

Emily Wolfe-Roubatis, BA, BSN and Diane L. Spatz, PhD, RN-BC, FAAN

TRANSGENDER MEN AND LACTATION:

WHAT NURSES NEED TO KNOW



Abstract

Research examining needs of postpartum transgender men in relation to lactation and infant feeding is missing from nursing literature. Accordingly, little is known about how perinatal nurses can best support this unique subset of postpartum patients. Case studies presented here reveal that transgender men would appreciate care from nurses who are knowledgeable about transgender individuals and their healthcare needs, but this type of care is not always available. Nurses need more education about how to best support transgender patients and families in order to achieve optimal lactation and infant nutrition in this population.

Key Words: Breastfeeding; Healthcare disparities; Lactation; Transgendered persons.

Recognizing the superior nutritional and immunological benefits conferred by human milk, the United States Department of Health and Human Services (US DHHS) included increasing the percentage of breastfed infants and increasing the support available to lactating individuals as key goals in the Healthy People 2020 report (US DHHS, 2010). In 2011, US DHHS strengthened their position with the release of *The Surgeon General's Call to Action to Support Breastfeeding* (2011a). Of particular concern to nurses, each of these publications and statements emphasize the unique role perinatal nurses play in supporting families to achieve optimal breastfeeding outcomes (US DHHS, 2011b).

As modern reproductive technology has evolved, women-identified people are not the only individuals involved in pregnancy, birth, and lactation. Transgender men (transmen) and gender nonconforming (GNC) individuals are able to conceive and deliver babies, and therefore, are candidates for postpartum breastfeeding. However, due to limited research, little is known about needs of transmen wishing to provide human milk to their children. The purpose of this article is to increase awareness around transmen and GNC people's lactation needs and to provide suggestions for optimizing nursing care of this population. Case studies are based on interviews conducted by the author. All names have been changed to respect privacy.

Terminology

Given the lack of education regarding lesbian, gay, bisexual, and transgender (LGBT) individuals in nursing education (Lim & Levitt, 2011), as well as the limited discussion of LGBT healthcare delivery in nursing literature (Eliason, Dibble, & DeJoseph, 2010), a definition of terms is warranted. It should be noted that these are generally accepted definitions for commonly used terms, but that individuals may differ in their understanding of, and identity to, each of these words and concepts.

- **Transgender**—An umbrella term used to describe a person whose gender expression and/or gender identity is different from their birth-assigned anatomical sex. Transgender includes trans, transman, transwoman, female-to-male (FTM), and male-to-female (MTF) (National Center for Transgender Equality, 2014).
- **Gender Nonconforming**—A person who does not present and/or express their gender as is stereotypically expected (e.g., a masculine female), or does not subscribe to being either masculine or feminine (Fenway Health, 2010).
- **Gender identity**—A person's psychological and internal sense of being male, female, or other; not necessarily correlated to their anatomical sex (National Center for Transgender Equality, 2014).
- **Gender expression**—A collection of external characteristics that demonstrate a person's gender identity including clothing, mannerisms, language, and behaviors (National Center for Transgender Equality, 2014).
- **Sex**—"In a dichotomous scheme, the designation of a person at birth as either 'male' or 'female' based on

RECENT STUDIES SUGGEST THE NURSING COMMUNITY HAS LAGGED BEHIND OTHER HEALTHCARE PROFESSIONS IN PUBLISHING RESEARCH, GUIDELINES, AND STATEMENTS OF SUPPORT RELATED TO TRANSGENDER HEALTH.

their anatomy (genitalia and/or reproductive organs) and/or biology (chromosomes and/or hormones)" (Fenway Health, 2010).

- **Sexual orientation**—A person's attraction to others of the same and/or different genders; typically described as lesbian, gay, bisexual, heterosexual, or asexual (National Center for Transgender Equality, 2014).

