Walden University

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Chinazo Echezona-Johnson

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2014

Abstract

Equitable Obstetrical Care for the Lesbian, Gay, Bisexual, and Transgender Community

by

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Doctoral Study Submitted in Partial Fulfillment

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Abstract

Research has indicated that Lesbian, Gay, Bisexual and Transgender (LGBT) patients are not always satisfied with their health-care experiences due to the limited training received by the nursing professionals caring for them. The purpose of this study, using critical-theory principles, was to examine how the LGBT population was represented and portrayed in mainstream obstetrical-nursing courses, curricula, textbook, and syllabi. The guiding research question was based on the exploration of how nursing schools in a metropolitan city incorporate LGBT health-care topics in their obstetrical-nursing education. A qualitative, intrinsic case study research method was employed. A purposeful, criterion sample of faculty at a community nursing school in a large urban city was recruited via social media and the school newspaper for the study. Data were collected via 30 document reviews and 10 unstructured interviews with open-ended questions. The data were analyzed by theme analysis and constant comparison. Emergent findings showed that LGBT content was minimal or absent entirely in obstetrical nursing curricula in associate degree nursing schools. Results indicated that nursing faculty were not knowledgeable about LGBT obstetrical health issues, and lacked the knowledge of how to incorporate LGBT issues into curriculum. Recommendations included quality professional development. As a result of this recommendation, a workshop was developed to train obstetrical faculty. The project will be evaluated using Kirkpatrick's 4-level models of training criteria. The training program will be a conduit between research and practice by demonstrating diverse ways to understand the LGBT population. This study supports positive social change by empowering future obstetric nurses to reject any practice that will repress, marginalize, and control their patients.

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Dedication

This research is dedicated to my husband and friend, Andre Johnson; my children, Jamilen, Chiandre, and Stephen; my parents, Fidelia Echezona and the late Samuel Echezona; my siblings, Dr. Ijeoma Ozed-Williams, Dr. Onwuatuegwu Echezona, and Dr. Okechukwu Echezona; my mentors and friends, Dr. April Martin, Susan Alexander, Jesse Martin-Alexander, Johnny (JR) Martin-Alexander, the late Bob Jennings, and the late Mary Burroughs; and my beloved cousin, the late Abanobi Echezona.

My husband and children have endured years of stress and a house full of papers and books. When the journey became overly tedious, my husband ran the household and raised our children. My son, Jay Jay, always had a good "pep talk" ready; my daughter, Chiandre, took over the cooking of many "yummy" family dinners; and my baby, Stephen, was always there for a hug and a good stress-relieving game of Hide-and-Seek. My parents firmly instilled in me the value of loving God and the importance of lifelong learning. My siblings set a high standard for me and supported me with prayer and love.

JR taught me that love is unconditional. His strength gave me the impetus to see this research through to completion. I will always love him just the way he is and admire him both as an individual and his journey. My beloved cousin, the late Abanobi Echezona, taught me the value of loving God, others, and myself. He gave me the most valuable tool for continuing my quest toward positive social change for all marginalized people. Dr. April Martin, Susan Alexander, the late Bob Jennings, and the late Mary Burroughs believed in me and ensured that I remained in school by contributing to my school fees and my life experiences. They taught me that everyone deserves to be loved.

I want to acknowledge and thank my friends and family for their understanding, support, and love, especially during my absence at family functions due to time constraints. I am grateful for your many sacrifices and your support, even on those days I was not myself. Special gratitude is extended to my aunt, Mrs. Ukamaka Ekejiuba; Dr. Lorraine Barnett; Melody Parker; Genevieve Jensen; Dr. Jane Lederer; Mike and Jill Sweeny; Roisin Rogers; Ralph Akazi; Chinyelu Oyedu-Ebere; Pastor George and Magdalene; Obioma Ukachukwu; Norma Hamil; Dr. Jane Lederer; Janine Hawkins; Amaka Nwobu-Ekwonu; Ifeoma Echezona-Ogu; Chinyere Ndubuisi; Helen Johnson; late James Johnson; late Mary Brown; Virgine Hilaire-Honore; Jacqueline Diakhate, Ifeyinwa Ugwu; Mr. and Mrs. Robert Jennings; Dr. April Martin; Susan Alexander; and my godchildren, JR Martin Alexander and Jesse Martin-Alexander. All of you have touched my life and significantly contributed to this journey through psychological, physical, and emotional support. Your friendship, love, prayers, and mentoring sustained me through completion of this study.

Words will never express the full extent of my gratitude for my husband, Andre Johnson. You extended your shoulder to cry on; prayed with me; stayed up through many nights with me so I would not feel lonely; comforted me whenever I confronted an obstacle; defended me from external attack; encouraged me toward the goal; and attended parent-teacher meetings, bake sales, graduations, pediatrician visits, and Sunday-school functions. You became “mommy” to allow me to achieve my dreams. Your love is from God. Thank you for that unconditional love that never ended, even on my worst days! My sincere thanks to my sons, Jamilen and Stephen, and my daughter, Chiandre. Thank you for not complaining when your mom was absent. Your hugs and kisses always reminded

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I love and cherish all of you, and I claim this degree in God's name for you all.

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I am grateful for my family, my friends, my coworkers, my colleagues, and my students, all of whom sacrificed much to enable me to attain this goal. Their support and encouragement were invaluable. I especially want to thank my doctoral committee for the patience and support that facilitated this study. Their expertise is highly valued. I will never forget the gentle teaching, guidance, and support of Dr. Cheryl Bullock, nor the encouragement she extended to me when I felt like giving up. Dr. Kathleen McKee provided detailed feedback and insight that significantly contributed to this work, as well as an extra measure of enthusiasm and passion that inspired me to continue. Gratitude is also extended to Dr. Nori Mora—the best URR—for the many recommendations. I am also thankful to Jill Eastwood and Lily Mathews for reading and rereading pages and pages of my project study toward its optimal presentation. I am most appreciative for your expertise and assistance. Without your help, this project study would never have reached the "finish line."

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Section 1: The Problem

Introduction

Regardless of related antidiscrimination laws; increasing recognition of same-sex marriages; political support; and the growth in global tolerance of lesbian, gay, bisexual, and transgender (LGBT) communities, stigmatization of this population continues (Obama, 2013). Finneran and Stephenson (2013) described how violence and hatred, sourced in stereotyping and discrimination, are encountered by these individuals in nearly every facet of their lives. Wojcik (2010) reported that, within 29 U.S. states, laws remain active that permit employers to terminate employees based solely upon their sexual orientation. In addition to the social stigma, members of the LGBT community face barriers within the health-care arena. Health-care practitioners have become aware of the distinctive care needs among individuals of the LGBT population as members of a gender minority. Clinicians have acknowledged that these unique needs can be best addressed by well-informed practitioners.

An equality index was developed as a guideline to eradicate discrimination against the LGBT community (*Human Rights Campaign,* 2011). Health-care facilities across the country were asked to assess and improve related policies and practice. Only 27 of the 87 health-care facilities surveyed across the United States met the standard for LGBT health-care equality. These facilities were rated on the following five areas of policy and practice: employment, patient discrimination, hospital visitation, decision making, and cultural competency.

Regardless of the recommendations of administrative, governmental, and accrediting stakeholders, health-care providers, care facilities, and education institutions

continue to exhibit reluctance with regard to integrating LGBT issues into their practices, policies, curricula, textbooks, and syllabi. This may be due to a complete lack or limited inclusion of LGBT issues within health-care education (Bleakley, 2013; Willen, 2013). Additional study is needed to better understand the health-care needs of this population, especially the obstetrical care needs of lesbians (Spidsberg & Sørlie, 2012; Strong & Folse, 2013).

Definition of the Problem

Chapman et al. (2012) found that individuals among the LGBT population have historically been dissatisfied with their health-care providers, including their obstetrical care providers. Complaints have encompassed insensitivity and inadequate or substandard care. Studies have indicated that the majority of LGBT adults refuse to divulge information related to their sexual orientation to health-care providers due to the unpleasant, highly critical, and distressing retorts often received in response to the provision of such sensitive data. LGBT individuals commonly encounter discrimination when presenting for health services. This patient population not only presents with higher incidence of disease, but also reflects low rates of analysis and screening for the most common illnesses such as cardiovascular and reproductive disease (Krehely, 2009).

Local Setting

Advanced-practice clinical nurses must demonstrate clinical expertise. To satisfy this requirement, they frequently serve as per-diem staff nurses. One of the largest teaching hospitals is located within a large metropolitan city of the United States, serving patients from diverse economic, social, and cultural backgrounds. The labor and delivery unit carries a heavy load of both complicated and routine obstetrical cases. The hospital

has 54 obstetrical and gynecological beds and averages more than 6,000 deliveries on an annual basis. The culturally diverse obstetrical, medical, and nursing staff consists of personnel with varied years of experience and education backgrounds.

A lack of culturally competent care for the LGBT population is evident within the described teaching hospital; yet, the institution has the resources to care for all patients equitably and professionally. With the recognition of same-sex marriages within the state, the policies of the hospital were revised to serve nontraditional families. The open visiting policies now recognize same-sex unions. Holistic and comprehensive nursing care is extended to LGBT patients within the labor and delivery setting. However, not all nursing staff are particularly comfortable with these patients and their families, and inappropriate and derogatory comments continue. Some nurses are uncomfortable taking the health and sexual histories of LGBT patients, they can fail to appropriately inform their patients on labor and delivery processes, and they are frequently uncomfortable with providing emotional support to these patients and their families.

As a result of the adverse views of many nurses toward the LGBT patient population within the described location, the teaching hospital does not receive high patient-satisfaction ratings. Any real or perceived discrimination against LGBT patients is naturally unfavorable for patient satisfaction and compliance (Ali, 2013). This problem may well be rooted in a lack of understanding caused by an absence of culturally competent curricula within academic institutions offering obstetrics-nursing education. Such dissatisfaction also affects quality of care and the payment reform of the Hospital Value-Based Purchasing Program (U.S. Department of Health and Human Services [USDHHS], 2011b).

Education Setting

Researchers have found that the lack of cultural competency within the realm of health care, as it relates to the LGBT patient population, is rooted in a gap in the basic education of nurses (Kevan & Weerakoon, 2010; Willen, 2013). This basic education does not adequately prepare or expose nurses to culturally and evidenced-based care for LGBT patients and their families. Nurses aspire to provide satisfactory care to their LGBT obstetrical patients; however, they frequently lack the skills to meet this goal (Fish, 2010; Lim & Bernstein, 2012).

The general curricula of nursing programs do not typically include topics related to the LGBT community, and nursing faculty do not customarily address issues related to this patient population within the classroom. Within clinical settings, nursing students are not exposed to obstetrical or general clinical situations dealing with the unique needs of these individuals. Additionally, curriculum and clinical settings do not emphasize such care. Didactic and clinical objectives are unrelated (Strong & Folse, 2013). The nursing profession is guided by many theories of practice such as the Orem theory of self-care and the Leininger theory of transcultural nursing. However, no theoretical foundation exists to explain or guide the nursing care of LGBT patient populations.

Nursing and other health-care professionals tend to make assumptions surrounding LGBT patients due to personal worldviews and societal stereotypes and prejudice. Professional nurses are more likely than nursing students to withhold care for homosexual individuals. Röndahl (2009a) found that both professional nurses and nursing students scored high on assessments of homophobic anger and guilt. In another study, Röndahl (2009b) found that two thirds of both nursing and medical students scored

lower than a passing 70% on a test related to the LGBT community. Nursing students attained poorer scores than medical students in overall knowledge surrounding this population.

Health-care workers are not adequately trained to understand the various relationships between patients and health-care providers and how such relationships influence health (Obedin-Maliver et al., 2011; Röndahl, 2009a). Additionally, the health-care system presupposes that all patients are heterosexuals. This presents the potential for prejudice affecting not only the LGBT patient population, but also their families and LGBT health-care professionals. Untrained health-care professionals may bar same-sex partners of obstetrical patients from visiting after childbirth. The health-care industry must respect and support sexual orientation to eliminate such inappropriate judgment (Gurney, 2011).

In clinical practice, health-care professionals struggle to provide competent care to the LGBT population. Gathering patient history related to sexual orientation improves patient-provider communication and encourages consistent patient attention to preventative care (USDHHS, 2011a, 2011b). Ali (2013) reported that health-care workers are uncomfortable discussing issues that may lead to a perception of prejudice. It is therefore important to reconstruct health-care education to include issues related to the LGBT population within care curricula (Obedin-Maliver et al., 2011). Gurney (2011) advanced that nursing students must have contact with LGBT patients to enhance cultural competency in the future care extended to individuals of this community.

The exclusion of, or limited training on, LGBT issues within nursing education affects every level of society, LGBT individuals, and the nursing profession as a whole.

Academically, the quality of nursing education may be critically scrutinized by other professions and dismissed as inadequate to meet the health-care needs of any marginalized or minority group. Most importantly, the lack of well-structured nursing education affects global, national, and local legislation related to the discrimination, prejudice, and physical harm directed to LGBT individuals (Plöderl et al., 2013). Moreover, the limited information on the LGBT population within basic nursing curricula and syllabi introduces adverse emotional and psychological problems to members of this community. Conflict between LGBT patients and nursing professionals can also have an undesirable outcome (Burton, Marshal, Chisolm, Sucato, & Friedman, 2013).

Rationale

A presidential memorandum, as well as and the Centers for Medicare and Medicaid Services, recommended that hospitals be required to demonstrate policies discouraging discrimination in patient visitation (*Human Rights Campaign,* 2011; USDHHS, 2011b). The Joint Commission (2011), an independent, nonprofit accrediting and certifying organization for health-care organizations and programs within the United States, now mandates nondiscrimination policies and standards. Health-care providers are expected to provide culturally competent care to all LGBT patients.

The Association of American Medical Colleges Group on Student Affairs and the Association of American Medical Colleges Organization of Student Representatives (2007) provided detailed training to assist health-care providers to effectively communicate with LGBT patients on matters of sexual orientation and gender identity. It is critical to understand how the LGBT population is represented and portrayed within mainstream obstetrical-nursing courses, curricula, textbooks, and syllabi. This current

study supports mainstream nursing programs as they work to meet various accreditation requirements. The goal of the research was to contribute to positive change in the training of health-care providers surrounding the care and treatment of the LGBT population. The purpose of the study was to examine the manner in which the LGBT population is represented and portrayed within mainstream obstetrical-nursing courses, curricula, textbooks, and syllabi.

Definitions

The LGBT population has been defined in various ways, which illustrates the challenging nature of an all-inclusive definition; however, related literature often uses the phraseology of gender or sexual minority (Kaiser Permanente, n.d.). In this current study, LGBT individuals are described by their sexual orientation. Members of this community come from a variety of cultural, social, and education backgrounds. It is difficult to determine the number of LGBT individuals within the United States because the majority of state and national surveys do not contain questions related to sexual orientation and gender identity (USDHHS, 2011a).

The following terms were used throughout this study and are defined for purposes of the research:

Associate degree in nursing: A 2-year academic-degree program within U.S. community colleges or nursing schools (American Association of Community Colleges, n.d.).

Biphobia: The fear and hatred of bisexual individuals (Irving, 2013; Nagoshi, Adams, Hill, Brzuzy, & Nagoshi, 2008).

Bisexual: An individual who is sexually, physically, and emotionally attracted to both genders (Durso & Meyer, 2013; Tong, Lane, McCleskey, Montenegro, & Mansalis, 2013).

Gay: Individuals with sexual feelings and attraction to members of their same sex (Collier, van Beusekom, Bos, & Sandfort, 2013; Heck, Flentje, & Cochran, 2013).

Heteronormativity: The belief that the only "normal" sexual orientation is heterosexuality (Röndahl, 2009a, 2011; Surtees & Gunn, 2010).

Heterosexual: An individual who is sexually, physically, and emotionally attracted to the opposite sex (Ross & Dobinson, 2013).

Lesbian: A female who is sexually, physically, and emotionally attracted to another female (Ross & Dobinson, 2013; Thomas, 2013).

Queer: A very publicly deployed identity in opposition to the normative (i.e., *straight*) culture and often associated with the attempt to change mores and social systems (Heck et al., 2013).

Same-sex cultural competency: The practice of creating an atmosphere of sincerity and collaboration with all patients. This can include changing forms to reflect LGBT sexual orientation, displaying same-sex pictures in waiting areas, educating staff on the LGBT culture and practice, restructuring confidentiality policies, and including questions of sexual orientation in patient interviews (Kevan & Weerakoon, 2010; Obedin-Maliver et al., 2011; Röndahl, 2009b; Tong et al., 2013).

Transphobia: The fear and hatred of transgender individuals (Irving, 2013; Nagoshi et al., 2008).

Significance and Research Questions

LGBT health concerns run parallel to those of other populations. If identification as a member of the LGBT community had no impact on the manner of treatment within the health-care system, related research would present solely academic interests. However, both research and experience has clearly evidenced that LGBT patients encounter considerable challenges with access to quality medical care (Elia & Eliason, 2010; Röndahl, Bruhner, & Lindhe, 2009). The significance of research related to the LGBT population that is focused on strategies toward achieving equitable health-care services cannot be underestimated. Health disparities within the LGBT population must be perceived in light of those experienced by other communities. LGBT individuals may also belong to other subpopulations. An African-American gay man may experience health disparities common to African-American males as well as those common to LGBT males (IOM, 2011).

Health-care providers must be adequately prepared for culturally competent practice. As long as society excludes the LGBT population from the definition of families, same-sex partners will be barred from access to health insurance designed for families. Any standardized national and private health forms must include different gender identities and sexual orientations. As a facet of health-care education, health-information technology must be modified to allow LGBT individuals to receive health services following a gender change. For example, a transgender woman, living as a man, will continue to need a cervical exam by an obstetrician. Curriculum must be updated to include these care needs (IOM, 2011; Joint Commission, 2011).

A fundamental and critical issue with lesbian and gay patients is withholding their true sexual orientation and other pertinent information due to past experiences with prejudice from health-care providers. Such lack of disclosure could result in detrimental consequences, not only to chronic illness but also to the care health providers are able to provide. However, due to internalized stigma, these patients may be unwilling to attend to their health-care needs and/or view themselves as undeserving of competent care, resulting in their compliance with discriminatory policies and practice (Kelley, Chou, Dibble, & Robertson, 2008; Makadon, 2011). Consequently, a significant need exists for additional research focused on resolving the limited information on the LGBT population within basic obstetric-nursing curricula, textbooks, and syllabi. To facilitate communication with health-care providers, legal and regulatory safeguards are needed for LGBT individuals to feel safe in revealing their sexual orientation and/or gender identities (Ali, 2013; USDHHS, 2013).

This study was conducted with the aim of determining how nursing schools within New York City that offer an associate degree in nursing incorporate health-care topics into their obstetrical-nursing education that relate to the LGBT population. The following research questions guided the study:

1. How is the LGBT population represented in obstetrical-nursing curricula, textbooks, and syllabi?

2. How do obstetrical-nursing faculty incorporate LGBT health issues into their teaching?

3. How do obstetrical-nursing students perceive their preparation by nursing schools to care for LGBT patients following graduation?

Review of the Literature

Overview

Kaiser Permanente (n.d.) reported that approximately 19% of patients under the care of any given health practitioner are members of the LGBT community. The specific care needs of this population differ enormously from those of heterosexual patients. Compared to other populations, LGBT women are least likely to have mammogram examinations and most likely to delay evaluation for needed medication. Transgender African-American women have a significantly high rate of diagnosed HIV and diabetes (Krehely, 2009; USDHHS, 2013).

Considering that a health-care environment wherein LGBT individuals are not embarrassed to disclose their sexual identity while seeking medical care is the ideal, then the existing gap between ideal and actual is vast. This disparity has been created by an assortment of social forces including homophobia (Agency for Health-Care Research and Quality, 2011). This current research was therefore designed to find an equally powerful social force to change this attitude. The goal underlying the study was to contribute to such change via the training of health-care providers on the care and treatment of the LGBT population. As a qualitative, intrinsic case study, this research addressed the local problem through a comprehensive investigation of the inclusion of LGBT care issues and their portrayal within nursing education. The findings enable an in-depth explanation of factors that may not otherwise emerge from an examination of solely quantitative data.

Homosexuality has been a documented practice for millennia with social, legal, and religious implications that have introduced stigmas, prejudice, discrimination, and stereotyping (Costa, Bandeira, & Nardi, 2013). During the 1950s and 1960s, the

homosexual community experienced periods of growth in social acceptance. Homosexuality has been decriminalized on an international basis. Riots and protests have brought awareness to the earlier inequity and social stigmatization (Brennan-Ing, Seidel, Larson, & Karpiak, 2013).

The purpose of the current study was to examine the manner in which the LGBT population is represented and portrayed within mainstream obstetrical-nursing courses, curricula, textbooks and syllabi. To identify relevant literature, the Walden university library databases were searched for the following key terms: *homosexual, LGBT, nursing student, LGBT health disparity, health care, nursing education, obstetrical, medical, curriculum, obstetrical nursing, medical education, LGBT statistics, nursing faculty, LGBT syllabus, LGBT rights, LGBT definition, lesbian, gay, transgender, bisexual,* and *transsexual.* In accordance with the philosophical assumptions of an advocacy or participatory worldview (Creswell, 2009; Lodico, Spaulding, & Voegtle, 2010), several theoretical perspectives were intertwined to discuss the issues encountered within LGBT communities and recommended steps toward positive social change.

An emancipatory worldview grounded this research because this perception supports the notion of freedom from the constraints and unfair organizations that bar individuals from their life purpose and ultimate personal growth (Creswell, 2008, 2009). The approach is self-freeing from the restriction of media, society, language, labels, and other processes of marginalization (Lodico et al., 2010; Merriam, 2009). An emancipatory worldview calls for debate, discussion, and practice that are conducive to positive change (Creswell, 2009; Lodico et al., 2010; Merriam, 2009). Critical theory was integrated into the study with this philosophical assumption.

Critical theory applies knowledge from the humanities and social sciences to critically assess a society or culture (Kellner, n.d.). To critical theorists, such as Jürgen Habermas, Theodore Adorno, Walter Benjamin, Herbert Marcuse, and Max Horkheimer, social organizations and scientific processes repress, marginalize, and control individuals (Corradetti, 2011). Critical theory facilitates analysis of the societal inconsistencies that withhold power and information from selected members of society by examining the respective social practice, its historical background, and related interpretations (McLaughlin, 1999). Jensen (1997) opined that the definitive goal of related critical theory is to alter society into a fair, balanced, humanitarian, and reunited culture. The construct discourages overspecialization of education and a controlling society. It also encourages rebellion in opposition to all types of prejudice including those grounded in religious belief, sex, and race.

Critical theory protects the ethical principles of worldwide justice while supporting the creation of a social balance between personal autonomy and collective societal cohesion. The construct facilitates study of the development and composition of cultural forms to bring social change. It tests notions of realism and reveals the social construction of ideas and opinions. Critical theory is reflexive in nature, meaning that reality, ideas, and perceptions are controlled by the philosophy, authority, and hegemony of the respective society. For critical theorists, power and economic, political, and social realities are controlled by the capitalist elite; that is, the schools, churches, and media (Seiler, n.d.).

Critical theory is used as an inclusive construct to explain other theories. In literary studies, it is the interpretation of texts. In critical social theory, it is applied to

explain and change the culture of a society that restricts and entraps its people. Critical social theory applies to the major social sciences to enhance understanding of the respective society (Bressler, 2007).

