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Same-Sex Mothers and Lactation

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Abstract
Investigation of the needs of same-sex mothers practicing lactation is limited in the nursing literature. The heteronormative structure of the healthcare system has stigmatized these postpartum women and minimized the level of nursing care provided. Case reports demonstrate that same-sex mothers value inclusivity and understanding of their healthcare needs that is missing in healthcare settings. Perinatal nurses must listen attentively and think critically about their words and actions to avoid inappropriate judgments when providing care to this population. Active engagement and ongoing competence education builds the foundation that will provide perinatal nurses the knowledge they need to best support the unique needs of same-sex mothers in their lactation experience.

Key words: Breastfeeding; Healthcare disparities; Lactation; LGBT persons.

Healthcare professionals in developed nations such as the United States and in developing countries recognize breast milk as the optimal sustenance to meet a newborn infant's nutritional and immunological needs (Lawrence & Lawrence, 2015). In concordance with this normative standard, the United States Department of Health and Human Services (US DHHS) released *The Surgeon General's Call to Action to Support Breastfeeding* to increase the percentage of breastfed infants and available support for lactating individuals for decades to come (US DHHS, 2011a). The important role of nurses is recognized in these publications and statements as they emphasize how nurses can support mothers and families to achieve their personal breastfeeding goals (US DHHS, 2011b).

Continued advances in assisted reproductive technology have increased the opportunity for same-sex female couples to build a family through pregnancy, birth, and lactation (Hayman, Wilkes, Halcomb, & Jackson, 2015). Sharing in this role of motherhood however becomes complex as breastfeeding requires one to be the biological parent to conceive, give birth, and provide human milk for the baby. Alternate options such as induced lactation are available for the non-birth mother to share in the maternal identity and contribute to lactation. There is a limited amount of research on the needs and degree of

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lactation support to same-sex mothers experiencing or planning to breastfeed. The purpose of this article is to increase awareness on the lactation experiences of same-sex female couples and to provide suggestions for nursing care to create a more inclusive and supportive environment for this population of mothers.

Background

The definition of a family has evolved in modern society with the acceptance and visibility of same-sex individuals composing the family unit. Most recent data from the United States Census Bureau report stated that "Out of the 594,000 same-sex couple households, 115,000 reported having children. Eighty-four percent of these households contained own children of the householder" (Lofquist, 2011, p. 2). These estimates show that alternate family structures continue to rise in the United States. In 2011, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* was released by the Institute of Medicine and National Research Council (IOM & NRC, 2011). This report stands as the primary evaluation of the status and future accessibility of healthcare to the U.S. lesbian, gay, bisexual, and transgender (LGBT) population (IOM & NRC).

Gaps in substantial scientific research exist according to the report, leading to the need for future studies on the health concerns and outcomes of the LGBT population (IOM & NRC, 2011). Treatment guidelines are prioritized but are lacking in most health institutions (IOM & NRC). The public health agenda acknowledges barriers in health access and the need for improved health equity to minimize the systemic stigma felt by LGBT populations (IOM & NRC). Increased training to provide ongoing competence for healthcare professionals about LGBT health is among the recommendations listed (IOM & NRC). Even with this progressive advance, this report fails to disaggregate the LGBT population and specify the needs of each unique group. Research related to lesbian and bisexual females and as same-sex couples are the primary focus for the purpose of the article.

The current state of knowledge indicates that self-identifying lesbians and bisexual women struggle in accessing equitable healthcare due to a history of discrimination, stigma, and homophobia (American College of Obstetricians and Gynecologists [ACOG], 2012; Chapman, Wardrop, Zappia, Watkins, & Shields, 2012; Hayman, Wilkes, Halcomb, & Jackson, 2013; IOM & NRC, 2011; Sabin, Riskind, & Nosek, 2015). The American College of Obstetricians and Gynecologists released a statement in 2012 identifying the barriers encountered by lesbian and bisexual women stating… "concerns about confidentiality and disclosure, discriminatory attitudes and treatment, limited access to health care and health insurance, and often a limited understanding as to what their health risks may be" (ACOG, 2012, p. 1). Homophobic and heteronormative assumptions and inadequate knowledge further marginalize these women and hinder them from receiving essential care (Chapman et al.; IOM & NRC; Marques, Nogueira, & de Oliveira, 2015).

