as lobbying the CCRNR, CASN, and CNA, to develop, and institute well researched competencies and teaching frameworks for including LBGTIQ health and wellness information.

Scardamalia and Bereiter (2003) state that "learning is an internal unobservable process that results in changes of belief, attitude or skill. Knowledge

building, by contrast, results in the creation or modification of public knowledge - knowledge that lives in the world and is available to be worked on and used by other people” (p. 1370). This research investigated educational core competencies in baccalaureate nursing curriculum in Canada in this particular way for the same reasons that Scardamalia and Bereiter state that knowledge building is the “production and continual improvement of ideas of value to a community, through means that increase the likelihood that what the community accomplishes will be greater than the sum of individual [learning] (p. 1370).

This research aims to add to the critical constructivist knowledge of nursing education focusing on the social location of LBGTIQ subjectivities and their exclusion from policy. Like Lomas (1993) articulated, this thesis is the passive diffusion of information. Its knowledge building will only work if the potential recipient is highly motivated, when the rewards of finding the information are high, and where there is a relatively small pool of information (Lomas, 1993). It is from this perspective that the thesis proceeds to address systemic rather than individual level interventions.

This study finds that nursing pedagogy appears to have problems in the area of knowledge transmission of LBGTIQ health and wellness content. Due to this gap our health care system is not educating nurses to be adequately prepared to care for people of all genders and an atmosphere of heteronormativity and cisgenderism persists. Morrison and Dinkel (2012) state that “because heterosexism [and cisgenderism] do not require an overtly homophobic [or transphobic] attitude on the part of an individual, the well-meaning nurse could be alienating patients

unintentionally. Awareness of heterosexism [and cisgenderism] as a concept is an important step in advancing nurses evaluation of the equality of delivered care” (p. 129). This atmosphere of heteronormativity and cisgenderism is repeated in community-based reports and the growing body of literature that show that health care is not prepared to address issues of diversity in sexuality and gender identity. It is further supported by this research with the finding that sexuality and gender diversity health and wellness issues are haphazardly included and under-defined in Canadian English-language nursing curricular policy frameworks. There is a need for knowledge translation of the extensive evidence-based research to be able for healthcare educators to integrate and act on the known health and wellness issues of LBGTIQ people.

With the inclusion of ‘all genders across the lifespan’ in the CCRNR document and most provincial/territorial policy documents is only giving lipservice to the issues without having any follow up for inclusion, this is a critical issue that schools of nursing have to address. While this thesis presses for the inclusion of sexuality health and wellness as well as gender diversity health and wellness, the needs are much more pressing for content that focuses on genderqueer. Sexuality health and wellness curriculum concerning cisgendered people is not as boundary breaking, as it is for trans people. While it would be beneficial to include more/better quality sexuality health and wellness information in the curriculum there is a specific recognition of the existence of transgendered/genderqueer people in the provincial/territorial documents reviewed. Without an educational program that

teaches nurses the foundational knowledge of providing care for all genders across the lifespan, there was no point in using the new language 'all genders' because trans people will continue to be treated inadequately by health care workers unprepared in the areas of sexuality and gender identity.

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APPENDIX A

Definitions

Current notions of sexuality and gender identity are outlined below and are particular to the social location of North America. Definitions are fundamental to the basis of understanding these topics, and due to the ever-changing sociological discussions of sexuality and gender identity the online user led dictionary seems to be the most appropriate way to reference many of these definitions despite it's possible issues of reliability (see: Fallis, 2008).

Ambiphilia - a behavioural sciences term used to describe sexual orientation as an alternative to the distinct and separate (binary) gendered hetero-homo conceptualizations. Like bisexuality, Ambiphilia describes sexual attraction to both men/masculine and female/feminine constructs, as well as the possibility of queer, intersex or transgender individuals. The term is used for identifying an individual's object of attraction without attributing a sex or gender identity to the person. This concept can avoid bias inherent western understanding of human sexuality; and avoid confusion and offense. *Adapted from:* Wikipedia (n.d.). *Bisexuality*. Retrieved March 23, 2017, from <https://en.wikipedia.org/wiki/Bisexuality>

Androphilia - a behavioural sciences term used to describe sexual orientation as an alternative to the distinct and separate (binary) gendered hetero-homo conceptualizations. Androphilia describes sexual attraction to men or masculinity. The term is used objectively for identifying an individual's object of attraction without attributing a sex or gender identity to the person. In his book *Androphilia, A Manifesto: Rejecting the Gay Identity, Reclaiming Masculinity*, Jack Malebranche (2007) uses the term to emphasize masculinity in both the object and the subject of male homosexual desire, and to reject the sexual nonconformity that he sees in some segments of the homosexual identity. *Adapted from:* Wikipedia (n.d.). *Androphilia and Gynephilia*. Retrieved March 23, 2017, from https://en.wikipedia.org/wiki/Androphilia_and_gynephilia

Figure 20: Sex and Sexual Orientation Matrix

		Sexual orientation	
		androphilic attracted to males person's sex not specified	gynephilic attracted to females person's sex not specified
Person's sex	male sexual orientation not specified	homosexual androphilic male	heterosexual gynephilic male
	female sexual orientation not specified	heterosexual androphilic female	homosexual gynephilic female

Andrea James: Wikimedia Commons.

<https://commons.wikimedia.org/wiki/File:Androphilia-gynephilia-chart.png>

Asexual – sometimes referred to as nonsexuality, it is different than celibacy- the abstention from sexual activity, because some asexual people do engage in sexual activity. In the broadest sense it is the lack of sexual attraction to others or the lack of interest in sexual activity. It may also be considered a sexual orientation. *Adapted from:* Wikipedia (n.d.). *Asexuality*. Retrieved March 23, 2017, from <https://en.wikipedia.org/wiki/Asexuality>

Biological Sex (anatomic, chromosomal, genetic, endocrinological, morphological and gonadal sex) – comprised of our anatomy, it includes our genitalia (internal and external sex organs), chromosomes, and naturally occurring hormones. Usually biological sex is labelled as *male*, *female*, or *intersex* based on the prevalence or absence of a Y chromosome and non-ambiguous sexual organs. *Adapted from:* Wikipedia (n.d.). *Human Sexuality*. Retrieved March 23, 2017, from https://en.wikipedia.org/wiki/Human_sexuality

Bisexuality (Polysexuality)- characterized by romantic / sexual attraction, or sexual behaviour towards both men and women. This identity falls in the middle of the heterosexual-homosexual continuum and has been ostracized by both the heterosexual and homosexual communities. Bisexuality as a label also solidifies the

distinction between heterosexual and homosexual. Polysexuality on the other hand is the contemporary reiteration of bisexuality that accounts for objects of affection that express diverse gender expression/identity outside of the traditional distinct separate dichotomous biological sex categories. Polysexuals are attracted to various but not necessarily all variations in gender identity/expression and biological sex.

Adapted from: Wikipedia (n.d.). *Bisexuality*. Retrieved March 23, 2017, from <https://en.wikipedia.org/wiki/Bisexuality>

Cross Dressing – the act of wearing clothes and other accoutrements commonly associated with the opposite gender. It has nothing to do with sexual orientation and has varieties, such as drag (king or queen), sexual fetishism, and passing. However with changing fashions in contemporary society this term is becoming outdated as women gain acceptance for wearing pants. Cross-dressing simultaneously reinforces and challenges gendered stereotypes of appropriate clothing. *Adapted from:* Wikipedia (n.d.). *Cross Dressing*. Retrieved March 23, 2017, from <https://en.wikipedia.org/wiki/Cross-dressing>

Cisgender (Cissexual, Cissexism) - used to describe an individual whose self-perception of their gender matches their biological sex, and personal identity. In this way it is the binary opposite to transgender. Cisgender is gender-normative, and the term is being debated in queer and trans theory due to its inability to challenge sex and gender constructs. Some gender theorists prefer 'non-trans' which openly challenges the assumptions that an internal consensus between biological sex and gender identity exists. These theorists propose that the term cisgender implies a non-trans privilege implicitly making trans people less authentic and inferior to their non-trans counterparts. *Adapted from:* Wikipedia (n.d.). *Cisgender*. Retrieved March 23, 2017, from <https://en.wikipedia.org/wiki/Cisgender>

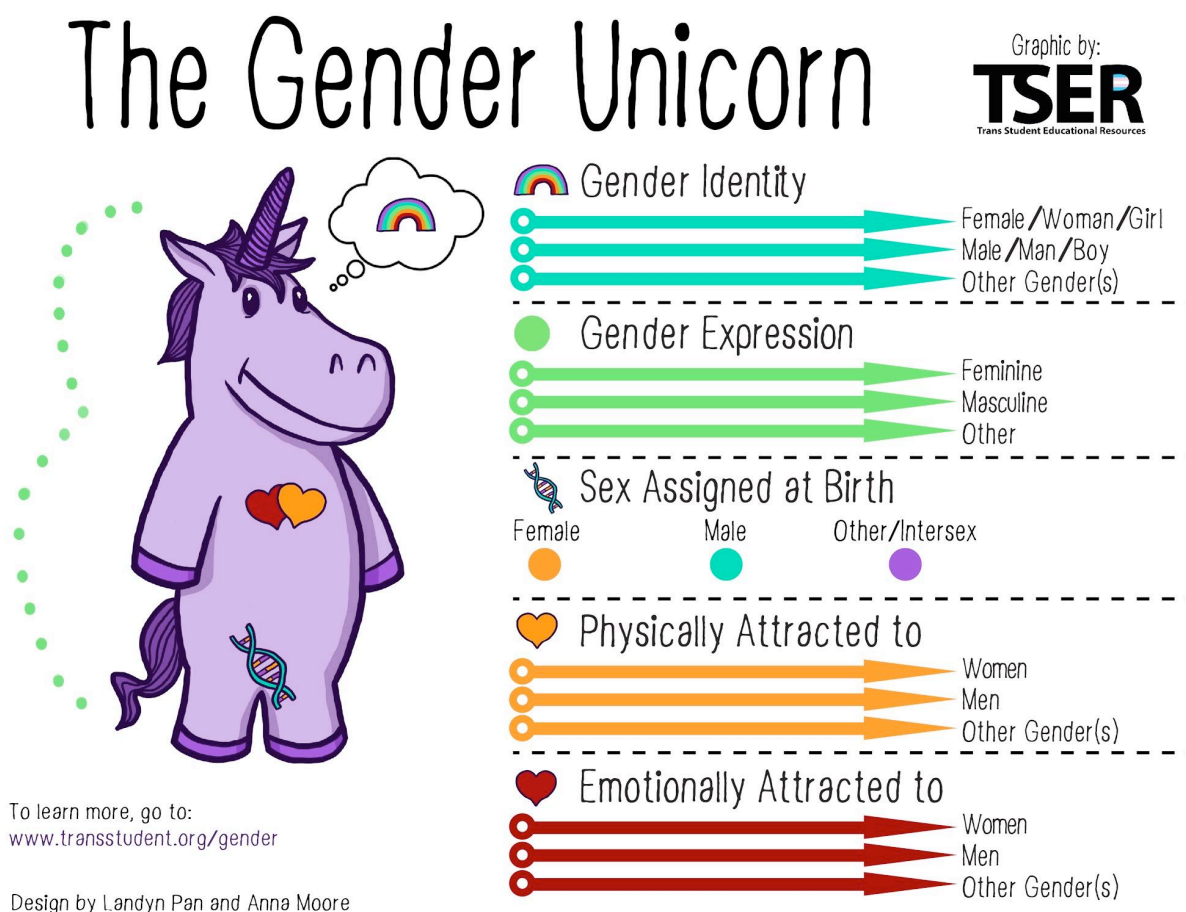
Family of Choice – persons, or a group of people, an individual sees as significant in their lives. Family of choice is comprised of the close and meaningful supportive relationships that an individual cultivates to form a tight kinship. It may include some, all, or none of an individual's family of origin (biological, birth, adopted family). These families are often not recognized in any institutional sense. *Adapted from:* University of California Berkeley Gender Equity Resource Center (2013). *Definition of Terms*. Retrieved March 23, 2017, from <http://ejce.berkeley.edu/geneq/resources/lgbtq-resources/definition-terms>