Background

Best available data suggest that between 4% and 11% of the population of the United States identifies as LGBT (Institute of Medicine [IOM] & National Research Council [NRC], 2011). In March of 2011, the IOM and NRC released a report *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. Commissioned by the National Institute of Health, the report functioned as the first comprehensive evaluation of both the health status and future needs of LGBT populations in the United States (IOM & NRC, 2011). In addition to specific health disparities discussed below, a key finding was the scarcity of scientifically rigorous research on the health needs and outcomes of LGBT populations in the United States. Lack of treatment guidelines outlining best practices for providers treating LGBT patients was highlighted (IOM & NRC, 2011). Increased funding toward research investigating LGBT health needs was advocated and there was a generalized call to action to decrease health disparities for LGBT populations, and increase training, research, and competence regarding LGBT health (IOM & NRC, 2011). It is important to note, although LGBT populations are often written about as one population, each group has unique needs and barriers to healthcare. This article will primarily focus on research related to transgender individuals.

More research is needed; however, existing research reveals that due to a history of stigma, violence, oppression, and discrimination, LGBT populations face unique and specific barriers to healthcare (Adams, 2010; American College of Obstetricians and Gynecologists [ACOG], 2011; IOM & NRC, 2011; Merryfeather &

Bruce, 2014). A 2011 joint report from the National Gay and Lesbian Taskforce and the National Center for Transgender Equality (Grant et al., 2011) revealed that 19% of transgender people were refused medical care at some point in their lives due to their gender identity, 50% reported having had to teach their medical providers about transgender healthcare, and 28% had delayed seeking care due to a fear of discrimination. In 2011, ACOG published a statement on healthcare needs of transgender people stating...“Lack of awareness, knowledge, and sensitivity in healthcare communities eventually leads to inadequate access to, underutilization of, and disparities within the health care system for this population” (2011, p. 1). Recognizing the public health crisis at hand, US DHHS included improving the “health, safety, and well being” of LGBT people by first “understanding the history of oppression and discrimination these communities have faced,” such as “legal discrimination in access to health insurance, employment, housing, marriage, adoption, and retirement benefits,” and a “shortage of health care providers who are knowledgeable and culturally competent in LGBT health,” into the Healthy People 2020 goals (US DHHS, 2010). Given these issues, perinatal nurses need adequate and accurate information to be competent to meet health needs of transgender individuals.

Recent studies in nursing journals suggest that the nursing community has lagged behind other healthcare professions in publishing research, guidelines, and statements of support related to transgender health (Eliason et al., 2010; Keepnews, 2011; Lim & Levitt, 2011; Merryfeather & Bruce, 2014; Zunner & Grace, 2012). Based on a 2005–2009 review of the top nursing journals, Eliason et al. (2010) noted of the 10 nursing journals with the highest impact factors, only 8 articles focusing on LGT issues (0.16% of all articles) and only 1 article mentioning transgender issues were found in a sample of nearly 5,000 articles. Five of the top 10 journals had no articles about GBT issues (Eliason et al., 2010). Similarly, using the keywords “transgender,” “nursing,” and “nursing care,” we searched PubMed, CINAHL, Web of Science, and MEDLINE for articles published in peer-reviewed nursing journals between 2008 and 2014 and found five articles on care of the transgender patient, three of which were dedicated to addressing the “silence” of the nursing community regarding transgender care (Eliason et al., 2010; Keepnews, 2011; Merryfeather & Bruce, 2014).

Minimal nursing literature exists regarding the role of the nurse in transgender healthcare in general and less is known about the relationship between nurses and the transgender man as perinatal patient. In searching PubMed, CINAHL, Web of Science, and MEDLINE for articles published between 2008 and 2014, using the keywords “transgender male,” “intrapartum,” “MTF,” “labor and delivery,” “LGBT,” “perinatal nursing,” and “lactation,” we found only one article exploring competent intrapartum nursing care for pregnant male patients (Adams, 2010) and no publica-

tions regarding nursing care and needs of transgender men in lactation.

