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FEATURE

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Supporting transvisibility and gender diversity in nursing practice and education: embracing cultural safety

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Many nursing education programs deserve a failing grade with respect to supporting gender diversity in their interactions with their students and in terms of the curricular content directed toward engaging in the safe and supportive nursing care of transgender clients. This situation contributes to transinvisibility in the nursing profession and lays a foundation for nursing practice that does not recognize the role that gender identity plays in the health and well-being of trans-clients and trans-nurses. This article seeks to raise readers' awareness about the problems inherent to transinvisibility and to propose several curricular and structural-level interventions that may serve to gradually increase the recognition of gender diversity in the planning and delivery of nursing education and practice. Contextualized in gender and intersectionality theory, cultural safety is presented as a viable and appropriate framework for engaging in these upstream approaches to addressing gender diversity in nursing education and practice. Among the structural interventions proposed are as follows: inclusive information systems, creation of gender neutral and safe spaces, lobbying for inclusion of competencies that address care of trans-persons in accreditation standards and licensure examinations and engaging in nursing research in this area.

KEYWORDS
discrimination/prevention and control, education, gender bias, gender identity, non-binary, nursing, transgender

Nursing education and practice settings have embraced perspectives that acknowledge the importance of ethnic and religious diversity in the planning and delivery of nursing care and promote the customization of care based on each person's unique holistic needs (Varcoe & Browne, 2015; Walsh Brennan, Barnsteiner, De Leon Siantz, Cotter, & Everett, 2012). However, nursing practice and education are embedded within wider social and healthcare systems, whose practices have frequently assumed the alignment of gender with birth sex (cis-normativity), and often fail to adequately recognize the implications that gender identities have for comprehensive and appropriate healthcare delivery (Bauer, Scheim, Deutsch, & Massarella, 2014; Bauer et al., 2009; Eliason, Dibble, & DeJoseph, 2010; Lim & Levitt, 2011). In this article, we challenge nursing educators to critically examine the structures within their organizations that perpetuate the emphasis on a cis-normative gender binary, or render gender diversity invisible due to informational erasure and policies that make identifying outside the binary hazardous (Bauer et al., 2009). In addition, we propose the application of cultural safety in the course of delivering education to nurses and in framing healthcare delivery to transgender and non-binary clients (Aboriginal Nurses Association of Canada, 2009; Varcoe & Browne, 2015).

Making substantive changes to the curricula and practices of nursing education programs will require acknowledgement of the importance of addressing gender diversity in the course of nursing care and committed investment of time, content development and resources to pursue this goal (Walsh Brennan et al., 2012). However, relatively simple adjustments during this critical period in new nurses' socialization to the profession may serve as upstream interventions to improve

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the quality and cultural safety of nursing care to transgender clients (Lim, Johnson, & Eliason, 2015). Nursing education surrounding trans-identities must lead by example and transcend the mere inclusion of content by engaging in structural and individual political actions that acknowledge the importance of gender identity to both our students and our clients (Lim et al., 2015).

1 | A BRIEF INTRODUCTION TO GENDER THEORY AND TERMS

Gender diversity is a neglected topic in many North American nursing programs and practice settings, which may ultimately influence the quality of health care received by those identifying outside the traditional gender binary (Bauer & Scheim, 2015; Bauer et al., 2009, 2014; Carabez, Pellegrini, Mankovitz, Eliason, Ciano, et al., 2015; Daley & MacDonnell, 2015; Eliason, Dejoseph, Dibble, Deevey, & Chinn, 2011; Gapka & Rupert, 2003; Grant et al., 2011; Heinz & MacFarlane, 2013; Lim et al., 2015; MacFarlane, 2015; Merryfeather & Bruce, 2014; Roller, Sedlak, & Draucker, 2015; Walsh Brennan et al., 2012; Walsh & Hendrickson, 2015; White Hughto, Reisner, & Pachankis, 2015; Zuzelo, 2014). Feminist theory challenges the structural, political and power relations that shape the social constructions of gender in society (Connell, 1995, 2009; Schippers, 2007; Stryker, 2008). Given the unique and fluid nature of social constructions, and the evident variability in gender performances and identity, there has been growing awareness of the infinite plurality of these performances, which may exist within, or outside, the traditional binary categories of masculine and feminine (Connell, 1995; Schippers, 2007). Butler (1990) has further suggested that gender is not merely a performance, but rather that it is performative in nature. Performativity suggests that gender does not necessarily originate from a defining physical reality, but rather that it is generated, reconstructed or reinforced through the use of language and action (Butler, 1990; Stryker, 2006). In other words, the embodied performance of gender, and the language used in these performances, contributes to the construction and understanding of gender by the individual engaged in the performance and within the social context at large (Butler, 1990; Stryker, 2006). Even cis-gendered individuals, whose gender identity aligns with that assigned based on external sexual characteristics at birth, may exhibit huge variability in their own performative gender presentation over time and in comparison with others within their assigned gender category (Butler, 1990; Connell, 1995, 2009; Schippers, 2007). Once the plural and fluid nature of social performative gender is acknowledged, the arbitrary assignment of gender performances to only two categories becomes decidedly problematic and unrealistic. Therefore, the existence of gender performances that fall outside the gender binary, or which cross ("trans") these categories is inevitable (Stryker, 2008).