Societal Challenges

Up until 1973, when the American Psychiatric Association removed the term *homosexuality* from the *Diagnostic and Statistical Manual of Mental Disorders,* this orientation was described as a sexual deviation (Heck et al., 2013; Meyer-Bahlburg, 2009). In 1952, homosexuality was defined as "a kind of pathological performance, such as sexual sadism, homosexuality, fetishism, transvestitism and pedophilia, including mutilation, rape and sexual assault" (Aggrawal, 2008, p. 47). In 1992, homosexuality was classified as an ego-dystonic disorder, rather than a mental illness, by the World Health Organization (as cited in Waidzunas, 2013). The USDHHS (2000) stipulated that one of the demographic issues affecting health disparity is sexual orientation. According to the USDHHS, mental health and safety can be jeopardized by personal, societal, and familial sexual identity.

U.S. society continues to perceive homosexuality as taboo and morally wrong. The LGBT community is highly stigmatized and encounters overt discrimination (Alves et al., 2012). The women's liberation movement and LGBT liberation groups have fought for their civil liberties (Wolf, 2009). The LGBT rights movement, the AIDS crisis in the 1980s and 1990s, and the feminist movement have exposed the challenges of the LGBT community. These include legal discrimination in accessing health insurance, employment, housing, marriage, adoption, and retirement benefits; lack of laws protecting against bullying in schools; and a lack of social programs appropriate for

LGBT youth, adults, and elders (Costa et al., 2013; Hatzenbuehler, Phelan, & Link, 2013).

In 2007, the American Red Cross and the American Association of Blood Banks recommended that the U.S. Food and Drug Administration reconsider its policy regarding the prohibition of blood donations from homosexual males. However, the agency refused to amend the policy (Vamvakas, 2009a, 2009b). The USDHHS (2013) acknowledged the health challenges of the LGBT population. This is very important because, in other versions of *Healthy People,* only the health issues of lesbian, gay, and bisexual individuals were identified; those of the transgender population were excluded. Recently, the American Association of Medical Colleges (2008) and Kaiser Permanente (n.d.) recommended amending health-care curricula and syllabi. The inclusion of how health-care providers should care for, and communicate with, LGBT populations was suggested (Snowdon, 2010).

Although the visibility of the LGBT population has increased, an understanding of their health issues remains limited. Widespread discrimination, ignorance, and insensitivity have become the norm within most health-care facilities. Health-care practitioners have deliberately refused to treat LGBT individuals (Haley-Bailey, Adams, Dickson, Hitter, & Luna, 2012). Researchers have found three major barriers inhibiting the delivery of primary and preventive health care to lesbian and bisexual women (Gurney, 2011). These barriers are (a) deficits in physician understanding of, and compassion toward, health issues specific to the lesbian population; (b) physician unwillingness to question women with regard to their sexual orientation; and (c) a reluctance among LGBT patients to divulge their sexual orientation. To provide

culturally competent care to this population, health-care providers must recognize and rise above these barriers to the provision of routine health care and increase effective communication with these patients.

The Kinsey Institute (n.d.) reported that, during the 1940s and 1950s, 12,000 men and women were surveyed across the United States and 4% of the men identified as exclusively homosexual while only 1% of the women responded with this identification. The U.S. Census Bureau (2000) found that, of 105.5 million households within the country during 2000, 5.5 million were headed by unmarried partnerships; 595,000 of these unions were same-sex partners. However, statistics related to the homosexual community have not been well investigated within the United States (Makadon, 2011).

An urgent need exists for change in antidiscrimination legislation and education addressing the LGBT population. The lack of training in related issues has created insensitivity to the basic needs of these individuals. An unwillingness to even address transgender people by a pronoun preferred within their community is evident (Surtees & Gunn, 2010). The majority of health-care practitioners are not knowledgeable in addressing the health-care needs of the LGBT cohort, especially in areas related to HIV prevention, hormone use, and gynecological care (Eliason, Dibble, DeJoseph, & Chinn, 2009). Greater practitioner exposure to the health needs of the LGBT patient population may remarkably ameliorate the described scenario. Equipping clinicians supporting LGBT clients with substance-abuse and mental-health problems with the same knowledge may increase the cooperative nature of their relationship with clients, particularly the transgender members of this community. This approach may facilitate the identification of gender concerns unconnected to ongoing treatment for substance abuse

or mental health because there are incidents when a connection exists between them; however, this is not always the case (Irving, 2013).

Broader Problem

Training and formal education on the health needs of LGBT patients have been minimized by a lack of resources and training tools; however, recent gains have been realized. A number of sources, such as individual trainers, foundations, professional associations, government agencies, and health-care organizations have developed critical tools and data that can be effectively integrated into training curricula and other models. Trainers knowledgeable in LGBT issues are needed in the areas of policy and legislation (Strong & Folse, 2013).

Gender identity has become a major focus of various media and a frequent topic of research. This attention is not only due to the rampant discrimination sourced in sexual orientation, but transgender individuals also suffer from discrimination rooted in their gender that extends to their access to quality health-care services. The LGBT community has historically been oppressed by American society, which has resulted in untold challenges to their well-being (Irving, 2013). Youth who are LGBT and homeless are particularly vulnerable to discrimination based upon their gender identity or sexual orientation. Health practitioners are insufficiently trained to adequately serve this cohort. This has been reported by LGBT youth, social workers, and the health practitioners themselves in prior study (Hatzenbuehler et al., 2013). Practitioners have asserted a lack of background in gender identity and sexual-orientation issues that would enable them to serve LGBT patients with professionalism and competence (Eliason et al., 2009).

Researchers have suggested that health issues, such as substance abuse, cancer, mental-health disorders, and HIV/AIDS, are common among gay men and lesbians (Snowdon, 2010). Snowdon (2010) reported that this population has experienced gains in protection and equity against bias; however, related literature has indicated that critical "bottlenecks" in health-care access remain. Boehmer (2002) reported that while studies on the LGBT population have increased, only 0.1% of all research funding is devoted to such investigation.

Health care. Although a significant reduction in prejudice against the LGBT community has been evident since the 1980s, such bias has not been eradicated. Siegel (2012) indicated that 33% of physicians continue to disagree with same-sex marriage and 42% will not allow students with HIV into medical school. Additionally, 66% of surveyed physicians will not refer their patients to a general surgeon diagnosed with HIV.

With the increase in related legislation and public support of the LGBT community, studies are emerging that support the eradication of health disparity among this population (Altman et al., 2012). Supportive legislation has been enacted internationally. U.S. laws now decriminalize sodomy, legalize same-sex marriages, provide similar rights to same-sex partners as their heterosexual counterparts, and allow LGBT members to serve openly within the armed forces (Devins & Mansker, 2010; Moyer & Castello, 2010). However, according to Glass, Kubasek, and Kiester (2011), homosexuality continues to be considered immoral by most Americans.

Attitudes toward LGBT populations are beginning to change across the globe (Sidibé, 2010). In Latin America, Brazil, and India, laws protecting the rights of LGBT individuals have been enacted. However, other countries continue to pass laws that

criminalize homosexuality and encourage homophobia and discrimination (Asal, Sommer, & Harwood, 2013). LGBT populations within Iran and Nigeria encounter open discrimination and violence from the government and citizens. Ultimately, homosexuality within these regions is punishable by death (Altman et al., 2012; Hawthorne, 2013).

Health disparity. It is not surprising that LGBT individuals procrastinate when medical attention is needed, or completely avoid the health-care system due to fear of discrimination. As reported in a study commissioned by the LGBT Health Access Project and conducted by John Snow, Inc. (2009), only 8% to 11% of LGBT individuals sought care within LGBT-identified health settings during 2006; hence, 90% sought care within conventional health-care systems (Clark, Landers, Linde, & Sperber, 2001). It is possible that those seeking medical attention within LGBT-identified settings were refused health care or received substandard care from conventional systems and practitioners uncomfortable with attending to their health needs (Kaiser Permanente, n.d.).

Earlier studies within Canada and the United States have identified excessive discrimination against the LGBT population within health-care systems (Obedin-Maliver et al., 2011). Surveys of LGBT patients have revealed adverse communication from health-care providers such as verbal and emotional abuse, refusal of medical treatment, rude behavior, and inadequate treatment (Sears, 2009). This type of discrimination encountered by senior members of this cohort discourages junior members from accessing the health-care system. Both personal and structural barriers are common. Personal barriers involve the attitudes of health-care providers from heterosexism to homophobia to heteronormativity. Structural barriers involve institutionalized policies

and procedures contributing to the lack of access to health insurance and knowledgeable practitioners.

The most fundamental and striking feature of the LGBT cohort is the continued lack of disclosure surrounding their sexual orientation. This scenario can have detrimental consequences, not only in particular areas such as treating sexually transmitted diseases (STDs), but also in limiting clinician ability to comprehend factors affecting the overall health of these patients. The practice also exacerbates a continuing bias against LGBT individuals among health-care clinicians. Although the American Medical Association supports the use of nondiscrimination guidelines for all health-care providers and facilities, 70% of the transgender population and 56% of LGBT individuals have experienced some form of prejudice from within the health-care arena (Khan, 2011). A 1991 survey of health practitioners within San Francisco, California indicated that 30% of the respondents viewed homosexuality as a threat to most social institutions (Ponce, Cochran, Pizer, & Mays, 2010). The participants also asserted that they would feel nervous within a workplace of homosexual colleagues or patients.

LGBT couples and their families are more likely to be uninsured for health care than their heterosexual counterparts (Institute of Medicine, 2011). This contributes to the limited access to care and health disparity within this population. U.S. laws precluding same-sex marriages may also act as a structural barrier to health care with harmful effects on the health of LGBT individuals. Insurance companies currently provide coverage to same-sex married partners and families, leaving unmarried LGBT couples and their families uninsured or underinsured. However, recent legislation allowing LGBT individuals the same rights as their heterosexual counterparts is beginning to reduce the

problem. For instance, employers are changing their health plans to include treatment related to gender transition. In 2008, the American Medical Association supported an end to the discrimination of transgender people by barring the withholding of health-insurance benefits (Khan, 2011). Furthermore, the Affordable Care Act will improve access to health care for all U.S. citizens including the LGBT community (USDHHS, 2011a, 2011b).

Studies have found that the LGBT population is generally stigmatized, discriminated against, and denied their natural and civil rights, as well as underserved within the health-care arena. Such treatment has been associated with myriad acute and chronic diseases prevalent within this population. The result is increased psychiatric disorders, suicide, cancer and substance abuse, and other serious and debilitating health and social issues (Addis, Davies, Greene, MacBride-Stewart, & Shepherd, 2009).

Differences between the manner in which the LGBT cohort and the general population utilize health facilities hold various implications for health-care practitioners The LGBT population experiences adverse mental and physical health but engages in limited personal health-care activities (IOM, 2011). They are likely to smoke, drink excessively, and sustain an overweight status. Unlike their heterosexual counterparts, lesbians may not be screened or receive cancer-prevention care; additionally, lesbians are frequently obese or overweight (Krehely, 2009). LGBT individuals are 44% more likely to struggle with alcoholism than the general population and frequently use illicit drugs (Dilley, Simmons, Boysun, Pizacani, & Stark, 2010). Studies have indicated an even worse scenario with gay men because the abuse, coupled with unsafe sex, can lead to the rapid spread of HIV/AIDS. Cochran, Mays, Alegria, Ortega, and Takeuchi (2007) found

that 30% of gay men consent to unprotected sex while under the influence of drugs or alcohol.

As a result of prejudice from health-care practitioners, lesbians may not take preventive measures and obtain early interventions such as breast examinations and PAP smears (Struble, Lindley, Montgomery, Hardin, & Burcin, 2010). Of all lesbian and bisexual women, 52% are less likely to receive mammograms than heterosexual women (Krehely, 2009). Transgender individuals have a higher incidence of STDs and AIDS, as well as increased rates of violence and victimization. This population is also more likely to present with mental-health problems and attempt suicide than heterosexuals and is not likely to carry health insurance (National Gay and Lesbian Taskforce, 2009).

Ibañez, Van Oss Marin, Flores, Millett, and Diaz (2012) found that older LGBT individuals frequently encounter culturally incompetent health-care providers and inadequate social services, which often leads to seclusion. Regardless of consistent research and advances in medicine and science toward containing and treating HIV, the disease continues to threaten the public health of U.S. citizens and populations around the world. Researchers have found that men who have sex with other men tend to have increased rates of the disease (Agency for Health-Care Research and Quality, 2011; Lim, 2013).

Obstetrical care. A growing number of lesbians are receiving obstetrical care. Care outcomes for this population of women and their infants are affected by their experiences during pregnancy and childbirth with regard to the attitudes and actions of health-care providers. Studies have shown that health-care results for lesbians are

improved when health-care providers comprehend, and are sensitive to, their unique needs as lesbians. Due to the donor insemination of the 1980s, a "baby boom" has ensued among this population (Bos, Gartrell, Peyser, & van Balen, 2008; Johnson, 2012).

The 2008 American Community Survey and the 2000 U.S. Census both revealed that an estimated 564,743 same-sex couples were residing within the United States. Among these partnerships, approximately 30% were lesbian couples and 17% were gay couples, all raising children. In 2001, it was estimated that between 12% and 35% of lesbian women had children (Bos et al., 2008), and a significant and growing number of LGBT women were having children, adopting, or caring for foster children (van Gelderen, Gartrell, Bos, & Hermanns, 2012). Over 4% of all U.S. adoptions were initiated by gay and lesbian individuals, and nearly 3% of all children in foster care across the country are parented by this population. Approximately 2 million children are living within families headed by LGBT parents (Gartrell & Bos, 2010).

Lesbians and bisexual women have more diverse health needs than gay men. They may encounter the same problems in their interaction with health-care providers that are reported by heterosexual women; however, they often prefer lesbian gynecologists or other nontraditional care providers or evade care entirely (Hayman, Wilkes, Halcomb, & Jackson, 2013; O'Shea, 2009). Studies have shown that, although the obstetrical care of lesbians has progressed in a positive fashion, negative experiences continue to be reported by this cohort as they seek care within this medical specialty. They still encounter physical and verbal abuse, as well as inappropriate information seeking by health-care practitioners.

Researchers have found that lesbians also have adverse experiences within maternity care that involve poor communication, exclusion and invisibility, and homophobia (Krehely, 2009; Lee, Taylor, & Raitt, 2011). As a result, lesbian couples have reported treatment that is different from that of heterosexual couples, involving verbal abuse and refused access to prenatal care. Lesbians frequently feel defeated by the heteronormative assumptions of the health-care system (Hayman et al., 2013). Midwives and nursing staff communicate that heterosexuality is the norm from antenatal to postnatal care. Rigid instructions surrounding visiting hours and the physical environment of obstetrical clinics, created by health brochures, posters, and commercials, support solely heterosexual couples.

Important advances in health technology have emerged along with the growing incidence of obstetrical-care needs among the LGBT community. LGBT men and women progress through the process of obstetrics in the same manner as their heterosexual counterparts; they conceive, gestate, and deliver. They also endure the process of bereavement following loss of a fetus. Although this population does not represent societal norms, obstetrical nurses must strive to provide an obstetrical experience free of prejudice and discrimination.

Curriculum. The time dedicated to topics related to the LGBT population during medical training conducted in the 2009-10 school year was minimal (Obedin-Maliver et al., 2011). Deans of allopathic and osteopathic medical schools within Canada and the United States were surveyed on the inclusion of LGBT issues in medical-school curriculum. Of the total sample, 49.5% of the respondents rated their curriculum as *fair* and 19.3% selected ratings of *poor* or *very poor* (Strong & Folse, 2013).

Public-health schools offer planned curricula and syllabi that address broad health requirements; however, their programs do not recognize the exceptional and diverse concerns of the LGBT population (Röndahl, 2011). Kelley et al. (2008) reported that 41% of such schools within the United States have no ongoing research related to LGBT health. Existing studies are primarily related to HIV and AIDS. Fewer than 10% of these public-health institutions have reported a student completing a doctoral dissertation on LGBT health. Less than 9% of the schools offered a course within the preceding 2 years that covered LGBT health topics extending beyond HIV and AIDS. Furthermore, research has shown that 77% of teachers discourage classroom discussion on homosexuality, and 85% of educators are opposed to integrating gay and lesbian content into their curriculum (Roffman, 2000).

During the 2009-10 school year, medical schools across the United States and Canada devoted minimal time to LGBT health-care content. Similarly, nursing schools did not ensure their students were cognizant of the health-care needs of the LGBT population (Obedin-Maliver et al., 2011). Researchers have indicated that nursing students exhibit a high incidence of homophobia and biphobia (Röndahl, 2009b). Röndahl, Innala, and Carlsson (2007) reported that 36% of the nurses and nursing students they surveyed responded that, if they have the option, they would not provide nursing care to an LGBT patient. Some of these participants cited inadequate training to properly care for this patient population.

U.S. medical schools are now addressing LGBT issues within their curricula and syllabi. Governing and accreditation bodies within the health-care industry, such as the IOM, the American College of Physicians, the Joint Commission, the American Medical

Association, and the Association of American Medical Colleges, have formed committees and/or published policies supporting eradication of this disparity (Kristen, 2010). As a result, discrimination of the LGBT population within the health-care education arena has virtually ended, providing safe environments for LGBT faculty and students and supporting the inclusion of LGBT issues within medical curriculum (Snowdon, 2010). However, experts of LGBT studies speculate that, if not handled well, the inclusion of such issues within medical curricula and syllabi may be insufficient to teach students about LGBT issues. This would serve only to cause confusion and contribute to the continued stereotyping of LGBT individuals. Conversely, Dudzinska-Przesmitzki and Eichler (2010) opined that integrating LGBT content into health-care curriculum with well-planned procedures will reduce homophobia among care providers and decrease their discomfort with providing health care to this population.

The limited information related to LGBT individuals within basic obstetric-nursing curricula and syllabi is a problem within the field of education and learning environments because it illustrates that diversity is inadequately taught within nursing schools. Nursing professionals are insufficiently trained to competently care for the LGBT community (Fish, 2010). Researchers have shown that basic nursing-education curriculum excludes substantial information surrounding the care, health issues, and needs of these patients and their families (Axtell, Avery, & Westra, 2010). Basic nursing curriculum concentrates primarily on care extended to the traditional nuclear family and extended family members. Nursing professionals are therefore not knowledgeable on the culture of the LGBT population. Consequently, within clinical settings including obstetric

care, the support of nursing professionals is often inadequate to meet the needs of these patients (Axtell et al., 2010; Chapman et al., 2012).

To combat exclusion within the health-care arena, as well as the limited knowledge of medical professionals with regard to the LGBT community, training on issues important to this patient population is critical. Kitts (2010) and Snowden (2010) have suggested that schools provide core curricula and syllabi pertaining to the LGBT community, offer related professional-development sessions, hire LGBT faculty, institute nondiscrimination policies, and form LGBT student groups. Similarly, notable scholars have suggested including LGBT issues within nursing curriculum; increasing the publication of related nursing articles and other research; adding the input from LGBT individuals to the protocol, policies, and procedures of health-care institutions; updating nursing textbooks to incorporate this topic; and conducting focus interviews and patient education on LGBT maternity-care issues (Eliason, Dibble, DeJoseph, 2010; Hayman et al., 2013). The Joint Commission (2011) recommended that the training of health-care practitioners include LGBT history, demographics, terminology, and background; general barriers to care; clinical issues; and resources for follow-up learning (pp. 7–19).

Implications

The findings of this current study are expected to contribute to positive change in the education of obstetrical-nursing professionals. The research may support nursing educators as they train nurses to extend culturally appropriate care to all patient populations. Stakeholders actively involved in implementing such change are state boards of nursing within various states, state education departments, national certifying and licensing organizations, accreditation bodies such as the combined Commission and the

National League of Nursing, nursing editors and scholars, nursing educators, and the Association of Women's Health Obstetric and Neonatal Nurses.

Obstetrical-nursing textbooks, curricula, and syllabi must be examined for potential modification. Such changes will affect the practice of obstetrical care providers, related institutional policies and procedures, obstetrical licensing and certification examinations, and obstetrical-nursing education. Modification may motivate additional study on a greater number of LGBT issues within the nursing profession (Graham, Bradford, de Vries, & Garofalo, 2011). To encourage this positive outcome, obstetrical-nursing textbooks and curricula, as well as the syllabi of nursing schools, could be revised to include LGBT history, definitions of related terminology, health issues common to this population, and the obstetrical needs of the LGBT community. Clinical curriculum could be modified to train obstetrical nurses in effectively communicating with LGBT obstetrical patients, avoiding heteronormative assumptions surrounding obstetrical patients, and acknowledging and recognizing the obstetrical needs of LGBT patients. The findings of this study may encourage obstetrical faculty to discuss and critically analyze the social and health issues of the LGBT community within both classroom and clinical settings (Röndahl, 2009b, 2011; Strong & Folse, 2013).

Summary

Global research has documented the ongoing marginalization, discrimination, and violence encountered by the LGBT population (Chapman et al., 2012). Many facets of society infringe upon the rights of these individuals, claiming the LGBT lifestyle violates social order and morality. Thus, myriad negative traits are attributed to LGBT individuals due to their lifestyle and sexual orientation. Research has indicated that, as a result of this

negative societal treatment, LGBT individuals are reluctant to disclose their sexual orientation, especially to health-care practitioners (Gurney, 2011). Consequently, innumerable acute and chronic diseases are presented within the health-care arena by the LGBT population.

Studies have indicated that health-care practitioners are inadequately prepared to effectively care for LGBT patients (Bleakley, 2013). Basic nursing-education curriculum excludes substantial information surrounding the care, health issues, and needs of these individuals and their families. Within the maternal-child health specialty, obstetrical nurses are beginning to recognize the health-care needs of this population; however, they continue to inadequately meet those needs. The findings of this current study support conventional nursing programs as they work to meet various accreditation constraints. The research may contribute to affirmative transformation of the education of health-care providers, as it relates to the care and treatment of the LGBT population.

The purpose of this study was to examine the manner in which the LGBT population is represented and portrayed within mainstream obstetrical-nursing courses, curricula, textbooks, and syllabi. The study was grounded in the philosophical assumptions of advocacy and a participatory and emancipatory worldview integrated with critical theory. The goal of the research was to contribute to positive social change superseding the unfair, unbalanced, and unethical societal norms that impede self-actualization for LGBT individuals. The research design and approach of the study are detailed and the selected case and participant-recruitment method implemented are described. The data collection and analysis are discussed, as are the strategies expected to ensure dependability of the study.

The results of this study are reported and a workshop will be designed and proposed to train obstetrical educators. Teaching methodologies will be designed that are conducive to adults from varying education and development backgrounds, as well as different cultures (see Appendix A). The project will be grounded in the Knowles andragogy principles and the New York State Department of Education (2011) professional teaching standards (PTS). A researcher self-analysis is presented and the strengths and limitations of the study are acknowledged. Recommendations for remediation of the study limitations, as well as the potential impact of the research on social change, are provided. The development and evaluation of the study are discussed along with the implications, applications, and direction for future research.

Section 2: The Methodology

A goal of this study was to contribute to positive change in the training of health-care providers surrounding the care and treatment of the LGBT population. The purpose of the research was to examine the manner in which the LGBT population is represented and portrayed within mainstream obstetrical-nursing courses, curricula, textbooks, and syllabi.

Research Design and Approach

Research is distinguished by two models of study—deductive or inductive (Lodico et al., 2010). The deductive approach, commonly known as the *top-down approach,* is applied to draw specific conclusions based upon a broad theory. The theory leads to forecasts surrounding likely occurrences. Conversely, the inductive approach, also known as the *bottom-up approach,* facilitates the observation of a particular phenomenon and subsequent conclusions (Creswell, 2009; Lodico et al., 2010). This current study involved an inductive approach with the intent to comprehensively, holistically, and naturalistically examine the research questions. Subjective information was used to reveal other unforeseen variables and innovative constructs. Unstructured interviews addressed sensitive questions to explore new areas of research and create innovative theory.