FTM (F2M, Female to Male, Transman) – a transsexual or transgender person whose biological sex at birth is/was female but identifies (and may appear physically) as a male. *Adapted from:* Wikipedia (n.d.). *Trans Man*. Retrieved March 23, 2017, from https://en.wikipedia.org/wiki/Trans_man

Gay (Male Homosexual) – sexual, or romantic attraction, or behaviour, between persons of the same-sex or gender. It is primarily a social identity. *Adapted*

from: Wikipedia (n.d.). *Gay*. Retrieved March 23, 2017, from <https://en.wikipedia.org/wiki/Gay>

Figure 21: Gender Unicorn



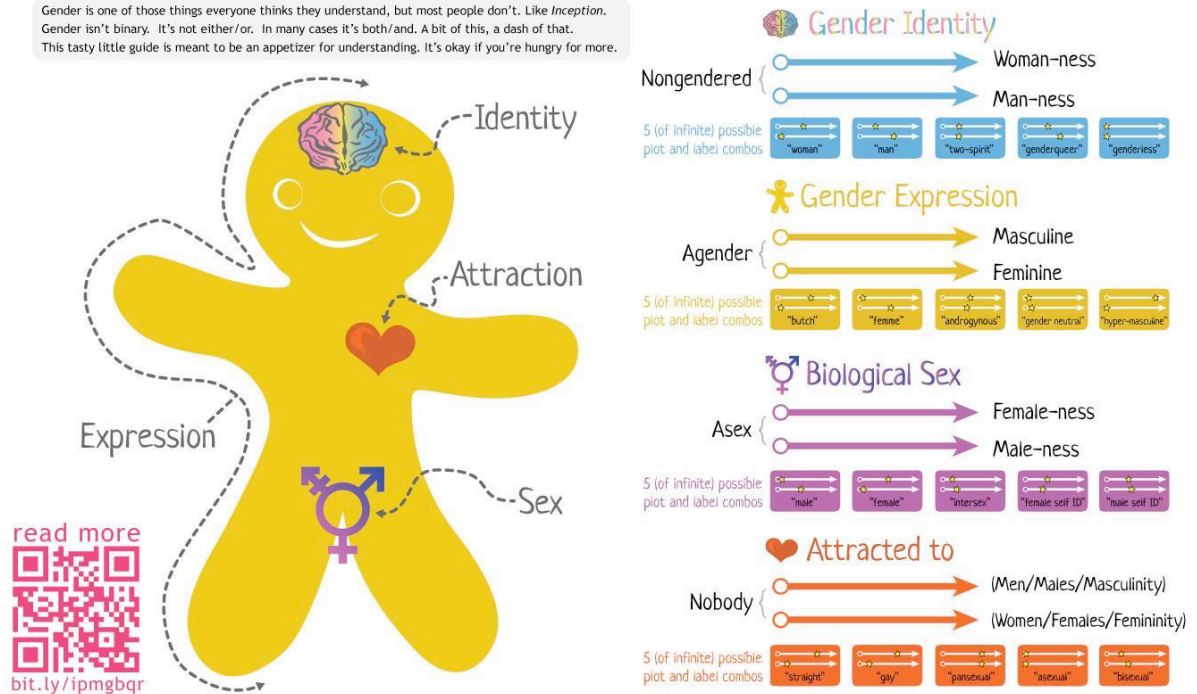
L. Pan and A. Moore. (n.d.) for the Trans Student Educational Resources. *The Gender Unicorn*. Retrieved March 23, 2017, from <http://www.transstudent.org/gender>

Figure 22: The Genderbread Person

The Genderbread Person v2.0

by its pronounced **METROsexual** .com

Gender is one of those things everyone thinks they understand, but most people don't. Like *Inception*. Gender isn't binary. It's not either/or. In many cases it's both/and. A bit of this, a dash of that. This tasty little guide is meant to be an appetizer for understanding. It's okay if you're hungry for more.



S. Kilerman (2012). *The Genderbread Person v2.0*. Retrieved March 23, 2017, from <http://itspronouncedmetrosexual.com/2012/03/the-genderbread-person-v2-0/#sthash.51uuLA2q.dpbs>

* Note the subtle but meaningful linguistic differences between Figure 21: the gender unicorn, and this figure, the genderbread person regarding the area of sex assigned at birth and biological sex, and the further clarification of attraction into components of physical and emotional attraction.

Gender Expression (see Gender Bread Person) – the ways in which an individual performs masculinity or femininity. It includes any and all mannerisms, personal traits, etc. which serve to communicate a persons identity and personality as they relate to gender and gender roles. Masculine, feminine, and androgynous gender expressions can be present in people of any sex despite often being associated with men, women, and non-binary genders respectively. Gender expression does not necessarily match biological sex. *Adapted from: Genderwiki (n.d.). Gender Expression*. Retrieved March 23, 2017, from http://gender.wikia.com/wiki/Gender_expression

Gender Identity (see Gender Bread Person) – refers to a person's private sense of, and subjective experience of, their own gender. It can be consonant or dissonant with the biological sex of an individual. In cases where the gender identity is dissonant with biological sex it is referred to as 'gender dysphoria', a clinical diagnosis that ultimately attempts to align gender identity, gender expression and biological sex. Gender Identity Disorder is defined by strong persistent feelings of discomfort with one's own biological sex and identification with the opposite gender. *Adapted from:* Wikipedia (n.d.). *Gender Identity*. Retrieved March 23, 2017, from https://en.wikipedia.org/wiki/Gender_identity

Gynephilia - a behavioural sciences term used to describe sexual orientation as an alternative to the distinct and separate (binary) gendered hetero-homo conceptualizations. Gynephilia is used to describe sexual attraction to women or femininity. The term is used for identifying an individual's object of attraction without attributing a sex assignment or gender identity to the person. This concept can avoid bias in inherent western conceptualizations of human sexuality; avoid confusion, and offense, when describing intersex and transgender people. *Adapted from:* Wikipedia (n.d.). *Androphilia and Gynephilia*. Retrieved March 23, 2017, from https://en.wikipedia.org/wiki/Androphilia_and_gynephilia

Heteronormativity – a pervasive and institutionalized ideological system that naturalizes heterosexuality as universal; it renders invisible same-sex couples and must continually reproduce itself to maintain hegemony over the other non-normative sexualities and ways of identity construction.

2 - the lifestyle norms and institutional practices that dictate people fall into distinct and complementary genders with natural (separate) roles in life. It also holds that heterosexuality is the only normal sexual orientation and states that sexual and marital relations are more fitting between a man and a woman. It implicates the alignment of biological sex, sexuality, and gender identity. *Adapted from:* Wikipedia (n.d.). *Heteronormativity*. Retrieved March 23, 2017, from <https://en.wikipedia.org/wiki/Heteronormativity>

Heterosexism (Institutionalized Homophobia, Sexual Prejudice, Straight Privilege, Heterosexual Bias, Compulsory Heterosexuality)- terms used to describe a bias exhibited by a society or community that is often subtle but nonetheless pervasive, whereby cultural institutions and individuals are conditioned to expect others to live and behave as if everyone were heterosexual. Heterosexism, like sexism, is firmly entrenched in the prevailing customs and traditions of society. Also, it seeks to fragment society into different categories of people and attempts to judge those disenfranchised groups to make them appear weak, impotent or inferior, thereby seeming to justify their 'lower' status. It serves to silence and erase the lives of the sexually diverse, creating a dearth of positive cultural images for gay lesbian, bisexual and trans people. *Adapted from:* St. Francis Xavier Pride (n.d.).

Heterosexism and Homophobia. Retrieved March 23, 2017, from <http://people.stfx.ca/xpride/materials.html>

2 - a system of attitudes, bias, and discrimination in favour of opposite sex sexuality and relationships. It can include the presumption that other people are heterosexual or that opposite sex attractions and relationships are the only norm and therefore superior. Very similar to heteronormativity, it can be overt/explicit/open, or implicit/hidden/covert and causes marginalization, discrimination, and anti-LGBT violence. *Adapted from: Wikipedia (n.d.). Heterosexism*. Retrieved March 23, 2017, from <https://en.wikipedia.org/wiki/Heterosexism>

Heterosexual (Straight, Heterosexuality) – sexual, or romantic attraction, or behaviour, between persons of opposite sex or gender. It may also refer to a social identity. *Adapted from: Wikipedia (n.d.). Heterosexuality*. Retrieved March 23, 2017, from <https://en.wikipedia.org/wiki/Heterosexuality>

Homophobia - the fear of homosexuals and homosexuality that may be expressed by feelings of discomfort in the presence of gays and lesbians. It may also include by rejecting them, or, by verbally or physically abusing them. Homophobia is often used as an umbrella term for all feelings of fear and dislike directed toward gays, lesbians, bisexuals and transgender people. Homophobia can be **societal, institutional, or internalised**.

Societal/Cultural Homophobia - permeates all aspect of social life and relates to the mainstream social and cultural norms that promote heterosexuality, gender norms, and broad based discrimination against LGBT people. Homosexuality is always considered as 'different', to be welcomed, tolerated, or despised. The media, film, TV, books, holiday brochures, insurance companies, religious institutions and schools all back this up. Closely linked to heteronormativity.

Institutional/Organizational Homophobia - systematic discrimination of LGBT people by government, business, employers, public services and other organizations. It happens when a company invites an employee and their husband or wife to an event, explicitly excluding same-sex relationships; or when the family membership only mentions opposite sex partnerships. This exclusion is not necessarily deliberate but means that institutions have not considered same-sex partners as an option. In schools this can emerge in sex and relationships education sessions tending to focus on heterosexuality as the accepted norm for all students. Closely related to heterosexism.

