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Queering nursing curricula: Understanding and increasing attention to LGBTQIA+ health needs

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ABSTRACT

Background: The LGBTQIA+ community has a long history of marginalization, disenfranchisement, and structural violence within the healthcare sector. Sexual and gender minority individuals may be wary of disclosing sexuality-related information to providers, and providers may not have received education on creating therapeutic relationships with these individuals.
Purpose: This paper explores factors that shape LGBTQIA+ individuals' daily lives and how these may influence care encounters. We argue for broadening nursing education to incorporate more specific and efficacious LGBTQIA+ education.
Discussion: We propose that consideration of LGBTQIA+ care in nursing education is an important means of meeting the American Association of Colleges of Nursing (AACN) Essentials of Baccalaureate Education for Professional Nursing. We further suggest specific strategies for so doing.
Conclusion: Attending to the inclusion of LGBTQIA+ populations when developing and planning nursing education activities assures that newly-graduated nurses can be safe, effective, and nonjudgmental providers of care to a variety of populations.

Introduction

The lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual and other sexual minority-identified individuals (LGBTQIA+) community has a long history of marginalization, disenfranchisement, and structural violence within and via the healthcare sector. Queer people continue to suffer from biases, discrimination, and subpar healthcare services as current medical and nursing education models often forego attention to this group (Bonvicini, 2017). Within the scope of this paper, we propose that nursing curricula can and should be broadened to incorporate more specific and efficacious LGBTQIA+ education.

Background & significance

The LGBTQIA+ population is significantly affected by health and health care disparities (see Table 1) similar to those typically seen when populations are subjugated by race, ethnicity, income level, and/or education. Such subjugation is called structural violence, which refers to the violent impacts of racism, classism, and homophobia as well as other biases on vulnerable and underprivileged groups (Bailey et al., 2017; DeWilde et al., 2019; Montesanti & Thurston, 2015; Wallace et al., 2015). In addition to the well-studied increased risks of human immunodeficiency virus (HIV) and other sexually transmitted infections (STIs), the LGBTQIA+ community demonstrates increased risk for "depression, anxiety disorders, substance abuse, suicidal ideation and attempts… generalized anxiety disorder, and substance abuse" (Neville & Henrickson, 2006, p. 135). According to an Institute of Medicine (2011) report, sexual and gender minority populations are also often at increased risk of other mental health problems, and may have significantly more traumatic experience—such as violence, victimization, or harassment—than other groups. Compared to their heterosexual and cisgender counterparts, the queer community also experiences higher rates of sexual violence and intimate partner violence—bisexual women in particular have nearly 2.5 times the risk of such experience as is imparted to heterosexual women (Brown & Herman, 2015; Menning & Holtzman, 2014). Additional discrepancies also exist within individual LGBTQIA+ identities. A report by the National Center for Transgender Equality (NCTE) found that "19% of [the] sample reported being refused medical care due to their transgender or gender non-conforming status"

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Table 1
Factors in health disparities among the LGBTQIA+ community.

Conditions	Culture	Psychosocial	Structural
HIV/AIDS	Increased tobacco, alcohol, substance use	Mental health: eating disorders, depression, anxiety, suicide, substance abuse	Concerns for confidentiality
Cancers: anal, breast, cervical	Bisexual erasure and isolation	Familial conflicts, social support deficits	Pathologized behaviors and identities
HPV[a]	Sexual practices: BDSM, barebacking[a], polyamory[a]	Limited seeking behaviors for condition prevention, care, and adherence	Discrimination, exclusive, and harassing practices
Other STIs[a] (i.e. gonorrhea and syphilis)	Binary gender norms	Social isolation of older adults	Poor access to insurance
Viral Hepatitis		Increased physical and sexual violence	Provider bias and poor cultural competence
Obesity		Non-disclosure of identity and practices	Increased rates of poverty

[a] Definitions for these terms can be found in Table 2.
Adapted from "Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns," by Dean, L., Meyer, I. H., Robinson, K., Sell, R. L., Sember, R., Silenzio, V. M. B., … Xavier, J., 2000, Journal of the Gay and Lesbian Medical Association, 4(3), p. 105. Copyright (2000) by Springer Nature.