In an attempt to support the dual Healthy People 2020 goals of increasing lactation and breastfeeding in the United States and improving care and health outcomes for transgender patients, the following case reports illustrate some of the concerns and experiences faced by transgender men regarding lactation and infant feeding. Clinical recommendations informed by the case studies and latest available guidelines on transgender health directly follow. Cases were recruited using social media outlets and word of mouth. Interviews were conducted both in person and via e-mail, according to each participant’s location and preference. Per the University of Pennsylvania Institutional Review Board, study approval is not required when fewer than five cases are obtained. All names have been changed to protect the privacy of the individuals.

Case Exemplars

Case One: Dan

Dan is a 45-year-old transgender man and father of two. Although “out” as transgender since 2001, Dan chose to forgo any surgical or hormonal interventions up until this point, meaning that following the birth of his first child, he was able to lactate and immediately began attempts to chestfeed his daughter. Dan, supported by his partner, Elena, began pumping in the hospital and received basic lactation support and instruction from the nursing staff. Dan, Elena, and their new son were discharged home 2 days following birth.

Dan attempted to increase his milk supply through frequent feeding and pumping sessions at home, but experienced a delay in lactogenesis II and continued to produce colostrum until 5 days after birth, resulting in limited weight gain by his son. Dan and Elena were instructed to supplement human milk feedings with formula and their new son was frequently bottle-fed formula and available expressed milk. Although Dan eventually produced enough milk to stop formula supplementation, he reported persistent and intense nipple pain and, therefore, spent the first 6 weeks exclusively pumping and bottle feeding his son. When asked to elaborate on the cause and details surrounding the nipple pain, Dan explained that he and his partner consulted a doula, visited a breastfeeding center, and spoke with their medical provider regarding the pain, but little worked in relieving the symptoms. Further details regarding the nipple pain are unavailable.

When asked how the hospital, breastfeeding center, and doula staff responded to his trans-identity, Dan explained that at the time, he passed as a masculine-appearing woman, and that the staff assumed Elena and he were a lesbian couple and that he did not correct them. That is, although Dan identified as a transgender man, he did not disclose his identity to any of his medical, nursing, or lactation providers the entire time he sought care. When asked about his decision to do so, Dan explained he felt as though staff could not disentangle pregnancy and lactation from womanhood. In his own words, Dan stated:

MINIMAL NURSING LITERATURE EXISTS REGARDING THE ROLE OF THE NURSE IN TRANSGENDER HEALTHCARE IN GENERAL; EVEN LESS IS KNOWN ABOUT THE RELATIONSHIP BETWEEN THE NURSING PROFESSION AND THE TRANSGENDER MAN AS PERINATAL PATIENT.

I didn't want to encounter adversity when already so vulnerable in the labor and postpartum process. If I need you [as a healthcare provider] to be focusing on specific medical concerns, I'm nervous to come out as trans.

Case 2: Troy

Troy identifies as transmasculine and prefers the pronoun “they.” They are in their late-20s and recently carried their first pregnancy, resulting in David, Troy, and their partner’s second child. Troy and their partner, Sarah, have another young son, Jackson, whom Sarah carried. Troy received prenatal care at the same birth center as Sarah and, therefore, was familiar with the staff and setting. The following is how Troy describes their experience, in their own words:

I got my care at [location redacted to protect privacy]. My partner also got care there when she gave birth to our first son. Since our kids are only a year apart, [location] didn't make me re-do the breastfeeding class they run but I did go with Sarah. I talked about my hesitations regarding nursing [breastfeeding] at my 8-week appointment with the midwife I saw. I fed David at the birth center about a half hour or so after he was born. Nursing [breastfeeding] was my #1 fear about carrying/birthing a child so I was relieved that I wasn't too hung up on it at [location] after I gave birth...

I was also lucky to have a birth that was very much in my control. I can really imagine a birth being very traumatic for a trans guy but I birthed standing, after only having had one (horrible) cervical check throughout labor. I spent most of my labor in a bath by myself with occasional heartbeat checks from the midwife or nurse. So the invasion of my space was so minimal. I was really anxious to have anyone “watch me” (not “see me”) nurse before I had David but the nurses at [location] were very non-invasive about it...