Internalized Homophobia- happens when an individual integrates society's negative ideas on homosexuality and turns this homophobia against her/himself or the against the GLBT community. Individuals that internalised homophobia will hate themselves for being LGBT and will feel valued if they reject everything LGBT. *Adapted from: Wikipedia (n.d.). Homophobia*. Retrieved March 23, 2017, from <https://en.wikipedia.org/wiki/Homophobia>

Intersex – the general term for a variety of sex development conditions in which a person born with reproductive sexual anatomy does not fit the typical ranges of male or female anatomy. Intersex is a socially constructed category that reflects real biological variation. The term hermaphrodite is offensive to many intersex people. Ambiguous gonads and genitalia, hormone deficiencies (or excesses), and/or extra (missing) chromosomes can all complicate the binary categories of male and female, leaving parents and doctors to decide if a person will be male, female, or intersex at birth. Intersex does not always appear at birth, it can become visible during puberty, or anytime in the lifecycle, or remain phenotypically irrelevant. *Adapted from:* Intersex Society of North America (2008). *What is Intersex*. Retrieved March 23, 2017, from http://www.isna.org/faq/what_is_intersex

Lesbian (Female Homosexuality) - sexual, or romantic attraction, or behaviour, between persons of the same-sex or gender. It is primarily a social identity. *Adapted from:* Wikipedia (n.d.). *Lesbian*. Retrieved March 23, 2017, from <https://en.wikipedia.org/wiki/Lesbian>

MSM (Men Who Have Sex With Men) – male persons who engage in sexual activity with members of the same-sex, regardless of self-identification. Used in social science research and epidemiology, this behavioural category is a critique of the social construct sexual identity and, provides more accurate description for understanding disease risk than terms gay, bisexual, pansexual, etc., which may miss portions of the population they are attempting to describe. This term does not necessarily mean penetrative intercourse, it connotes all same-sex sexual activities that can be engaged in. *Adapted from:* Wikipedia (n.d.). *Men who have sex with men*. Retrieved March 23, 2017, from https://en.wikipedia.org/wiki/Men_who_have_sex_with_men

MTF (M2F, Male to Female, Transwoman) - a transsexual or transgender person whose biological sex at birth is/was male but identifies (and may appear physically) as a female. *Adapted from:* Wikipedia (n.d.). *Trans woman*. Retrieved March 23, 2017, from https://en.wikipedia.org/wiki/Trans_woman

Pansexual (Omnisexual) – sexual attraction, desire, romantic love or emotional attraction towards persons of *all* gender identities and biological sexes. They are not limited by traditional, distinct and separate gender and sexual binaries. Pan, or omni, sexuality is sometimes considered a fourth sexual orientation. This term, unlike bisexuality accounts for intersex people as the object of desire and is more akin to polysexuality (see: bisexuality). *Adapted from:* Wikipedia (n.d.). *Pansexuality*. Retrieved March 23, 2017, from <https://en.wikipedia.org/wiki/Pansexuality>

Queer – an umbrella term for sexual and gender minorities that are not heterosexual, heteronormative, or gender binary. In some understandings queer as a

label challenges existing conceptions of lesbian, gay, bisexual, trans, intersex for being assimilationist, oppressive, hegemonic, and having entrenched discourses and ideologies. In other cases queer is faddish of a younger generation and loses specificity as an identity category but it in its essence still challenges heteronormativity and operates outside of gender roles. It arose in reaction to the mainstreaming and dominant discourses in gay and lesbian studies for ignoring race/ethnicity, intersex, and trans folk. It has socio-political connotations because of the context in which it was reclaimed and queer gained popularity among activists and those who reject traditional gender identities and distinct sexual identities. It is not commonly a synonym for lesbian, gay, bisexual, transgender (LGBT) because those labels rely on distinct essentialist sexual identities. *Adapted from: Wikipedia (n.d.). Queer.* Retrieved March 23, 2017, from <https://en.wikipedia.org/wiki/Queer>

Questioning (Curious) – the process of exploration of one's gender, sexual identity, sexual orientation, or all concepts relating to an individual's sex and gender. *Adapted from: Wikipedia (n.d.). Questioning.* Retrieved March 23, 2017, from [https://en.wikipedia.org/wiki/Questioning_\(sexuality_and_gender\)](https://en.wikipedia.org/wiki/Questioning_(sexuality_and_gender))

Sexual Identity (Sexual Orientation)- refers to how one thinks of oneself in terms of whom one is sexually and romantically attracted to. Closely related to sexual orientation, identity refers to an individual's conception of themselves. Identity and subsequent orientation involves in an ideal sense, a process of coming to terms with one's sexual desires and romantic attractions. The process of coming to terms with a sexual identity and subsequent label of a sexual orientation, involve knowing oneself and a decision to come out or disclose to others the object of one's sexual and emotional attractions. Someone may not identify as a particular sexual orientation but express behaviours commonly associated with that sexual orientation (see: queer eye for the straight guy, or men who have sex with men). *Adapted from: Wikipedia (n.d.). Sexual Identity.* Retrieved March 23, 2017, from https://en.wikipedia.org/wiki/Sexual_identity

Transgender (Gender Variant)- a general term for a variety of individuals, behaviours, groups involving tendencies to vary from culturally conventional established normative gender roles. In effect a person's gender identity is inconsistent with their biological sex resulting in gender expressions that are perceived to be outside of the cultural gender norms. This is not a sexual orientation but a term used to understand and describe a person whose psychological self differs from the social expectations for gender expression of their biological sex. A transgender may have characteristics that are normally associated with a particular gender, but identify elsewhere on the traditional gender continuum, transgendered people may or may not seek surgery to bring their bodies in line with their gender identity. *Adapted from: Wikipedia (n.d.). Transgender.* Retrieved March 23, 2017, from <https://en.wikipedia.org/wiki/Transgender>

Transition – a complicated, multistep process that can take years, as transgender people align their anatomy with their gender expression and or sexual bodies with their gender identity. *Adapted from:* University of California Berkeley Gender Equity Resource Center (2013). *Definition of Terms*. Retrieved March 23, 2017, from <http://ejce.berkeley.edu/geneq/resources/lgbtq-resources/definition-terms>

Transphobia - a range of negative attitudes and feelings towards transsexualism and transsexual or transgendered people, based on the expression of their internal gender identity. Many trans people also experience homophobia from people who associate their gender identity with homosexuality. Whether intentional or not, transphobia can have severe consequences for the target of the negative attitude. *Adapted from:* Wikipedia (n.d.). *Transphobia*. Retrieved March 23, 2017, from <https://en.wikipedia.org/wiki/Transphobia>

Transsexual – an individual who chooses to undertake surgeries to modify biological sex characteristics to align with their gender identity. A transsexual person is similar to a transgender person in that their gender identity is inconsistent with their biological sex, however, transsexual is a medical term and usually implicated some degree of sex reassignment surgery. *Adapted from:* Wikipedia (n.d.). *Transsexual*. Retrieved March 23, 2017, from <https://en.wikipedia.org/wiki/Transsexual>

Transvestite (Cross-dressing)– an individual who chooses to wear clothing of the opposite gender for personal satisfaction, pleasure or comfort. This is an outdated term. *Adapted from:* Wikipedia (n.d.). *Transvestism*. Retrieved March 23, 2017, from <https://en.wikipedia.org/wiki/Transvestism>

Two-Spirit (Berdache)– an umbrella term for individuals who fulfil one of many mixed gender roles in native cultures. This designation of third gender identity recognizes and values gender categories that are not dichotomous. *Adapted from:* Wikipedia (n.d.). *Two-spirit*. Retrieved March 23, 2017, from <https://en.wikipedia.org/wiki/Two-Spirit>

WSW (Women Who Have Sex With Women) - female persons who engage in sexual activity with members of the same-sex, regardless of self-identification. Used in medical literature, social science research, and epidemiology this behavioural category is a critique of sexual identity as a social construct and, also provides more accurate description for understanding disease risk than terms lesbian, bisexual, pansexual, etc., which may miss portions of the population they are attempting to describe. This term does not necessarily mean penetrative intercourse, it connotes all same-sex sexual activities that can be engaged in. *Adapted from:* Wikipedia (n.d.). *Women who have sex with women*. Retrieved March 23, 2017, from https://en.wikipedia.org/wiki/Women_who_have_sex_with_women

DISCLAIMER

Information relevant to sexuality and gender identity is very subjective and therefore people who are affected by it show an expressed interest in verifying it's accuracy and relevance to their lived experience, therefore the validity of entries on the user led encyclopaedia Wikipedia are potentially more valid than those printed in traditional encyclopaedias due to a number of factors. The traditional publication process has been known to delay the dissemination of current information. And while there is debate within the field (particularly regarding gender identity) about varying aspects of certain statements, the mass collaboration (read: crowdsourcing) offered by Wikipedia can and does mitigate some of the internal bickering on relevant issues therefore affording the audience the opportunity for limited subjectivity in these definitions.

Furthermore, like any encyclopaedia, there are possibilities for omissions of information and any reader interested in the particulars of a topic should conduct further investigation.

APPENDIX B

LBGTIQ Health and Wellness Curricular Resources

Title: {this} is Reteaching Gender and Sexuality

Author: Reteaching Gender and Sexuality

Date: 2010

Available online: <https://vimeo.com/17101589>

This video is a simple quick primer that intends to get people thinking. The information in this 2.5 minute clip is a excellent to use to start a classroom discussion or, can be used to educate after conducting a sexuality and gender scenario rather than personalizing any critique. While the website is limited, there is more information available at: <http://www.reteachinggenderandsexuality.org/>

Title: Competencies for Counselling Gay, Lesbian, Bisexual and Transgendered Clients

Author: Association for Lesbian, Gay, Bisexual & Transgender Issues in Counseling

Date: Unknown

Available online: <http://www.algbtic.org/>

This US based organization has a journal dedicated to LGBT Issues in Counseling and hosts an annual conference. The first incarnation of this paper was a 5 page list of competencies in point form. Since double checking the resource the organization has further clarified and expanded on the counseling competencies. The single document that covered all sexualities and gender identities has been divided into two separate documents the first being 26 pages dealing specifically with transgender clients (2009). This document now, authored and reviewed by committee highlights 8 areas, gives a preamble, and framework and reads more like a journal article. The second document of this association is an additional 43 pages (2012) addressing counseling competencies with lesbian, gay, bisexual, queer, questioning, intersex and allies. It is interesting that intersex is included in this 43 page document and not in the transgender specific document. This second document is especially valid for its discussion of counsellor as ally and the section is relevant to all health and helping professions.

Title: Curriculum checklist for LBGT Inclusion

Author: Shane Snowdon

Date: Unknown

Available online: <https://lgbt.ucsf.edu/lgbt-education-and-training>

This one-page checklist primarily designed for medical curriculum is a good baseline for anyone trying to identify where and how to begin to complete a full curricular review for LGBT content. It is broad and basic enough that it makes sense to a

layperson, but includes generous amounts of vaguity to require foundational knowledge to implement.

Title: How to Choose a Care Provider

Author: Winnipeg Gay/Lesbian Resource Centre

Date: 1999

Available online: no

This booklet/guide for LGBT people and PHAs is a handy resource for figuring out what sexually and gender diverse people look for in a care provider. The 20 page booklet opens with the mandate to enable people to choose providers that are not phobic, are knowledgeable and sensitive about sexual gender and ethnic diversity; it highlights the following concerns in great detail: disclosure/privacy/confidentiality, language and environment that conveys the above and doesn't assume heterosexuality. The booklet recommends that the reader evaluate the initial meeting with the care provider and goes as far as to suggest they interview the care provider. It also offers information about potential for recourse by listing the complaints process and governing bodies, something that very few clients are aware of.

Title: Policy Scan of North American Universities Regarding Gender Diversity and Inclusion

Author: Andrew Harvey, Memorial University of Newfoundland Trans Needs Committee

Date: 2012

Available online: <http://cfsontario.ca/wp-content/uploads/sites/50/2015/11/TransPolicyScan.pdf>

This practical resource pinpoints 7 areas and provides practical solutions to inclusion and how to address trans-oppression in non-discrimination policies, health care services, housing, washrooms, records and documenting, programming/training/support, and athletics/sports facilities

Title: Breaking down barriers: A tool to address inequalities in LGBT2-SQ healthcare in Sudbury, Ontario: Health care provider handbook

Author: LGBT2-SQ students and the Nornern Ontario School of Medicine

Date: 2015

Available online: http://www.rainbowhealthontario.ca/wp-content/uploads/woocommerce_uploads/2014/08/Breaking-Down-Barriers-Handbook.pdf

While geared towards physician client interaction the same principles can be gleaned from this resource.

Title: LGBT Health Matters: An education and training resource for health and social service sectors

Author: Brian Dunn, The Centre: A Community Centre Serving and Supporting LGBT people

Date: 2006

Available online:

http://www.sexualhealthcentresaskatoon.ca/pdfs/p_lgbt.pdf

This document is 186 pages of pure gold. broken into 5 modules it provides curriculum for educating people in a whole host of LGBT relevant information. It has exercises designed to help people explore and understand the different perspectives faced by sexually and gender diverse. It can easily be used for classroom curriculum. Anyone can simply cherry pick scenarios or information and supplant it into a course in any area. While this manual is less gender creative than I would use, it is an excellent resource for the general populace. It should be considered a primary resource for nursing pedagogy to start introducing into curriculum.