The approach selected for this study has been tested and found to be effective for education research. Creswell (2009) noted that, given the objectives and nature of a research study, several strategies can be implemented. A research strategy, as a general plan, governs the manner in which research questions are answered, the sources from which the data will be gathered, and the difficulties that can be expected during the

process. A strategy may, for example, be experimental, a case study, ethnographic, cross-sectional, exploratory, or descriptive in nature. It may involve a survey. Of the designs discussed by Creswell, case study was the most appropriate for the current research. This design focuses on a specific case (e.g., a group or organization), and the case itself is the primary focus of the research, which is exploratory in nature. More specifically, an intrinsic case study is guided by the interest of the researcher and does not intend to generate new theory or generalize across cases. Consequently, an intrinsic case-study approach was selected to guide this research.

The aim of an intrinsic case study is to gain new information on a specific individual, group, event, or organization. Such study does not seek to generalize broad-based research findings. This study examined how the LGBT population is represented and portrayed within mainstream obstetrical-nursing courses, curricula, textbooks, and syllabi. Case studies can combine the characteristics of both qualitative and quantitative research. One of the most important elements of such study is that it applies a holistic approach to explain the major issues of a case in a real-life context. Toward this end, the modes of collection will vary and generalizability of the results is not a goal (Hancock & Algozzine, 2006). Case studies tend to present powerful internal validity because they provide in-depth, thick descriptions. However, they also present poor external validity due to the study of outlier cases on an individual basis (Creswell, 2008; Hancock & Algozzine, 2006).

A case-study approach was appropriate for the current research because, unlike experimental or quasiexperimental approaches, such a design enables a full understanding of how and why a research intervention is successful or unsuccessful based

upon a specific case. In contrast, quasiexperimental research is used to draw causal comparisons between nonrandom existing groups, and experimental research assigns interventions to study random groups. Perry (1998) noted that qualitative research produces understanding and insight, while quantitative research generalizes insight targeted to the population of interest. Which method is adopted depends upon the respective advantages. Researchers opt for quantitative research when statistics, surveys, and experimental designs are desired for rigor and academic objectivity (Creswell, 2009; Lodico et al., 2010). Neuman (1997) asserted that, in qualitative research, no statistical processes are used to analyze data. Creswell (2009) advanced that qualitative research provides a greater theoretical contribution, but with certain disadvantages, such as the exclusion of meaning and purpose, which precludes an understanding of human behavior.

Setting and Sample

Obstetrical-nursing faculty and students from one nursing school comprised the sample in this study. Much is learned from one case; however, the findings may not be generalizeable to a larger population. The study site was an urban, private nursing school located in the northeastern region of the United States. The setting for the study was a school that offers a combination of classroom theory and laboratory practice, supervised within a diversity of health-care facilities. The nursing curriculum includes instruction in the foundations of nursing concepts, pharmacology, obstetric and neonatal nursing, nutritional therapy, and microbiology for health-related sciences, as well as professional trends in nursing. Related research and evidence-based practice, legal and ethical issues, and economical and political issues germane to the profession are also addressed in the nursing program.

Students enrolled in the study site of this research ranged in age-group, ethnicity, and gender. The institution offers remedial services, academic/career counseling, and placement services for graduates. Students are eligible for federal aid, state grants, and direct loans. The school is registered by the State Board of New York. Upon completion of an associate degree, students are eligible to take the exam for licensure (i.e., for a National Council Licensure Examination-Registered Nurse). Graduates from this school of nursing are widely and gainfully employed throughout New York and other states. A permission letter was obtained from the school prior to initiation of this study (see Appendix B).

Interview data were collected from the nursing-school directors and the obstetrical-nursing faculty or adjunct faculty involved in the didactic and clinical obstetrical instruction of the study-site institution. The participating students were enrolled in the school and had completed or were in the process of completing an obstetrical-nursing course. The study sample was recruited by placing an ad in the school newspaper and on the school billboard, as well as on social Web sites, describing the research and requesting volunteers to participate (see Appendix A).

A purposeful, criterion sample of 15 participants was recruited for this research. Criterion sampling involves the selection of cases that meet set criteria of importance to the study. Such sampling can be valuable for recognizing and comprehending cases with needed information (Creswell, 2008, 2009; Lodico et al., 2010) and the process is cost and time effective. Criteria sampling can facilitate the collection of important data that may not be feasible with probability sampling techniques. However, Lodico et al. (2010) cautioned that this method may not generate a representative sample of the target

population, resulting in findings that are not generalizeable to other populations while strong in quality.

The majority of the student participants in this study ranged from 20 to 25 years of age. One half of these students had been enrolled with the study site for three semesters; 63% were enrolled in obstetrical nursing during the third semester. The highest academic level attained by 38% of the sample is high school and 13% hold a bachelor's degree. Of the total sample, 63% are female and 135 identified as Other (see Table 1). The majority of the faculty participants had been teaching at the study-site school for between 1 and 5 years. Those who participated in the drafting of the obstetrical curriculum and syllabi totaled 86% of the study sample. Of all the faculty participants, 57% taught both classroom and clinical obstetric instruction, all were female, and all were between 40 and 49 years of age; 71% hold a master's degree and 29% had earned a doctorate (see Table 2).

Ethical Considerations

A number of ethical considerations exist for research involving human participants. These include whether the researcher could mislead the participants, whether there is a potential for harm to the sample, whether an invasion of privacy is possible, and whether informed consent is an appropriate request (Lodico et al., 2010). In this study, informed consent was a prerequisite. The consent form provided a detailed explanation of the study so each participant could make an informed choice or rational decision as to whether to participate. Permission to begin the research was provided by the Walden University Institutional Review Board (IRB) and the campus president of the study-site school (see Appendix B).

Table 1

Demographics of the Student Participants (N = 8)

Demographic	Percentage of sample
Semesters at the study site	
3	50
4	38
> 4	13
Semester enrolled in obstetrical nursing	
3rd semester	63
4th semester	38
Highest degree	
High school	38
General Education Development High School Equivalent	25
Associate	25
Bachelor	13
Gender	
Female	63
Male	25
Other	–
Age	
20–25	62
26–30	13
31–35	25

To preserve participant confidentiality, names were not used within the study documentation and the specific geographical setting of the research was not revealed. The informal, conversational interviews were approximately 30 minutes in length and audiotaped. Recording the sessions contributed to rich, thick descriptions. All respondents received assurance of utmost confidentiality and a commitment to protect that confidentiality. The heavy schedules of the majority of the participating faculty and students allowed minimal time for the study interviews. This problem was resolved by

Table 2

Demographics of the Faculty Participants (N = 7)

Demographic	Percentage of sample
Years teaching	
1–5	43
6–10	29
11–15	14
> 15	14
Years at study site	
1–5	43
6–10	14
11–15	29
> 15	14
Assisted with drafting of obstetrical curriculum and syllabi	
Yes	86
No	14
Teach classroom or clinical obstetrics	
Both	57
Classroom	29
Clinical	14
Highest degree	
Master's	71
Doctorate	29
Less than master's	0
Gender	
Male	29
Female	71
Other	0
Age	
30–39	14
40–49	57
50–59	15
60–69	14

simplifying the sessions to ensure collection of the required information in the shortest time possible.

To control for bias in this study, reflective notes were recorded by me following each interview. A peer debriefer reviewed the notes and listened to the recorded interviews for any bias. The peer debriefer signed an IRB-approved confidentiality form. The interview audiotapes were transcribed immediately following each session. Each transcript was assigned a number and catalogued with the date and time within a password-protected computer belonging to me. For instance, Faculty 1 was interviewed December 7th at 9:47pm. The transcript was catalogued as *Fac_one127947p.* Student 6 was interviewed December 10th at 10:19am. The transcript was catalogued as *Student_six12101019a.*

Role of the Researcher

As an adjunct professor at the study site, I was an emic insider participating in the nursing program (Creswell, 2009). The terms *emic* and *etic* refer to two differing approaches to the study of individuals or groups. The emic approach involves the viewpoint of an insider, while the etic approach pertains to the perception of an outsider. An emic approach is inductive in nature and considers the perspectives and statements of the research participants. Conversely, an etic approach applies hypotheses, theories, concepts, and viewpoints that are external to the research setting.

As a colleague and member of the school faculty, I easily established trust with the participants. Creswell (2008, 2009) described the qualitative researcher as an instrument of the data collection. The purpose of the study, expectations of participation, the data to be collected, the length of participation, and the assurance of voluntary

participation in the study were clearly explained to all participants, as well as my ability to conduct the study. Member-checking techniques and methodical approaches were included to receive participant feedback related to the data collected and to give the participants an opportunity to ask questions.

The goal behind this study was to investigate how a nursing school within a metropolitan city that offers an associate degree in nursing incorporates health-care topics related to the LGBT population in its obstetrical-nursing education. Toward this end, an assessment was conducted to determine how this population is represented within obstetrical-nursing curricula, textbooks, and syllabi; the various ways obstetrical-nursing faculty incorporate LGBT health issues into their teaching; and whether obstetrical-nursing students are prepared to care for LGBT patients following graduation. No preconceived expectations existed surrounding the results of the data collection. Any pertinent expectations, bias, and assumptions of my own were divulged. As noted earlier, I maintained a research journal of field notes containing any personal reflections and insight from the interviews.

Data Collection

A number of methods were used to collect data in this study to increase the reliability of the findings (Lodico et al., 2010). Data triangulation of multiple sources facilitated a multidimensional report of the case under study. Data were collected during two open-ended, unstructured interviews of nursing-school faculty. The interview questions were preevaluated via a pilot test to ensure they would draw the intended data to effectively answer the research questions.

This study was based upon the philosophical assumption of an emancipatory worldview that calls for dialogue and practices that are advantageous to positive change (Lodico et al., 2010), as well as critical theory that facilitates the investigation of societal discrepancies by exploring social practices, past environment, and interrelated understanding (McLaughlin, 1999). According to Creswell (2009), the distinctive tenets of qualitative research include using the researcher as the primary instrument in data collection and analysis to recognize the significance of the lived experience. Qualitative research also involves inductive methods and practices. Prior to data collection in this study, the following documents were obtained: (a) a letter of cooperation from the president of the study-site school, (b) IRB approval from Walden University, (c) a signed letter of confidentiality by a peer debriefer, and (d) signed consent forms from all study participants.

The first stage of data collection was the pilot test to determine whether the interview instructions and questions were efficacious and comprehensible. This involved posing the interview questions to a convenience sample of five colleagues selected from a community nursing school on a random basis to assist in evaluating potential participant reactions, ascertaining errors within the interview questions, timing the study interviews, and developing the process of data analysis (McNamara, 2009; Turner, 2010; see Table 3). The pilot-test participants confirmed that the interview questions and instructions were worded clearly and in a neutral, open-ended manner. They reported that the interview could be conducted within 20 to 30 minutes and suggested that the interview protocol be followed by probing questions to guarantee comprehensive answers to the research questions.

Table 3

Demographics of Pilot-Study Participants

Participant	Gender	Nursing specialty	Type of teaching	Type of program	Type of interview
A	Male	Psychiatry	Clinical	Associate	Telephone
B	Female	Medical/ Surgical	Clinical	Associate	Face-to-face
C	Male	Medical/ Surgical	Classroom	Associate	Face-to-face
D	Female	Medical/ Surgical	Classroom	Associate	Face-to-face
E	Female	Pediatrics	Clinical/ Classroom	Associate	Face-to-face

The second stage of data collection consisted of individual interviews with the participants. Seven obstetrical faculty members and eight obstetrical students were interviewed. The student sessions were conducted in a vacant office provided by the study-site school. The faculty interviews occurred within the individual offices of the participants. The process used an interview protocol developed specifically for this study and containing open-ended questions (see Appendix B). All sessions were recorded. Creswell (2008) noted that open-ended questions give respondents the opportunity to share their experiences without restriction.

The interview recordings were transcribed by me. All participants were contacted prior to the interviews to establish their consent and arrange an appointment in advance. Confidentiality was assured and all respondents were informed that any information

generated through the interviews would be used exclusively for academic purposes. The interviews were conducted on a face-to-face basis. As noted earlier, due to the heavy schedules of both the faculty and students, it was necessary to conduct two faculty sessions and two student sessions by telephone.

Data Analysis

As noted earlier, research can be distinguished as belonging to one of two models—deductive or inductive (Lodico et al., 2010). The deductive approach, commonly known as the top-down approach, allows specific conclusions to be drawn based upon broad theory. The theory leads to predictions surrounding expected occurrences. The inductive approach involves the observation of a specific phenomenon and drawing conclusions. Methodologies employed in the deductive approach are typically developed prior to the onset of the study and are often not subject to change during the course of the research; consequently, the generation of alternative explanations is discouraged. However, the inductive approach involves methodologies that are continuously developed and modified according to the changing dynamics of the study, most of which cannot be ascertained prior to the onset of the research (Creswell, 2009).

According to Creswell (2008), "Documents consist of public and private records that qualitative researchers obtain about a site or participants in a study, and they can include newspapers, minutes of meetings, personal journals, and letters" (p. 230). In this current study, the Data Use Agreement was signed by the president of the study-site school. The obstetrical syllabus and curriculum were analyzed page and page and line by line for any word or phrase pertaining specifically to the LGBT population. Three faculty members (i.e., Faculty Participants 1, 3, and 5) shared their class/lecture and clinical

notes, which were also reviewed for any mention of LGBT health issues in either the class or clinical instruction. To achieve the goals of this study, interviews and document analysis were suitable qualitative data-collection techniques (see Table 4).

Table 4

Analysis of Obstetrical-Nursing Material

Material	Estimated lines	Lines with LGBT content	Estimated illustrations (%)	Illustrations with LGBT content (%)
Textbook	38, 240	54 (0.14%)	300	0
Syllabus	1,400	0	0	0
Curriculum	630	0	0	0
Lecture lesson plan	624	1 (0.16%)	0	0
Clinical lesson plan	210	0	0	0

Note. LGBT = lesbian, gay, bisexual, and transgender.

The interview transcripts and field notes were reviewed numerous times. Manual coding and data extraction facilitated the identification of themes. The themes were described and detailed examples were provided. Ideas frequently mentioned during the interviews and with the greatest amount of evidence to support them were noted and highlighted, as recommended by Creswell (2008), as well as Zhang and Wildemuth (2009). The codes were descriptive and analytical in nature and not only reflected the data gathered, but were also independently interpretable without further information, as suggested by Merriam (2009). The codes disclosed information related to the study that

drew the attention of readers. Similar codes and ideas were grouped into themes/categories, as recommended by Zhang and Wildemuth (2009).

Validity and Reliability

Various methods can be applied to validate qualitative data and the related findings. To ensure the trustworthiness of qualitative studies, four types of criterion are suggested within existing literature—transferability, credibility, dependability, and confirmability (Lodico et al., 2010; Zhang & Wildemuth, 2009). Triangulation strengthened the credibility of the data collected in this current study and highlighted any conflict within the data. Various sources of data collection were used and all data were checked for inconsistencies. The field notes supplemented the interview transcripts. The interview data were compared to the field notes and all conflicts were documented and discussed. Member checks and the use of a peer debriefer ensured against the influence of any researcher bias. Member checking is the reiterating or summarizing of information with the respondents during or after the interview process to check for accuracy. Peer debriefing is the process of using neutral colleagues to critically appraise the accurate and comprehensive nature of the data-collection and data-analysis process (Creswell, 2009). A colleague who signed a confidentiality form reviewed the data for any bias, assumptions, or prejudice.

The data collection and analysis in this study have been thoroughly described, which included detailed descriptions of the setting, participants, and all interactions. The process and documentation of data collection, member checking, and data analysis also assists with future replication of the study. Special attention was given to discrepant data. Any conflicting data or outliers were reviewed, reexamined, and triangulated with the

various data sources reported, as recommended by Lodico et al. (2010). Following the Merriam (2009) guidelines, any unresolved discrepant data were adjusted to fit the established themes/categories.

Delimitations, Limitations, and Assumptions

According to Creswell (2009), to control the range of a study, delimitations are set to decrease the amount of time devoted to pointless lines of inquiry that are unrelated to the general study. Limitations are factors affecting a study that the researcher has little or no control. Stating the limitations provides meaning and greater accuracy to the results. This current study was delimited to obstetrical-nursing faculty and students currently enrolled in an obstetrical course or those who had completed the course. The study was also delimited to exploring how a nursing school incorporates health-care topics related to the LGBT population in obstetrical-nursing education. With the small sample size, the findings may only be applicable to obstetrical teachers and students (a) in private, associate-degree nursing schools, and (b) employed within the same state as the study sample. Due to time constraints, some of the participants may not have answered in a completely open manner; consequently, the results might not accurately reflect the opinions of all members of the study population. Additionally, one faculty member and two students were unable to perform member checking.

According to Lodico et al. (2010), assumptions are factors affecting a study but uncontrolled. In this current research, it was assumed that gender, role, and sexual orientation would not significantly affect the perceptions of the participants. It was also assumed that all interview respondents answered all questions honestly and to the best of their ability.

This study commenced after receiving Walden University IRB approval and the letter of cooperation from the president of the study-site school (see Appendix B). Data collection began immediately after informed consent was obtained from all participants. The pilot study was conducted in 1 day and, within 3.5 weeks, the individual interviews were conducted, transcribed, and member checked. The analyses of the documents were completed in 2 weeks. Within 1 week, a peer debriefer reviewed the notes and listened to the recorded interviews for any bias. The data were analyzed to determine how the LGBT population is represented and portrayed in mainstream obstetrical-nursing courses, curricula, textbooks, and syllabi.

Qualitative Findings

Interpretation of the data progressed from inductive to deductive. Comprehensive data were reduced to general codes or themes, as suggested by Creswell (2008). Creswell also described five steps of qualitative data analysis. First, the recorded interviews were transcribed. The preliminary analysis was subsequently performed by reading the interview transcripts numerous times for emerging themes. This process is referred to as open coding. Each emerging theme was then associated with the appropriate research question. A coding scheme is developed to translate the themes into codes. This linking of themes to the codes is referred to as axial coding. The transcripts were again read while noting and bracketing the codes, and the themes were color coded for easier visual analysis. The selective coding of data was applied when evidence from the transcripts emerged. For interrater reliability, the interview data were reviewed by a colleague familiar with the coding scheme. Finally, the data were then divided into themes.

The implementation of manual coding and extraction of the interview data were supported by a statistical computer software known as AQUAD 7 to summarize the LGBT language within the curricula, syllabi, and textbook to, in turn, organize the text, coding, and findings (Creswell, 2008; Merriam, 2009). For the document review, theme analysis and constant comparison were performed. Any terms remotely pertaining to the LGBT topic were grouped into patterns for descriptive analysis. This facilitated the development of thematic categories of representation and the placement of LGBT issues within the documents. The data collected with the two described methodologies were triangulated to add to the credibility and reliability of the study (Zhang & Wildemuth, 2009).

In qualitative research, the report of the findings allows for the creative interpretation and flexibility of the researcher (Creswell, 2008). Many investigators have examined various strategies or formats for presenting research findings in written form. These include the following approaches: scientific, storytelling, thematic, descriptive, theoretical, performance, natural history, chronological, zoom lens, narrative, amalgamation, and data display (Creswell, 2008; Glesne, 2011; Lodico et al., 2010; Merriam, 2009). For this current study, the thematic approach was used to report the findings. According to Lodico et al. (2010), with this approach, "text is organized in terms of [a] discussion of themes that arise from [the] data analysis" (p. 312). This is a flexible strategy and common method; however, it can limit the development and advanced analysis of the data (Merriam, 2009). To provide a visual presentation of the data, a comparison table and a hierarchical tree diagram will be used to characterize "the themes and their interconnections" (Creswell, 2008, p. 261; see Table 5).

Table 5

Data-Analysis Coding

Codes	Subcodes
1. Integration	1.1. Limited knowledge 1.2. Uncomfortable/Inexperienced 1.3. Lacked teaching methods
2. Representation	2.1 Not in textbook 2.2 Unfairly represented 2.3 Modify curriculum
3. Perceptions	3.1 Unsocialized/Unprepared 3.2. Stigmatized

Code 1: Integration

Code 1 relates to critical theory, which was developed to analyze the historical background, related interpretations, and societal practices that deny power and information from selected members of society (McLaughlin, 1999). This also addresses the question of how nursing schools that offer an associate degree in nursing incorporate health-care topics related to the LGBT population in their obstetrical-nursing education.

Code 1.1: Limited knowledge. The participants in this study had limited to no knowledge surrounding LGBT health issues including those within the realm of obstetrics. Of the total sample, 33% admitted that their minimal knowledge on the population was sourced in media broadcasts of the ongoing political movement for the legalization of same-sex marriage. According to Student Participant 7, “I know that they are in this fight to get married. . . . Every time you turn on the news, that’s all you hear.” Only 13% of the participants mentioned other issues related to this population such as

health-care disparities and the stigmatization of the population throughout American society as a whole.

The majority of the study participants admitted having limited knowledge surrounding LGBT issues associated with obstetrics, with the exception of the prevalence of HIV and STDs (see Figure 1). Student Participant 4 commented, "I have no knowledge that they have obstetric issues. . . . I mean, can they get pregnant? I guess they have HIV and STDs." Student Participant 3 stated, "I read that they have a lot of STDs because they sleep around. . . . I do not know a lot about them when it comes to obstetrics." When this participant was asked to clarify her comments, she added, "I am so naïve. . . . I do not think of them in that way. I mean, they do not need birth control or have babies. I think they just adopt. Am I right?" Of the sample of faculty participants, 100% did not mention any other obstetrical issues regarding the LGBT population, with the exception of STD, HIV, and same-sex marriage; 17% admitted having no knowledge on obstetrical LGBT issues.

Of the total sample, 60% of the participants explained sexual orientation and sexual identity inaccurately; 27% did not know the definitions of the two concepts, and only 13% of the participants explained sexual orientation and sexual identity correctly. A majority of the faculty participants (71%) defined sexual orientation and sexual identity inaccurately. Of the participants who defined sexual orientation and sexual identity inaccurately, 73% interpreted the two concepts as synonymous (see Figure 2). Faculty Participant 7 commented, "I thought sexual orientation and sexual identity means [*sic*] the same thing. . . . You see what I mean? How can I teach something I do not know? I tell you, these terminologies need to be in the textbooks."

Figure 1. Participant knowledge on obstetrical health issues of the lesbian, bisexual, gay, and transgender community.

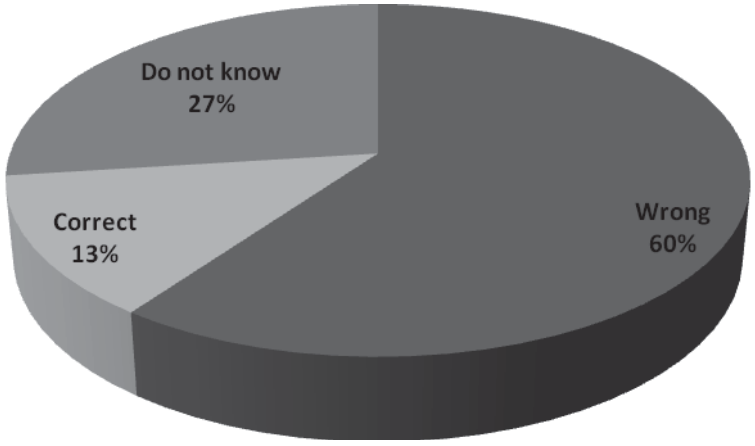

Figure 2. Participant knowledge on the difference between sexual orientation and sexual identification.

Code 1.2: Uncomfortable/Inexperienced. The faculty participants admitted that they feel uncomfortable initiating LGBT topics during class or clinical instruction. One of these participants attributed this to her lack of experience caring for the LGBT population; another noted the discomfort due to her religious beliefs. When encouraged to further explain this latter comment, the faculty participant stated, "I feel like I am going against my religious beliefs whenever I try to bring up the homosexual population. . . . I may be offending the students." Student Participant 5 confirmed this by commenting, "I remember a student asked a professor a question about LGBT and the professor turned red and started stammering. It was so funny!" Faculty Participant 7 reported,

> Our students are not prepared to care for this population in OB or other classes. . . . I am uncomfortable discussing LGBT issues in classroom or in clinical. I am uncomfortable because of my upbringing as a Catholic, my lack of knowledge and experience with the population, and my apprehension that I am promoting the lifestyle . . . and how the students will perceive it. I need help to teach about the issues.