(Grant et al., 2010, p. 4). Statistics on bisexual women also detail increased risk for poverty and overall lower health when compared to their lesbian peers (Fredriksen-Goldsen et al., 2010). The same report by the NCTE found that over 50% of its transgender and gender-nonconforming sample reported "having to teach their medical providers about transgender care." Further, a recent study of the experiences of older adults identifying as lesbian, gay, bisexual, or transgender (LGBT) noted that many had experienced discrimination at the hands of health care providers and that they were sometimes hesitant to disclose their sexuality to providers (Burton et al., 2019a). Clearly, clinicians are often unprepared to meet the special demands of this population and may not even be aware that their patients have such needs.

Demystifying LGBTQIA+ identities

Scholars often discuss the LGBTQIA+ community as a single population, but this group is truly comprised of a collection of differing identities. To best prepare clinicians for treating this collective, it is therefore crucial to begin with understanding of each of these as well as some of the terminology that may apply to this community (see Table 2). With regard to sexual identity, gay and lesbian identifiers most notably describe cis-gender men and women, respectively, with a sexual orientation towards the same sex. Bisexual-identified individuals are sexually oriented to both male and female sexes. Other sexual identities like pansexual, asexual, and questioning*, too, have entered current discourse (Gold, 2018).

On the other hand, the "T" represents the transgender groups of the LGBTQI, an identity describing one's gender—not sexual—identity. Trans* individuals do not identify with their assigned sex at birth. In contrast, intersex persons are characterized by sexual ambiguity of genitalia, secondary sex characteristics, non-binary genetics, etc. (Enke, 2012). Other gender identities such as genderqueer, gender-fluid, and bigender are also becoming more recognized (Bonvicini, 2017). The "queer" or questioning identifier encompasses all nonnormative gender and sexual identities, functioning as an umbrella term for the entire LGBTQIA+ community. It is of special note that sexual and gender identities can exist in mutual ex- or inclusion of one another—such as a transgender woman who is also a lesbian or a bigender-identified person who also identifies as queer. Further, these identities intersect with other cultural, political, and biological constructs such as age, socio-economic status, ethnicity, religion, immigration status, etc., to yield different compositions of identity (Stenger & Roulet, 2017; Sterzing et al., 2017). The experience of a 50-year-old, cisgender Black lesbian living in the American south thus differs from that of a 35-year-old transgender man who identifies as queer and lives in New York. In describing the impact of such intersecting identities, Crenshaw (1989) wrote that "the intersectional experience is greater than the sum of [for example] racism and sexism" (p. 140) to express how a single individual experiences identity in the context of social structures: not as partly due to each aspect, but *entirely* to the combination of all.

Nursing education must therefore prepare its graduates to effectively understand and interact with patients whose life experiences are shaped by these intersecting and at times stigmatized identities. This requires development of student competence in identifying the structural

Table 2
Glossary of terms.

Asexual	Describing a person who has little to no interest in sexual intercourse.
Barebacking	Engaging in anal intercourse without a condom.
Bigender	A gender identity identified by feeling that one has two fully functioning gender identities, whether experienced simultaneously or at varying times.
Cisnormativity	The assumption that all persons have a gender identity congruent with their assigned sex.
Cisgender	Having a gender identity that is congruent with one's assigned sex.
Gender	The roles, behaviors, activities, attributes and opportunities that any society considers appropriate for people based on their identity as male or female. It interacts with but is different from biologically determined sex.
Gender non-conforming	A person whose behavior or appearance does not conform to prevailing cultural and social expectations about what is appropriate to their presumed gender.
Gender-fluid	A non-binary gender identity that fluctuates along the spectrum of masculine to feminine identity.
Genderqueer	A person who does not subscribe to conventional gender distinctions but identifies with neither, both, or a combination of male and female genders.
Heteronormativity	The idea that binary gender identity (i.e. male or female) and heterosexual orientation are the norm, to the exclusion of all other identities.
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome; a virus that attacks T-cells which are part of the body's immune system defenses.
HPV	Human papillomavirus; the most common sexually transmitted infection (STI), it is a virus that can lead to certain types of cancer and genital warts.
Intersex	A general term for a variety of conditions in which a person is born with a reproductive or sexual anatomy that does not match the typical definitions of female or male anatomy.
Non-binary genetics	Sex chromosome arrangements other than XX (female) and XY (male).
Pansexual	A person who is not limited in their sexual choice with regard to biological sex, gender, or gender identity.
Polyamory	The practice of engaging in multiple sexual relationships with the consent of all the people involved.
Queer	An umbrella term for sexual and gender minorities. Formerly a pejorative, now adopted as an empowering identity.
Questioning*	A person who has not defined or is in the process of redefining their sexual orientation or gender identity
Sex	A label assigned to an individual at birth based on genital anatomy and/or chromosomal arrangement. Not necessarily aligned with gender identity.
STI	Sexually transmitted infection; an infection transmissible via sexual contact
Trans*	An umbrella term referring to all communities and individuals with nonconforming gender identities and/or expressions.
Transgender	Having a gender identity that is not congruent with one's assigned sex.