Title: My gender workbook: How to become a real man, a real woman, the real you, or something else entirely.

Author: Kate Bornstein

Date: 1998 (however updated version also available)

Available online: partially: <http://www.yorku.ca/spot/caitlin/bornstein.pdf>

This book is a good place to start looking for activities and information regarding all genders. It includes easy to understand self assessment activities in sex and gender that are designed to educate and inform while also lead self discovery. The queer understanding of gender elaborated throughout the book undeniably depicts gender as a performative and social construct. If 'all genders' is assumed knowledge this book should be required reading.

Title: Health Care Without Shame: A Handbook for the Sexually Diverse and Their Caregivers

Author: Charles Mosher

Date: 1999

Available online: No- publishers website

<http://www.greenerypress.com/hcws.htm>

This book is a good foundation for consumers and practitioners, while published in the USA 17 years ago, it was written by a clinical sexologist who wanted to address issues that are neglected in most health practitioner discussions. It uses language that will help guide readers through the sensitivities of becoming a sex positive health care practitioner and raise an awareness of the subtleties of client patient interaction to ensure healthy and open communication.

Title: Lesbian, Gay, Bisexual, Transgendered, or Intersexed Content for Nursing Curricula.

Author: Brennan, Barnsteiner, Siantz, Cotter & Everett.

Date: 2012

Available online: DOI: 10.1016/j.profnurs.2011.11.004

This journal article while published in the USA outlines some ways that are useful for targeting teaching particular attitudes, skills, and knowledge in the area. It includes brief mention of strategies for teaching but is not a extremely practical resource for anyone looking to change curriculum, it is more geared to rationalizing why there is a need for changing curriculum.

Title: Healthcare Equality Index 2010

Author: Human Rights Foundation (USA)

Date: 2010, updated annually

Available online: <http://www.hrc.org/hej>

One of the few good parts of the USA style of healthcare system is their continual improvement, the Healthcare Equality Index is an annual survey of healthcare policies and practice. As part of a larger national annual survey of facilities this document reports on LGBTIQ patients and families. It reports on changes to healthcare system (at the institutional level) and provides a national benchmark for inclusion of LGBTIQ people, workers, and their known health and wellness issues.

Title: Lesbian health inequalities: A cultural minority issues for health professionals.

Author: Juornal article, Ruth P. McNair

Date: 2003

Available online: <https://www.mja.com.au/journal/2003/178/12/lesbian-health-inequalities-cultural-minority-issue-health-professionals>

This article like many others discussed in the current research included a table to suggest guidelines for health care workers to enhance their care to the population. This short table addresses knowledge and understanding, communication skills, attitudes, and the practice environment. While it does not provide concrete examples of how to go about 'being non-judgemental' for example, it summarizes some of the issues discussed for lesbian women in particular.

Title: Caring for Lesbian Health: A Resource for health care providers, policy makers, and planners.

Author: Maria Hudspith and the Ministers Advisory Council for Women's Health

Date: 1999

Available online:

<http://www.health.gov.bc.ca/library/publications/year/1999/caring.pdf>

This document is 17 years old and still relevant. While the organizational resources listed may not be in service, the tips for health planners and policy makers, as well as the tips for physicians and healthcare practitioners can provide a foundational rationale for implementing change. However it must be noted that this document does not adequately address transgender, bisexual, and queer health and wellness issues.

Title: Being Safe, Being Me: Results of the Canadian Trans Youth Health Survey

Author: Canadian Trans Youth Health Survey Research Group, UBC School of Nursing

Date: 2015

Available online:

https://www.dal.ca/content/dam/dalhousie/pdf/Diff/gahps/SARAVYC_Trans%20Youth%20Health%20Report_EN_Final_Web.pdf

SARAVYC, the research group dedicated to researching stigma and resilience among vulnerable youth, including street involved youth, LBGTIQ youth, and sexually exploited youth, during the research produced a report on trans health. This report outlines some pretty relevant, current health and wellness issues facing trans youth. This research was conducted by a faculty member in a nursing school in Canada.

Title: LBGT Health Matters Project: An Educational and Training Resource for Health and Social Service Sectors

Author: Canadian Rainbow Health Coalition, The LBGT Centre Vancouver

Date: 2006

Available online:

http://www.sexualhealthcentresaskatoon.ca/pdfs/p_lgbt.pdf

Over 160 pages of modules designed to be used for educating and training health professionals in the area of LBGT health and wellness. For any educator looking for specific resources to help integrate curriculum, this is a good starting point. This document should be given to every teaching health professional for light reading.

Title: Critical Issues in Practice with Gay, Lesbian, Bisexual and Two-Spirited People: Educational Module for Professionals in the Fields of health and Allied Health

Author: Shari Brotman and Bill Ryan

Date: 2001

Available online:

http://www.sexualhealthcentresaskatoon.ca/pdfs/p_critical.pdf

This document outlines 5 modules for integrating LBG health and wellness issues into health curriculum. It does not include trans and queer health but can easily be adapted to include those areas by a knowledgeable person.

Title: Trans Health Project

Author: Ontario Public Health Association

Date: 2004-2006

Available online: http://www.opha.on.ca/getmedia/166e2574-3eaf-4bfc-8c32-31a072d44233/2004-06_pp.pdf.aspx?ext=.pdf

This paper collected research in the area of trans health and calls for the Ontario Public Health Association to disseminate and information and advocate for the inclusion of trans healthcare curriculum for health care workers, while it does not

offer educational modules it is evidence based research than can be used to support the imminent need for inclusion in curriculum and policy. Further information about trans health and wellness issues can be found online at <http://transpulseproject.ca/>.

Title: Improving the Access and Quality of Public Health Services for Bisexuals

Author: Cheryl Dobinson and others

Date: 2005

Available online: http://www.glhv.org.au/files/bisexual_health_canada.pdf

Co-published as an article in the Journal of Bisexuality, this research highlights health and wellness issues for bisexuals.

Title: Guidelines for Care of Lesbian, Gay, Bisexual, and Transgender Patients

Author: Gay and Lesbian Medical Association

Date: 2006

Available online:

http://www.outforhealth.org/files/all/glma_guidelines_providers.pdf

Despite having Transgender in the title the document focuses on Lesbian, Gay and Bisexual clients and provides information on how to create a welcoming inclusive practice environment. It does not include trans issues.

Title: Halifax Rainbow Health Project: Inclusion Program Assessment Tool Guidelines

Author: Nova Scotia Rainbow Action Project, LGB Youth Project and AIDS Coalition of Nova Scotia

Date: 2006

Available online: no

This tool provides a framework for assessing if health care services are inclusive. It primarily focuses on hospital policies and procedures. It is a very useful resource for any health care institution to begin it's own internal audit of inclusion.

For more information on resources available please go to:

<http://www.rainbowhealthontario.ca/resources/>

APPENDIX C

Letter of Introduction, Ethics Approval Letter, Survey,

Letter of Introduction

From: Chrisshortall@gmail.com

To: All heads of Nursing schools in Canada

Date 09/17/2012

Subject: Masters Student Requests for Support. Canada Wide Research in Nursing

Does someone in your faculty/department have an expressed interest in sexuality, sexual health, or transgender health, either as a researcher or a teacher?

I am a master's student in the Applied Health Services Research program at Memorial University of Newfoundland. I am contacting all institutions in Canada that offer any Baccalaureate degree in Nursing to assess the feasibility of a study that will investigate sexuality, sexual health, and transgender health in accredited Canadian undergraduate nursing curricula.

To do a systematic inquiry, I am planning to collect and analyze curricular materials from across the country. This would necessitate the interest/support of nursing faculties from across Canada.

This is not a request to participate! Rather I'm contacting you to gauge the feasibility of this approach to my study.

Please advise me by **Sept 28** if you or someone in your faculty/department may be willing to be contacted with a request to participate at a later date, after my study has received ethics approval from Memorial University.

Chris Shortall, B.Sc. (H)
d34css@mun.ca



Ethics Office
Suite 200, Eastern Trust Building
95 Bonaventure Avenue
St. John's, NL
A1B 2X5

February 15, 2013

Mr. Chris Shortall
 55 Longs Hill
 St. John's, NL
 A1C 1V3

Dear Mr. Shortall

Reference #13.026

Re: Rendering the Invisible Transparent: A Qualitative Analysis of Transgendered and Sexuality Content in Canadian Accredited Baccalaureate Nursing Curriculum

Your response was reviewed by the Chair of the Health Research Ethics Board and **full approval** was granted effective **February 15, 2013**.

This approval will lapse on **February 14, 2014**. It is your responsibility to ensure that the Ethics Renewal form is forwarded to the HREB office prior to the renewal date. *The information provided in this form must be current to the time of submission and submitted to the HREB not less than 30 nor more than 45 days of the anniversary of your approval date.* The Ethics Renewal form can be downloaded from the HREB website <http://www.hrea.ca>.

This is to confirm that the following documents have been reviewed and approved or acknowledged (as indicated):

- Application, approved
- Survey and cover letter, approved

The Health Research Ethics Board advises THAT IF YOU DO NOT return the completed Ethics Renewal form prior to date of renewal:

- *Your ethics approval will lapse*
- *You will be required to stop research activity immediately*
- *You may not be permitted to restart the study until you reapply for and receive approval to undertake the study again*

Lapse in ethics approval may result in interruption or termination of funding

email: info@hrea.ca

Phone: 777-8949

FAX: 777-8776

Mr. Chris Shortall
Reference #13.026
February 15, 2013

Page 2

It is your responsibility to seek the necessary approval from the Regional Health Authority or other organization as appropriate.

Modifications of the protocol/consent are not permitted without prior approval from the Health Research Ethics Board. Implementing changes in the protocol/consent without HREB approval may result in the approval of your research study being revoked, necessitating cessation of all related research activity. Request for modification to the protocol/consent must be outlined on an amendment form (available on the HREB website) and submitted to the HREB for review.

This research ethics board (the HREB) has reviewed and approved the research protocol and documentation as noted above for the study which is to be conducted by you as the qualified investigator named above at the specified site. This approval and the views of this Research Ethics Board have been documented in writing. In addition, please be advised that the Health Research Ethics Board currently operates according to *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*; *ICH Guidance E6: Good Clinical Practice* and applicable laws and regulations. The membership of this research ethics board is constituted in compliance with the membership requirements for research ethics boards as defined by *Health Canada Food and Drug Regulations Division 5; Part C*.

Notwithstanding the approval of the HREB, the primary responsibility for the ethical conduct of the investigation remains with you.

We wish you every success with your study.

Sincerely,



Dr. Fern Brunger
Chair
Non-Clinical Trials
Health Research Ethics Board

C VP Research c/o Office of Research, MUN
VP Research c/o Patient Research Centre, Eastern Health
HREB meeting date: February 21, 2013

email: info@hrea.ca

Phone: 777-8949

FAX: 777-8776

Invitation to Participate

From: chrisshortall@gmail.com

To: All faculty staff nursing institutions canada

Date: 02/19/13

Subject: Researching Sexuality and Gender Identity content in Canadian
Baccalaureate Nursing Curricula

Please consider completing this online survey. If you have any questions about this research or would like more information, please contact me at this email address. If you feel that someone else at your institution would be more suitable to complete this survey, please forward it to them.

<http://sexualityandtransgender.limequery.com/index.php/325165/lang-en>

My name is Chris Shortall, I am a Masters student in Applied Health Services Research at Memorial University of Newfoundland. This research has been approved by the Health Research Ethics Board in Newfoundland

<http://www.hrea.ca/home.aspx>.