Code 1.3: Lack of teaching methods. The faculty participants agreed that they do not have the skills to effectively integrate LGBT topics into their classrooms and clinical instruction. The primary concern seemed to be the potential to offend the students by being overly graphic. This fear stems from their lack of knowledge surrounding the LGBT population and their lack of knowledge on appropriate teaching strategies to convey the information without distorting it or confusing the students. Faculty Participant 1 explained, "I may say the wrong thing or overemphasize an issue to the point of

offending my students." Faculty Participant 2 stated, "I need some training on how to introduce the topics without disrupting my class or straying off course from the curriculum." When encouraged to elaborate, this interviewee asserted that she will need information about the population and how to incorporate their health issues into her classroom.

Code 2: Representation

Code 2 is associated with the emancipatory worldview of restriction and other processes of marginalization initiated by media and society as a whole via language and labels (Lodico et al., 2010; Merriam, 2009). It also relates to the critical literary theory applied to the interpretation of texts to expose the repression, marginalization, and control of individuals by social organizations and scientific processes (Corradetti, 2011). Data reflecting this code will facilitate answering Research Question 1, which asked, "How is the LGBT population represented in obstetrical-nursing curricula, textbooks, and syllabi?" The same data will be analyzed to answer Research Question 2, which asked, "How do obstetrical-nursing faculty incorporate LGBT health issues into their teaching?"

Code 2.1: Not in textbook. According to the interview respondents, LGBT issues are nearly nonexistent within obstetrical curriculum. Student Participant 8 commented,

> I do not know anything about LGBT in OB. I took OB last semester; nothing was mentioned in class about them. Even the textbooks do not talk about them. . . . This is the only time I heard anything about LGBT at [name deleted]. I have heard about LGBT, but I do [*sic*] not know the meaning until I saw the flyer you posted.

This statement confirmed the data presented in Table 2 that reflects 14% of a textbook containing LGBT-related information and 16% of lecture lesson plans containing such

information. Many participants affirmed that this lack of information is due to the nursing-school culture, which is conducive to addressing solely issues that are "politically correct." Student Participant 1 stated,

> I have been in other schools, and it is the same thing. I remember a student asked a professor a question about LGBT and the professor turned red and started stammering. It was so funny. . . . The professor did this every time the gays are brought up in the class.

Code 2.2: Unfairly represented. The study participants confirmed that, when LGBT issues are mentioned in the course textbook, the information is not typically represented fairly or presented in the same depth as other obstetrical areas and issues. Only 14% of the text is dedicated to LGBT issues in the obstetrical textbook. The participants also noted that, when they hear of LGBT issues, it is typically along with adverse health topics such as HIV, STD, or cancer. Of the total study sample, 63% admitted that, in general, their knowledge on the LGBT population is limited to their susceptibility to violence, HIV and other STDs, as well as other adverse health issues such as anal cancer. Faculty Participant 2 commented, "All I know about them is that they are more at risk for sexually transmitted diseases. . . . I really do not know a lot about them. . . . I guess it does not really interest me." Student Participant 3 stated, "I remember the professor mentioning briefly about LGBT when we were discussing STD. Apart from that, LGBT was not mentioned anywhere else."

Code 2.3: Modify curriculum. All of the study participants agreed that obstetrical curriculum, textbooks, and clinical experiences do not include LGBT health issues. All of the interviewees mentioned that the current obstetrical curriculum does not

prepare them to teach or care for the LGBT population. Student Participant 4 affirmed this by stating, “It should be included in the curriculum. How can we take care [of] these people when we graduate?” Of the total study sample, 87% verbalized that content surrounding the LGBT population should be included in the obstetrical curriculum and that nursing educators must be educated in how to include this content. Faculty Participant 3 stated, “I think nurses know that they are there but nurses are not comfortable discussing how to care for them. It should be in the curriculum, in OB, especially with issues of fertility.”

Of the total study sample, 13% were against such content within solely obstetrics curriculum, as was reflected in the following excerpt from the interview with Student Participant 6: “I do not think they should only be in the OB curriculum.” When probed as to why such content should be in the formal school curriculum, many of the participants mentioned the importance of cultural competency, holistic practice, practicing equitably, and meeting state and federal mandates. Student Participant 6 stated,

> It should be included in the curriculum. Nurses need to learn how to care about every type of patient. I don’t understand the lifestyle but it is not for me or anybody to judge them. I want to be a good nurse to everybody—gay or not.

Student Participant 9 affirmed,

> It should be part of nursing curriculum in OB because a lot of them do have children or seek MD help with getting pregnant. I do not know why it is not in the curriculum. It is either lack of knowledge or lack of comfort on the part of the professors. . . . Everybody pretends they are not in existence but they are a big part of the society.

Code 3: Perceptions

Code 3 relates to the emancipatory worldview and the notion grounded in critical theory that supports the critical assessment of society and organizations that restrict individuals from achieving their life purposes and ultimate personal growth (Creswell, 2008, 2009; Kellner, n.d). Data reflecting this code will facilitate answering Research Question 3, which asked, "How do obstetrical-nursing students perceive their preparation by nursing schools to care for LGBT patients following graduation?"

Code 3.1: Unsocialized/Unprepared. The interviewees in this study noted that nursing schools do not prepare students to succeed within the current health-care environment. Students are not prepared to be knowledgeable on the current trends in nursing. Faculty Participant 7 confirmed this in the following interview comments:

> Our students are not prepared to care for this population in obstetrics or any other department. I have to admit that I am uncomfortable discussing LGBT issues in classroom or in clinical. I am uncomfortable because of my upbringing as a Catholic, my lack of knowledge and experience with the population, and how the students will perceive it. I will need help and information on how to teach the issues without offending anybody.

Faculty Participant 5 stated, "In nursing and in this school, we do not prepare students how to care for LGBT patients in obstetrics or anywhere else." Faculty Participant 5 opined,

> Students are not socialized to this population. I think it has to do with nursing culture, of not confronting issues until it becomes a problem. Other disciplines are dealing with these health-care disparities and looking for ways to counteract them,

> but nursing is still in its infancy with these issues. The health issues of the population should be incorporated from Nursing 101 . . . starting from our nursing basic education. . . . Nursing educators and researchers shy away from it because of the stigma attached to it.

Code 3.2: Stigmatized. The study participants reported that the nursing profession portrays LGBT issues as insignificant and abnormal. By minimally including LGBT topics or totally excluding the topics from classroom and clinical instruction, the nursing profession contributes to the stigmatization and oppression of the LGBT population. The data presented in Table 4 reflects that only 16% of lesson plans are dedicated to the discussion of LGBT health issues, and no mention of these issues is reflected within clinical notes. Student Participant 4 reported, "In nursing school, we do not talk about the population in our classrooms and clinical. It is as if it is a taboo or a secret." Student Participant 3 stated,

> It is a secret. . . . The profs know that homosexuals exit, but I guess they are not important for us to learn in nursing school. I guess it is too dirty for nursing. What confuses me is that it is not mentioned in any of my classes since I came to [school named]. [The] nursing profession is still in denial.

Discrepant Information

Differing data provide opposing information surrounding a code because it does not substantiate the code (Creswell, 2008). Discussion of the discrepant information will facilitate the credibility of the study results. In this current study, discrepant data were sourced in the statement of one who opined that the initial reluctance to include LGBT health issues in the obstetrical lectures was not only due to a lack of knowledge

surrounding the LGBT community, but also a deep personal hatred for the population. She stated, “I have always questioned how it will benefit my students, the society, and the profession. Why do we need to acknowledge this lifestyle? We already have [an] extensive cultural-competency class.” When encouraged to clarify, she stated,

> The lifestyle is not clear to me. I have limited information about the population . . . . I can understand and even teach about the gays, the lesbians, and even the bisexuals, but the transgender lifestyle is an abomination practice. . . . We do not need to promote the lifestyle by teaching it to our students. . . . I know everybody is now making a big deal about it.

When asked to comment further on the “abomination practice,” this participant simply conveyed that she will not include the transgender population in the class lecture because it is abnormal. This detestation of transgender individuals did not fit any of the established codes and is beyond the scope of this study. It did not pertain to lesbians, gays, nor the bisexual community so will need to be addressed in future research.

Summary of the Findings

The findings of this study indicate many gaps in the obstetrics didactic and clinical curriculum, textbooks, and lecture notes of nursing schools that offer associate-degree programs. A critical finding was the number of faculty and obstetrical students who lack knowledge on LGBT issues including sexual orientation and sexual identification. The results highlighted a number of critical needs for faculty development including how to infuse LGBT content, such as transgender individuals and gender identity, into lesson plans. Related gaps reflect the lower degree of attention to gender identity, as envisaged by obstetrical LGBT patients.

The results of this study indicate that associate-degree nursing schools must review how well they are training their students to competently provide services to the LGBT population within obstetrical settings. Obstetrical curriculum and textbooks reflect a low frequency of LGBT topics, as well as adverse material. Obstetrical faculty are inconsistent in terms of addressing or incorporating these issues in their didactic and clinical curriculum. Curriculum must include a focus on transgender issues, which have virtually been ignored by some faculty members. School leadership must integrate teachers who are LGBT or who have scholarly knowledge on LGBT issues to revamp the obstetrical curriculum. Obstetrical faculty must be empowered and coached to attend national, local, and state education conferences that deliberate on LGBT issues to gain related scholarly knowledge and to learn different ways of incorporating LGBT health issues in their didactic and the clinical curriculum. Obstetrical faculty who have no scholarly knowledge on LGBT issues will greatly benefit from this exposure.

Based upon the results of the data analysis in this study, a professional education workshop will be developed. Core features of the program will involve a content focus on the LGBT population and their obstetrical care, active learning by educators, consistency sustained over time, and a requirement for collective participation. The findings of this study will increase the knowledge and skills of educators, as they relate to caring for the LGBT community. As a result, these educators will change their didactic and clinical instruction, improving the education of obstetrical nursing students on LGBT health issues and the obstetrical nursing care of this community. Consistent and collective knowledge will change the attitudes and beliefs of obstetrical faculty surrounding the LGBT population.

Chapter Summary

The case-study methodology adopted for this research yielded sufficient data for reliable recommendations. The findings may not be generalizable to other populations. The objective was to have an enhanced understanding of the case studied (Baxter & Jack, 2008). Many strategies were employed to ensure dependability of the findings. For efficient theme analysis and constant comparison, qualitative data from the document reviews and the open-ended and unstructured interviews were analyzed and supported by statistical computer software known as AQUAD 7. The qualitative results indicated that nursing schools that offer associate-degree nursing programs are not adequately incorporating LGBT health issues into their curriculum and are not effectively training their students to effectively care for this cohort. The evidence showed that this is due to the erroneous perceptions of faculty with regard to the LGBT population and lack of knowledge and skill surrounding how to incorporate LGBT issues into their didactic and clinical curriculum.

Section 3: The Project

Given the importance to the nursing profession of cultural competency and patient satisfaction, the purpose of this study was to examine the manner in which the LGBT population is represented and portrayed within mainstream obstetrical-nursing courses, curricula, textbooks, and syllabi. The Knowles (Knowles, Holton, & Swanson, 2012) andragogy of adult learning principles and the New York State Department of Education (2011) PTS were used to train the obstetrical educators and design teaching methodologies that are useful for adults from various education, cultural, and developmental backgrounds. The workshop will teach the educators about the LGBT population and methodologies to incorporate LGBT health issues equitably into obstetrical-nursing curricula while meeting the four key elements of learning—motivation, reinforcement, retention, and transference (Merriam & Bierema, 2013).

The training program developed in this current study will become the model for other professional-development programs such as laboratory and simulation programs. Consequently, a description of the project study, including rationale, goals, and objectives, is provided. A review of existing related literature will focus on research and theory pertaining to professional development, andragogy, and the New York State Department of Education (2011) PTS. Additionally, a project-implementation timetable is provided and existing supports, potential barriers, resources, and project evaluation are addressed. Finally, social changes for the community and potential stakeholders are identified and discussed.

Rationale

This examination of the manner in which the LGBT population is represented and portrayed within mainstream obstetrical-nursing courses, curricula, textbooks, and syllabi yielded and confirmed the stance throughout related literature that nurse training in LGBT issues is excluded or highly limited within nursing education. Nursing educators are not knowledgeable on LGBT health-care issues and they exclude LGBT issues from their didactic and clinical instruction. Nursing students are not motivated to learn content related to LGBT issues because their obstetrical textbooks, syllabi, and curricula exclude this population. Nursing educators could be overwhelmed with attempting to incorporate LGBT issues into their didactic and clinical instruction. Those interested in incorporating such issues into the obstetrical curriculum do not have the tools to do so in their classrooms or clinical sites. These educators would benefit from a workshop on basic LGBT knowledge, LGBT health disparities, and ways of incorporating LGBT issues into their obstetrical classroom and clinical instruction using adult learning principles. A well-developed faculty workshop could serve to significantly decrease the problems of interest in this study.

Based upon the results of the data analysis, a workshop will be developed to train obstetrical-nursing educators. The expected knowledge, skills, attitudes, and beliefs that will be transferred from the learning environment to clinical practice are (a) knowledge of LGBT terms and health-care issues; (b) instructional techniques that incorporate LGBT health-care issues into classroom and clinical education using adult learning principles; and (c) various ways of changing nursing-student attitudes toward the LGBT population within obstetrical settings.

Review of Literature

This review of literature related to the problem under study began with searching Google Scholar and databases at the Walden University and Duke University libraries (i.e., ERIC, the Education database developed by SAGE, ProQuest Central, Science Direct, and Academic Search Complete). Keywords used in the search included *professional-development format, content, effective professional-development process, professional development, evaluating professional development, implementation of new skill and knowledge, teacher satisfaction and teacher reactions to professional development, andragogy, pedagogy, Knowles, adult learner, effective educator, teaching standards,* and *the New York State Professional Teaching Standards.* With the demands from state, federal, and local stakeholders for quality education along with the restructuring of school curriculum and innovation in learning and teaching, there is a constant need and demand for professional development for educators. These stakeholders have invested large amounts of money for professional-development activities toward increased knowledge and instructional capabilities in educators.

Professional Development

Professional development is defined as procedures and actions planned to improve the professional comprehension, abilities, and mind-sets of educators so they can, in turn, develop their students (Berger, Eylon & Bagno, 2008; Guskey, 2000). Professional development is any activity used to prepare educators for improvement in teaching performance. This can equate to a wide range of learning opportunities such as courses, workshops, book clubs, study groups, coteachimg, mentoring, reflection on

lectures, and participation in process improvement (Desimone, 2009). Characteristics of professional development include the enhancement of educator practice, skill, and knowledge toward student achievement and, more specifically, active learning, content focus, coherence, and duration.

Guskey (2003) described the most commonly cited attributes of effective professional development as the adequacy of the professional-development activity, its structure, and the time organized to intensify and increase participant knowledge and learning. Another trait of a successful professional-development activity is the support of planned and purposeful collaborative efforts between the participants and school leadership. With unambiguous goals to enhance positive learning outcomes for students, there must be a clear method of aligning the initiatives of a professional-development program with program evaluation. Guskey noted that a high-quality professional-development activity is also aligned to both practice and school goals, centered on academic content, ongoing, site based or school based, and conducive to strong collaboration among all participating educators (Wei, Darling-Hammond, & Adamson, 2010).

Professional-development programs are important to assist educators during, before, and after any curriculum change and implementation (Visser, Coenders, Terlouw, & Pieters, 2013) to manifest changed attitudes, beliefs, teacher practices, and positive learning outcomes for students (Sato, Wei, & Darling-Hammond, 2008). Related literature has shown that some educators do not consider these professional programs to be effective as an education/instruction reform (Leach & McFarland, 2014). Professional-development objectives fail because the educators are not supported or coached after

completing the training program (Lowden, 2003). This is significant because these programs are expensive and serve as a corrective action for reforming the education system in areas such as

> revamping teacher evaluation systems . . . ensuring that school leaders and teachers have the professional development and support opportunities they need to be successful, creating incentives to place effective teachers in high-need schools and subject areas, and developing comprehensive support systems to help turn around low-performing schools. (Perez-Johnson et al., 2011, p. 1)

Guskey (2003) warned that, for the success of any professional-development program, collaboration between regional administrators and the educators of the program site must manifest. Unsuccessful programs have not motivated educators to learn nor changed the progression of teachers in a positive direction. Historically, evidence has indicated that professional-development programs designed to change the attitudes and beliefs of educators rarely succeed in accomplishing their objectives (Hunzicker, 2011; Lieberman & Pointer Mace, 2008). However, the model of teacher change is a different approach. It proposes a different order for the three major effects of professional development—changes in behavior before changes in attitude and beliefs (Guskey, 2000; see Figure 3).

The successful execution of a professional-development program will result in a positive change in teacher attitudes and beliefs. For a successful professional-development activity, the content must be student centered and help educators to develop their instructional ability to teach particular content that will have strong constructive

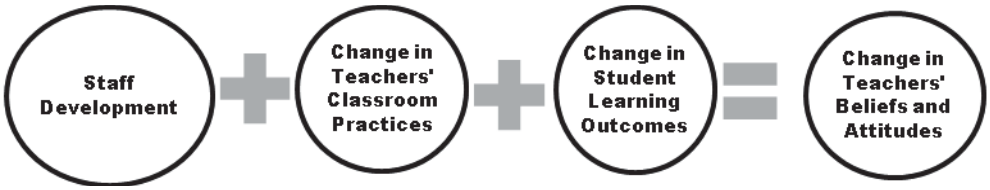

Figure 3. Model of teacher change.

outcomes on practice. Additionally, the content must emphasize assessment, reflection, active teaching, and observation (Darling-Hammond & Richardson, 2009).

Andragogy

Knowles enumerated six assumptions of andragogy that distinguish it from pedagogy. The pedagogical model is the learning environment wherein the student is dependent upon the teacher for all learning. The teacher carries the responsibility for what and when the learner will learn (Noor, Harun, & Aris, 2012). Pedagogy advances that children accustomed to learning a precise subject matter are usually inspired by external reward and punishment, have inadequate experience, and exhibit dependent behavior (Tallent & Crowley, 2012). In contrast, Werner and Rogers (2013) posited that andragogy refers to the growing body of knowledge and technology related to the art and science of adult learning. The teacher is merely a facilitator of learning. Knowles postulated that adults want their participation in learning to be voluntary and meaningful. Adult learners are also autonomous, independent, and self-directed. Older learners are intrinsically motivated; they use past experience as a rich learning resource, and their orientation is centered on problems rather than content. Their readiness to learn is

associated with a need to perform a task with a transition point (Corley, 2008; Henschke, 2011).

Professional Teaching Standards

The New York State Department of Education (2011) PTS were accepted by the Board of Regents in 2011 and include knowledge of students and student learning, content and instructional planning, instructional practice, effective learning environments, the assessment of student learning, professional responsibilities, and expected professional growth. The standards were developed as part of career development and preparation for teachers. They will be used to evaluate educator effectiveness in teaching and the relationships they cultivate with their students to promote their learning, growth, and achievement. The standards address the diverse needs of learners including those of students for whom English is a second language. They also describe an effective teacher as a lifetime learner, progressing through a variety of career growth and professional-development activities.

Professional-Development Workshop

This examination of the manner in which the LGBT population is represented and portrayed within mainstream obstetrical-nursing courses, curricula, textbooks, and syllabi yielded and confirmed the stance throughout related literature that content on LGBT health issues is excluded from, or highly limited in, nursing education. The proposed professional-development workshop—Queerobstetrics- LGBT in Obstetrics Nursing: Train the Trainer—is designed to

1. Introduce LGBT terminology, explain how LGBT identity can affect health, and focus on the unique obstetric health issues facing the LGBT community.

2. Strive to empower obstetric faculty members to proactively incorporate LGBT health issues into the didactic and clinical obstetric curriculum by providing innovative instructional designs.
3. Assist faculty members to effectively prepare obstetric nursing students through the development of core competencies facilitating their proper care of the LGBT population within the obstetrical setting.

The fundamentals of the new train-the-trainer workshop are entrenched in, and in alignment with, adult learning principles (Knowles, Holton, & Swanson, 2012), as well as the New York State Department of Education (2011) PTS. This workshop also provides detailed suggestions for instructional methodologies. It is a model professional-development workshop that may be customized as needed to fit the plans and priorities of individual schools.

Program Outcome and Learning Objectives

The proposed program will introduce LGBT terminology, explain how LGBT identification can affect health, and focus on the unique obstetric health issues facing the LGBT community. This program will support obstetric faculty members as they assist nursing students through the core competencies of caring for the LGBT population within the obstetrical setting. The workshop will also strive to empower faculty members to proactively incorporate LGBT health issues into the didactic and clinical obstetric curriculum by providing innovative instructional designs (see Appendix A).

Upon completion of the described workshop, participants will be able to

1. Define LGBT identities and issues encountered within the obstetrical health-care setting.

2. Examine the particular hurdles and challenges that LGBT individuals encounter as they attempt to access obstetric health care.
3. Discuss alternative ways of incorporating LGBT obstetrical issues into classroom and clinical instruction using adult-learning principles and instructional techniques.
4. Answer questions and provoke discussion surrounding the development of simple steps toward removing barriers to care for the LGBT community.

Learning Tasks

Task 1. For the first learning task, participants will gain an understanding of LGBT identities and issues within obstetrical health-care settings, as well as challenges the LGBT cohort encounters when attempting to access obstetrical health care. This learning task will encourage the educators to actively process information learned with regard to the LGBT population and their obstetrical issues as they accomplish the learning objectives. Caffarella and Daffron (2013) noted that learning develops when a learning task encourages learners to actively process the information delivered. The prerequisites for Task 1 are participation in the needs-assessment survey, familiarity with peer-reviewed literature focused on the LGBT population, and a completed read of the Joint Commission (2014) *Field Guide.* These prerequisites will enable the participating educators to understand the unique obstetrical health issues commonly experienced by the LGBT community (see Appendix A).

Task 2. The second learning task involves learner observation and critique of various classroom instructional techniques and simulations. This task will support the educators as they build and critically assess their own knowledge base of LGBT health

issues. It will also empower them, as obstetric faculty members, to proactively incorporate LGBT health issues into their didactic and clinical curriculum via innovative instructional designs. Studies have shown that tasks encouraging students to integrate the information they are studying increases their learning (Jackson, & Bruegmann, 2009; Loeb, Miller, & Strunk, 2009). The participants will be tasked with differentiating between methods to determine the most appropriate and effective for adult learners. Prerequisites for this task are submission of a teaching philosophy; completion of the Principles of Adult Learning Scale developed by Conti (1998; see Appendix A); and observation and critique of classroom teaching simulations.

Task 3. To ensure that workshop participants can effectively incorporate LGBT health-care issues into their classroom and clinical teaching through various instructional techniques and their simulation, a project-based presentation will be required. Embedded within the cognitive elements of projects are the driven components intrinsic to their purposes and goals. Markham (2011) advanced that project-based learning motivates students to master the content through various tasks. The assignment will apply to both Tasks 1 and 2 (see Appendix A).

Participants will be divided into two groups. Each group of three participants will develop a project-based presentation describing how to effectively include LGBT health-care issues into their classroom and clinical teaching through various instructional techniques suitable for adult learners. For each presentation, the goal for the learners is to state and explain three LGBT concepts and how they will incorporate the concepts into their classroom and clinical instruction. The presentation will be assessed using a rubric (see Appendix A). Rubrics allow adult learners to concentrate on important areas of

assessment and reduce any confusion from unclear instructions. A rubric creates a map that students can follow to achieve optimal academic performance (Stevens & Levi, 2013).