factors—such as gender, culture, age, and socioeconomic status—that can influence an individual's health. Structural competence requires that nurses understand how factors external to the individual—whether social or systemic—affect health and health potential (Shannon et al., 2015). For example, many studies have documented relationships between poverty and poor health outcomes: in one study of low income women at risk for HIV, findings indicated significant post-traumatic stress disorder (PTSD) symptomology among women living in highly impoverished areas (Golin et al., 2016). Another study found that bisexual-identified older adults reported both disadvantaged socioeconomic status and poorer health overall compared to other groups (Fredriksen-Goldsen et al., 2016).

Poverty is itself a structurally stressful characteristic that may carry with it housing or food instability, being unable to afford basic clothing or hygiene items, lack of access to transportation, and/or increased proximity to or risk of violence. Each of these possible effects of poverty can create a specific vulnerability for the individual. As vulnerabilities accumulate, the range of possible outcomes decreases and negative effects become more likely (Shameem et al., 2014; Simmons et al., 2015). Sexual minority individuals are thus rendered structurally vulnerable because their sexual identity or orientation may be stigmatized, which can lead to anything from disparaging comments to physical violence (Burton et al., 2019a). To understand how LGBTQIA+-identified individuals may experience the effects of structural factors, an exploration of queer theory is a helpful starting point.

Queer theory

Building on earlier feminist scholarship and the practice of deconstruction, queer theory offers a critical perspective on that which appears, in the dominant discourse, as normal, desirable, even natural, and how compliance with norms is compelled and rewarded, while noncompliance or deviance is "policed" and punished (Chevrette, 2013). Its origins trace back to Foucault (1978), who charts the emergence in the early nineteenth century of the homosexual as a "species," noting that same-sex activities were named a problem or a threat calling for moral condemnation, criminalization, medicalization, and psychiatrization (Murray et al., 2017).

One key assumption of queer theory is that the logic of the heterosexual order is deeply embedded across our social and cultural practices, norms, and institutions. Sometimes referred to as "heternormativity," Butler (1990) calls this the "heterosexual matrix": "that grid of cultural intelligibility through which bodies, genders, and desires are naturalized," (p. 151) arguing that genders are not "natural" but rather cultural productions. Butler reminds us of Simone de Beauvoir's famous claim that one is not born a woman but becomes one: "woman" is not "natural," but a social category that has been discursively naturalized. Queer theory also studies how myriad aspects of biological sex do—or fail to—map onto the ways that sexuality is both lived and embodied erotically and culturally, constructed as a legible or illegible gender in the social sphere, and as an identity that is experienced and/or conveyed. It also analyzes the often violent social, political, (bio) medical, and legal repercussions—good intentions notwithstanding—that result when individuals deviate from norms and normative expectations.