I was anxious to start [breastfeeding] soon after delivery since I know how important that is. It ended up being good because David is an insanely sleepy baby and was in a sleepy baby coma after birth so if he hadn't latched who knows what might have happened. All of the midwives and nurses at [location] are very experienced with helping nursing parents and I chose to focus on the “new par-

ent/new baby” aspect of the experience vs. the “new trans parent” experience since I know that's not their area of knowledge or expertise...

If I get pregnant again, which I might, I would get care at [location] again. But it all makes me a little depressed that [location] practitioners aren't getting more “on top of” trans issues. They have a large midwifery staff and I sensed that a few of the midwives are very sensitive to these issues due to questions they asked me and the manner in which they handled my concerns. The midwife who saw me at 8 weeks (and who delivered my older kid) was awesome and even pressed me to consider trying to have Sarah nurse the new baby. But a lot of the practitioners seem more like “the sisterhood” oriented which I get. I read Ina May Gaskins too. I had a badass natural birth too. But being sensitive to being a practice that might attract queers, too, is important. (Personal communication, March 17, 2014)

Ten days after labor, Troy and David began experiencing breastfeeding difficulties and Troy sought out a trans-friendly lactation counselor. In order to find one, Troy networked with a trans and GNC lactation group on Facebook and asked friends for recommendations. Troy described their experience with the lactation counselor as positive due to the fact that the counselor “was really good about respecting my space/body/preferred pronouns/etc,” and her willingness to educate herself about transgender health and identities (Personal communication, March 17, 2014). In addition to seeking the help of a lactation counselor, Troy attended a bimonthly breastfeeding support group for new parents. In Troy’s own words:

Every other week I do attend the Breastfeeding Support Group... My partner encouraged me to attend when David was 5 days old just to try since I was feeling a lot of dysphoria and also was very grossed out by breastfeeding (I still pretty much am). Being around it helps me a lot, and also even though I'm not super open about trans stuff I do talk about dysphoria, body image issues, etc. and it's a safe space for that. The nurse/lactation counselor who runs the group is older and seems very “old school.” She does not come off as very educated about queer and trans issues so this is why it's not a subject for me (I guess she just thinks I'm a butch lady or something). (Personal communication, March 17, 2014)

Suggested Clinical Implications

Recommendations for improving care for perinatal transgender patients and families are offered as follows.

Create a welcoming clinical environment

- Develop and post a visible nondiscrimination policy in the patient waiting room.
- Display physical signs of inclusion and safety through “safe space” stickers, (available online, these stickers can be placed on office doors or reception desks and indicate the environment is open to and accepting of LGBT patients), and educational materials applicable to all family constellations.
- Create gender inclusive health forms by including a “transgender” or “other” option in addition to “male” and “female.”

Develop a relationship based on trust and respect

- Make no assumptions about your patient’s gender identity. Open-ended questions such as “how do you describe your gender identity,” or “what pronoun do you prefer,” allow for open communication and honest answers.
- Document your patient’s preferred pronoun and gender identity and change previously collected data accordingly.
- Ask your patient what terms they prefer for relevant body parts. For example, a transman may prefer to use the term “chestfeeding” rather than “breastfeeding.”
- When asking a transgender patient or family questions, make sure they are pertinent to the task at hand; for example, asking parents how they intend to explain their relationship to their child is unnecessary if providing lactation support.
- As with all patients, ask before touching a body part during a physical exam. Ask how someone prefers to be examined and, if they disclose discomfort, limit the amount of direct observation or touching to the minimum medically necessary.

Educate yourself and your colleagues

- Provide LGBT-specific cultural literacy and sensitivity training for all staff in your healthcare setting by using the resources provided below. Additionally, many metropolitan areas have LGBT-specific health clinics that offer trainings and guidance for non-LGBT focused health settings.
- Take responsibility for learning about trans-specific healthcare and lactation practices by becoming familiar with the best practice guidelines below.
- Approach your nurse manager, nurse educator, or clinical nurse specialist about holding educational sessions or grand rounds on transgender lactation and LGBT family support.
- Over time, compile a list of trans/GNC knowledgeable lactation referrals in your area; if there are none, consider using the resources below and becoming one.