Throughout this article, the term "transgender" is used as an umbrella term to collectively refer to individuals who embody gender performances that transcend the culturally and socially constructed barriers associated with their sex-assigned gender (Merryfeather, 2011; Merryfeather & Bruce, 2014; Stryker, 2008). Therefore, the term "transgender" should be considered in a poststructural way as inclusive of all gender performances that cross the boundaries of the traditional gender binary of man and woman including, but not limited to, individuals identifying as: trans-women, trans-men, gender queer, gender fluid, non-binary, gender non-conforming, two-spirited, gender retired, transsexual, intersex, cross-dressers, drag queens and drag kings (Butler, 1990; Merryfeather, 2011; Merryfeather & Bruce, 2014; Namaste, 2000; Scheim & Bauer, 2015; Stryker, 2006). It is also important to recognize that the terms adopted by trans-persons possess both personal and wider political meaning and that these labels are subject to constant renovation and social reconstruction by these individuals and larger social groups (Butler, 1990; Connell, 1995, 2009; Namaste, 2005). While collective patterns of social performativity provide some tangible qualities, or descriptions commonly associated with gender labels, in practice, the possibilities are as infinite as there are individuals, perspectives or social encounters (Connell, 1995, 2009; Dervin, 2011).

While the current discussion focuses on considering gender diversity in the course of comprehensive nursing education and care, it is also important to note that gender identity represents only one of the many intersecting social categories and qualities that may exert an influence on a person's life and health (Hankivsky, 2012). While gender remains a major influence on how individuals relate to one another, social relations and health may be further impacted by intersectional identities established along social gradients based on the following: racialization, sexual orientation, socioeconomic status, educational attainment, age and many others (Hankivsky, 2012). A person is certainly more than their gender, yet failing to acknowledge one's gender identity can create distress and contribute to gender-related stigma, which is harmful to a trans-person's health and sense of well-being (Bauer & Scheim, 2015; Rutherford, McIntyre, Daley, & Ross, 2012; White Hughto et al., 2015).

2 | CONFRONTING MEDICALIZATION, PSYCHIATRIC NORMALIZATION AND HEALTHCARE BARRIERS

In "Madness and Civilization," Foucault (1965) discussed the practice of positioning socially non-conforming individuals as abnormal and mentally ill. Indeed, the assignment of psychiatric diagnoses to gender non-conforming individuals has served as a major mechanism of institutionalizing the policing of gender and legitimizing transphobia by positioning trans-persons as suffering from a psychiatric disorder (Stryker, 2008; Stryker & Whittle, 2006). Every day, trans-persons live this legacy, since the vast majority of people wishing to physically transition are unable to access hormones, surgery or change their gender on official documents without medical confirmation through a diagnosis of "gender identity disorder" (American Psychiatric Association, 2000), or more recently "gender dysphoria" (American Psychiatric Association, 2013; Egale, 2016; Trans Equality Society of Alberta, 2016).

Trans-persons have existed in culturally diverse societies throughout history and are a normal part of human diversity; therefore, medicalizing gender non-conforming and trans-identities, and establishing structures to police gender identity, represents an inappropriate form of social control (Stryker & Whittle, 2006). It is for this very reason, that the World Professional Association for Transgender Health (2010) issued a press release that urged the de-psychopathologization of gender variance around the world. While disrupting psychiatric normalization is a desirable goal, it must also be acknowledged that delisting these diagnoses could have undesirable practical consequences for low-income transsexuals, who require a medical diagnosis to have their gender reassignment surgeries (GRS) funded by health systems and insurance plans (Namaste, 2005). Therefore, in the quest for recognizing gender variability as a normal part of human existence, it is essential that viable alternate pathways to affordable hormonal and GRS treatment are considered before removing the already limited options for trans-persons (Namaste, 2005).