Program Structure and Format

The program designed in this study will incorporate cost-effective strategies and require two external instructors for the three sessions. This will give the participating obstetrical faculty opportunities to learn new things from industry experts. The external instructors will use their expertise surrounding LGBT health issues to assist the participants to achieve the program objectives. The program will be promoted by weekly e-mail and memo reminders.

The program format for the learning tasks will involve small groups of 12 obstetrical-nurse educators for each session. The sessions will be structured as workshops comprised of minilectures, small-group discussions, problem-based learning, observation, simulation, and reflective practice. Instructional resources, such as PowerPoint, posters, and LCD's, will support the instruction. Participants will receive reference lists for LGBT-related content; PowerPoint handouts; the Principles of Adult Learning Scale (Conti, 1998); peer-reviewed articles on the LGBT population; and extra paper and pens. The workshops will be conducted within a large classroom or conference room on one of the nursing-school campuses. The rooms must be conducive to learning and technology-ready with Wi-Fi. Seating will be configured into a team-style arrangement with seats of six around oblong tables because this configuration promotes team interaction (Caffarella & Daffron, 2013). Refreshments and lunch will be served.

Related literature has indicated that sustained and intensive professional programs are the most effective and successful; consequently, the workshop designed in this current study will be conducted monthly for 3 days, 8 hours each day, with 60 minutes for lunch and two 15-minute breaks. Facilitators will be instructed to focus on encouraging audience participation and providing a background on the LGBT population and the Knowles andragogy versus pedagogy. Discussion groups are intended to be mixed to reflect different age-groups, gender, and experience levels. The instructors are also to encourage the participants to discuss their philosophies on education and ask probing questions related to various instructional methods. They must be knowledgeable on alternative techniques and strategies for questioning and discussion and create a supportive educational environment that encourages students to take risks, emphasizing "group participation and the transfer and application of new learning" (Fleming, as cited in Cafferella & Daffron, 2013, p. 240).

Practice and Feedback

A vast array of instructional strategies will be used during the workshop designed in this current study. For the two learning tasks, interactive instruction strategies will be incorporated. This type of strategy is dependent upon discussion and the sharing of information among all participants. It is grounded in the notion that students must learn intellectual and social skills from both peers and teachers (Jackson & Bruegmann, 2009). The interactive instruction strategy permits a variety of methods including discussion and cooperative learning (Vaughn et al., 2010). Discussion is a verbal method of examining a topic, concept, or experience. It encourages a group process and interaction while aiding students as they seek to answer confusing questions related to their worldviews.

Discussion can be open ended or guided (Baker & Clark, 2010). The interaction can help students achieve a better understanding of content, rendering it relevant and clear.

Another strategy for examining a topic is cooperative learning. This is an instructional strategy with specific elements involving a structured form of group learning. Studies have indicated that cooperative learning fosters high self-esteem, high achievement, effective use of higher level reasoning, and the ability to work collaboratively (Nguyen, Terlouw, Pilot, & Elliott, 2009; Vaughn et al., 2010). Two types of cooperative learning will be incorporated in the workshop designed in this study. Formal cooperative learning facilitates the completion of group goals. It is formal because the educator facilitates and monitors the group. This type of learning can be used in conjunction with group discussion. Informal cooperative learning is typically used to introduce subjects to participants. It involves minilectures and small-group learning (Mason CTE , n.d.). Cooperative learning has five components—positive interdependence, individual accountability, promotive interaction, social skills, and group processing (Wlodkowski, 2008; see Appendix A).

Discussion. After a minilecture introducing LGBT terminology, the obstetrical-nurse educators participating in the workshop designed in this study will be divided into groups of four learners. Each group will discuss the LGBT population and the Knowles adult-learning principles, as well as the impact of these principles on obstetrical-nursing curriculum. The participants will be instructed to interact to develop ways of effectively changing their didactic and clinical instruction via the Knowles model. Each group will briefly present their ideas to the balance of the class. This task will help the educators to understand and simulate the adult-learning practice necessary for incorporating LGBT

issues into obstetrical nursing. The process will enable the participants to receive feedback from the workshop facilitators and their peers, with regard to their effective use of the Knowles adult-learning principles (Caffarella & Daffron, 2013; see Appendix A).

Minilectures. Following a minilecture to introduce various instructional techniques that support adult-learning theory, the obstetrical-nurse educators participating in the workshop will observe and critique classroom simulations of instructional techniques. Their critiques will focus on the effectiveness of incorporating LGBT health-care issues into their didactic and clinical curriculum. The participants will observe classroom simulations implementing different instructional techniques and discuss the adequate and appropriate nature of the techniques with the workshop facilitator. This type of activity will enable the learners to process, consolidate, and retain a greater amount of information (Baker & Clark, 2010). It will also help the participants to understand and simulate newly acquired information and appropriate instructional methods suitable for adult learning and obstetrical-curriculum modification. The learners will receive feedback from both the instructor and their peers.

Cooperative learning. To incorporate cooperative learning, workshop participants will formulate answers to questions asked by the facilitator on health-care disparities encountered by the LGBT population within the obstetrical setting. They will share their responses; listen to the responses of other group members to the same question; and create new, well-developed answers to the questions. Wlodkowski (2008) explained that cooperative learning will enable students to process, consolidate, and retain a greater amount of information. It will also help learners to understand and simulate the instructional practices necessary for the prevention of health-care disparity

among the LGBT population as they seek access to obstetrical settings. Cooperative learning allows educators to receive feedback from the instructor and their peers on their effective use of the Knowles adult-learning principles (Mason CTE , n.d.).

The responsibilities of the facilitators of the workshop include outlining the topics of discussion; establishing the length of time for discussion; determining the composition and size of the discussion groups; reporting or sharing the techniques examined; demonstrating excellent observation, listening, interpersonal, and intervention skills and abilities; serving as experts in the structuring and developing of the group dynamics; providing immediate feedback to the group; organizing suitable formal groups for specific projects; guiding group activity; transcribing strategies; and conducting debriefing activities. Learner responsibilities include sharing answers to questions posed in the workshop and associated rationale; evaluating the group process; evaluating possible answers and rationale for application to given situations; discussing factors involved in presented situations; exchanging ideas and explaining how factors will be addressed; explaining strategies discussed; posing questions for discussion; demonstrating excellent observation, listening, interpersonal, and intervention skills and abilities; and directing other group members to recognize ideas that contributed to the group process.

Cooperative-learning activities enable group participants to process, consolidate, and retain a greater amount of information. They also help group members to understand and simulate the adult-learning practice necessary for orientation modification (Baker, & Clark, 2010). As noted earlier, participants also receive immediate and timely feedback

from their instructor and peers with regard to their choices of instructional methods (Baker, & Clark, 2010; Nguyen et al., 2009; Vaughn et al., 2010).

Program Implementation

To successfully implement a new program, a well-planned implementation process is important. The change process includes not only a change in attitudes, but also the acquisition of new skill. The CBAM was applied in this study. This construct includes three analytical measurements toward the provision of tools and techniques to determine educator concerns so the necessary support can be provided. The first analytical measure is innovation configurations, which provides a depiction of the workshop. This will assist in focusing and guiding the workshop implementation. The second measure is referred to as levels of use, which describes the participant use of newly acquired knowledge. This dimension can be combined with observation and the innovation configuration to support this measure and can range from no use to high use. The third innovation is stages of concern, which addresses the concerns of the participants via open-ended interviews and questionnaires (see Appendix A).

Resources, Support, and Barriers

To reduce costs, it is important to collaborate with the organizational leadership for support of the change process and also for resources needed in the implementation of the workshop. For this project under study in this current research, the school is willing to provide clerical support, technology, and space for the workshop. An estimated budget was developed to exhibit the importance of collaboration with school leadership to develop a cost-effective workshop (see Appendix A). Two internal staff will coordinate

and evaluate the program. The workshop will be conducted within a large classroom or conference room on the school campus.

Potential barriers to implementation of the project under study in this current research include the planning necessary for the educators to attend the workshop. Due to their heavy schedules, finding 3 days for the workshop may be impossible for the educators. Additionally, because this professional program entails a cultural change for the institution, suspicion and an unwillingness among institutional leadership and other stakeholders to change established traditions could manifest. Finally, convincing all stakeholders to find space within an already-entrenched curriculum could also pose a barrier to implementation.

Timetable

The program proposed in this study will be conducted quarterly for 3 days, 8 hours each day, with 60 minutes for lunch and two separate 25-minute breaks. One month preceding program initiation, the obstetrical educators will be invited through school e-mail to register for the workshop. The external workshop presenters/facilitators will be booked and the program objectives and prerequisites will be sent to all registrants and institutional leadership. Hotel and travel arrangements will be made for the external presenters/facilitators and, 2 weeks before the workshop, final arrangements will be made with the institution for all needed teaching equipment and other resources. One week prior to the workshop, confirmations will be distributed to all registrants and final confirmations will be obtained from the external facilitators and the school for the needed equipment and classroom (see Figure 4).

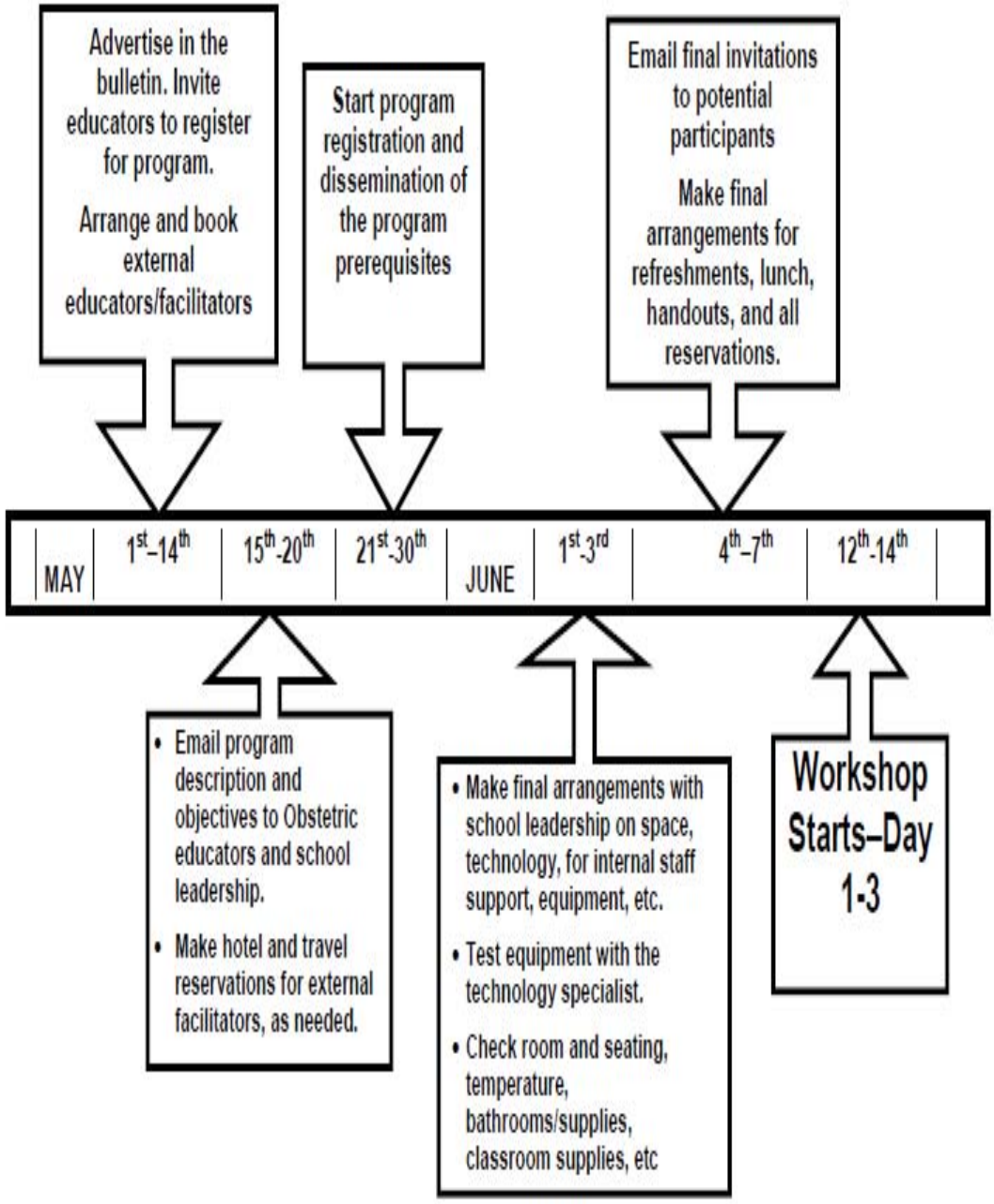

Figure 4. Timeline for the planning process and inception of the professional development workshop

Roles and Responsibilities

Transfer of learning. Essential individuals to the transfer of learning are the nursing directors, school leadership, and the didactic and clinical nursing faculty. The nursing directors and school leadership will support the participating educators as they work to transfer their newly acquired skills. These key individuals can also assist with designing, delivering, and assessing the proposed program. The didactic and clinical nursing faculty will ensure the transfer of learning by updating policies to reflect their newly acquired skills and serving as mentors to the obstetrical-nursing students.

Strategies and techniques. To determine the appropriate strategies and techniques for the transfer of learning, the educators will be assessed using the second dimension of the CBAM (Hall & Hord, 2011). Strategies will be implemented to measure the newly acquired knowledge of the participants. Educator preferences are considered along with resource availability and the knowledge and skills to be transferred (Caffarella & Daffron, 2013). Strategies to be used will include individual coaching and mentoring of the faculty members to support application of their newly acquired skills while modifying their didactic and clinical curriculum. Follow-up sessions will "reinforce and extend the learning from the original activity" (p. 229).

Program Evaluation

Program evaluation involves examination and recommendations for improvement or discontinuation. There are two types of program evaluation. One is a formative evaluation, which assesses whether the program is delivered in the manner intended. It is conducted while the program is in progress. A summative evaluation evaluates the program outcomes and is conducted upon completion of the program (Lodico et al.,

2010). Other methods exist, such as the objective-based approach, which relies upon objectives supported by benchmarks. The objectives determine the data to be collected. Another method is the goal-free evaluation, which assesses for unexpected outcomes. Another type is the expertise-oriented evaluation that employs an evaluator as an expert judge. Data are collected and presented by the program participants to the evaluators to be judged for effectiveness. The final method is the participant-oriented evaluation, which assesses the program participants who are actively involved in every aspect of the program evaluation.

Advantages and Disadvantages

Program-evaluation methods provide ongoing information to stakeholders during and after the program with flexible reporting of the findings. The findings are used immediately to make decisions and changes. The data collected are also used to make changes as the study is progressing. Program-evaluation studies use both qualitative and quantitative data; consequently, they offer all of the advantages of qualitative and quantitative designs. Program evaluation requires researcher involvement with the participants. For instance, in an objective-based evaluation, the objectives guide the data collection, whereas a participant-oriented evaluation involves the participants in data collection, data analysis, instrument design, and the reporting of the findings (Kleinsorge, Roberts, Roy & Rapoff, 2010; Lodico et al., 2010).

In objective-based evaluation, evaluators can be so focused on the objectives that they neglect "other unanticipated outcomes or benefits to participants" (Lodico et al., 2010, p. 326). For goal-free evaluation, because objectives are not required, it is difficult to include program outcomes in the evaluation. As a result, the correct data may not be

collected. Unlike quantitative designs, program evaluation requires the use of internal and external evaluators. The evaluation process can deplete program funds and present a tedious process for staff. Staff may consider the evaluation as just another program and may not accept, trust, or collaborate with external evaluators. This can introduce another barrier to collecting the correct data. Lastly, data collection can be influenced by researcher/evaluator bias (Kleinsorge et al., 2010).

Monitoring

During the program proposed in this study, a process for monitoring will be established by asking the participating educators to use their new skills and report their benefits, as well as to use those techniques that will allow them to transfer their newly acquired knowledge and skills. After program implementation, the educators will be provided with follow-up assistance and encouraged to adapt their new skills to their classrooms and clinical sites, as needed. A formal Likert-type survey (see Appendix A) will be used to measure the teaching techniques of the educators. A formal observation checklist (see Appendix A) will facilitate monitoring to confirm whether the educators are able to apply what they learned in their work settings, to evaluate the new skills the participants learned as a result of the program, and to assess whether the educators are more effective instructors as a result of the program.

The described study instruments will be implemented 1 month following completion of the workshop. They will be tested with a pilot group of five educators to determine reliability and construct, item, and content validity. The survey will be disseminated to the educators upon completion of the program and 1 month after completion of the program. This survey will facilitate the assessment of educator

feedback received immediately after the program and after they have applied their newly learned skills. The formal observation checklist will reflect how the educators are integrating LGBT issues into their didactic and clinical instruction. Data will be analyzed using descriptive statistics (i.e., frequency, mode, median, and mean; Lodico et al., 2010) and the results will be reported in a graphical format to all executive stakeholders. To ensure confidentiality, all data will be stored in a locked safe in my office and within a confidential computer folder.

The proposed program will be evaluated using the four Kirkpatrick (1994) models-of-training criteria—reaction, learning, behavior, and results. These criteria will be used to assess learning outcomes and evaluate the overall program (Praslova, 2010). The Kirkpatrick model will be applied to the proposed program to evaluate its effectiveness in meeting the preestablished goals, objectives, and outcomes. Reaction criteria ascertain the affective reactions and utility judgments of the program participants and their perceptions of the program. Put simply, the goal will be to determine whether the educators enjoyed the program and the extent of their learning. The learning criterion assesses knowledge outcomes. Behavioral criteria are also known as transfer criteria and are used to measure the transfer of learning. Results criteria are used to appraise the extent the program achieved the desired outcomes and later reinforcement for the educators (Orlando, 2009; Praslova, 2010).

Informal interviews were conducted to gather preliminary evaluations from the participants with regard to their learning experiences in the new program. An interview protocol was established specifically for this study and was used in these interviews to glean the effectiveness of the program. These sessions were conducted during work

breaks and within informal settings (see Appendix A). All information collected will be held strictly confidential, recorded, and stored within a confidential folder. The results will be shared with the external and internal instructors participating in the program either verbally or by e-mail. This information will be used to restructure the ongoing program and develop future programs.

For the learning criteria, a project-based presentation will be required to ensure the participants can incorporate LGBT health-care issues into their classroom and clinical teaching via different instructional techniques (see appendix A). The learners will develop a project-based presentation on the effective care of the LGBT community and incorporate it into their classroom and clinical teaching using various instructional techniques suitable for adult learners. Behavioral criteria will be used to assess whether these obstetrical educators were able to transfer their workshop learning by integrating LGBT obstetrical health issues into their classroom and clinical curriculum.

The results criteria assess the degree to which the workshop achieved the desired outcomes. The measure is the degree to which the workshop satisfied the three significant purposes of education—the acquisition of skills, preparation for independent thinking and action, and socialization (Biesta, 2009). Three months after completion of the workshop, the results will be measured with a Likert-type survey (see Appendix A) administered to obstetrical faculty, obstetrical students, and student alumni to ascertain their perceptions surrounding whether LGBT health issues were incorporated into the obstetrical curriculum. The data collected by the survey will also assist in ascertaining the effectiveness of the curriculum in preparing nursing students to care for LGBT patients within obstetrical settings. As noted earlier, data will be analyzed using descriptive

statistics (i.e., frequency, mode, median, mean; Lodico et al., 2010) and the results will be reported in a graphical format to executive stakeholders. To ensure confidentiality, all information will be stored in a locked safe in my office and within a confidential computer folder.

Implications and Conclusion

Critical social theory is applied to explain and attempt to transform the aspects of a societal culture that restricts and entraps its people. This construct incorporates the major social sciences to enhance understanding of the respective society. Studies have shown that professional-development activities contribute not only to the professional growth of educators, but also to social justice and positive change (Apple, 2013; Parker, 2010). The proposed professional-development workshop holds the potential to provide a wide range of evidenced-based teaching methodologies for educating obstetrical nurses on LGBT health issues, linking didactic and clinical content, promoting collaboration among educators and stakeholders toward empowering obstetrical educators to become more proactive, and on identifying the connection between research and practice.

The goal of this study was to contribute to equitable and competent health care for LGBT patients within all care settings. The assumption is that this equitable care will eradicate the societal infringement on the human rights of the LGBT population. Related training and education programs could improve service provision and treatment outcomes. Such programs could include sensitivity training on sexual orientation. The comfort levels and experience of health practitioners dealing with LGBT individuals must be evaluated before and after this training.

Applying the Knowles andragogy principles and the New York State Department of Education (2011) PTA, the proposed workshop will train obstetrical educators to design teaching methodologies that are useful for adults from different education, cultural, and developmental backgrounds. The goals embedded within the workshop and the objectives, implementation timetable, existing supports, potential barriers, resources, and project evaluation have been discussed. Social changes will be addressed and the potential stakeholders identified. The workshop is intended to become a model for other professional-development programs implemented to integrate LGBT health issues into health-care curriculum.

Section 4: Reflections and Conclusions

Introduction

Data drawn via a case-study analysis prompted the development of the proposed professional-development workshop— *Queerobstetrics- LGBT in Obstetrics Nursing: Train the Trainer.* The literature review centered on professional development and andragogy background. Section 4 will address the quality of the professional-development workshop including limitations. Additionally, the results of the project study, in relation to nursing scholarship and future trends in nursing, will be discussed. Finally, the prospective effect of the project on social change and the implications for future research will be discussed.

Project Strengths and Recommendations for Remediation of Limitations

This workshop met all of the characteristics of a successful professional-development program, as described by Guskey (2003). The workshop goals are aligned to participant practice and institutional objectives. The proposed program is centered on academic content and is ongoing, site based or school based, and encourages strong collaboration among educators (Wei et al., 2010). The workshop is designed to promote active learning with a primary focus on content that is adequately structured and organized to intensify and increase participant learning and retained knowledge. Workshop activities are supported by institutional leadership and the program is designed for a purposeful, collaborative effort between participants and school leadership.

The examination of this study is focused on obstetrical nursing; however, the findings can easily be generalized to populations within other health-care disciplines. Due to the educational activities and responsibilities of the participating educators, the 3 days

of data collection may be perceived as lengthy. This limitation can be solved by conducting the workshops on different days, on weekends, or on alternating days according to the schedules of the study sample and school site. Because the proposed program entails a culture change for the institution, suspicion or an unwillingness among institutional leadership and other stakeholders to change established traditions could manifest. However, this potential barrier could be overcome by collaborating with the institutional leaders and other stakeholders. Convincing these individuals to find space within an already entrenched curriculum could also emerge as a challenging issue; however, demonstrating to educators the ease in which LGBT content can be integrated could avoid this additional potential barrier.

Scholarship

Education can transform individuals, allowing them to improve their circumstances. Education can be gained through both reflection and experience and manifest within both formal and informal settings. It is learner centered while involving the active participation of students. Each learner brings unique experiences to the education setting and each learns differently. The teacher is a role model, a mentor, and a facilitator. An effective teacher uses a variety of teaching methods to reach different learners.

The adult-learning theories of Knowles facilitated the planning and development of this study and ensured that the content and teaching plan were problem centered and relevant to the lives and experiences of learners. Learners were provided with the opportunity to be autonomous and self-directing. Transformational, experiential, and multiple-intelligence theories are all evident when didactic content is integrated with

theory and practical experience. To accommodate the preferred intelligence of each student, a combination of teaching methods were employed such as role playing, storytelling, case study, discussion, observation, and presentation. The Skinner model of operant conditioning was applied to change the behavior of the learners (McKerchar, Morris, & Smith, 2011).