Queer socio-discursive praxes—the act of engaging in critical social discourses through self-identification—seek to destabilize "normality" and the naturalized or essentialized relations of power/knowledge. Identifying oneself as a member of the LGBTQIA+ community openly challenges presumptions of heterosexual, cisgender identity that are often the default for institutions such as healthcare systems (Chevrette, 2013). Traditionally, such heteronormativity operates as a form of power/knowledge that pervades society and naturalizes and exalts monogamous heterosexual relationships and practices, while pathologizing, criminalizing, and variously discriminating against non-heteronormative ways of living, including homo- and bisexuality, bondage/discipline/submission/sadism and/or masochism (BDSM) erotic play culture, polyamory, public and commercial sex, etc. (Rubin, 1984). However, heteronormativity is not restricted to the domain of sex or sexuality, but rather it structures normative models of self-other relationships: assumptions about how people engage in romantic relationships, what defines families, how responsibility is assigned in the home, and more. Queer persons are thus forced to evaluate society as outsiders, or the other, creating "a sense of detachment from the dominant ideology" (Gross, 2001, p. 18). Resonant with Butler's theory of gender construction, queer people may engage in different types of gender performance when they recognize gender as a construct and employ its theatrics to "pass" as heterosexual or of a certain gender—often in the need to avoid social stigma or physical danger. This self-protective and yet subversive strategy works to undo existing forms of naturalization at individual levels and yields control to its queer user in choosing what to reveal of the self. In reclaiming control over how one is perceived, the act of passing thus pushes back against the assignment of a stigmatized identity and demands that others engage only with what the individual *chooses* to reveal or display about their identity (Nicolazzo, 2016). At the same time, however, engaging in performance that is irreflective of the individual's true and personal experience of gender can reinforce for others the "normalcy" of binary gender and heteronormative social discourse (Chevrette, 2013). In other words, passing may also allow presumptions to go unchallenged, thereby negating the impact of identifying as a sexual minority (Nicolazzo, 2016).

Caring for LGBTQIA+ people

The medical and health care environment may be a particular site of heteronormative biases and enforced othering for the LGBTQIA+ community. Owing to the lack of comprehensive federal legislation against sexual orientation or gender identity discrimination, sexual and gender minority individuals may be wary of disclosing sexuality-related information to healthcare providers (Burton et al., 2019a; Clift & Kirby, 2012). At the same time, providers may not have received education on how to facilitate disclosure or even on the importance of asking about gender or sexual identity (Carabez et al., 2015). Nonetheless, studies have demonstrated that there is a direct relationship between feeling comfortable disclosing this information to a health care provider and receipt of consistent, effective care (Whitehead et al., 2016). It is therefore imperative that pre-licensure education prepares nursing students for the provision of safe, effective, nonjudgmental care to LGBTQIA+ populations.

Challenges in undergraduate nursing

Nursing education must provide adequate preparation for the baccalaureate generalist practitioner to achieve competence in the clinical environment, as well as to be adaptable to changing health care systems and needs. The latter is especially critical in modern health systems, which serve a range of individuals, families, and communities—and which continue to evolve rapidly (Tanner, 2010). Challenges to the efficacy of nursing education range from the persistent shortage of appropriately prepared nursing faculty to the difficulties presented by the increasing need for interdisciplinary approaches to care (Rich & Nugent, 2010). As a result, some types of content may be less emphasized than others—among them, culturally and professionally appropriate strategies for the care of vulnerable populations, including sexual minorities (Burton et al., 2019b).

Cultural competency with vulnerable populations

The interaction between nurse and patient frequently relies on the nurse's use of empathetic communication in the development of rapport and mutual understanding (Ward et al., 2012). Unfortunately, the efficacy of empathy may be reduced when there is a perceived power differential between nurse and patient—such as when the patient identifies as a member of stigmatized population (Roche & Keith, 2014). Whether or not the nurse is implicitly or explicitly biased against some

characteristic of the patient, the effects of past experiences of bias or stigmatization as well as the impression of expected or enforced heteronormativity may result in anticipatory distress in the patient and reduce the therapeutic potential of nurse-patient interaction (Burton et al., 2019a; O'Donovan et al., 2012). Empathy alone therefore does not suffice to ensure trust and effective communication between nurse and patient when the latter is of a vulnerable group.

Possibly a more useful construct than empathy in such cases is an holistic approach to nursing care, which calls for the nurse to attend to "the patient's physical, psychological, and emotional needs [along] with his or her social and cultural beliefs by establishing and maintaining a healthy connection between these areas of a patient's life while meeting his or her health needs" (Selimen & Andsoy, 2011, p. 483). While this model is often invoked in the context of spiritual needs, we suggest that it can also be useful to aid the nurse in preparing to establish effective rapport with patients who may be distrustful of care providers. For LGBTQIA+ individuals, this is vital because it may allow the nurse to address factors in health disparities that might not otherwise be identified—including trauma history, substance use/abuse, mental health issues, risk for impact or sequelae of sexually transmitted infections (STIs), and other issues. It is therefore incumbent upon nursing educators to incorporate attention to these sources of vulnerability and to the specific needs of the LGBTQIA+ community into student-directed content (Lim et al., 2015).