As nurses working within larger biomedical and bureaucratic health systems, we must ask ourselves whether our own practices are pathologizing those who identify outside the gender binary, and whether we are willing to disrupt systemic practices that position trans-persons as an abnormal "other" within a fixed binary conceptualization of gender? Multiple studies in Canada and the United States have documented significant barriers to adequate healthcare among trans-persons (Bauer et al., 2014; Gapka & Rupert, 2003; Grant et al., 2011; Heinz, 2011; Heinz & MacFarlane, 2013; MacFarlane, 2015; Roller et al., 2015; Sperber, Landers, & Lawrence, 2005). In their study of 6,450 transgender and gender non-conforming Americans, Grant et al. (2011) report that 19% of their respondents were refused care due to their trans status (higher numbers were reported by people of color), 50% had to teach their medical providers about transgender care, and 28% postponed seeking medical care due to discrimination. Bauer et al. (2014) reported similar findings in Canada with 21% of Ontario-based respondents (n = 433) reporting avoidance of the emergency department (ED) because of the perception that their trans status would have a negative effect on the encounter. Negative experiences related to trans status were reported by 52% of ED users presenting in their felt gender (Bauer et al., 2014). Although slightly better on Vancouver Island, 23% of trans-islanders experienced poor care in EDs, and 46% reported having to educate their providers in the ED (Heinz, 2011; Heinz & MacFarlane, 2013). Clearly, trans-persons are regularly encountering healthcare providers that lack knowledge and skills surrounding the provision of safe and appropriate transgender health care, and this picture undoubtedly includes nursing staff. Therefore, the need to address transgender health in the course of nursing education is evident.

3 | THE RELATIVE INVISIBILITY OF GENDER DIVERSITY IN NURSING EDUCATION

As a result of the dominance of cis-normative and heteronormative perspectives (Bauer et al., 2009), there is often extremely limited discussion of gender diversity in many nursing curricula, and many discussions that include gender diversity may do so in the context of discussing non-binary status as a potential risk factor for other conditions, such a mental health issues and sexually transmitted infections (Carabez, Pellegrini, Mankovitz, Eliason, Ciano, et al., 2015; Carabez, Pellegrini, Mankovitz, Eliason, & Dariotis, 2015; Cornelius & Carrick, 2015; Daley & MacDonnell, 2015; Eliason et al., 2010; Lim, Brown, & Jones, 2013; Lim & Levitt, 2011; Lim et al., 2015; Merryfeather & Bruce, 2014; Röndahl, 2009; Walsh Brennan et al., 2012; Walsh & Hendrickson, 2015). Further evidence of nursing's silence on trans-health is provided by Eliason et al.'s (2010) CINAHL search of the top ten nursing journals from 2005 until 2009, which only identified eight articles addressing lesbian, gay, bisexual and transgender (LGBT) health (0.16%) among the 5,000 that were published. None of these articles were published by U.S. researchers, and the majority were published outside of North America (Eliason et al., 2010).

The most commonly articulated strategy to enhance transgender awareness during nursing education is the inclusion of greater transgender content in nursing curricula, including: information on terminology, the distinctions between sexuality and gender and how to ask non-judgmental, open-ended questions about sexuality and gender (Lim et al., 2013; Rutherford et al., 2012; Strong & Folse, 2015; Walsh Brennan et al., 2012; Zelle & Arms, 2015). However, a survey of faculty in American nursing programs (n = 1,231) estimated that the median time devoted to LGBT health was a paltry 2.12 hr (Lim et al., 2015). Carabez, Pellegrini, Mankovitz, Eliason, Ciano, et al. (2015) interviewed 268 nurses in the San Francisco Bay area about their comfort level in providing care to LGBT patients and reported that 80% of their respondents had no education in relation to LGBT issues. Likewise, a small survey of Texas nursing programs suggested that an average of 1.6 hr was dedicated to LGBT content (Walsh & Hendrickson, 2015). We cannot know how much of this time was dedicated to transgender health and issues, or whether there was a clear distinction made between sexuality and gender, but it appears reasonable to conclude that consideration of transgender health is woefully inadequate in many American nursing programs. While the time allocated to discussion of transgender health in Canadian nursing curricula is unclear, several studies have identified the need for greater coverage of transgender health topics in Canadian nursing and health professional programs in general (Bauer et al., 2009; Daley & MacDonnell, 2015; Gapka & Rupert, 2003; McIntyre, Daley, Rutherford, & Ross, 2011; Merryfeather & Bruce, 2014). In addition, the significant barriers to safe and appropriate health care for transgender clients reported in Canadian studies also provides some indirect evidence that coverage of transgender health is often inadequate (Bauer et al., 2009, 2014; Gapka & Rupert, 2003; Heinz & MacFarlane, 2013).