The evaluation methodology and its practical requirements served as both positive and negative reinforcement. The group presentations and reflections of learners were recognized and given intermittent and positive reinforcement. This reinforcement conditions learners to practice in a positive manner. Thus, the probability of the reinforced behavior reoccurring is high. The classroom simulation broke down the eventual experiences the learners will encounter into small, manageable steps, allowing them to progress from easy to complex tasks. Assessment is crucial to the education process; otherwise, academia would be a closed system, monopolized by omnipotent teachers and bureaucrats. The continual personal and peer review helped to revise and improve the workshop designed in this study, clarify workshop objectives, reform teaching methodologies, and assess the knowledge and comprehension of the learners.

Project Development and Evaluation

The program developed in this current study was divided into three phases. Results from the qualitative analysis led to problem detection, the identification of stakeholders, and keywords for the literature search. Project objectives were constructed following a review of the research results. While developing the proposed program, the amount of work needed for its development was overwhelming. Theories, teaching and research methodologies, and research studies all needed to be removed. I collaborated

with all stakeholders to determine their needs. This collaborative process facilitated the creation of clear goals and objectives, as well as an understanding of the perceptions of these individuals. Their ideas were effectively used to align the learning tasks with the objectives of the workshop. Different collaborative strategies were employed such as cooperative learning, Think-Pair-Share, and Jigsaw. The workshop will link practice and theory for obstetrical educators. It will serve as a resource tool for cognitive and practical curriculum modification within the realm of obstetrical nursing. The workshop will empower learners to communicate with their colleagues and students, collaborate with major stakeholders, manage diversity, and facilitate problem solving within their classrooms and clinical settings.

Leadership and Change

Changes within the field of education are necessitated by the constant modification to educational paradigms; demands for innovative educational technology; globalization; and economic, political, and societal transitions. To coordinate the demands of their students and colleagues, many educators struggle to learn and accept these changes. To effectively change the obstetrical curriculum and implement the workshop designed in this study, comprehensive collaboration among all significant stakeholders was critical, especially between institution leadership, faculty, and the students. The purpose of this collaboration is to obtain stakeholder feedback on, and support of, the proposed workshop. The workshop will serve as a medium to allow all stakeholders to receive an enhanced depiction of pending change and highlight their important roles. Since any change process is rarely accepted with ease, especially when involving such a controversial population, transformational-leadership skill is important

to facilitate the change process. Developing a strong team to implement the change; consistent related communication; and the empowerment of all stakeholders are very important for implementation success. Any short-term changes are communicated to all stakeholders. In keeping with the transformational-leadership style, the workshop would be regularly evaluated and adjusted, as needed, to accommodate their values, goals, and interests.

As a transformational leader, I will ensure that the proposed workshop remains aligned with the goals and values of the educators; offers the educators ways of achieving their goals; empowers them to act in the interest of the overall society; and provides them with a vision to assist them with achieving self-actualization. The educators would be informed of the rationale and importance of incorporating LGBT obstetrical health issues into their didactic and clinical instruction. These health issues will be reframed to emphasize how their exclusion from obstetrical curriculum could adversely affect faculty, students, the nursing profession, health-care in general, and American society as a whole. The faculty would be provided with solutions for proactively blocking future adverse outcomes involving the exclusion of LGBT health-care issues from obstetrical nursing. Finally, the educators would be empowered to assume active roles and advocate for change within obstetrical-nursing curriculum and related education as a whole.

Self-Analysis of Researcher

As I continue as a scholar and practitioner, I plan to continue with research investigating evidenced-based teaching theories and methodologies toward positive social change. I hope to contribute to education policy by proposing a relaxation or eradication of rigid, archaic rules that limit the admission of adult students and reduce the exposure

of students to innovative teaching methods and adaptable and nontraditional curriculum. Additional effort is needed to invest in the training, retention, and recruitment of qualified educators willing to implement innovative and stimulating teaching methodologies. Additionally, the accreditation process must be revamped to support nontraditional schools.

In keeping with my core values and beliefs surrounding personal growth, interpersonal skills, collaboration, fairness, and justice, I strongly believe in global social change. Personally, social change translates to using my professionally acquired expertise as a health-care, education, and legal professional to improve the practice of health-care providers. Social change also equates to using current research to change laws that negatively influence the quality of education on a global basis. Furthermore, it is seeking out educational resources and professional associations as a way to improve personally and professionally. Finally, I believe that social change demands a consistent reevaluation of my beliefs and prejudices so they do not affect my practice within the classroom and beyond.

I hope to continue to grow as an educator. I am open to innovative, philosophical, and educational perspectives that will allow me to serve as an educator who inspires students to value learning. I desire to continue my personal learning and refine my teaching methodologies on an ongoing basis. I desire to be an effective mentor and a role model for my students, as well as instrumental in using my skills and talents to transform their lives. Students, in turn, convert their families and change communities. I desire to bring hope and transformation to those who need it the most. As an educator, I can both

actively and passively influence future education policy on local, state, federal, and international levels that affect higher education.

As I reflect on the doctoral process, I am humbled by the many obstacles I have overcome. During the development of the study and the proposed workshop, the amount of reading and work entailed was frequently overwhelming. Initially, I struggled with the integration of myriad theories, studies, and methodologies to provide a solution for the local problem. I learned that, without the collaboration and support of all stakeholders, the creation of a workshop toward this end would be a tedious and futile effort. I learned the importance of using a variety of academic resources to create a solution that would not only resolve the problem identified in this study, but also develop a tool that holds the potential to instill positive change in nursing education on a global basis.

It took great effort to conquer the isolation of doctoral study in an online institution. Nonetheless, I learned the importance of time management, customer service, patience, and communication. I now realize that the skills and knowledge I have gained are invaluable. I have transformed into a critical thinker and a conscientious scholar and practitioner. I am no longer overwhelmed with deciphering any type of research. I can critically analyze and discuss studies with the expertise of a researcher, albeit a novice researcher. I am excited about the skills I have acquired as a doctorate-prepared educator and now feel confident that I can contribute to the scholarship of my profession.

Potential Impact on Social Change

The development of this study confirmed the significance of developing a professional-development workshop within both a local and global context. The workshop designed in this study holds the potential to provide educators with a wide

range of evidenced-based strategies to incorporate LGBT health-care issues into didactic and clinical nursing curricula. This study served as a conduit between research and practice by demonstrating methods of executing research within education settings. A critical stance was taken to empower educators to aggressively confront both inequality and disproportionate power displays within the classroom and American society as a whole.

Critical theorists, such as Paulo Freire (as cited in Singer & Pezone, 2013), had a pedagogical goal of providing education to marginalized populations. They vigorously disputed oppression and unequivocally critiqued social and human injustice. This current study may transform the manner in which the health-care industry inappropriately treats and relates to the LGBT population within the realm of obstetrics and in general. The research will contribute to the global fight against violence and discrimination toward the LGBT cohort. Nursing educators will be empowered to become transformative educators who will denounce societal inequalities; speak out against the marginalization of people; and encourage nursing students across the globe to creatively empathize with all human beings, regardless of their sexual orientation and sexual identification.

Implications, Applications, and Directions for Future Research

Numerous researchers have examined the health-care disparity among members of the LGBT population. However, few have mentioned the reeducation and empowering of health-care educators toward changed attitudes. Associate-degree nursing schools must strive to review the methods they incorporate to train their students to provide competent care for all people (Obedin-Maliver et al., 2011; Röndahl, 2009a).

The results of this study indicate that, within the study site, minimal LGBT health issues are incorporated in didactic and clinical obstetrical-nursing education. The curriculum has virtually ignored the transgender population within the majority of programs. The goal of this study was to explore how well obstetrical-nursing schools are preparing their students to competently care for LGBT patients within obstetrical settings. However, no practical tools exist to measure the competency of nursing-school graduates, as it relates to caring for LGBT cohorts. Therefore, it is recommended that future studies directly measure these variables.

Conclusion

This project study resulted in the development of a workshop for obstetrical nurse educators. The case-study model allowed data to be collected that facilitated the construction of a resolution to a local problem. Although the focus is restricted to the field of health care that serves women, children, and their families, the workshop designed in this study can be adjusted to meet the needs of the institution. The doctoral-study progression provided close scrutiny and acceptance of the potential of educators as instruments of social change. The onus is on educators to promote social change by linking practice and theory. This examination of the manner in which the LGBT population is represented within mainstream obstetrical-nursing courses, curricula, textbooks, and syllabi confirmed the stance throughout related literature of the exclusion of LGBT health issues within nursing education. It is hoped that obstetrical faculty and their leadership will utilize the findings of this study toward considerable adjustments in their nursing programs.

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Appendix A: The Project

For the entire project with all the teaching resources click or copy this link into your browser:

https://sites.google.com/a/waldenu.edu/chinazo-echezona-johnson-ed-d-project-study/research

Queerobstetrics® - LGBT in Obstetrics Nursing

Train-The-Trainer

Professional Development Workshop

Ceus Pending
Refreshments and Lunch will be served

Developed by:
Chinazo Echezona-Johnson, Ed.D (c), MSN, LL.B, RNC-MNN

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Train-The-Trainer

WORKSHOP AGENDA

Curriculum Overview

Learning Objectives:

1. Define LGBT identities and issues in obstetrical health-care setting
2. Examine the particular hurdles and challenges that LGBT people encounter when accessing obstetric health care
3. Discuss alternative ways to incorporate LGBT obstetrical healthcare issues into classroom and clinical instructions using adult learning principles instructional techniques
4. Discuss alternative ways to conduct incorporate LGBT obstetrical healthcare issues into classroom and clinical instructions using adult learning principles

Three-Day Curriculum Includes:

- ✓ Learners' exercises and assessments
- ✓ All slides and graphics
- ✓ Video dramatizations of classroom instruction
- ✓ Case studies and role plays
- ✓ Facilitator guides
- ✓ Peer reviewed articles on LGBT
- ✓ PowerPoint Handouts
- ✓ Surveys
- ✓ Assessments

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Train-The-Trainer

DAY ONE: Introductory Knowledge

Time: 8:30 am -5:00 pm

Topic	Key Points	Supporting Content, Assessments, and Planning Tools
8:30 am- 9:00 am Registration/Breakfast		
9:00am – 09:30am Introduction/Course roadmap	• Facilitator introduces his/herself and any affiliation • Reviews agenda for the session (breaks, location of restrooms, schedule appropriate norms) • Introduces learners to the program • Reviews ground rules • Review the preferred outcomes for the session	• The Joint Commission's Field Guide • Read and discuss two peer reviewed articles about adult learner • PowerPoint Handout • Principles of Adult Learning Scale • by Gary Conti • Video presentation
09:30am – 11:30am LGBT Healthcare Issues in Obstetrics	• Background on LGBT identities and issues in obstetrical health-care setting • Challenges that LGBT people face in accessing obstetric health care	
11:30am – 11:45 am Break/Snacks		
11:45am – 12:45 pm Andragogy vs pedagogy -Review	• Review the elements of Knowles'andragogy and Pedagogy	
12:45 pm – 1:45 pm Lunch		
1:45pm – 3:00pm ABCs of LGBT –Myth and Terminology	• Mix the discussion groups to reflect different age groups and experience level • Understand myths about LGBT population • Discuss different LGBT terminology	
3:00 pm – 3:15 pm Break/Snacks		
3:15pm -4:30pm Nursing the LGBT Obstetric Patient	• Nursing interventions into the didactic/clinical content • Assign group members for presentation	
4: 30pm – 5:pm Wrap-Up for the day	• Summarize today's content • Brief review of tomorrow's agenda • Questions • Sign-Out	

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DAY TWO: Instructional techniques to and simulation incorporate LGBT health issues into the didactic and clinical obstetric curriculum

Time: 8:30 am -5:00 pm

8:30 am- 9:00 am Registration/Breakfast		
Topic	**Key Points**	**Supporting Content, Assessments, and Planning Tools**
9:00am – 10:00am Nursing Core competencies of LGBT obstetrical care	• Empower the obstetric faculty members to proactively incorporate LGBT health issues into the didactic and clinical obstetric curriculum	observe a video of classroom teaching simulation Critique video New York State Teachers Website to instructional websites
10:00am -10:15 am Break/Snacks		
10:15am -11:45 am How to embed LGBT healthcare Issue into Classroom and Clinical Content?	• Observe classroom instructional techniques and simulation. • On how to proactively incorporate LGBT health issues into the didactic and clinical obstetric curriculum • Discuss/Brainstorm different instructional techniques and simulations to incorporate LGBT health issues into the obstetrics curriculum	
11:45am – 1:45 pm Working lunch – Two hours Meet with group -Share ideas -Discuss Presentation		
1:45 pm – 3:15 pm 21st Century Instructional Methodologies	• Critique different classroom/clinical instructional techniques and simulation. • Practice using new techniques to incorporate LGBT issues into classroom/clinical content	
3:15pm – 3:30 pm Break/Snacks		
3:30 pm – 4:15 pm Preparation for presentation tomorrow	• Submit to and Discuss topic with facilitator • Receive overview for tomorrow's presentation	

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DAY THREE: Assessment and Reflection

Time: 8:30 am -5:00 pm

Topic	Key Points	Supporting Content, Assessments, and Planning Tools
8:30 am- 9:00 am Registration/Breakfast		
9:00am – 10:00 am Presentation Overview	• Each group of three participants will develop a project-based presentation on how to effectively care for LGBT healthcare issues into their classroom and clinical teaching by using different instructional techniques simulation suitable for adult learners. • For each presentation, the goal of the learners is to state and explain three LGBT obstetrical concepts and how they will incorporate them into their classroom and clinical instructions	• Presentation Rubric
10:00am – 11:00am Break/Snacks Groups' Final Meeting		
11:00am – 12:30 pm First Group Presentation	• Critique/Questions/Reflections	
12:30pm -1:30 pm Lunch		
1:30pm – 3:00p Second Group Presentation	• Critique/Questions/Reflections	
3:00pm – 3:15 pm Break/Snacks		
3:15 pm-4:15pm Conclusion	• Summarize today's content • Reflections • Questions • Course and Faculty Evaluation	
4:15p -5:00p Wrap-Up	• Certificates/CEUs • Sign-Out	

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Train-The-Trainer

FACILITATOR GUIDE

Opening Remarks

1. Thank the person who introduced you
2. Thank the educators for coming to listen to the presentation
3. Establish your credibility - explain your experience, share your interest in the materials being presented, but **DO NOT** show off your credentials (this is especially important for a potentially hostile group)
4. Present your agenda (the main ideas and expectations)
5. Tell the audience what you hope they will gain, learn or understand by the end of the presentation
6. State the ground rules (i.e. when will you answer questions - during or after presentation? Will there be any breaks, etc.)
7. Give a time frame for your presentation

FACILITATOR PROMPTS

Adult Learning Concepts

1. Adults enter the room with a solid sense of self
   - They are attached to their beliefs, ethics, style
2. Adults bring a wealth of experience into the room
   - They will also mask how much they **DON'T** know
   - They need to know **WHY**
3. Adults are responsive to **INTERNAL** motivators
   - They learn best in an atmosphere of support, trust, empathy
4. Adults have a readiness to learn anything that helps them cope.
   - Relate the learning to their duties at work

What is especially challenging about this material

1. Admitting that you don't know
2. Dealing with the discomfort of sexual material and new language/terms
3. Accepting that their usual & well-thought-out way of treating patients might actually be offensive or rejecting to some people

Common Value Systems for Determining How to Treat Others

- I treat others as I like to be treated- **The Golden Rule**
- I treat others as they deserve to be treated
- I treat all people the same
- I treat others according to their needs
- I treat others as they want to be treated- **The Platinum Rule**
- I treat others according to the way they treat me

Adapted from HHC Cultural Competence training

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Train-The-Trainer

Purpose:

This model offers:

1) a workshop plan to introduce LGBT terminology, explanation of how LGBT identity can affect health, and will focus on the unique obstetric health issues facing the LGBT community

2) a workshop that will strive to empower the obstetric faculty members to proactively incorporate LGBT health issues into the didactic and clinical obstetric curriculum by providing innovative instructional designs

3) a workshop that will attempt to assist faculty members to facilitate obstetric students through the core competencies of caring for LGBT population in the obstetric setting.

The fundamentals of the new *Queerobstetrics® - LGBT in Obstetrics Nursing: Train-The-Trainer workshop* are entrenched and in alignment with the adult learning principles, and the New York State Professional Teaching Standards (PTS) (2011). This workshop also provides detailed suggestions for instructional methodologies. This model professional development workshop may be customized as needed according to the plans and priorities of individual schools.

Learning objectives for program outcome

At the end of the program, participants will be able to:

1. Define LGBT identities and issues in obstetrical health-care setting

2. Examine the particular hurdles and challenges that LGBT people face in accessing obstetric health care

3. Discuss alternative ways to conduct incorporate LGBT obstetrical healthcare issues into classroom and clinical instructions using adult learning principles instructional techniques

4. Discuss alternative ways to conduct incorporate LGBT obstetrical healthcare issues into classroom and clinical instructions using adult learning principles

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Train-The-Trainer

STRUCTURE AND FORMAT OF PROGRAM

The program format for this learning task will be for small groups of 12 obstetrical nurse educators for each session. The format will be workshops made up of mini-lectures, small group discussions; problem based learning, observations, simulations, reflective practice.

Team style arrangement promotes team interaction (Caffarella & Daffron, 2013).

The workshops will take place in a large classroom or a large conference room in one of the nursing school's campuses. The school's classrooms and conference rooms must be conducive to learning and must be technology-ready with wifi. The type of seating will be a team style arrangement with seats of six around oblong tables.

To promote the comfort of the educators, refreshments and free hot lunch will also be served.

In keeping with the literature findings of sustained and intensive professional programs as the most effective, the program will be conducted monthly for three days for eight hours with 30 minutes break time each day, and one hour lunch.

The instructor's notes should focus on encouraging the audience participation, giving background on LGBT and Knowles's Andragogy vs pedagogy; and mixing the discussion groups to reflect different age groups, gender and experience levels. The instructor's should also encourage the participants to talk about their philosophy about education, ask probing questions about different instructional methods, be knowledgeable of alternative techniques and strategies for questioning and discussion, create a supportive educational environment that encourages students to take risks.

The project has three sections

- The first section institutes the introductory knowledge
- The second section empowers the obstetric faculty members to proactively incorporate LGBT health issues into the didactic and clinical obstetric curriculum
- The third section assesses the knowledge of the educators.

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Train-The-Trainer

Suggested Materials:

- PowerPoint presentation and handouts
- Posters , Flip charts, LCD panels, Dry erase markers
- Reference lists for LGBT and Andragogy
- Extra papers and pens
- Peer reviewed articles
- Computer with Internet access for the presenter
- Data projector

A model plan for the facilitator is provided at the end of this document. There is a hyperlink for all documents, supporting instruments and resources developed will be provided.

Prerequisites

1. Mandatory participation in the needs assessment survey - Principles of Adult Learning Scale by Gary Conti
2. Read the Joint Commission's Field Guide, (2010)
3. Read two peer reviewed article about LGBT population
4. Read and discuss two peer reviewed articles about adult learner
5. The New York State Professional Teaching Standards (PTS) (2011).

Introduction/Overview

- Facilitator introduces his/herself
- Reviews agenda for the session (breaks, location of restrooms, schedule appropriate norms)
- Introduces participants to the program
- Makes explicit connections to LGBT content throughout the training activities
- Reviews setting norms and ground rules to encourage learning reflection engagement and sharing
- Review the preferred outcomes for the session

See Facilitator's Guide

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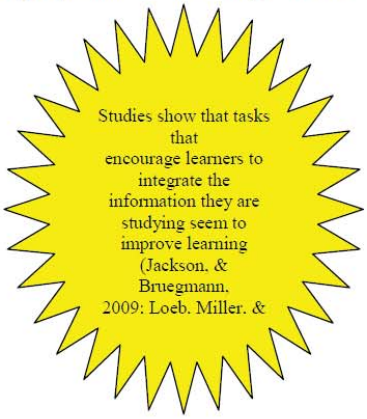
Queerobstetrics® - LGBT in Obstetrics Nursing

Train-The-Trainer

1. LEARNING TASK ONE - INTRODUCTORY KNOWLEDGE

Learning Task One

- The first learning task is that the learners will comprehend LGBT identities and issues in obstetrical health-care setting; and challenges that LGBT people face in accessing obstetric health care.
- This learning task will encourage the educators to actively process the information about LGBT population and their obstetric healthcare issues.
- The task will help the educators to accomplish their learning objectives. According to Caffarella & Daffron, learning develops when the learning task encourages the learner to actively process the information (2013).
- Understand how to embed nursing interventions into the didactic/clinical content



Learning Outcomes

- Verbalized knowledge of session objectives
- Articulate alternative ways to incorporate LGBT obstetrical healthcare issues into classroom and clinical instructions using adult learning principles instructional techniques
- Understand the learning needs of LGBT population in obstetric nursing
- Understand how and when to implement LGBT elements into obstetric nursing
- Explore and make connections between LGBT healthcare issues and nursing profession standards
- Comprehend ways to influence the adult learner

Facilitator shows *YouTube* video to the learners

Give the educators the exercise: "TRASH THAT MYTH EXERCISE /MYTH OR FACT"

Reflection

Video presentation

After the video concludes, the facilitator shows this quote.

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Train-The-Trainer

Quote: "At some point in our lifetime, gay marriage won't be an issue, and everyone who stood against this civil right will look as outdated as George Wallace standing on the school steps keeping James Hood from entering the University of Alabama because he was black."
— George Clooney

Facilitator asks participants to respond through a brief pair-share discussion.

- **What did you learn from the video?**
- **What questions are you left with?**
- **What does this tell us about LGBT in obstetric education?**

Discussion:

Give the participants: "TRASH THAT MYTH EXERCISE /MYTH OR FACT" answer sheet

- **What did you learn from the exercise?**
- **What questions are you left with?**
- **What does this tell us about LGBT in obstetric education?**

Jigsaw

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Train-The-Trainer

INSTRUCTIONAL PLAN FOR LEARNING TASK ONE					
Title:	**Train-the-trainer: integrating LGBT health issues into obstetrics nursing education**				
Learning objectives:	**At the end of the program, participants will be able to: (1) Define LGBT identities and issues in obstetrical health-care setting (2) Examine the particular hurdles and challenges that LGBT people face in accessing obstetric health care**				
Date and Time:	**Monday to Friday, August 2014 9:00 am to 5:00 pm**				
Group size:	**Small group of New York Nursing educators for each session.**				
Target population:	**New York Nursing educators**				
Learning Task One	**Purposes**	**Alignment with outcomes and objectives**	**Prerequisites**	**Instructional techniques/Methods**	**Instructor's notes**
♦ Learners will comprehend LGBT identities and issues in obstetrical health-care setting and particular hurdles and challenges that LGBT people face in accessing obstetric health care	▶ This learning task will encourage the educators to actively process the information about LGBT population and their obstetric healthcare issues. ▶ Help the educators to accomplish their learning objectives.	To be able to understand LGBT population plight in obstetrical nursing can affect health, and will focus on the unique obstetric health issues facing the LGBT community.	▶ Read The Joint Commission's Field Guide ▶ Read a peer reviewed article about LGBT population ▶ Read and discuss two peer reviewed articles about adult learner motivation ▶ Mandatory participation in the needs assessment survey	Workshops made up of: ●problem based learning ●observations ●simulations ●reflective practice ●Mini-lecture ●Small group discussion	▶Give background on LGBT identities and issues in obstetrical health-care setting, the particular hurdles and challenges that LGBT people face in accessing obstetric health care; Knowles' Andragogy vs pedagogy ▶ Mix the discussion groups to reflect different age groups and experience level ▶ Focus on encouraging the participation and time keeping.
PRACTICE AND FEEDBACK: Interactive instruction strategy using small group discussion and cooperative learning.					
ASSESSMENT PLAN: Group presentation assessed using project-based the rubrics					
INSTRUCTIONAL RESOURCES AND EQUIPMENT NEEDED:					
FOR INSTRUCTOR • PowerPoint presentation • Posters • Flip charts • LCD panels • Dry erase markers			**FOR PARTICIPANTS** • Reference lists for LGBT, Andragogy • PowerPoint Handouts • Extra papers and pens • Principles of Adult Learning Scale • by Gary Conti • Peer reviewed articles		
LEARNING ACCOMMODATIONS/ ROOM ARRANGEMENT NEEDED: **The workshop will occur in a large classroom. The type of seating will be a team style arrangement with seats of 4 around oblong tables.**					

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Train-The-Trainer

2. LEARNING TASK TWO - INSTRUCTIONAL TECHNIQUES TO AND SIMULATION INCORPORATE LGBT HEALTH ISSUES INTO THE DIDACTIC AND CLINICAL OBSTETRIC CURRICULUM

Learning Task Two

- The second learning task is that the learners will observe and critique different classroom instructional techniques and simulation.
- To proactively incorporate LGBT health issues into the didactic and clinical obstetric curriculum by providing innovative instructional designs, and to facilitate the core competencies of caring for LGBT population in the obstetric setting obstetric
- This task will support the educators in building and incorporating the information to their own knowledge base of LGBT.
- It will also empower the obstetric faculty members to proactively incorporate LGBT health issues into the didactic and clinical obstetric curriculum by providing innovative instructional designs.
- The educators will be able to observe and critique different classroom instructional techniques simulations. This will help them differentiate between what methods are appropriate and effective for adult learners.