Professional ethics

There are also important ethical implications for appropriate care of LGBTQIA+ populations that should be addressed in undergraduate nursing education. The provision of safe, effective, nonjudgmental care to such individuals is a means of fostering autonomy, practicing nonmaleficence, offering respect for persons, and advancing justice—all of which are fundamental principles of ethical nursing care (American Nurses Association, 2015). In no case should a nurse's personal identity or belief system be allowed to subvert these principles, such as in cases where religious bias against LGBTQIA+ persons is invoked as a reason to deny or refuse to participate in care. Such acts are a direct violation of the American Nurses Association Code of Ethics for Nurses, which explicitly states that "The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of *every* person" (American Nurses Association, 2015, p. v). This must be emphasized at all levels of nursing education, such that it is not even a consideration in the professional environment upon entry to practice.

In the case of a stigmatized population, autonomy is often restricted as structural forces can limit the individual's ability to access the full array of available options and decide freely among them (Entwistle et al., 2010). Recognizing the limitations of an individual's situation in order to support truly informed decision-making is an important function for nursing care, and one that has been identified by patients as a critical part of the care process (Joseph-Williams et al., 2014). Fostering autonomy is thus important not only to patient decision-making, but to creating a therapeutic environment where the individual feels supported and welcomed. For example, a study of self-disclosure revealed that those of sexual minority status were more likely to disclose their orientation in contexts that they viewed as supportive of their autonomy, rather than restrictive or controlling (Legate et al., 2012).

To create such an environment, it is critical that care providers demonstrate both nonmaleficence and respect for persons. The establishment of trust in the nurse-patient relationship may hinge on the patient's assessment of the nurse as being respectful and well-intentioned regardless of patient characteristics (Rørtveit et al., 2015). As with structural considerations, baccalaureate nursing curricula often lack emphasis on the need to adapt the ways in which the nurse demonstrates respect for persons and nonmaleficence with different populations. The importance of this is reflected in the results of a study of LGBTQIA+ individuals' needs and desires for culturally competent care environments that found many were most comfortable with providers who demonstrated facility with appropriately gender-neutral language, understanding of structural constraints, and non-stigmatizing behaviors (Wilkerson et al., 2011). This was especially important if there were environmental cues that caused LGBTQIA+ patients to feel marginalized, such as heteronormative or binary gender language on intake forms or lack of attention to diversity in clinical mission statements. The latter finding was also endorsed by participants in a study of older LGBT adults' needs and desires with regard to their health care, in which several participants reflected on the need for clinical environments to demonstrate inclusivity of LGBTQIA+ persons through appropriate communication with patients and their partners as well as visual cues such as magazines or other materials that reflect attention to diversity in gender and sexuality (Burton et al., 2019a).

Issues such as those of language and other influences that serve to marginalize LGBTQIA+ individuals can also be viewed as issues of justice and equity in nursing practice. Justice in nursing practice refers to the fairness of practice-related decisions as well as to the equitable distribution of resources among those in need of care (American Nurses Association, 2015). In cases of marginalized populations, this may involve providing additional care and resources to affected individuals such that they ultimately have the same potential for health as do their non-marginalized peers. Varcoe et al. (2014) posit an "equity-transformative" framework for nursing, noting that while "equity is a goal that is never fully attained," it is "possible to promote [equity] in every moment, situation, and context" (p. 272). As a more concrete example, Weber (2010) proposes that particularly where LGBTQIA+ populations have often been overlooked—such as in regard to parenting—nurses have particular capacity to counteract stigmatizing influences by assuring access to appropriately designed resources and information that is equitable with that of heterosexual and/or cisgender populations.