Numerous barriers to incorporating greater LGBT health content into nursing education have been discussed. Lim et al. (2015) reported that many American baccalaureate program faculty possessed limited knowledge and readiness to teach about LGBT health, although LGBT faculty reported higher levels of knowledge and confidence in teaching in this area. One common barrier to including any additional content in nursing curricula is the presence of over-stuffed curricula

and fatigue related to trying to incorporate individual "minority/special needs group" issues into already full curricula (Carabez, Pellegrini, Mankovitz, Eliason, & Dariotis, 2015; Lim et al., 2015; Merryfeather & Bruce, 2014; Sirota, 2013).

Some faculty in Lim et al.'s (2015) study remarked that incorporating LGBT topics into the National Council Licensure Examination for Registered Nurses (NCLEX-RN®) and greater institutional support could motivate change related to LGBT content. Other respondents noted that without requirements for LGBT content in accreditation standards, institutional barriers and policies may prevent some programs from incorporating this content, especially within faith-based organizations that emphasize heteronormative and cis-normative perspectives (Lim et al., 2015). Ultimately, high-level structural and policy changes such as incorporating lesbian, gay, bisexual, transgender, queer and more (LGBTQ+) competencies into national accreditation standards and licensure examination test plans may have an important role to play in motivating on-the-ground changes in practice (Lim et al., 2015).

4 | EMBRACING CULTURAL SAFETY

Given the barriers identified above, interventions that depend less on content inclusion, but rather support an acknowledgement of gender diversity, and reinforce the importance of considering gender diversity in the course of nursing care may be the best approaches to motivate change in nursing education and practice settings. Such interventions fall within a cultural safety framework, which is presented as an individualized and comprehensive approach to interacting with each person we encounter in our nursing practice.

4.1 | Cultural safety

Cultural safety presents a framework that moves beyond a reduction of complex individual experience to a list of assumed qualities, and the need to understand a group is replaced with acceptance (Aboriginal Nurses Association of Canada, 2009; Kirmayer, 2012; Varcoe & Browne, 2015). Caring for the unique experience of each individual is the focus. Nurses cannot assume to know the individual's experience and must instead ask how care can be adapted to best support this particular individual patient at this specific time. Cultural safety is grounded in reflexivity. To avoid perpetuating harm, nurses must be aware of the social inequalities and biases that have historically affected individuals from this group, as well as cognizant of their own biases and assumptions, and the power (im)balance that is necessarily present in any professional encounter (Aboriginal Nurses Association of Canada, 2009; Kirmayer, 2012; Varcoe & Browne, 2015). Through awareness of history and the self, and through eschewing assumptions by asking patients about their needs, nurses can provide care that is individualized, appropriate and culturally safe (Aboriginal Nurses Association of Canada, 2009; Varcoe & Browne, 2015).

In order for nurses to promote cultural safety for their peers and clients, they must first learn to recognize their own assumptions for what they are (Carabez, Pellegrini, Mankovitz, Eliason, & Dariotis, 2015; Kirmayer, 2012; Peter, Du Bois, & Finnessy, 2015; Zuzelo, 2014). Awareness of personal assumptions and societal forces must be incorporated into every aspect of nursing education. By normalizing conversations about the impact of gender, ethnicity, sexuality and other constructs that work to constrain or empower an individual, nursing students learn to be conscious of the social processes that intersect to affect an individual's experience (Hankivsky, 2012; The Joint Commission, 2011; Zuzelo, 2014). While there has been some criticism that cultural safety's emphasis on power inequality focuses on vulnerabilities rather than strengths (Kirmayer, 2012), we argue that the awareness of power dynamics is an emancipatory approach that can be used to highlight strengths and can result in continued advocacy and challenging of norms in students' future practice (Carabez, Pellegrini, Mankovitz, Eliason, & Dariotis, 2015; Daley & MacDonnell, 2015; Eliason et al., 2010; Peter et al., 2015).