I am investigating sexuality and gender identity content in Baccalaureate Nursing curricula in Canada and am contacting all institutions listed on the CASN directory. All responses are anonymous and any forwarded curriculum materials or information requests will be kept confidential as per research protocol. Please consider completing the online survey and assisting my qualitative research investigating sexuality and gender identity content in Canadian Baccalaureate Nursing curricula.

<http://sexualityandtransgender.limequery.com/index.php/325165/lang-en>

Chris Shortall

B.Sc.H. Acadia, 2002.

Student, Applied Health Services Research, MUN

200351534

Full Survey as it appeared on LimeSurvey

Title: A Qualitative Analysis of Sexuality and Transgendered Content in Canadian Accredited Baccalaureate Nursing Curriculum

Author: Chris Shortall, B.Sc.H. – Division of Community Health and Humanities, Faculty of Medicine, Memorial University of Newfoundland.

Informed Consent

Thank you for your interest in this research study. People of diverse sexual orientations and gender identities often report interacting with healthcare professionals who are unaware or unknowledgeable about their particular health needs (Neville & Henrikson, 2006). This research study is part of a Masters in Applied Health Services Research in the Division of Community Health and Humanities at Memorial University of Newfoundland (MUN) under the supervision of Dr. Rick Audas. It has been approved by the Health Research Ethics Authority (HREA) at Memorial University of Newfoundland (reference # 13.026). Further information can be obtained about the HREA at <http://www.hrea.ca/home.aspx>.

The investigator, Chris Shortall, and his supervisor, Dr. Rick Audas, will be the only persons who have access to the study data. LimeSurvey.org, an open source free unlimited survey design program from Germany, will host the online survey. The investigator will de-identify all data prior to discussing data analysis with his supervisor. The data will be retained on the investigators password protected personal computer at his home in St. John's, NL. If any changes to the study are made or new information becomes available, you will be informed. The data for this study will be retained for five years, at which point it will be deleted from the investigator's personal computer.

The purpose of this study is to identify the quality of sexual health, sexuality, and transgender information in Canadian accredited baccalaureate nursing curricula. Nurses are recognized as an important part of the healthcare system and often have the most frequent contact with patients. This research study is intended to gather information that will help future health professionals learn to provide quality care to people of diverse sexual orientations and gender identities.

The study questions are brief, and there are many opportunities to provide the investigator with more information. It is suggested that you attach or forward relevant curriculum materials for analysis. There are 24 questions in this survey including subsequent requests for curriculum materials such as syllabus, reading lists, Powerpoint slides, handouts and lecture notes. It is hoped that you can gather these and attach them to your survey, or email them directly to the investigator. It is requested that you grant permission to analyze curriculum materials for this study.

The survey should take 30-45 minutes to complete with the possibility of additional time necessary to collect and forward the documents requested. It is important to the study that requested curriculum resources, if available, are forwarded to the investigator. The curriculum materials will immediately be stripped of any identifying information and these documents will be kept in confidentiality with all survey responses. The data will be synthesized and your curriculum materials will not be shared with anyone outside of the research team. You have the choice not to answer any question, and you may withdraw from the study at any time.

Data from this research study will be used for completion requirements of a Master's thesis in Applied Health Services Research at Memorial University of Newfoundland. Upon completion of the degree, an electronic copy of the thesis and therefore the study findings, will be distributed to the primary contact at each participating school. This research may also appear as a conference poster, in lectures, or as an article in a peer-reviewed journal.

There is no known harm to you as a participant or to your respective institution by participating in this research. There are also no known direct benefits to your participation.

If you have submitted data and would like it removed, a period of 25 days is allotted before data will be aggregated. Once data has been aggregated it will be difficult to identify any particular responses and therefore unable to be completely removed.

I appreciate your time and energy in taking part in this study. You can feel free to contact myself, my supervisor, or the HREA at any time if you have questions about this research study.

You should print a copy of this consent form for your files.

If you have any questions please feel free to contact the investigator:

Chris Shortall, B.Sc.H.

1-709-746-7891

chrisshortall@gmail.com

collect calls will be accepted

This research has been reviewed by the Health Research Ethics Authority and found to be in compliance with Memorial University of Newfoundland's ethics policy (reference # 13.026). If you have ethical concerns about the research (such as the way you have been treated or your rights as a participant), you may contact the HREA at

**Ethics Office
Health Research Ethics Authority
Suite 200, 2nd floor, 95 Bonaventure Avenue
St. John's, NL. A1B 2X5
t: 709-777-6974
f: 709-777-8776
e: info@hrea.ca
web: www.hrea.ca**

Please complete the following to electronically sign this informed consent:
By signing this consent form I agree that: [**check boxes, all must be checked to proceed**]

The study has been explained to me

I have been provided the contact information of the investigator for purposes of questioning.

I have been explained any possible harms, benefits, and the protocol for possible changes in this research

I understand I have the right not to participate and the right to stop at any time without consequences

I understand I have the choice to not answer any specific question

I understand that my information will be kept confidential with the investigator

I understand that no identifying information will be published, released, printed, or publically discussed without formal written consent

I have printed a copy of this consent form for my files

START OF SURVEY

Please indicate your institution

[drop down box]

Please indicate the type and varieties of BN offered

Select all that apply

Part time

Full time

Fast track

Collaborative

Post RN

Other [specify]

Instructions

This survey asks about the Baccalaureate Nursing curriculum at your institution. It focuses on what sexual orientation and gender identity health and wellness issues are addressed. These topics are often difficult to teach and many educators may be unaware of the particular and pressing health disparities that lesbian, bisexual, gay, transsexual, transgender, intersex, and queer (LBGTIQ) people face.

This survey is intended to be completed by the head of the nursing school or designate. This survey may request information that you do not know. If there is someone who is more qualified or you simply do not have the time, please forward

this survey to the most knowledgeable person about curriculum, sexual orientation and, gender identity health and wellness issues.

At any point you want to take a break from the survey please click SAVE SURVEY AND RETURN LATER. You will be prompted to enter your email address, to which a personalized link will be sent to you. Note that the email address you provide will not be available to the investigators (i.e. your answers will remain anonymous). Please feel free to contact the investigator at any time if you have questions. *Some of the questions have been approved for use by Obedin-Maliver, et al. (2011) from their research study investigating Medical School Curriculum in North America.*

If you do not know how to answer a question, any response will be beneficial to the research.

GENERAL

- 1. As far as you are aware does the licensing examination in your region contain questions on sexual orientation and/or gender identity?**

YES

NO

DON'T KNOW

Please elaborate on the licensing examinations and regulatory bodies in your province regarding inclusion of sexual orientation and/or gender identity content:

OPEN TEXT BOX

- 2. Does your institution provide faculty development on sexual orientation and/or gender identity issues?**

YES

NO

DON'T KNOW

Please elaborate on faculty development or institution lead initiatives that may include sexual orientation and/or gender identity issues:

OPEN TEXT BOX

- 3. Is there a clinical placement, internship or practicum that allows for addressing sexual orientation and/or gender identity?**

YES

NO

DON'T KNOW

Please elaborate on clinical placements, internships or practicum that may address sexual orientation and/or gender identity:

OPEN TEXT BOX

- 4. Are there any nursing faculty members at your location that conduct research, or show an interest in research regarding sexual orientation and/or gender identity topics?**

YES

NO

DON'T KNOW

Please elaborate on any sexual orientation and/or gender identity research you may know of:

OPEN TEXT BOX

- 5. Do you know of any curricular resources and/or teaching materials (online, in your institution's library, or otherwise) regarding sexual orientation and/or gender identity?**

YES

NO

DON'T KNOW

Please elaborate on curricular resources and/or teaching materials that may be used:

OPEN TEXT BOX

- 6. Is it left up to the course instructor to determine the content on sexual orientation and/or gender identity to be included in each course?**

YES

NO

DON'T KNOW

Please elaborate on how/if sexual orientation and/or gender identity content is integrated into existing content:

OPEN TEXT BOX

- 7. Has sexual health content been removed from the curriculum?**

YES

NO

DON'T KNOW

Please elaborate on what has been removed:

OPEN TEXT BOX

- 8. What strategies do you think are or would be helpful in increasing sexual orientation and/or gender identity content at your institution?**
(check all that apply)

Curricular materials focusing on health/health disparities among these populations

Faculty willing and able to teach sexual orientation and gender identity content

Institutional support for teaching sexual orientation and or gender identity curricular content

More evidence based research regarding sexual orientation and or gender identity health/health disparities

More time in the curriculum to be able to teach sexual orientation and or gender identity curricular content

Methods to evaluate sexual orientation and or gender identity content

Curricular material coverage required by accreditation and examination bodies

More clinical placement, internship or practicum sites that address sexual orientation and or gender identity

NONE

DON'T KNOW

CURRICULUM

9. Are independent projects on sexual orientation and/or gender identity an option available for students?

YES

NO

DON'T KNOW

Please elaborate on student projects that address sexual orientation and/or gender identity:

OPEN TEXT BOX

10. When learning how to conduct a sexual history, are students taught to obtain information about same-sex relations (e.g. asking "do you have sex with men, women, or both")?

YES

NO

DON'T KNOW

Please elaborate on what same-sex information students are taught to obtain:

OPEN TEXT BOX

11. Are students taught the difference between behaviour and identity with regards to sexual orientation?

YES

NO

DON'T KNOW

Please elaborate on how students are taught the difference between behaviour and identity and other information about sexual orientation:

OPEN TEXT BOX

12. Are students taught the difference between identity and presentation with regards to gender?

YES

NO

DON'T KNOW

Please elaborate on what information students are taught regarding gender transitioning:

OPEN TEXT BOX

13. Are there any scenarios in your curriculum that specifically deal with sexual orientation and/or gender identity?

YES

NO

DON'T KNOW

Please elaborate on specific scenarios:

OPEN TEXT BOX

14. Does your institution include non-traditional families in scenarios to indicate that families and significant others are not always the opposite sex?

YES

NO

DON'T KNOW

Please elaborate on specific same sex scenarios:

OPEN TEXT BOX

15. Are people of diverse sexual orientation and/or gender identity mentioned as:

CULTURAL COMPETENCY
 SPECIAL POPULATION
 DIVERSE POPULATION
 VULNERABLE POPULATION
 OTHER

Please elaborate how/where sexual orientation and/or gender identity content is integrated:

OPEN TEXT BOX

16. Are nursing students taught that oppression exists among sexual orientation and/or gender identity (e.g. adolescent bullying)?

YES

NO

DON'T KNOW

Please elaborate on where in the curriculum students are taught that sexual orientation and/or gender identity oppression exists:

OPEN TEXT BOX

17. Are students taught to demonstrate sensitivity and respect for diversity in sexual orientation and/or gender identity? (e.g. communication skills)

YES

NO

DON'T KNOW

Please elaborate on how students are taught to demonstrate sensitivity and respect for sexual orientation and/or gender identity:

OPEN TEXT BOX

18. How does your institution teach and examine students to practice with non-judgmental attitudes?

OPEN TEXT BOX

19. How does your institution teach and examine the impact of personal values and assumptions on interactions with clients? Please provide specific examples.