Applying the essentials of baccalaureate education for professional nursing practice

In order to assure that nursing education adequately prepares students to practice with LGBTQIA+ populations in culturally competent and professionally ethical ways, direct consideration of how such preparation can be integrated into baccalaureate nursing education is vital. One approach is to consider how meeting the American Association of Colleges of Nursing (AACN) (2008) Essentials of Baccalaureate Education for Professional Nursing Practice can provide opportunities for such preparation. The AACN (2008) Essentials represent the elements necessary for baccalaureate nursing education to successfully "enable graduates to practice within complex healthcare systems and assume the roles: provider of care; designer/manager/coordinator of care; and member of a profession" (p. 3). These roles provide nurses with opportunities to attend to the care needs of LGBTQIA+ populations and we therefore propose that there are specific educational opportunities related to the Essentials. Although meeting the needs of LGBTQIA+ individuals can and should be addressed throughout baccalaureate nursing curricula, we have focused in this paper on those Essentials that reference Patient Safety (Essential II); Evidence Based Practice (Essential III); Health Care Policy (Essential V); Interprofessional Communication and Collaboration (Essential VI); and Clinical Prevention and Population Health (Essential VII). We have chosen these specific Essentials because we believe they are the most readily accessible for nursing educators already struggling with complex and increasingly unwieldy curricula, as these Essentials offer obvious opportunities to incorporate attention to the needs of LGBTQIA+ persons into existing curricula.

Patient Safety (Essential II)

This Essential targets the leadership development of baccalaureate-prepared nurses in the context of complex systems and the minimization of harm risks to both patients and providers (2008). Although many professionals consider this Essential to focus mainly on the avoidance of medical or nursing errors, it is important to also recognize the

importance of patients' *perception* of safety—such as the feelings of support for autonomy that LGBTQIA+ individuals noted increased their comfort with providers (Joseph-Williams et al., 2014). Attending to the needs of LGBTQIA+ patients may mean that nursing education must specifically foster social and cultural awareness of the needs of this population. This can be accomplished at multiple levels, although the newly prepared baccalaureate nurse typically works in what the Essentials describe as a "microsystem" of healthcare—that is, the "system" of interactions that occur directly between the patient and the nurse. This microsystem may be the last opportunity for the nurse to create safety and a sense of respect for the LGBTQIA+ patient, even in situations where that patient has not experienced these before. Nursing education can therefore focus on the dynamics of this interaction, such as by reinforcing consistent use of gender- and sexuality-neutral pronouns: "they" instead of "he or she;" "partner or spouse" instead of "husband or wife." This would be especially important in taking an initial health history, wherein the nurse can ask the patient directly and sensitively how they identify themselves in terms of gender and sexual orientation. Direct questions, when asked in a respectful and engaged manner, are the best approach—for example, asking "What pronouns do you prefer?" or "Do you engage in sex with men, women, both, or something else?" While this language may at first feel awkward for the nurse, as with other types of screening, comfort is established with repetition and reinforcement (Brennan et al., 2015; Burton & Carlyle, 2015).

Evidence Based Practice (Essential III)

The third Essential focuses on the translation of nursing science and research into appropriate clinical applications, with emphasis on understanding how different types of evidence are relevant to nursing knowledge development. This is an important nexus at which to consider the needs of LGBTQIA+ populations because there is a dearth of nursing research involving these populations (Cloyes, 2015), as well as a need to address the vulnerability inherent in identifying as a sexual or gender minority (Whitehead et al., 2016). Baccalaureate nursing graduates are expected to understand how practice standards may adversely affect patients, and given the evidence for stigmatization and marginalization of LGBTQIA+ individuals in healthcare systems there is ample opportunity for nurse-initiated change in this area (Roche & Keith, 2014). Nursing education can take advantage of this opportunity by selecting materials with an LGBTQIA+ focus for coursework—such as reviewing some of the literature cited in this paper in the context of a research class, or implementing simulation scenarios with LGBTQIA+-identified characters—this may be especially helpful in developing comfort with the health history questions recommended above. Such changes can serve both to normalize the recognition and inclusion of LGBTQIA+ populations in the care environment and to support students in learning about specific needs of LGBTQIA+ persons in this environment.

Health Care Policy (Essential V) and Interprofessional Communication and Collaboration (Essential VI)

In the area of health policy, the Essentials encourage baccalaureate nursing education to address health care access, equity, and social justice, as well as the impacts of socio-cultural factors on practice. Clearly the status and needs of LGBTQIA+ populations fall within this mandate, particularly in the context of whether policies result in appropriate and ethical treatment of this population (Keuroghlian et al., 2018). Further, new nurses may access professional organizations to learn about their roles and to seek career development support, and the policies of these organizations can influence practice. Exploring and questioning the inclusivity of these policies for LGBTQIA+ persons offers an excellent opportunity for undergraduate nursing students to develop facility with health care policy.