Know your resources

- The Gay and Lesbian Medical Association’s “Guidelines for Care of Lesbian, Gay, Bisexual, and Transgender Patients” (http://glma.org/_data/n_0001/resources/live/GLMA%20guidelines%202006%20FINAL.pdf)
- UCSF Center of Excellence in Transgender Health, “Guidelines and Best Practice” (<http://transhealth.ucsf.edu/trans?page=lib-00-02>)
- The Fenway Institute’s National LGBT Health Education Center, offering training and consulting to healthcare organizations regarding LGBT healthcare practices. Accessible at www.lgbthealtheducation.org/
- The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding – Report available for free download (www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx)
- The National Center for Trans Equality (<http://transequality.org/>)
- The World Professional Association for Transgender Health (www.wpath.org/)
- Out For Health, “Resources for Providers” (<http://outforhealth.org/for-providers.html>)

When asked to elaborate on their negative feelings regarding breastfeeding, Troy wrote:

My major (vanity) concern was and is chest size. Although I'd really like top surgery, because of finances/society/etc., I am unlikely to get it but I am blessed with barely-A cups naturally. In “normal” life I wear sports bras and I'm good to go; I don't even really have to bind to get “sir'd” frequently. I knew that having giant milk-filled boobies would drive me bonkers and it does. And also having to think about them all the time is and was my concern. I am used to waking up, hiding them, and then looking great. Now they're just so there all the

time and I constantly have to take them out, look at them. They leak, I need better bras (that are girly), etc. So much boobie talk/so many boobie thoughts/ etc. I am anxious about how they will look after...I don't like nursing but I didn't have to get pregnant since I have a perfectly healthy and fertile spouse and I think it's my job to nurse kids I birth at least until 6 months. I respect people who don't feel that way and I don't really care what they do with their kids but for me it was not an option not to nurse unless I was experiencing problems that I couldn't handle. My personal mantra has been “You don't have to like it, you just have to do it.” (Personal communication, March 17, 2014)

Case 3: Malcolm

Malcolm is a nurse practitioner specializing in the care of transgender and GNC individuals. As the primary healthcare provider for many of his patients, he provides prenatal care as necessary. Malcolm was asked about referrals he makes to lactation specialists, ways that the nursing community can better support lactation among trans and GNC patients, and if he was aware of any specific clinical guidelines related to transmen and lactation. Malcolm and I communicated by e-mail. His responses are shared below:

I am not sure that clinical guidelines specific to this would need to exist. The process is no different then for non-trans individuals choosing to nurse. If the person has not yet had top surgery and I am seeing them for pre-natal care, I do ask about plans for bottle versus breast-feeding. I usually send people around here to the breast feeding resource center in X. I know [name of practitioner] there and would be comfortable talking to her about sending a FTM [female-to-male transgender person] her way.

Honestly, it has a lot to do with whether the patient is living/passing as male- with regard to if/ where I send them. In my experience, FTMs who are non-hormone/non-op can go really wherever they want and are generally accustomed to directing their providers. By keeping GNC/trans gender patients out of the hospital environment and by providing education for staff, especially around language (correct pronoun use, feeding instead of breast-feeding, etc), nurses can create more trans inclusive environments and support lactation. (Personal communication, March 16, 2013)

Conclusions

According to Provision One of the American Nurses Association (ANA, 2001) *Code of Ethics*, “the nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems” (p. 1). Perinatal nurses are better able to provide care consistent with the ANA (2001) *Code of Ethics* when they are knowledgeable about the various unique subsets of patients they may encounter in their clinical setting, such as transgender individuals, in addition to the general population of patients who identify as women during the childbearing process. The case studies of two patients presented here suggest that transgendered and GNC patients may feel the need to remain silent about their transgender identity in the perinatal setting because they assume caregivers’ lack of knowledge regarding transgender identity and healthcare issues. There is minimal coverage in this topic in the nursing literature; therefore, nurses need to take an active role in seeking education about the healthcare needs of transgender individuals.