OPEN TEXT BOX

20. Does your institution provide education for students in the following content areas at any point in the curriculum? Please indicate if the courses are elective or required

	Topic Covered in a required course	Topic Covered in an elective	Not in curriculum per se	Don't know
Sexual Orientation				
Coming Out				
Gender Expression				

Sex Reassignment Therapy				
Intersex and 'Disorders of Sex Development'				
Transitioning (eg. Male-to-Female, or Female-to-Male)				
Adolescent Sexual Health				
Safer Sex				
Sexually Transmitted Infections and/or HIV/AIDS				
Barriers to accessing medical care for diverse sexual orientations and gender identities				
Problematic alcohol, tobacco, and drug use				
Chronic diseases relevant to people of diverse sexual orientations and gender identities				
Mental health of particular populations				
Body image				
Unhealthy relationships/partner violence				
Parenting/insemination				

21. The items in the previous question may not comprise a complete list of sexual orientation and/or gender identity health and wellness topics. Other topics may include geriatric care, health insurance policies, medical decision-making, and visitation rights. **Please list other sexual orientation and/or gender identity related topics that your baccalaureate program covers.**
OPEN TEXT BOX

22. What do you think are the five most important issues that nursing students need to be aware of when learning about sexuality and gender identity issues?
OPEN TEXT BOX

23. Can you please provide the curricular materials (syllabus, reading lists, Powerpoint slides, handouts, lecture notes, etc.) used in the following areas:
Communication Skills
Nursing Practice – Interpersonal Skills -
STI's/Safer Sex/HIV
At risk Populations/Vulnerable Populations/Special Populations/Diversity

Adolescent Health
Women's Health

Please attach as an email to chrishortall@gmail.com

**24. Is there any other information you want to provide about LBGTIQ
content in nursing curriculum?**

OPEN TEXT BOX

Thank you for your time and for participating in this research study.

Appendix D

Professional Curricular Policy Guiding Documents Reviewed for Critical Content Analysis

National

Canadian Council of Registered Nurse Regulators (2012). *Competencies in context of entry-level registered nurse practice: A report of the 2011-2012 jurisdictional competency process*. Author: Canada. Available online at: http://www.ccrnr.ca/assets/jcp_rn_competencies_2012_edition.pdf

Canadian Nurses Association. (June, 2008). *Code of ethics for registered nurses: Centennial edition*. Author: Ottawa. Available online at: www.cna-aiic.ca/cna/documents/pdf/.../Code_of_Ethics_2008_e.pdf

Canadian Nurses Association. (2004). *Position Statement: Promoting culturally competent care*. Author: Ottawa. Available online at: https://cna-aiic.ca/~media/cna/page-content/pdf-fr/ps73_promoting_culturally_competent_care_march_2004_e.pdf

Canadian Nurses Association. (2010). *Position Statement: Promoting cultural competence in nursing*. Author: Ottawa. Available online at: https://www.cna-aiic.ca/~media/cna/page-content/pdf-en/ps114_cultural_competence_2010_e.pdf?la=en

Canadian Nurses Association. (2011). *Position Statement: Registered nurses, health and human rights*. Author: Ottawa. Available online at: https://www.cna-aiic.ca/~media/cna/page-content/pdf-en/ps116_health_and_human_rights_2011_e.pdf?la=en

Canadian Nurses Association. (2012). *Position Statement: Mental health services*. Author: Ottawa. Available online at: https://www.cna-aiic.ca/~media/cna/page-content/pdf-en/ps85_mental_health_e.pdf?la=en

Canadian Nurses Association. (2013). *Position Statement: Social determinants of health*. Author: Ottawa. Available online at: https://www.cna-aiic.ca/~media/cna/files/en/ps124_social_determinants_of_health_e.pdf?la=en

Canadian Nurses Association. (2015). *Framework for the practice of registered nurses in Canada*. Author: Ottawa. Available online at: www.cna-aiic.ca/en/becoming-an-rn/the-practice-of-nursing/

Canadian Nurses Association & Canadian Federation of Nurses Unions (2015). *Joint position statement: workplace violence and bullying*. Author: Ottawa Available online at: https://www.cna-aic.ca/~media/cna/page-content/pdf-en/workplace-violence-and-bullying_joint-position-statement.pdf?la=en

CASN (2011). *CASN position statement: Baccalaureate education and baccalaureate programs*. Author: Ottawa. Available online at: <http://casn.ca/wp-content/uploads/2014/10/BaccalaureatePositionStatementEnglishFinal.pdf>

CASN (2014). *CASN accreditation program standards*. Author: Ottawa. Available online at: <http://www.casn.ca/wp-content/uploads/2014/12/2014-FINAL-EN-Accred-standards-March-311.pdf>

CASN (2015). *Entry-to-practice mental health and addiction competencies for undergraduate nursing education in Canada*. Author: Ottawa. Available online at: http://www.casn.ca/wp-content/uploads/2015/11/Mental-health-Competencies_EN_FINAL-3-Oct-26-2015.pdf

CASN (2014a). *Entry-to-practice public health nursing competencies for undergraduate nursing education*. Author: Ottawa. Available online at: <http://casn.ca/wp-content/uploads/2014/12/FINALpublichealthcompeENforweb.pdf>

National Council of State Boards of Nursing (April, 2016). *National council licensure examination for the registered nurse: NCLEX-RN test plan*. Author: Chicago, Il. Available online at: https://www.ncsbn.org/RN_Test_Plan_2016_Final.pdf

Alberta

College and Association of Registered Nurses of Alberta, and the Nursing Education Program Approval Board. (Jan, 2013). *Standards for Alberta nursing education programs leading to initial entry to practice as a registered nurse*. Available online at: http://nurses.ab.ca/Carna-Admin/Uploads/2013_NEPAB_RN_Standards_Criteria.pdf.pdf

College and Association of Registered Nurses of Alberta (May, 2013). *Entry-to-practice competencies for the registered nurses profession*. Available online at: http://www.nurses.ab.ca/content/dam/carna/pdfs/documentlist/standards/rn_entrypracticecompetencies_may2013.pdf

College and Association of Registered Nurses of Alberta (May, 2011). *Scope of practice for registered nurses*. Available online at: http://www.nurses.ab.ca/content/dam/carna/pdfs/DocumentList/Standards/rn_ScopeOfPractice_May2011.pdf

College and Association of Registered Nurses of Alberta (Sept, 2005). *Position statement: Vulnerability*. Available online at:
http://www.nurses.ab.ca/content/dam/carna/pdfs/DocumentList/PositionStatements/Vulnerability_Sept2005.pdf

British Columbia

College of Registered Nurses of British Columbia. (April, 2015). *Competencies in the context of entry-level registered nurse practice in British Columbia*. Available online at:
<https://www.crnbc.ca/Registration/Lists/RegistrationResources/375CompetenciesEntryLevelRN.pdf>

College of Registered Nurses of British Columbia. (October 2014). *Competencies for CRNBC certified practice: Reproductive health - sexually transmitted infections*. Available online at:
<https://www.crnbc.ca/Standards/CertifiedPractice/Documents/ReproductiveHealth/471CoreCompetenciesReproductiveHlthSTIs.pdf>

College of Registered Nurses of British Columbia. (Nov, 2012). *Professional standards for registered nurses and nurse practitioners*. Available online at:
<http://crnbc.ca/Standards/Lists/StandardResources/128ProfessionalStandards.pdf>

College of Registered Nurses of British Columbia. (August, 2016). *Guidelines for nursing education programs preparing for a review by the CRNBC educational review committee*. Available online at:
<https://www.crnbc.ca/PracticeSupport/Documents/693GdlforNrsgEdProgram.pdf>

College of Registered Nurses of British Columbia. (March, 2016). *Scope of practice for registered nurses: Standards limits conditions*. Available online at:
<https://www.crnbc.ca/Standards/Lists/StandardResources/433ScopeforRegisteredNurses.pdf>

Manitoba

College of Registered Nurses of Manitoba. (Nov, 2013). *Standards for nursing education programs*. Available online at:
https://www.crnmb.ca/uploads/document/document_file_82.pdf?t=1442260466

College of Registered Nurses of Manitoba. (May, 2013). *Requisite skills and abilities*. Available online at:
https://www.crnmb.ca/uploads/document/document_file_201.pdf?t=1442260579

College of Registered Nurses of Manitoba. (Oct, 2013). *Standards for RN clinical competence assessment*. Available online at:
https://www.crnmb.ca/uploads/document/document_file_95.pdf?t=1442260479

College of Registered Nurses of Manitoba. (Sept, 2013). *Standards of practice for registered nurses: Nursing practice expectations*. Available online at:
https://www.crnmb.ca/uploads/document/document_file_89.pdf?t=1442260471

College of Registered Nurses of Manitoba. (Sept, 2013). *Entry level competencies for registered nurses*. Available online at:
https://www.crnmb.ca/uploads/document/document_file_92.pdf?t=1438266411

New Brunswick

Nurses Association of New Brunswick. (Feb, 2014). *Becoming a registered nurse in New Brunswick: Requisite skills and abilities*. Available online at:
<http://www.nanb.nb.ca/media/resource/NANB-RequisiteSkillsAbilities-E.pdf>

Nurses Association of New Brunswick. (Feb, 2015). *Approval review process: Baccalaureate nursing programs in New Brunswick*. Available online at:
<http://www.nanb.nb.ca/media/resource/NANB-ApprovalReviewProcessBaccalaureateNursingProgramsNB-E.pdf>

Nurses Association of New Brunswick. (Feb, 2013). *Standards for nursing education in New Brunswick*. Available online at:
<http://www.nanb.nb.ca/downloads/Standards%20for%20Nursing%20Education%20in%20NB%20English%20FINAL%20COPY.pdf>

Nurses Association of New Brunswick. (Nov. 2012). *Standards of practice for registered nurses*. Available online at:
http://www.nanb.nb.ca/downloads/NANB%20Standards%20of%20Practice%20for%20Registered%20Nurses%202012_E.pdf

Nurses Association of New Brunswick. (May, 2013). *Entry-level competencies for registered nurses in New Brunswick*. Available online at:
<http://www.nanb.nb.ca/downloads/Entry%20level%20Competencies%20May%202013-E.pdf>

Newfoundland and Labrador

Association of Registered Nurses of Newfoundland and Labrador. (May, 2013). *Competencies in the context of entry-level registered nurse practice: 2013-2018*. Available online at: [http://www.arannl.ca/documents/publications/Competencies in the Context of Entry Level Registered Nurse Practice 2013 18.pdf](http://www.arannl.ca/documents/publications/Competencies_in_the_Context_of_Entry_Level_Registered_Nurse_Practice_2013_18.pdf)

Association of Registered Nurses of Newfoundland and Labrador. (2013). *Standards of practice for registered nurses*. Available online at: [https://www.arannl.ca/sites/default/files/Standards of Practice for Registered Nurses.pdf](https://www.arannl.ca/sites/default/files/Standards_of_Practice_for_Registered_Nurses.pdf)

Association of Registered Nurses of Newfoundland and Labrador. (2013). *Approval process for basic nursing education programs*. Available online at: [https://arannl.ca/sites/default/files/documents/RD Approval Process for Basic Nursing Education Programs.pdf](https://arannl.ca/sites/default/files/documents/RD_Approval_Process_for_Basic_Nursing_Education_Programs.pdf)

Northwest Territories and Nunavut

Registered Nurses Association of the Northwest Territories and Nunavut (Sept, 2013). *Entry-level competencies for registered nurse*. Available online at: https://www.crnmb.ca/uploads/document/document_file_92.pdf?t=1438266411

Registered Nurses Association of the Northwest Territories and Nunavut (Apr, 2014). *Standards of practice for registered nurses and nurse practitioners*. Available online at: http://nwtntnu_nurses.ub5.outcrop.com/sites/default/files/Standards-of-Practice-for-RNs-and-NPs-2014.pdf

Registered Nurses Association of the Northwest Territories and Nunavut (Sept, 2012). *Becoming a nurse in the Northwest Territories and Nunavut: Requisite skills and abilities*. <http://rnanntnu.lamp.yk.com/wp-uploads/2013/05/RSA-Documents-Final-Documents-2012.pdf>

Nova Scotia

College of Registered Nurses of Nova Scotia. (2013). *Entry-level competencies for registered nurses in Nova Scotia*. Available online at: <http://crnns.ca/wp-content/uploads/2015/02/Entry-LevelCompetenciesRNs.pdf>