Facilitator asks learners to respond through a brief pair-share discussion

What does this tell us LGBT content in obstetrical nursing syllabus, textbook, lectures presently? How about in the future?

Video presentation

Think-Pair-Share discussion

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Train-The-Trainer

INSTRUCTIONAL PLAN FOR LEARNING TASK TWO

Title: *Train-the-trainer: integrating LGBT health issues into obstetrics nursing education*

Program outcome: *The workshop will also strive to empower the obstetric faculty members to proactively incorporate LGBT health issues into the didactic and clinical obstetric curriculum by providing innovative instructional designs. Also, this project will attempt to assist faculty members to facilitate obstetric students through the core competencies of caring for LGBT population in the obstetric setting.*

Learning objectives: At the end of the program, participants will be able to: (1) discuss alternative ways to incorporate LGBT obstetrical healthcare issues into classroom and clinical instructions using adult learning principles instructional techniques

Date and Time: : *Monday to Friday, August 2014 9:00 am to 5:00 pm*

Group size: Small groups of 12 New York educators for each session.

Target population: New York Nursing educators

Learning Task Two	Purposes	Alignment with outcomes and objectives	Prerequisites	Instructional techniques/ Methods	Time Frame/ Instructor's notes
Observe and critique different classroom instructional techniques simulation.	▶Support the educators in building and incorporating the information to their own knowledge base of LGBT and Knowles's Andragogy ▶This will help them differentiate between what methods are appropriate and effective to teach LGBT health issues to adult learners.	To proactively incorporate LGBT health issues into the didactic and clinical obstetric curriculum by providing innovative instructional designs, and to facilitate the core competencies of caring for LGBT population in the obstetric setting obstetric, the participants will be able to observe and critique different classroom instructional techniques simulations.	▶Submit teaching philosophy ▶Complete Principles of Adult Learning Scale by Gary Conti ▶Observe and critique classroom teaching simulation	Workshops made up of: •Problem based learning •Observations •Simulations •Reflective practice •Mini-lecture •Small group discussion	95 minutes ▶Encourage the participants to talk about their philosophy about education ▶Ask probing questions about different methods Prompt participants to talk about their experiences ▶Be knowledgeable of alternative techniques and strategies for questioning and discussion ▶Create a supportive educational environment that encourages participants to take risks

Practice and Feedback: Interactive instruction strategy using small group discussion and cooperative learning.

Assessment Plan: Group presentation assessed using project-based the rubrics

Instructional resources and equipment needed:

For Instructor

- PowerPoint presentation
- Posters
- Flip charts
- LCD panels
- Dry erase markers

For Participants

- Reference lists for LGBT, Andragogy
- PowerPoint Handouts
- Extra papers and pens
- Principles of Adult Learning Scale by Gary Conti
- Peer reviewed articles

Learning accommodations/ Room Arrangement Needed: The workshop will occur in a large classroom. The type of seating will be a team style arrangement with seats of 4 around oblong tables.

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3. LEARNING TASK THREE – ASSESS AND REFLECT

Learning Task Three

- Each group of three participants will develop a project-based presentation about how to effectively care for LGBT healthcare issues into their classroom and clinical teaching by using different instructional techniques simulation suitable for adult learners.
- For each presentation, the goal of the learners is to state and explain three LGBT concepts and how they will incorporate them into their classroom and clinical instructions.
- The presentation will be assessed using rubric.

Rubrics allow the adult learner to concentrate on important areas of the assessment. Also, rubrics reduce the confusion connected with unclear instructions. A rubric creates a map that students can use to achieve the best possible level of academic performance (Stevens & Levi, 2013). Behavioral criteria will be used to assess if the obstetric educators were able to transfer what they learned at the workshop by integrating LGBT obstetric health issues into their classrooms and their clinical curriculums.

Learning Outcomes

- Verbalized knowledge of session objectives
- Articulate alternative ways to incorporate LGBT obstetrical healthcare issues into classroom and clinical instructions using adult learning principles instructional techniques
- Understand the learning needs of LGBT population in obstetric nursing
- Understand how and when to implement LGBT elements into obstetric nursing
- Explore and make connections between LGBT healthcare issues and nursing profession standards
- Comprehend ways to influence the adult learner

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Train-The-Trainer

LEARNING ASSESSMENT		
Time	**Instructor Activities**	**Learner Activities**
20 min	Set up situation for the preparation of the outline	Identify elements necessary to make a presentation outline
330 min	Identify project teams Guide project	Develop a presentation. Revise with feedback
60 min	Identify areas of process to document	Document the group process
60 min	Review the presentation	Make a presentation to a Workshop participants
10 min	Debrief activity	Identify group process

ACTIVITY – PRESENTATION	
TOPIC::	*TRAIN-THE-TRAINER: LGBT IN OBSTETRICS NURSING*
Objective:	Develop and make a presentation about how to incorporate LGBT issues into their obstetrical classroom and clinical instructions using adult learning principles
TIME:	**1-2 HOURS**
Techniques / Equipment:	Library, online sources, Handouts, an assigned topic, and a target group. Monitor content and support participation.
Objective 1:	Demonstrate how to incorporate LGBT issues into their obstetrical classroom and clinical instructions using adult learning principles
TIME:	**20 MINUTES**
Process 1: *In small groups of four:*	• Identify elements necessary to make a presentation outline. • Research the appropriate information on LGBT health issues in obstetrics • Identify the needs and understanding of a specific target group (Obstetric Nursing Students). • Create an outline for the presentation that will effectively deliver this information to a specific target group (Obstetric Nursing Students).
Group Success:	**Everyone in the group has given feedback for revisions.**
Accountability:	Hand in to instructor outline signed by all members of the group. Document the group process.
Objective 2:	Present the revised activity to a specific group.
Time:	**30-45 minutes**
Group Success:	**Everyone in the group has been involved in developing and making the presentation.**
Process 2: *In small groups of four:*	• Revise the outline created in Objective 1 after receiving instructor feedback. • Use the revised outline to create a presentation for this group.
Group Success:	**Everyone in the group has been involved in developing and making the presentation.**
Accountability:	Document the group process. Make the presentation to the group. Receive feedback from the group.
Debrief:	What were the best sources of information? What did you learn in the process of developing the outline? How well is your group working together?

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Presentation Rubric

Score Levels		Content	Scholarly Writing	Organization	Presentation
EXCELLENT	4	*Is well thought out and explains how to incorporate LGBT issues into the obstetrical classroom and clinical instructions using adult learning principles. Has clear goal that is related to the topic. Reflects application of critical thinking Is pulled from a variety of up-to-date sources*	*No spelling, grammatical, or punctuation errors High-level use of vocabulary and word choice*	*Information is clearly focused in an organized and thoughtful manner. Information is constructed in a logical pattern.*	*Multimedia is used to clarify and illustrate the main points. Format enhances the content. Presentation captures audience attention.Presentation is organized and well laid out.*
PROFICIENT	3	*Explains how to incorporate LGBT issues into the obstetrical classroom and clinical instructions using adult learning principles. Has clear goal that is related to the topic. Has application of critical thinking that is apparent. Is pulled from several sources*	*Few (1 to 3) spelling, grammatical, or punctuation errors Good use of vocabulary and word choice*	*Information is clearly focused in an organized and thoughtful manner. Information is constructed in a logical pattern*	*Multimedia is used to illustrate the main points. Format is appropriate for the content. Presentation captures audience attention. Presentation is well organized.*
ADEQUATE	2	*Explains how to incorporate LGBT issues into the obstetrical classroom and clinical instructions using adult learning principles. Has no clear goal Has application of critical thinking that is apparent Is pulled from a limited number of sources Has some factual errors or inconsistencies*	*Minimal (3 to 5) spelling, grammatical, or punctuation errors Low-level use of vocabulary and word choice*	*Project has a focus but might stray from it at times. Information appears to have a pattern, but the pattern is not consistently carried out in the project. Information loosely supports the solution.*	*Multimedia loosely illustrates the main points. Format does not suit the content. Presentation does not capture audience attention. Presentation is loosely rganized.*
INADEQUATE	1	*Provides inconsistent information about how to incorporate LGBT issues into the obstetrical classroom and clinical instructions using adult learning principles. . Has no clear goal Has no apparent application of critical thinking pulled from few sources Has significant factual errors, misconceptions, or misinterpretations*	*More than 5 spelling, grammatical, or punctuation errors Poor use of vocabulary and word choice*	*Content is unfocused and haphazard. Information has no apparent pattern.*	*Presentation appears sloppy and/or unfinished. Multimedia is overused or underused. Format does not enhance content. Presentation has no clear organization.*
					TOTAL POINTS

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CHECKLIST OF TOOLS AND RESOURCES

If executed as presented, this workshop entails using of several technology resources and tools. It is suggested that all web-based resources be checked in advance to guarantee that wireless access and any other limitations that will prevent the use of the resources.

1. Mandatory participation in the needs assessment survey - Principles of Adult Learning Scale by Gary Conti
2. Read the Joint Commission's Field Guide, (2010)
3. Read two peer reviewed article about LGBT population - Article one and Article Two
4. Read and discuss two peer reviewed articles about adult learner – Article one and Article two
5. The New York State Professional Teaching Standards (PTS) (2011).
6. Facilitator guide
7. Handout

Instructional Methods

- Video presentation
- PowerPoint Presentation
- Discussion
- Think-Pair-Share
- Jigsaw
- Agenda
- Brainstorm
- Observation
- Learning Task 1
- Learning Task 2
- Learning Task 3
- LGBT Terms
- Lecture A
- Lecture B

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4. LGBT TERMS

These terms and definitions are not all-encompassing, changing and sometimes mean different things to different people. They are provided as a starting point for discussion and learning.

Ableism: The pervasive system of discrimination and exclusion that oppresses people who have mental, emotional and physical disabilities.

Ageism: Any attitude, action, or institutional structure which subordinates a person or group because of age or any assignment of roles in society purely on the basis of age" (Traxler, 1980, p. 4). Ageism works against the young and the old and benefits those between 30-early 50s.

Ally: A person who confronts heterosexism, sexism, homophobia, biphobia, transphobia and heterosexual privilege in themselves and others out of self-interest and a concern for the well being of lesbian, gay, bisexual, transgender, queer, intersex and asexual people and believes that dismantling heterosexism, biphobia, transphobia and genderism/cis-sexism is a social justice issue.

Androgyne: A person with physical traits of male and female
Anti-Semitism: "Semitic" originally referred to a family of languages that included Hebrew. But it came to be applied directly to hatred of the Jews. It is the systematic discrimination and oppression of Jews, Judasim, and the cultural, intellectual, and religious heritage of the Jewish People.

Asexuality: A sexual orientation generally characterized by not feeling sexual attraction or a desire for partnered sexuality. Asexuality is distinct from celibacy, which is the deliberate abstention from sexual activity. Some asexual people do have sex. There are many diverse ways of being asexual.

BDSM: Bondage and Discipline, Dominance and Submission, Sadism and Masochism. BDSM refers to a wide spectrum of activities and forms of interpersonal relationships. While not always overtly sexual in nature, the activities and relationships within a BDSM context are almost always eroticized by the participants in some fashion. Many of these practices fall outside of commonly held social norms regarding sexuality and human relationships.

Bear Community: a part of the queer community composed of queer men similar in looks and interests, most of them big, hairy, friendly and affectionate. The community aims to provide spaces where one feels wanted, desired, and liked. It nourishes and values an individual's process of making friends, of learning self-care and self-love through the unity and support of the community. Bears, Cubs, Otters, Wolves, Chasers, Admirers and other wildlife comprise what has come to be known as the Brotherhood of Bears and/or the Bear community. See also: Ursula

Bigendered: Having two genders, exhibiting cultural characteristics of masculine and feminine roles

Biphobia: fear or hatred of people who are bisexual, pansexual, omnisexual, or nonmonosexual. Biphobia is closely linked with transphobia and homophobia.

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Transgender: used most often as an umbrella term, some commonly held definitions 1. Someone whose gender identity or expression does not fit within dominant-group social constructs of assigned sex and gender. 2. A gender outside of the man/woman binary. 3. Having no gender or multiple genders.

Transsexual (TS): A person who lives full-time in a gender different than their assigned birth sex and gender. Many pursue hormones and/or surgery. Sometimes used to specifically refer to trans* people pursuing gender or sex confirmation.

Transvestite: This is an outdated and problematic term due to its historical use as a diagnosis for medical/mental health disorders. Cross Dresser has replaced transvestite, see above definition.

Triggers: Words or phrases that stimulate an emotional response because they tap into anger or pain about oppression issues.

Tryke: A trans female-identified person who is attracted to/loves other women.

Two Spirit: Many Native American Tribes have three, five or even seven genders. These dual-gendered people, or "two-spirited" are viewed differently in different Native communities. Sometimes they are seen without stigma and considered emissaries from the creator, treated with the deference and respect, or even considered sacred – but this is not always the case. "Two-Spirit" is the closest thing to an appropriate umbrella term of referring to these gender traditions among Native peoples. However, there are a variety of definitions and feelings about the term "two spirit."

Ursula: Some lesbians, particularly butch dykes, also participate in Bear culture referring to themselves with the distinct label Ursula.

Womyn: some womyn spell the word with a "y" as a form of empowerment to move away from the "men" in the "traditional" spelling of women.

Borrowed from http://lgbcenter.ucdavis.edu/lgbt-education/lgbtqia-glossary

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5. WORKSHOP EVALUATION

Objectives: Informal interview/survey will be used to evaluate the learners' preliminary and ongoing approval with the learning experience. This instrument will be used to informally interview the educators about the effectiveness of the program. The informal interview will occur formatively during breaks and in informal settings.

Formal Likert Survey scale

PARTICIPANT QUESTIONNAIRE

Title of the Program: *Train-The-Trainer: LGBT in Obstetrics Nursing* **Date:** _____

1 =No	2= Somewhat	3 =Yes, definitely
Were the program objectives clear	1	2 3
Were the instructional techniques and materials helpful in your learning of the material	1	2 3
Did the instructor focus the presentation on the program objectives and use the instructional techniques and methods well	1	2 3
The overall program contributed to your knowledge and/or skill base.	1	2 3

Please identify any information and/or skill you can use from the program

Please suggest improvements for this program

Adapted from: Caffarella, R. S., & Daffron, S. R. (2013). Planning Programs for Adult Learners: A Practical Guide. John Wiley & Sons: San Francisco, Jossey-Bass

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FORMAL OBSERVATION CHECKLIST

Title/Topic of Lesson: QUEEROBSTERICS®: LGBT IN OBSTETRICS NURSING TRAIN-THE-TRAINER: LGBT IN OBSTETRICS NURSING

Instructor: _____ **Date:** _____ **Observer:** _____

Setting: _____ **Number of students:**_____ **Video #** _____

Directions: Use this checklist for classroom observations. Place a check beside the activities observed. If the element was not covered, note in the space beneath the element or under Observer's Comments.

	INSTRUCTIONAL ACTIVITIES	√	DEMONSTRATED ACTIVITIES (List examples)
INTRODUCTION	Provided review of previous work as warm-up exercise for students		
	Stated lesson objectives and reviewed the agenda		
	Provided opportunities for students to become familiar with lesson materials		
	Checked students' background knowledge on the topic/lesson		
	Included any LGBT issues		
	Other:		
PRESENTATION	Used appropriate presentation style(s) for content and audience		
	Gave adequate/appropriate explanation of new concepts		
	Responded to students' questions		
	Answered questions immediately		
	Periodically checked students' comprehension		
	Incorporated any LGBT issues		
	Other:		
PRACTICE	Set up practice activities clearly		
	Gave examples and/or demonstrations		
	Monitored/assisted all students (individually, paired, and grouped)		
	Used a variety of communicative strategies for practice of language skills and content		
	Integrated any LGBT issues		
	Other:		
APPLICATION	Gave students time to apply what was learned		
	Gave students time to share their application (work)		
	Gave students an opportunity to comment/evaluate each other's work, as appropriate		
	Added any LGBT issues		
	Other:		
EVALUATION	Evaluated students' application of concepts		
	Gave students an opportunity to evaluate the lesson, as appropriate		
	Included any LGBT issues		
	Other:		
FOLLOW-UP	Gave students opportunities to review materials over time		
	Gave students opportunities to ask questions orally or in writing during class		
	Gave students a task to further investigate content		
	Other:		

Observer's comments:

Modified and adapted from Short, D.J. and Echevarria, J. (1999) *The Sheltered Instruction Observation Protocol: A Tool for Teacher-Researcher Collaboration and Professional Development*. Center for Applied Linguistics Online Resources: Digests. Retrieved August 4, 2010 from http://www.cal.org/caelanetwork/pdfs/ObservingProvidingFinalWeb.pdf

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Train-The-Trainer

1

Principles of Adult Learning Scale (PALS)
Developed by Gary J. Conti

Directions: The following survey contains several things that a teacher of adults might do in a classroom. You may personally find some of them desirable and find others undesirable. For each item please respond to the way you most frequently practice the action described in the item. Your choices are *Always*, *Almost Always*, *Often*, *Seldom*, *Almost Never*, and *Never*. If the item does not apply to you, circle number 5 for never.

Always	*Almost Always*	*Often*	*Seldom*	*Almost Never*	*Never*
A	AA	O	S	AN	N

Question/Item	Response Category	Value
1. I allow students to participate in developing the criteria for evaluating their performance in class.	A AA O S AN N	
2. I use disciplinary action when it is needed.	A AA O S AN N	
3. I allow older students more time to complete assignments when they need it.	A AA O S AN N	
4. I encourage students to adopt middle class values.	A AA O S AN N	
5. I help students diagnose the gaps between their goals and their present level of performance.	A AA O S AN N	
6. I provide knowledge rather than serve as a resource person.	A AA O S AN N	
7. I stick to the instructional objectives that I write at the beginning of a program.	A AA O S AN N	
8. I participate in the informal counseling of students.	A AA O S AN N	
9. I use lecturing as the best method for presenting my subject material to adult students.	A AA O S AN N	
10. I arrange the classroom so that it is easy for students to interact.	A AA O S AN N	
11. I determine the educational objectives for each of my students.	A AA O S AN N	
12. I plan units which differ widely as possible from my students' socio-economic backgrounds.	A AA O S AN N	
13. I get a student to motivate himself/herself by confronting him/her in the presence of classmates during group discussions.	A AA O S AN N	
14. I plan learning episodes to take into account my students' prior experiences.	A AA O S AN N	
15. I allow students to participate in making decisions about the topics that will be covered in class.	A AA O S AN N	
16. I use one basic teaching method because I have found that most adults have a similar style of learning.	A AA O S AN N	
17. I use different techniques depending on the students being taught.	A AA O S AN N	
18. I encourage dialogue among my students.	A AA O S AN N	
19. I use written tests to assess the degree of academic growth rather than to indicate new directions for learning.	A AA O S AN N	
20. I utilize the many competencies that most adults already possess to achieve educational objectives.	A AA O S AN N	
21. I use what history has proven that adults need to learn as my chief criteria for planning learning episodes.	A AA O S AN N	
22. I accept errors as a natural part of the learning process.	A AA O S AN N	
23. I have individual conferences to help students identify their educational needs.	A AA O S AN N	
24. I let each student work at his/her own rate regardless of the amount of time it takes him/her to learn a new concept.	A AA O S AN N	

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Question/Item	Response Category	Value
25. I help my students develop short-range as well as long-range objectives.	A AA O S AN N	
26. I maintain a well disciplined classroom to reduce interference to learning.	A AA O S AN N	
27. I avoid discussion of controversial subjects that involve value judgments.	A AA O S AN N	
28. I allow my students to take periodic breaks during class.	A AA O S AN N	
29. I use methods that foster quiet, productive desk work.	A AA O S AN N	
30. I use tests as my chief method of evaluating students.	A AA O S AN N	
31. I plan activities that will encourage each student's growth from dependence on others to greater independence.	A AA O S AN N	
32. I gear my instructional objectives to match the individual abilities and needs of the students.	A AA O S AN N	
33. I avoid issues that relate to the student's concept of himself/herself.	A AA O S AN N	
34. I encourage my students to ask questions about the nature of their society.	A AA O S AN N	
35. I allow a student's motives for participating in continuing education to be a major determinant in the planning of learning objectives.	A AA O S AN N	
36. I have my students identify their own problems that need to be solved.	A AA O S AN N	
37. I give all my students in my class the same assignment on a given topic.	A AA O S AN N	
38. I use materials that were originally designed for students in elementary and secondary schools.	A AA O S AN N	
39. I organize adult learning episodes according to the problems that my students encounter in everyday life.	A AA O S AN N	
40. I measure a student's long term educational growth by comparing his/her total achievement in class to his/her expected performance as measured by national norms from standardized tests.	A AA O S AN N	
41. I encourage competition among my students.	A AA O S AN N	
42. I use different materials with different students.	A AA O S AN N	
43. I help students relate new learning to their prior experiences.	A AA O S AN N	
44. I teach units about problems of everyday living.	A AA O S AN N	

Always	*Almost Always*	*Often*	*Seldom*	*Almost Never*	*Never*
A	**AA**	**O**	**S**	**AN**	**N**

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41. I encourage competition among my students.	A AA O S AN N	
42. I use different materials with different students.	A AA O S AN N	
43. I help students relate new learning to their prior experiences.	A AA O S AN N	
44. I teach units about problems of everyday living.	A AA O S AN N	

Always	*Almost Always*	*Often*	*Seldom*	*Almost Never*	*Never*
A	AA	O	S	AN	N

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Scoring the Principles of Adult Learning Scale (PALS)

Positive Questions
Question numbers 1, 3, 5, 8, 10, 14, 15, 17, 18, 20, 22, 23, 24, 25, 28, 31, 32, 34, 35, 36, 39, 42, 43, and 44 are positive items. For positive questions, assign the following values: Always=5, Almost Always=4, Often=3, Seldom=2, Almost Never=1, and Never=0.

Negative Questions
Question numbers 2, 4, 6, 7, 9, 11, 12, 13, 16, 19, 21, 26, 27, 29, 30, 33, 37, 38, 40, and 41 are negative items. For negative questions, assign the following values: Always=0, Almost Always=1, Often=2, Seldom=3, Almost Never=4, and Never=5.

Missing Questions
Omitted questions are assigned a neutral value of 2.5.