Therefore, to promote cultural safety for trans-persons, we argue not simply for curriculum inclusion, but more importantly for structural and curricular changes that promote safety for transgender individuals, and acknowledge and reflect gender diversity (Rutherford et al., 2012). Such change has the power to achieve what mere curriculum inclusion cannot—creating a new normal, grounded in reflexivity and respect, which recognizes the diversity of the population.

5 | STRUCTURAL AND CURRICULAR INTERVENTIONS FOR NURSE EDUCATORS

Acknowledging diversity and promoting cultural safety begins by educating nurses and modeling change in education and practice. Nursing educators should call for structural-level changes in education institutions, while concurrently implementing small but important individual changes in classroom interactions and conversations. By normalizing culturally safe spaces in nursing programs and classes, transvisibility may be enhanced, and nursing students will be given the awareness to translate this advocacy into their practice (Aboriginal Nurses Association of Canada, 2009; Varcoe & Browne, 2015).

5.1 | Information systems

Erasure is the process by which transinvisibility is perpetuated in education, health and other institutions (Bauer et al., 2009). It begins with the language used on the institution and program website (Lim et al., 2013). A statement of inclusivity signals acceptance and safety to potential students, whereas failure to acknowledge gender diversity cultivates invisibility. Erasure is further perpetuated by application forms that allow for only two gender options (The Joint Commission, 2011). Immediately, trans-persons are rendered invisible, and their gender identity dismissed (Bauer et al., 2009). Additionally, if forms and information systems do not allow registering students to state a preferred name, future contact with the school, including admission letters, official forms, class rosters and student identification cards, may be inconsistent with their gender identity and provoke feelings

of gender-related distress. This inaccuracy may create frustration and discomfort, or worse, unintentionally “out” a student as transgender. In addition to being harmful to transgender students, information systems that allow for only two gender categories reinforce for all students the erroneous notion of a gender binary. Nursing educators should advocate for more inclusive information systems within their programs, which are not only more accurate, but also normalize gender diversity and model inclusivity.

5.2 | Creating gender neutral/safe spaces

Gender-neutral washrooms are becoming more common and represent an important structural-level change (The Joint Commission, 2011). Their presence respects privacy and provides options for anyone who may be uncomfortable in such highly gendered spaces. Other gender-segregated areas such as women only drop-in centers, or other social resources intended to promote gender equality and create safe spaces, can unintentionally contribute to gender marginalization by making these spaces either implicitly or explicitly inaccessible to transgender users (Bauer et al., 2009; The Joint Commission, 2011). More gender inclusive spaces, such as those that serve LGBTQ+ interest groups, can counter that segregation and offer safety for those that do not identify or “qualify” as women or men (Lim et al., 2013). Nursing educators can advocate for more expressly gender-neutral spaces in their institutions to convey cultural safety to trans-persons and to model awareness and advocacy for their students.

Educators can also suggest that advisors, and any interested instructors, obtain ally training and certification that can be displayed visibly to promote safety (Lim et al., 2013; The Joint Commission, 2011). By openly advertising safe spaces and connections for trans-individuals, educators can promote cultural safety and demonstrate institutional auspices.

5.3 | Classroom leadership

Erasure is perpetuated in classrooms when instructors fail to offer students the chance to state a preferred name or pronoun. By forfeiting the opportunity to allow students to self-identify, instructors unknowingly contribute to transinvisibility in their classrooms. Enacting this gesture is a simple step that even instructors who feel they lack adequate knowledge to address trans-issues can take. It also models a simple behavioral modification that students can carry into their practice, taking a step toward recognizing and validating trans-identities (Rutherford et al., 2012).