College of Registered Nurses of Nova Scotia. (2012). *Standards of practice for registered nurses*. Available online at: <http://crnns.ca/wp-content/uploads/2015/02/RNStandards.pdf>

College of Registered Nurses of Nova Scotia. (2016). *Position statement: Promoting culturally competent care*. Available online at: <http://crnns.ca/wp-content/uploads/2016/08/Promoting-Culturally-Competent-Care.pdf>

College of Registered Nurses of Nova Scotia. (2016). *Change of sex designation on birth certificate: Questions and answers for RNs and NPs*. Available online at: <http://crnns.ca/wp-content/uploads/2016/01/Change-of-Sex-Designation-on-Birth-Certificates-Q-and-A-for-RNs-and-NPs.pdf>

Ontario

College of Nurses of Ontario. (2014). *Competencies for entry-level registered nurses practice*. Available online at: https://www.cno.org/globalassets/docs/reg/41037_entrytopracitic_final.pdf

College of Nurses of Ontario. (2012). *Fact sheet: Requisite skills and abilities*. Available online at: <http://www.cno.org/globalassets/docs/reg/41078-skillabilities-4pager-final.pdf>

College of Nurses of Ontario. (2009). *Practice guideline: Culturally sensitive care*. Available online at: http://www.cno.org/globalassets/docs/prac/41040_culturallysens.pdf

College of Nurses of Ontario. (2002). *Practice standard: Professional standards*. Available online at: http://www.cno.org/globalassets/docs/prac/41006_profstds.pdf

Registered Nurses' Association of Ontario. (2007). *Position statement: Respecting sexual orientation and gender identity*. Ontario: Author. Available online at: <http://rnao.ca/policy/position-statements/sexual-orientation-gender-identity>

Prince Edward Island

The Association of Registered Nurses of Prince Edward Island. (Sept, 2011). *Entry-level competencies 2011-2015*. Available online at: <http://www.arnpei.ca/images/pdf/Entry-Level%20Competencies%202011-15.pdf>

The Association of Registered Nurses of Prince Edward Island. (Apr, 2011). *Standards for nursing practice*. Available online at: <http://www.arnpei.ca/images/pdf/Standards%20for%20Nursing%20Practice2011.pdf>

Saskatchewan

Saskatchewan Registered Nurses' Association (Dec, 2013). *Standards and foundation competencies for the practice of registered nurses*. Available online at: http://www.srna.org/images/stories/Nursing_Practice/Resources/Standards_and_Foundation_2013_06_10_Web.pdf

Saskatchewan Registered Nurses' Association (June, 2015). *Program approval for established RN programs*. Available online at: http://www.srna.org/images/stories/Registration/Admin_Manual_Program_Approval_Established_RN_FINAL_2015_06_11.pdf

Yukon

Yukon Registered Nurses Association. (Jan 2013). *Standards of practice for registered nurses*. Available online at: <http://yrna.ca/wp-content/uploads/Standards2013.pdf>

Appendix E

Coded/Thematic Identification of Question “What are the 5 most important areas needed to be included in curriculum”

Using a categorization system to identify the themes, the emergent issues were as follows. The heading was chosen from the options and best represents the subsequent responses

RELATIONAL PRACTICE

COMMUNICATION

how to create a safe space

treatment options

resources for these clients

basic language that is respectful

Use of Inclusive language

Examining the power of language. Pronouns for example and learning non-binary pronouns (or devising)

that nurses need to communicate a willingness to talk with clients about concerns

that nurses can make a difference by opening a conversation about sexuality and gender health issues

Eliciting Sexual Health information from a client

how to discuss topic with patients

how judgement impacts patient care

HETEROSEXISM PERSONAL PHOBIAS

heterosexism as many don't even know what this term means

Escape from binary thinking

attitude toward sexuality and gender issues

knowledge base on research and theory of gender issues

Having a male body does not preclude having a feminine gender, and the reverse

their own attitudes & beliefs

non judgemental attitude

that nurses need to be knowledgeable and comfortable about these issues

Examine normative assumptions

non-judgemental practice

how attitudes impact patient safety

interaction of the self with others, biases etc

understanding their own values and judgements and how this impacts caring for these pts

Assumptions

Make no assumptions

students learning to leave their judgement and attitudes at the door as they are called to be nurses

that nurses need to examine their personal views, values and attitudes to prevent imposing on others

understanding

Celebration of DIVERSE POPULATIONS

Individuality

openness to individual pt needs

not everyone is the same and that there are significant differences just as no two people are the same

cultural competence

just because a choice is the "normal" way doesn't mean it is the only way it is just more common

Acceptance

Sensitivity

respect and awareness

sensitivity training

Empathy

support peers and other professionals facing some of these challenges of their own sexual identity

SPECIFIC POPULATION HEALTH ISSUES

financial issues for health and pension coverage

Oppression

implications for health

Common queer health challenges

social/political realities of being gay/lesbian/transgendered

Abuse

issues of mental health and abuse

health promotion re specific issues affecting the glbt population

social/psychological barriers and challenges

insemination/adoption/parenting

research on gay, lesbian, trans issues

reactions to hatred, homophobia

advocacy for equity

that these issues hugely impact people's' health
 ethical concerns
 supports
 risks
 confidentiality
 need to reframe health education and health screening to more appropriately meet
 needs
 research

POSSIBLE NEW HEADING **RELATIONAL PRACTICE** 'defined by CASN final report
 National Nursing Education Framework

*An inquiry that is guided by conscious participation with clients using a number of
 relational skills including listening, questioning, empathy, mutuality, reciprocity, self-
 observation, reflection, and a sensitivity to emotional contexts.*

POSSIBLE NEW HEADING **HARM REDUCTION** defined by BC harm reduction strategies and
 services REFERENCED in *Entry to practice public health nursing competencies for
 undergraduate nursing education* CASN involves a range of non-judgemental approaches and
 strategies aimed at providing enhancing the knowledge skills resources and supports for
 individuals their families and communities to make informed decisions to be safer and
 healthier.

Appendix F

Verbatim Comments Collected in Survey

As far as you are aware does the licensing examination in your region contain questions about sexuality and/or gender identity- - comment

Faculty have developed and included learning modules about gender and health in social determinants, concept courses and as discussion topics in other course such as professional practice. CNO includes scenario based questions in the CRNE which include gender and sexual identity as a context for answering questions about practice and health teaching.

As the CRNE is undergoing changes, I am not sure if the new NCLEX will contain this content.

I don't believe it does.

Does your institution provide faculty development on sexual orientation and/or gender identity issues- - comment

Related to research and equity in both teaching and research work.

Not specifically, however, faculty are welcome to conduct continuing education on their own. Often guest speakers come to UNIVERSITY to present on this topic and faculty are welcome to attend if they are interested.

To date I am not currently aware of any structured PD sessions that address this piece.

I think it would be useful. I'd love to be part of an initiative to do that.

We have ongoing classes available for "positive space" whereby all students will be aware of safe environments re. sexuality and sexual identity will be offered.

Not yet but there are plans for faculty development in this area.

Information available through student services. Sessions are not mandatory

Is there a clinical placement, internship or practicum that allows for addressing sexual orientation and/or gender identity- - comment

Community nursing course

Not specifically. Students are encouraged to address sexual orientation and/or gender ID issues in their practices generally and to recognize the importance of these topics in all areas of health.

Students do not have exclusive access to this information but are taught to acknowledge the individuality of each client including their sexual preferences/orientation.

It is ironic that we're in XXXXXXX, the gay/lesbian capital of Canada, and we don't really address this issue in clinical.

Students in their final third year have opportunity to work in AN URBAN NEIGHBOURHOOD where they may work with transgendered pts. Students may work with homosexual clients in clinical sites and/or community settings.

Not specifically. Some students are placed at Public Health where they work on the sexual health team or where they may do workshops in schools with their preceptor.

Depending on agencies and faculty available. We have had such opportunities. I am unaware if there are current placements.

Are there any nursing faculty members at your location that conduct research, or show an interest in research regarding sexual orientation and/or gender identity topics- - comment

Not in nursing but in other faculties, anthropology, psychology, health and aging.

Yes this is a topic that I am interested in as faculty. I teach a Human Sexuality course and this content is included in the course. Guest lecturers are often invited to share personal perspectives re: sexual orientation and/or gender ID topics.

To date, I haven't discussed or received any information on this piece.

I'd like to.

Two of us have developed and conducted an upper division nursing elective course dealing with Sexuality and Health Promotion across the Lifespan which covers these topics extensively.

depending on the grants received

Do you know of any curricular resources and/or teaching materials (online, in your institution's library, or otherwise) regarding sexual orientation and/or gender identity- - comment

The Social Work department at our university has a lot of resources on this topic and our library is well stocked with them.

The current text used in **Health and Healing I, Fundamentals of Nursing (Potter and Perry)** currently discuss **gender identity in their Sexuality chapter**. Also our library has the video/documentary which I use in class (a bit dated) "The Canadian Closet"

We currently use the chapter on sexuality from Potter and Perry as required reading for our students in first semester.

Not in nursing. In social work maybe.

We've electronically made these materials available to our students enrolled in the Nursing **Elective** course.

We offer an **elective** in Sexuality.

via library

included in at least 2 courses in curricula - e.g., **explored through a learning package with same sex male couple in one course, lecture provided to students in course re: sexual orientation and health promotion.**

Not with that specific focus, however in community health, family course texts resource information is available.

in various courses where applicable

Is it left up to the course instructor to determine the content on sexual orientation and/or gender identity to be included in each course- - comment

Course instructor will initiate idea but will need to present to our curriculum group for approval and support to move content changes forward, we have this content in some of our courses.

Absolutely!

To clarify, the degree to which the content on sexual orientation is covered is left to the course instructor as the course is an introductory course to Health and Healing.

The focus/week on sexuality is prescribed in the curricular content.

not in courses where content is required objective. Otherwise, faculty are encouraged to create opportunities to explore topic where appropriate.

However one of our program abilities is Professional identity and ethics and we have outcomes threaded throughout the program speaking to diversity of culture, gender, religion, age, etc.

Has sexual health content been removed from the curriculum- - comment

Content has not been removed as it barely exists. Only faculty who are comfortable or knowledgeable include sexuality content.

Sexual health is woven into all 4 years in many courses from Patho to health and healing streams

To date, I don't believe it has.

I don't know if it was ever included.

Some is covered in the health assessment course

What strategies do you think are or would be helpful in increasing sexual orientation and/or gender identity content at your institution- [Other]

Need a conscious instructor capable to teach this topic as if not exposed and aware to the issues they would not be adequately prepared to identify their own heterosexism

Are independent projects on sexual orientation and/or gender identity an option available for students- - comment

Students who express an interest may complete projects if specific faculty agree. This largely depends on faculty comfort and knowledge re: the appropriateness of student's expressed interest.

As part of the evaluation for the semester one course on fundamentals of nursing, students do a presentation to the class. There are several choices of topics related to sexual orientation.

But I think they could be.

Students who have taken the Sexuality and Health Promotion elective course have been able to seek out clinical placement sites whereby they can utilize some of their teaching skills with clients at risk.

in an independent study course

It is possible for students to take an Independent Study course which they could design around such a project. if an elective course was available and open to our students they could take it.

if students choose to do this

When learning how to conduct a sexual history, are students taught to obtain information about same-sex relations (e.g. asking "do you have sex with men, women, or both")- - comment

Part of history taking

Students in the BScN program are not generally taught this however they may take an elective course (COURSE NUMBER) that does provide this information and opportunity for practice.

There may be some who do this, but not formally.