If Essential V is also integrated with Essential VI on interprofessional teamwork, this may be a powerful opportunity for the implementation of team-based learning in nursing education, which has been suggested to promote the development of professional skills such as ethically-driven decision-making and developing culturally competent plans of care (Currey et al., 2015). Allowing students to work through the policy ramifications of caring for LGBTQIA+ populations in teams can enhance their ability to rationalize and defend decisions as well as to identify how to navigate caring for marginalized persons within a team environment. This can increase student confidence in interprofessional communication, as well as promote attention to marginalizing factors in the care of LGBTQIA+ persons.

Clinical Prevention and Population Health (Essential VII)

This is perhaps one of the most readily applied Essentials when considering nursing care of LGBTQIA+ populations, in that these individuals are affected by specific types of vulnerabilities and health disparities (Whitehead et al., 2016). It is vital that baccalaureate nursing education account for the needs of, sociocultural influences on, and vulnerabilities among LGBTQIA+ persons—and how those may differ from other less vulnerable groups (Fredriksen-Goldsen et al., 2016). Even within the aggregate of sexual and gender minority individuals, there are distinct groups with differing needs and experiences. For example, both bisexual- and transgender-identified individuals have been marginalized within LGBTQIA+ communities due to internalized heterosexism and cisnormativity and have reported rejection and lack of engagement by both health care providers and community organizations (Logie et al., 2012). In addition, many states lack dedicated LGBTQIA+ health centers and even where these are located, comprehensive services may not be available or accessible (Martos et al., 2017). Without specific attention LGBTQIA+ population care in baccalaureate nursing education, it is likely that many individuals from these populations will never encounter a provider who is appropriately prepared to provide appropriately safe and nonjudgmental health care services. The dearth of such providers can only serve to deepen the disparities between LGBTQI individuals and other groups. Nursing education must therefore account for those vulnerabilities and disparities that most perniciously affect LGBTQIA+ populations, and equip students to attend to them appropriately. The use of LGBTQIA+-focused simulations or even standardized patients can again be useful here, as well as the inclusion of LGBTQIA+ considerations in community or needs assessment projects. The latter strategy can help to make these considerations more visible to learners, as well as prompt students to identify how readily available are appropriate resources and supports for LGBTQIA+ populations.

Implications and conclusions

Nursing education is challenged by the combination of ever-increasing demand for nursing professionals with ever-shrinking resources for their education, as well as by the rapidly changing landscape of health care globally. This is particularly difficult given that there are often systemic and programmatic barriers to curriculum change, which can lead to knowledge gaps for practicing nurses. Unfortunately, one of the slowest areas of focused change in nursing education has been in the realm of LGBTQIA+ health. Few nurses report more than scant education on LGBTQIA+ issues, even in those regions where this population is readily evident and most accepted socially (Carabez et al., 2015). We propose that incorporating LGBTQIA+ content into some existing nursing education practices can improve nursing students' comfort and facility with LGBTQIA+ health care, and that doing so helps to reduce the potential for repeat marginalization of these populations (Burton et al., 2019a).

Given that LGBTQIA+ individuals may be vulnerable to a range of health-related issues that may or may not be directly related to their sexual and gender identifications, it makes sense that nurses be educated in the interactions and *intersections* of these with health and health care needs. For nursing educators, the need to first understand social constructions of and theoretical perspectives on LGBTQIA+ identity is fundamental to the capacity to incorporate effective and appropriate

content on care of those who so identify. In this paper, we offer an introduction to this type of content as well as demonstrate how the provision of ethical and holistic care is best practiced with LGBTQIA+ populations. Creating an educational environment that attends to such care offers nursing students the opportunity to identify gaps in their own knowledge and understanding as well as to develop appropriate skills for creating diverse and inclusive nursing practice. Attending to the inclusion of LGBTQIA+ populations when developing and planning nursing education activities assures that newly-graduated nurses can be safe, effective, and nonjudgmental providers of health care with a variety of populations.

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None.

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