During classroom and practice education, instructors can challenge their students to consider how gender affects the issue at hand. By bringing gender into a discussion of any other health issue, and then further challenging students to consider those who do not conform to strictly masculine or feminine performances, students begin to understand and appreciate the complexity of the effects of gender on health. This also serves to reinforce the concept of cultural safety, as it becomes evident that the health risks and assets of transgender individuals are as unique as the individuals themselves (The Joint Commission, 2011). As suggested previously, this does not require extensive knowledge about transgender individuals (especially as such knowledge can only be reductionist), but simply an openness to explore potential issues alongside students. If educators are willing to engage with these questions, students will be more likely to do the same in their own lives and practice (Peter et al., 2015). Integrating discussions of gender in this way also negates the need to try to add specific gender-related classes into already full curricula. Instead, gender is routinely considered in each encounter with a patient, as a social construct that affects health and well-being (Hankivsky, 2012; Varcoe & Browne, 2015).

If educators are interested in bringing gender issues into their classrooms to a larger extent, the World Professional Association for Transgender Health has released a free, downloadable booklet detailing standards of care for transgender individuals (World Professional Association for Transgender Health, 2012). There may also be local transgender or LGBTQ+ advocacy groups that can provide lectures, information sessions and other services for educators and students. A quick Internet query will link the searcher to a multitude of trans-resources. Engaging the trans-community acknowledges their presence and their insight as experts, while promoting trust and dialogue between nurses and these community members (Lim et al., 2013; Merryfeather & Bruce, 2014; Rutherford et al., 2012). Such engagement also models for students how to recognize, respect and access groups and individuals with specialized knowledge, which are important non-traditional resources that can enhance nursing care in their future practice.

5.4 | Advocating for diversity

Beyond the individual classroom and institution, educators can advocate for transgender awareness and inclusion in the health institutions and organizations they work with in practicum settings (Lim et al., 2013). This type of advocacy and role modeling is powerful and teaches nursing students that they have the potential and the responsibility to do the same in their own practice. Instructors can request practicum placements with organizations that work with transgender clients to expose nursing students to greater diversity and to promote connections with these important community groups.

To ensure gender issues are addressed more widely, educators can advocate for inclusion of gender-related content in accreditation standards and in NCLEX-RN® or other licensure examinations (Lim et al., 2015). This can prompt engagement where transinvisibility and transphobia are particularly entrenched and can inspire nursing educators everywhere to consider issues they may not have previously been aware of (Rutherford et al., 2012; Zuzelo, 2014).

To promote institutional diversity, nursing educators can also advocate for hiring practices that actively recruit faculty from various ethnic backgrounds, abilities or who are openly LGBTQ+ (Lim et al., 2013). By inviting and actively seeking diversity, nursing programs can benefit from varying and rich perspectives that will broaden student’s awareness and challenge them in different ways.

Another way to bring attention to transgender health is to conduct related nursing research to support this area of knowledge development in the profession. Nursing literature and research that focuses on transgender health is lacking and would serve to further awareness, knowledge building and change (Eliason et al., 2010; Lim et al., 2013; Merryfeather & Bruce, 2014; Strong & Folse, 2015; Zelle & Arms, 2015). Interested faculty can consider incorporating elements that recognize gender diversity into their research projects on other topics, to add new depth and understanding to nursing knowledge and to highlight potential needs and opportunities.

Structural and individual changes such as these serve to mainstream gender diversity in educational institutions. Nurses who are educated in such settings will be more conscious of their own sociocultural perspectives, possess greater awareness of gender issues and will have greater familiarity with emancipatory ways to challenge structures and practices that perpetuate the false gender binary and transinvisibility. Students educated in this manner will carry that awareness and reflexivity to their practicum placements and their future practice and will continue to advocate for their patients, incorporating gender diversity and cultural safety in new and innovative ways.

6 | CONCLUSION

While considering gender diversity is but one of the many elements of diversity that should be considered in the course of effective nursing education and practice, it should be accorded similar levels of consideration as other factors that may impact health and wellbeing. Cultural safety presents a viable and appropriate framework on which to facilitate safe educational and practice spaces for everyone who is "othered" by dominant perspectives and structures in society (Aboriginal Nurses Association of Canada, 2009; Varcoe & Browne, 2015). Modeling gender inclusiveness and acceptance in nursing education settings should be combined with upstream structural interventions to influence practice related to gender diversity within the profession as a whole. Increasing content related to gender diversity in nursing curricula may certainly support this goal; however, content alone will not necessarily translate into a change in practice. Ultimately, incorporating standards of practice related to the nursing care of trans-persons into nursing education, accreditation standards and licensure examinations could serve as potent motivators for change in the profession.

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