As part of the assessment of Sexuality students are asked to identify number of partners in order to identify risk of STIs. Same sex includes similar gender identity and sexual identity.

I don't think so. I introduce lectures on "taking a health history" with how we limit others' self expression, i.e. a space for "marital status" and the gay/ lesbian/ trans client says "What are my options?" They usually laugh but it gets them thinking.

we teach students interviewing and counselling skills in the lab

Are students taught the difference between behaviour and identity with regards to sexual orientation- - comment

In the social determinants of health course and when students use specific scenarios for their learning, behaviour and identity are embedded in the content.

Not specifically. If this information is included it is up to individual faculty and is not specifically included in our curriculum.

Students in the BScN program are not generally taught this however they may take an elective course (COURSE NUMBER) that does provide this information and opportunity for practice.

Maybe informally.

Yes a clear discussion of the difference between sexual identity and gender identity is discussed.

I don't think so.

not extensively.

Are students taught the difference between identity and presentation with regards to gender- - comment

As before ABOVE COMMENT In the social determinants of health course and when students use specific scenarios for their learning, behaviour and identity are embedded in the content.

Not generally in the nursing core courses, although there are several courses that list gender as a topic that is included in courses. It is my experience that faculty cover this topic in a variety of ways and for those who are more knowledgeable it is covered in more depth. I don't feel that general faculty have a great understanding of the differences.

Unless it is done informally, but it is not formally in the curriculum.

I must confess that we do not discuss this piece in any great depth.

not extensively.

Are there any scenarios in your curriculum that specifically deal with sexual orientation and/or gender identity- - comment

New media clips used in our theory class, we have one in which gender identity is in flux - the individual is struggling with this questions and we have two others in which it is clear, in one of these sexual identity is not a main feature of the scenario and in the other it is core information

Not in the general curriculum that I am aware of. Students in the BScN program are not generally taught this however they may take an elective course (COURSE NUMBER) that does provide this information and opportunity for practice.

To date only the ones included in the video/documentary 'The Canadian Closet'

there are a number of case studies related to sexual orientation and gender identity.

Middle ages adult First Nation male undergoing bowel resection for Ca and who is palliative is homosexual and is hoping to marry his partner Eric

Interviewing clients in taking a sexual health history or wherever it might be appropriate to include this in the nurse-client interaction.

There are likely others, but I know of one in an acute care nursing course where one of the partners in a same sex relationship is hospitalized and has surgery

case studies and presentation from guest speakers.

Does your institution include non-traditional families in scenarios to indicate that families and significant others are not always the opposite sex- - comment

Minimally and again depends on the faculty teaching a course. Certainly non-traditional families are included and may or may not include same sex parents but not in any depth (in my opinion)

We do discuss how the traditional family has changed/is changing but I don't believe we currently have any scenarios that highlight this piece.

But it is the 21st century and it's time we did.

We teach students to use gender non-specific terms like "partner" or "family member".

**Are people of diverse sexual orientation and/or gender identity mentioned as:
- comment**

depends on faculty teaching course and more likely would include diverse sexual orientation and less likely includes gender identity

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**Are people of diverse sexual orientation and/or gender identity mentioned as:
- comment**

depends on faculty teaching course and more likely would include diverse sexual orientation and less likely includes gender identity

This is integrated in a first year course on Health and Healing which examines this concept across the lifespan and within a diverse population.

**Are people of diverse sexual orientation and/or gender identity mentioned as:
- comment**

depends on faculty teaching course and more likely would include diverse sexual orientation and less likely includes gender identity

don't know

Are nursing students taught that oppression exists among sexual orientation and/or gender identity (e.g. adolescent bullying)- - comment

this is part of the large lecture presentation and again is brought to life in in-class discussions in other courses.

I think sexual orientation is covered quite well in the context of bullying and children/adolescence, and I am not sure if the same applies to gender ID.

Again it is discussed as part of our course on Health and Healing.

there are films, documentaries etc that professors have access to that outline oppression, educate re adolescent coming out.

I bring it up in my classes as it's been topical/current news.

And we have students who share this as their lived experience!

Are students taught to demonstrate sensitivity and respect for diversity in sexual orientation and/or gender identity (e.g. communication skills)- - comment

Yes and the depth of this teaching varies according to faculty.

Through their cultural competency and holistic understanding of the client, students are taught to be sensitive to the needs of the individual client.

It is more generic than specific

In health assessment, helping relationships courses.

How does your institution teach and examine students to practice with non-judgmental attitudes-

We have this foremost in our professionalism content which is developed and evaluated in classroom based courses as well as clinical practice courses. We know that we need to do better and are looking at new ways to do this that thread the non-judgmental attitudes from the first year all the way through the program.

This material is taught throughout the curriculum over 4 years. Generally faculty work hard to included teachings about non-judgmental attitudes overall.

Many courses include issues of diversity and respect, but it is up to the individual instructor what to emphasize.

Role play

Case studies

use of simulation

Again, this is built into many courses that span the 4 year program. Most importantly, this is part of one of our end of semester Learning Outcomes that be met each semester in clinical. In addition, this expectation is progressive in depth of understanding/application as the student progresses to the next semester.

I believe I begin with role modelling this piece when I teach in the classroom and in clinical. Also we do cover nurse-client therapeutic relationship and look at the strategies that support effective communication versus those that do not, including asking 'why' and having an opinion. Most of the scenarios presented to test this piece and of course abilities to develop a therapeutic rapport with one's client in clinical assists in evaluating this.

Done in first semester course through a 3 hour lecture on sexuality than through role modeling of language used by professor who taught the course

We have a very diverse student population so concepts related to all diversity are inherent in the classroom and also part of course content in most courses

* focus on the individual * client-centred care * humanistic nursing theories (Parse, Watson, Paterson/zderad) which emphasize empathy

We introduce the need to validate information and to not make judgements or assumptions about patients/families/populations right away in the program. We discuss perspectives throughout the program and encourage students to be open to other perspectives. They write a paper on an assumption and how they would validate it and what other perspectives they might have considered.

Our University as a whole, emphasizes non-judgemental attitudes and inclusive language for all populations, including those of sexual diversity. We have "safe" spaces on campus, and faculty who have been trained in this area have stickers on our office doors.

Four Self & Others courses in the program that include teaching students about non-judgmental attitudes

Ethics components are included in the initial theory course, a second theory course and in the clinical practice courses

Yes, we endeavour to teach and model embracing diversity (not only tolerating, which implicitly invokes dominant perspective). Faculty use a variety of teaching and learning opportunities, strategies, approaches to promote student awareness, comfort and competence with diversity, vulnerability, marginalization.

Direct observation of clinical practice, course presentations and papers, Class case studies and discussion

through critical thinking and self reflection. Standards for nursing practice and expectations are reinforced throughout the curriculum.

How does your institution teach and examine the impact of personal values and assumptions on interactions with clients-

Yes through clinical simulations and in supervised practice first with clinical faculty and later with clinical preceptors in the final year.

This material is taught throughout the curriculum over 4 years. Generally faculty work hard to included teachings about personal values and assumptions.

Very poorly, in my opinion. I teach 4th year students who still think their personal beliefs and values have no impact on their practice.

Role play

Case studies

self reflection

Again woven throughout many courses in the classroom via the use to theorists/philosophies (ie. Parse, Leininger, Paterson and Zderad, etc.)

We try to do this through reflection. Students are asked to complete narrative reflections that examine how their personal values influence their practice and the decisions they make at the bedside.

done in first semester through unpacking issues of judgement

through case studies, class discussions, self tests

In interviewing skills, cultural competence is taught, and the repercussions of bias discussed.

Our nursing care plan format has a column for how assumptions are validated through assessments and actual evidence. Students complete and submit care plans using this thought process throughout the program. They are always asked how they would validate a hypothesized problem with assessments and what evidence they actually collected to prove the anticipated problem exists or does not exist. It is equally important for them to prove (through validation) that a problem exists as well as proving it does not exist.

We recognize that our own personal values and opinions most definitely influence interactions we would have with clients. That's why it's so important in our language, posture and attitude to convey a sense of inclusiveness and value in diverse populations of people.

Same as previous answer (Ethics components are included in the initial theory course, a second theory course and in the clinical practice courses)

Discussion activities, lecture, readings.

Role play, class discussions, assigned readings, feedback of instructor observation of clinical practice.

discussion, reflection, hypothesis, decision making/critical thinking, etc.

Please list other sexual orientation and/or gender identity related topics that your baccalaureate program covers.

I think I have included all the information that I have here

None that I am aware of.

ethics related to

Many workshops, seminars, and presentations on supporting/being supported as LGBT person open to faculty and students.

As this is a collaborative program, I am not entirely sure of what aspect of this piece is covered at our partnered institution and to what degree.

we speak of heterosexism, definitions of what homophobia etc mean, how it impacts nursing care in institutions, at the bedside, through attitudes and values and how it puts patients at risk

None.

nothing else

We also offer a **Psychology Course and can be taken as an elective** for our BSN students if they wish.

This is another option for them to get this information through our curriculum.

be advised that in the following question I answered 'in a required course' for several of the items. That does not mean the entire course was on that content, **the content was included within the course**

What do you think are the five most important issues issues that nursing students need to be aware of when learning about sexuality and gender identity issues- [1]

basic language that is respectful

that nurses need to be knowledgeable and comfortable about these issues

Escape from binary thinking

communication

acceptance

Individuality

heterosexism as many don't even know what this term means

knowledge base r/t gender issues

empathy

oppression

openness to individual pt needs

Use of Inclusive language

their own attitudes & beliefs

don't really know

financial issues for health and pension coverage

non judgemental attitude

What do you think are the five most important issues that nursing students need to be aware of when learning about sexuality and gender identity issues- [2]

how to create a safe space

that nurses need to communicate a willingness to talk with clients about concerns

Examine normative assumptions

diverse populations

understanding

sensitivity

how judgement impacts patient care

attitude toward sexuality and gender issues

social/political realities of being gay/lesbian/transgendered

heterosexism

understanding their own values and judgements and how this impacts caring for these pts

Eliciting Sexual Health information from a client

multiplicity of issues

respect and awareness

sensitivity training

What do you think are the five most important issues that nursing students need to be aware of when learning about sexuality and gender identity issues- [3]

interaction of the self with others, biases etc

that these issues hugely impact people's' health

Personal phobias

issues related to

abuse

issues

how attitudes impact patient safety

assumptions

reactions to hatred, homophobia

non-judgemental practice

treatment options

Make no assumptions

not everyone is the same and that there are significant differences just as no two people are the sa

specific population health issues

resources for these clients

What do you think are the five most important issues that nursing students need to be aware of when learning about sexuality and gender identity issues- [4]

need to reframe health education and health screening to more appropriately meet needs

that nurses can make a difference by opening a conversation about sexuality and gender health issues

Having a male body does not preclude having a feminine gender, and the reverse

ethical concerns

supports

risks

students learning to leave their judgement and attitudes at the door as they are called to be nurses

confidentiality

health promotion re specific issues affecting the glbt population

cultural competence

social/psychological barriers and challenges

insemination/adoption/parenting

clinical or simulated experience

What do you think are the five most important issues that nursing students need to be aware of when learning about sexuality and gender identity issues- [5]

support peers and other professionals facing some of these challenges of their own sexual identity

that nurses need to examine their personal views, values and attitudes to prevent imposing on others

Examining the power of language. Pronouns for example and learning non-binary pronouns (or devising)

research

implications for health

just because a choice is the "normal" way doesn't mean it is the only way it is just more common

research on gay, lesbian, trans issues

Common queer health challenges

how to discuss topic with patients

issues of mental health and abuse

advocacy for equity

Is there any other information you want to provide about sexuality and gender identity content in Canadian nursing curriculum-