Factor 1: Learner-Centered Activities

Question #	2	4	11	12	13	16	19	21	29	30	38	40	Total Score
Score													

Factor 2: Personalizing Instruction

Question #	3	9	17	24	32	35	37	41	42	Total Score
Score										

Factor 3: Relating to Experience

Question #	14	31	34	39	43	44	Total Score
Score							

Factor 4: Assessing Student Needs

Question #	5	8	23	25	Total Score
Score					

Factor 5: Climate Building

Question #	18	20	22	28	Total Score
Score					

Factor 6: Participation in the Learning Process

Question #	1	10	15	36	Total Score
Score					

Factor 7: Flexibility for Personal Development

Question #	6	7	26	27	33	Total Score
Score						

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Think-Pair-Share

Purpose: To ensure maximum discussion within a group.

Time	Instructor Activities	Learner Activities
30 min	Present simulation on classroom instructional techniques simulation. Guide activity	Share information on and feelings about simulation
30 min	Collect and comment on information Debrief activity	Share information and feelings Discuss aids to process
Activity – Think-Pair-Share		
Organizer:	Increases the discussion on establishing an alternative ways to classroom instructional techniques simulation.	
Objective:	Share information on and feelings about current obstetric curriculum	
Time:	• 30 minutes	
Techniques / Equipment:	• Details of a case, situation or question. Monitor and encourage participation.	
Process *Individually:*	• Think about current orientation of new employees and the implications.	
In pairs:	• Discuss the situation and your thoughts around the situation	
Group Success:	Both people can explain the point of view of the other.	
Accountability:	Share the information and personal feelings about current orientation of new employees with others.	
Debrief:	Identify how discussing the situation added to how well you could identify your feelings about the situation. Identify how sharing information added to how well you know the material. (Retrieved from Mason CTE, n.d.)	

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Discussion – Small Group – Knowledge

Purpose: To clarify characteristics of things or systems.

Time	Instructor Activities	Learner Activities
35 min	Identify the elements of obstetrical syllabus where LGBT health issues could be incorporated Guide activity	Discuss how to incorporated LGBT health issues could be discussed in class Observed classroom instructional techniques simulation.
20 min	Collect information. Debrief activity	Describe characteristics of materials Describe group process

Activity – Discussion – Knowledge	
Organizer:	Observe and critique different classroom instructional techniques simulation.
Objective:	Discuss how to incorporated LGBT health issues could be discussed in class and the observed classroom instructional techniques simulation.
Time:	• 55 minutes
Techniques / Equipment:	• Personal experience, written information on observed simulation, Monitor and encourage participation and the exchange of ideas
Process: *In groups of four:*	• Read different ways of classroom instructional techniques simulation. • Expand characteristic with a description • Provide an observable consequence. • Are there other characteristics? Add them
Group Success:	Everyone in the group can explain the characteristics.
Accountability:	Describe each characteristic by randomly calling on members to report on group activity.
Debrief:	How did your group members add to your knowledge? (Retrieved from Mason CTE, n.d.)

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Train-The-Trainer

Evaluation of Obstetrical Nursing Program Survey

I recently conducted a study about LGBT health issues in obstetrics nursing education. I am following up to see if LGBT health issues are now being incorporated in the LGBT obstetrics nursing education. Here is a questionnaire that will help me in gathering the required information to finalize the research. Your assistance by answering the questions will be highly appreciated. Confidentiality is assured on all sources of information given. CONTACT INFORMATION: CHINAZO ECHEZONA-JOHNSON, WALDEN UNIVERSITY, Richard W. Riley College of Education and Leadership, 155 5TH Ave S Ste 100, Minneapolis, MN 55401-2511, chinazo.echezona-johnson@waldenu.edu

* Required

ABOUT YOU

1. What is your role in school? *
   - ☐ Director
   - ☐ Faculty
   - ☐ Student
   - ☐ Other:

2. How many years in your current role? * Choose...

3. What is your age? *
   - ☐ Below 20
   - ☐ 20 -30
   - ☐ 31-40
   - ☐ 41-50
   - ☐ Above 50

4. If you are a director or faculty, are you involved in drafting and revision of the obstetrical curriculum and syllabi? * Choose...

5. If you are a director or faculty, are you involved in classroom or clinical teaching of obstetrical curriculum and syllabi? * Choose...

6. If you are a student, when did you take obstetrical nursing course? * Choose...

7. What is your gender? *
   - ☐ Male
   - ☐ Female
   - ☐ Other:

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Evaluation of Obstetrical Nursing Program Survey

ABOUT YOUR SCHOOL:

8. On a scale of 1 to 5, how important do you think it is to spend time on LGBT health in the formal nursing school curriculum? *

	1 Unimportant	2 Somewhat unimportant	3 Neutral	4 Important	5 Very important
	○	○	○	○	○

9. How knowledgeable are you about sexual orientation and sexual identity? * Safety Item

	1 Poorly	2 Somewhat poorly	3 Adequately	4 Well	5 Very well
	○	○	○	○	○

10. How well does the formal curriculum in your school address LGBT Health OVERALL? *

	1 Poorly	2 Somewhat poorly	3 Adequately	4 Well	5 Very well
	○	○	○	○	○

11. How well do your pre-clinical classes address LGBT Health OVERALL? *

	1 Poorly	2 Somewhat poorly	3 Adequately	4 Well	5 Very well
	○	○	○	○	○

12. How well does your non-obstetrical clinical rotation address LGBT Health OVERALL? *

	1 Poorly	2 Somewhat poorly	3 Adequately	4 Well	5 Very well
	○	○	○	○	○

13. In particular, how well does your obstetrical clinical rotation address LGBT Health OVERALL? *

	1 Poorly	2 Somewhat poorly	3 Adequately	4 Well	5 Very well
	○	○	○	○	○

14. How can you rate your fellow teachers' knowledge on LGBT issues?

	1 Poorly	2 Somewhat poorly	3 Adequately	4 Well	5 Very well
FOR DIRECTORS/FACULTY/OTHERS	○	○	○	○	○

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Train-The-Trainer

Concerns-Based Adoption Model (CBAM)
Levels of Use of an Innovation

ID: _____ Classroom/Clinical:_____	Your ID # is the last four digits of your social security #. Indicate if you teach classroom or clinical or both.

Instructions: Please read the descriptions of each of the eight levels related to adoption of technology. Choose the level that best fits where you are in the incorporation of LGBT health issues in the obstetrical didactic and clinical curriculum.

①	**Level 0: Non-use** I have not incorporated LGBT health issues into my classroom and/or clinical instructions.
②	**Level 1: Orientation** I am seeking or acquiring information about incorporating LGBT health issues into my classroom and/or clinical instructions.
③	**Level 2: Preparation** I am preparing for the first use incorporating LGBT health issues into my classroom and/or clinical instructions.
④	**Level 3: Mechanical Use** I focus most effort on the short-term, day-to-day use of incorporating LGBT health issues into my classroom and/or clinical instructions. My effort is primarily directed toward mastering tasks required to incorporating LGBT health issues into my classroom and/or clinical instructions.
⑤	**Level 4 A: Routine** I feel comfortable using incorporating LGBT health issues into my classroom and/or clinical instructions.
⑥	**Level 4 B: Refinement** I vary the incorporating LGBT health issues into my classroom and/or clinical instructions. I am working on using different instructional methodologies to maximize the effects with my students.
⑦	**Level 5: Integration** I am combining my own efforts with related activities of other teachers and colleagues to achieve impact in the classroom.
⑧	**Level 6: Renewal** I reevaluate the incorporating LGBT health issues into my classroom and/or clinical instructions, seek major modifications of, or alternatives to, present the LGBT health issues to achieve increased impact, examine new developments in the field, and explore new goals for myself and my school or district.

Griffin, D. and Christensen, R. (1999). Concerns-Based Adoption Model (CBAM) Levels of Use of an Innovation (CBAM-LOU). Denton, Texas: Institute for the Integration of Technology into Teaching and Learning.

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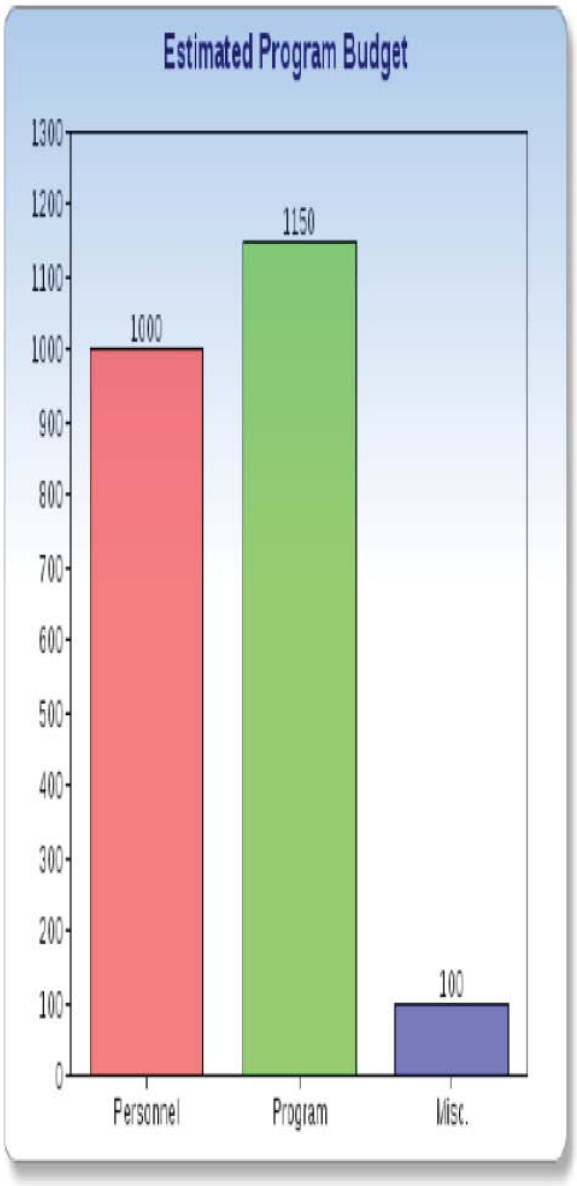


PERSONNEL	
Salary	
2 External instructors/facilitators (2 @ $100/hr for 4 hours)	$800
1 Technology specialist (1@ $50/hr)	$200
Internal staff for clerical duties, focus groups and evaluation (supplied by the School)	$0
Total Salary	**$1000**
OPERATING	
Travel (for external staff) ($150/per staff)	$750
Refreshments (Coffee, Bagels, Fruits, Beverages)/Hot lunch x 3 days	$300
Communication	
Telephone (supplied by the School)	$0
Internet (supplied by the School)	$0
Supplies	
Duplicating (supplied by the School)	$0
Equipment (supplied by the School)	$0
Marketing Plans (supplied by the School)	$0
Facilities	
Classroom, lecture halls (supplied by the School)	$0
Other costs (Tips, etc)	$100
Total Operating	**$1150**
TOTAL DIRECT COSTS	**$1050**
INDIRECT COST	**$100**
TOTAL PROJECT	**$1250**

Chinazo.Echezona-Johnson@waldenu.edu

Appendix B: Research Documents

CONSENT FORM

You are invited to take part in a research study to examine how the LGBT population is represented and portrayed in mainstream obstetrical-nursing courses, curricula, and syllabi.

The researcher is inviting students, obstetrical-nursing faculty or adjunct faculty involved in the didactic and clinical obstetrical instruction. The participating students must be enrolled in the study-site school and must have completed or be in the process of completing an obstetrical-nursing course to be in the study. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Chinazo Echezona-Johnson, who is a doctoral student at Walden University. You may already know the researcher as an adjunct professor, but this study is separate from that role.

Background Information:

Goal of the study is to discover:

- How nursing schools within New York City that offer an associate degree in nursing incorporate health-care topics in their obstetrical-nursing education that relate to the LGBT population by assessing the LGBT population representation in obstetrical nursing curricula and syllabi; learning different ways obstetrical nursing school faculty incorporate LGBT health issues into their teaching; and determining if obstetrical nursing students are prepared by nursing schools to care for LGBT patients after graduation.

Procedures:

If you agree to be in this study, you will be:

- interviewed face-to-face or by telephone.
- The interview will last approximately 30 to 60 minutes and will be audio taped.
- asked to share the course syllabus, curriculum and textbook with the researcher.
- asked to review the interview transcripts for accuracy.

Here are some sample questions:

- What do you think about LGBT in obstetrical nursing
- Tell me what you know about LGBT population?
- Do you think that you have enough information to teach (take care of obstetrical LGBT patients?

Voluntary Nature of the Study:

This study is voluntary. Everyone will respect your decision of whether or not you choose to be in the study. No one at St. Paul School of Nursing will treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind during or after the study. You may stop at any time.

Risks and Benefits of Being in the Study:

Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as such as fatigue, stress or becoming upset. Being in this study would not pose risk to your safety or well-being.

By participating in this study, you contribute to the advancement of obstetrical nursing. By participating in this study, SPSON students and faculty will contribute to the provision of concrete evidence for obstetrical nursing education, the enhancement of quality of obstetrical nursing, and the teaching of obstetrical nurses.

Payment:
You will not be paid for participating in this study.

Privacy:
Any information you provide will be kept confidential. The researcher will **NOT** use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. Data will be kept secure by a password protected folder in the researcher's computer. Data will be kept for a period of at least 5 years, as required by the university.

For the audio recording and the interview transcript, only the researcher and one educator colleague will have access. The tapes will be transcribed by the researcher and erased once the transcriptions are checked for accuracy. Transcripts of your interview may be reproduced in whole or in part for use in presentations or written products that result from this study. Neither your name nor any other identifying information (such as your voice) will be used in presentations or in written products resulting from the study.

Contacts and Questions:
You may ask any questions you have now. Or if you have questions later, you may contact the researcher via Chinazo.Echezona-Johnson@waldenu.edu or at 347-742-4114. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Her phone number is 1-800-925-3368, extension 3121210. Walden University's approval number for this study is 12-05-13-0175573 and it expires on December 4, 2014.

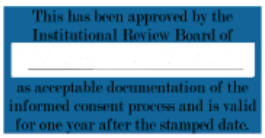
The researcher will give you a copy of this form to keep.

Statement of Consent:
You have read the above information and you feel that you understand the study well enough to make a decision about your involvement. By signing below, you understand that you are agreeing to the terms described above.

Printed Name of Participant/Date of Consent

Participant's Signature

Researcher's Signature



CONFIDENTIALITY AGREEMENT

Name of Signer: _____

During the course of my activity in collecting data for this research: **Equitable Obstetrical Care for the Lesbian, Gay, Bisexual, and Transgender Community: A Case Study**. I will have access to information, which is confidential and should not be disclosed. I acknowledge that the information must remain confidential, and that improper disclosure of confidential information can be damaging to the participant.

By signing this Confidentiality Agreement I acknowledge and agree that:

1. I will not disclose or discuss any confidential information with others, including friends or family.
2. I will not in any way divulge, copy, release, sell, loan, alter or destroy any confidential information except as properly authorized.
3. I will not discuss confidential information where others can overhear the conversation. I understand that it is not acceptable to discuss confidential information even if the participant's name is not used.
4. I will not make any unauthorized transmissions, inquiries, modification or purging of confidential information.
5. I agree that my obligations under this agreement will continue after termination of the job that I will perform.
6. I understand that violation of this agreement will have legal implications.
7. I will only access or use systems or devices I'm officially authorized to access and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.

Signing this document, I acknowledge that I have read the agreement and I agree to comply with all the terms and conditions stated above.

Signature: _____ **Date:** _____

Interview Protocol

Topic: Equitable Obstetrical Care for the Lesbian, Gay, Bisexual, and Transgender Community

Interviews

Introductory Protocol

To assist my note-taking, I would like to record the interview today. Please sign the consent form. Please note that only me and one of my colleagues will be able to listen to the tapes which will be ultimately destroyed after they are transliterated. Also, before we begin, you have to sign a consent form created to meet the IRB human subject requirements. This document affirms that: (1) all information from this interview is confidential, (2) your involvement is voluntary and you can choose to stop at any time if you become uncomfortable, and (3) my goal of doing this interview is to cause any harm. Thank you for your agreeing to contribute to this interview. This interview will not be more than one hour.

Introduction

You are invited to take part in a research study to examine how the LGBT population is represented and portrayed in mainstream obstetrical-nursing courses, curricula, and syllabi. The goal of this study is to not evaluate you but to learn more equitable Obstetrical Care for the Lesbian, Gay, Bisexual, and Transgender Community.

A. Interviewee Background

1. How long have you been teaching? **(Faculty).**
2. How long have you been at this institution? **(Faculty and Students).**
3. Are you involved in drafting and revision of the obstetrical curriculum and syllabi?

   (Faculty).
4. Are you involved in classroom or clinical teaching of obstetrical curriculum and syllabi?

   (Faculty).
5. When did you take obstetrical nursing? **(Students).**
6. What is your highest degree? **(Faculty and Students).**

B. Individual Knowledge

1. Tell me what you know about LGBT population in general?
2. Please describe your knowledge on LGBT issues in obstetrics?
3. Tell me how you feel about including LGBT health in formal nursing school curriculum? Why?
4. In your own words explain what is sexual orientation and sexual identity
5. Do you think that you have enough information to teach/take care of obstetrical LGBT patients?
6. Here is a list. Please tell me how they are covered in your obstetric syllabi?
    a. LGBT History
    b. Gender identity development
    c. Other health issues other than HIV/AIDS
    d. LGBT relationships and families
    e. Resources for the LGBT population
    f. HIV/AIDS
    g. Accreditation agencies' standard of care for LGBT patients
    h. Current federal laws affecting LGBT population obstetric nursing care of the of the LGBT population

C. Institutional Perspective

1. How does the formal obstetric curriculum in your school address LGBT Health?
2. Based on your classroom and clinical curriculum, please tell me if the Obstetrical nursing course program in your school prepare students to effectively serve the LGBT population of their patients?
3. How well do your pre-clinical classes address LGBT Health?
4. Tell me how your obstetrical clinical rotations address LGBT Health?

Post Interview Comments:


Participants Needed
Seeking volunteers to take part in a doctoral dissertation research
"Equitable Obstetrical Care for the Lesbian, Gay, Bisexual, and Transgender Community"
You are eligible to participate if:
• You are an Obstetrical classroom and/or clinical faculty
• You are a student currently taking Obstetrical Nursing or has completed Obstetrical Nursing
Please note that participants will be interviewed
For more information or if you want to participate, please send an email to:
Chinazo.Echezona-Johnson@waldenu.edu

Letter of Cooperation from a Community Research Partner

Date: 11-27-13

Dear: **Chinazo Echezona-Johnson:**

Based on my review of your research proposal, I give permission for you to conduct the study entitled **Equitable Obstetrical Care for the Lesbian, Gay, Bisexual, and Transgender Community**, within the [redacted], New York. As part of this study, I authorize you to interview the Obstetrical nursing faculty, and Nursing students, and review Obstetrical curriculum and syllabus. Participants will be given the opportunity to review interview transcripts. Individuals' participation will be voluntary and at their own discretion.

We understand that our organization's responsibilities include: providing a space for the interview and making available the Obstetrical curriculum and syllabus. We reserve the right to withdraw from the study at any time if our circumstances change.

I confirm that I am authorized to approve research in this setting. I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the research team without permission from the Walden University IRB and [redacted]

Sincerely,

[redacted]

Authorization Official/ [redacted]
Contact Information

Curriculum Vitae

CHINAZO ECHEZONA-JOHNSON, RNC-MNN, LL.B, MSN, PCC

- Nearly 22 years of experience as professional advanced registered nurse.
- Ability to direct complex projects from concept to fully operational status.
- Goal-oriented individual with strong, transformational leadership capabilities.
- Organized, highly motivated, and detail-directed problem solver.
- Proven ability to work in unison with staff, volunteers, and board of directors.
- Consummate registered nurse who is passionate about the potential and impact of nursing.
- Innovative educator devoted to nursing education and learning.
- Career-development expert.
- Accomplished nursing professor with comprehensive blend of hands-on professional and academic nursing experiences.

EDUCATION

Ed.D Candidate, Walden University, (2009-Present)
Field: Higher- education and Adult Learning
Dissertation: *Equitable Obstetrical Care for the Lesbian, Gay, Bisexual, and Transgender Community*

Post Graduate Certificate, Population Case Coordination, Duke University
Field: Population Care management Health (June-September 2012)

LL.B, University of WolverHampton, England
Field: Law

Master of Science in Nursing, Herbert H. Lehman College, City University of New York, (1994-1996)
Field: Parent-Child Clinical Nurse Specialist

THESIS: *An Analysis of Intercultural Nursing Theory by Madeleine Leninger on Nursing Practice and Competence in Obstetric Units*

Bachelor of Science in Nursing, Herbert H. Lehman College, City University of New York (1989-1993)
Field: New York State Registered and Licensed Nurse

EMPLOYMENT

New York City Hospital and Health Cooperation (2012-Present)
Assistant Director of Maternal-Child Nursing Education

- Clinical supervision and education of professional and nonprofessional nursing staff; Supervision and education professional and nonprofessional staff

St. Paul's School of Nursing and New York Institute of Technology School of Nursing (2009 – Present)
Adjunct Nursing Professor

- Procurement of clinical sites; recruitment and retention of clinical instructors; supervision of staff and students at the clinical sites; classroom instruction; Part-time clinical and classroom supervision of associate-degree and bachelor-degree nursing students in hospitals, nursing homes, and community institutions

Visiting Nurse Service of New York (2006-Present)
Per-Diem Homecare Consultant and Public Health Nurse

- Clinical intake of patients in the hospital for homecare; supervision of ancillary staff; care and coordination of care for diverse patient population; orientation and "on boarding" of new employees

Hagedorn Psychiatric Hospital, Glen Cove, NJ (2000-2012)
Charge Nurse, Geriatric-Psych

- Comprehensive psychiatric clinical care of adult and geriatric patients

Borough of Manhattan Community College, NY, NY. (2006-2007)
Assistant Professor, Maternal-Child Nursing

- Classroom instruction for nursing students; clinical supervision of students in hospitals, nursing homes, and community institutions

Bronx-Lebanon Hospital Center, Bronx, NY. (2001-2006)
Maternal- Child Clinical Instructor

- Clinical supervision and education of professional and nonprofessional nursing staff

Mount Sinai Medical Center, NY (1999-2001)
Labor and Delivery and Pediatrics Staff Nurse

- Clinical coordination of care for diverse patient populations; participation in quality assurance and research; charge-nurse responsibilities

New York Presbyterian Hospital (1992-1999)
Maternal-Child Staff Nurse

- Clinical coordination of care for diverse patient populations; participation in quality assurance and research; charge nurse-responsibilities

CONFERENCES/CONTINUING EDUCATION

- Strategies for Patient Safety and Quality Care, March, 2012
- Advancing Evidence-Based Practice in Your Hospital, April, 2013
- The Fetal Heart Monitoring Knowledge Review & Assessment, February, 2012
- Perinatal Medication Administration Competence Assessment Tool (ACAT)
- Neonatal Orientation and Education Program (NOEP) Pre & Posttest.
- Antepartum and Intrapartum Fetal Heart Rate Monitoring: Clinical Competencies and Education Guide, March, 2013
- Pediatric Advance Life Support, October, 2013
- Postpartum Hemorrhage and Teamwork, October, 2013
- Teamstepps and Crisis Management, November, 2013

PRESENTATIONS/SPECIAL PROJECTS

JICOS International
Healthcare Education Consultant

- Directed the procurement of clinical sites for independent private nursing schools; and recruited and retained clinical instructors for private nursing schools
- Clinical Education Consultant – Organized and coordinated of system-wide pain management for Kingsbrook Jewish Medical Center

Bronx Lebanon WIC

- Spearheaded the Baby-Friendly initiative
- Lead the initiation of the perinatal bereavement committee

Metropolitan Hospital

- Headed the Patient-centered Care in Maternal-child department for nursing Systematized customer service training for all staff
- Contributed to the Baby Friendly Initiative
- Structured and developed the transition nurse initiative
- Organized the perinatal bereavement committee