“Perinatal nurses enter their specialization with the assumption that the adolescent and adult patients ad-

Suggestions for Nursing Care

Try to Ask...	Try to Avoid...
The patient’s plan for postpartum feeding, paying attention to the word choices of the patient (e.g., lactation, chestfeeding, nursing, etc.)	Asking questions not directly relevant to the situation (e.g., plans for future hormone or surgical therapies, how the child will be accepted in school, etc.)
The patient what pronouns they prefer; if you make a mistake, apologize and use the correct one next time	Assuming the patient’s sex and gender identity
How they would like nurses to refer to their body parts (e.g., chest, breast, etc.)	Assuming the patient’s preference for body parts terms
If the patient is comfortable with the nurse touching their body before assisting in feeding	Having more staff in the room than necessary as this might be construed as staff wanting to look at or gawk at the patient
Any colleagues who are uncomfortable with your patient to read some of the resources provided, and to refrain from making comments about, or interacting with, your patient	Focusing on the transgender aspect of the patient rather than their identity as a new parent in need of lactation support

mitted to their care will be female” (Adams, 2010, p. 1). However, this assumption is not always valid. Perinatal nurses in general, and lactation providers specifically, need to challenge this assumption and familiarize themselves with the needs of their transgender patients. As a nursing community, if we work to disentangle our own assumptions and understandings about our patients’ relationships to their bodies and gender identities, we can create more patient-centered care. Perinatal nurses and the lactation community, rooted in advocacy and family-centered care, can lead the nursing profession in affirming, informed, and successful transgender lactation care. ❖

Emily Wolfe-Roubatis, RN, BSN, BA is a student in the women’s health nurse practitioner and midwifery programs at the University of Pennsylvania, School of Nursing, in Philadelphia, PA. She can be reached at emwo@nursing.upenn.edu.

Diane L. Spatz is a Professor of Perinatal Nursing & Helen M. Shearer Professor of Nutrition at the University of Pennsylvania School of Nursing & Nurse Researcher & Manager of the Lactation Program at the Children’s Hospital of Philadelphia, Philadelphia, PA. The author can be reached via e-mail at spatz@nursing.upenn.edu

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2014 MCN Practice Paper of the Year

Diane Angelini, EdD, CNM, NEA-BC, FACNM, FAAN and Elisabeth Howard, PhD, CNM, FACNM: **Obstetric Triage: A Systematic Review of the Past Fifteen Year: 1998-2013**. Published in MCN June 2014 Ahead of Print and in MCN September/October 2014, volume 39, number 5.

Dr. Angelini is a Clinical Professor, Department of Obstetrics and Gynecology, Warren Alpert Medical School of Brown University; Director, Midwifery, Women and Infants Hospital, Providence, RI; Senior and Co-Founding Editor, *Journal of Perinatal and Neonatal Nursing*, www.jpnnjournal.com.

Dr. Howard is a Clinical Assistant Professor, Department of Obstetrics and Gynecology, Warren Alpert Medical School of Brown University, Women and Infants Hospital, Providence, RI.

2014 Research Paper of the Year

Mary G. Mazur, BSN, RN, Judith Mihalko-Mueller, RN, Helen Callans, BS, RN, Deetra Klesh, BSN, RN, Heather Sell, MSN, RN, and Diane Bendig, ASN, RN: **Reproducibility of Non-Invasive Bilirubin Measurements**. Published in MCN July/August 2014, volume 39, number 4.

Mary G. Mazur, Judith Mihalko-Mueller, Helen Callans, Deetra Klesh, Heather Sell, and Diane Bendig are Staff Nurses, Providence Hospital, Alternative Birth Care Unit, Southfield, MI.

These authors will receive a cash award and a certificate of achievement.

CONGRATULATIONS!