Multiple barriers have limited the chance for same-sex mothers to start a family. Procedures necessary to achieve pregnancy such as donor sperm, intrauterine insemination, and in vitro fertilization involve high costs and impede mothers from joining motherhood due to lack of financial security (Goldberg & Scheib, 2015; Hayman et al., 2015; Wojnar & Katzenmeyer, 2014). Same-sex couples desiring to become mothers may also be discouraged as emotional and familial support lacks in relation to heterosexuals (Hayman et al.; Wojnar & Katzenmeyer). Nurses, particularly perinatal nurses, need awareness of these obstacles to provide optimal maternal care to same-sex couples.

For non-birth mothers, induced lactation, the process of stimulating breast milk in a woman who has not been pregnant, may pose as a means to participate in motherhood and share in the maternal–child bond. Inducing lactation requires both multiple hormones and frequent stimulation of the breast, and because nonbiological partners do not undergo the same hormonal changes as birth mothers, they must use nonpharmacological, pharmacological, and hormonal supplementation methods (Table 1) in combination to achieve the physiology necessary for milk production (Wittig & Spatz, 2008). However, these women may not be aware of the opportunity due to lack of national recognition. Literature on induced lactation is very minimal with much of the research outdated and targeted to adoptive parents (Auerbach, 1981; Bryant, 2006; Wittig & Spatz). Only two case reports were found on the subject of induced lactation between same-

Table 1. Inducing Lactation for Nonbiological Partners

Method	Agent/Action	Mechanism	Reason	Reference
Nonpharmacological	Nipple stimulation via hand or pump	Facilitates circulation of the breast	Mimics the suckling of a newborn	Wittig & Spatz (2008)
Pharmacological	Galactagogues such as metoclopramide or domperidone	Dopamine antagonist	Mimics stages of pregnancy and the postpartum period of lactation in the female body	Wittig & Spatz (2008); Bryant (2006)
Hormonal supplementation	Exogenous estrogen and progesterone; oxytocin	Stimulates alveolar and ductal systems of the breast; stimulates milk ejection reflex	Mimics natural hormonal cycles during pregnancy	Wittig & Spatz (2008)

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sex mothers (Wahlert & Fiester, 2013; Wilson, Perrin, Fogleman, & Chetwynd, 2015). Nurses need to familiarize themselves with this opportunity of induced lactation and the skills and preparation involved so to advocate fully for these women.

The nursing literature lags in reporting the maternal needs of lesbian and bisexual female couples. No reviews were found and nursing literature available include studies of qualitative design with primary focus on the pregnancy and birth experience. The topic of breastfeeding and lactation support for same-sex mothers is missing in nursing journals. Lactation resources available come from parents and providers of this community who conduct the research themselves (Farrow, 2015).

To improve care and lactation outcomes among same-sex mothers, the following cases highlight some of the experiences and concerns of same-sex mothers about pregnancy, lactation, and infant feeding. Primary focus is on the perspective of the birth mother. Clinical recommendations for nursing care based on these cases directly follow. Recruitment of women for the cases was through word of mouth and email. Interviews were conducted via phone. Per the University of Pennsylvania Institutional Review Board (IRB), an IRB application is not required with three or fewer cases. Participants self-selected pseudonyms for privacy purposes.

The heteronormative structure of the healthcare system has stigmatized these same-sex mothers and minimized the level of nursing care provided.

Case Exemplars

Case One: Lindsay

Lindsay is a bisexual woman with a thriving and healthy seven-and-a-half-year-old daughter. She chose to have a child with her partner due to a biological pull and agreed that they could support the infant emotionally and financially. It was an easy decision at the time as Lindsay wanted to carry the child and go through the experience, whereas her partner did not and wanted to be there for support. Little did they know that an abdominal birth defect would lead to a special birth, multiple surgeries, and a prolonged stay in the neonatal/infant intensive care unit (N/IICU). During this time, Lindsay felt heartbroken but learned that despite these complications she could contribute to her daughter's healing through her own milk as medicine. Lindsay, in her own words, describes the experience:

I thought I had a normal, regular pregnancy and I found out at my 20-week ultrasound that she had a birth defect. They [providers] *could have supported us at our local hospital, but I didn't feel comfortable knowing that they were suggesting termination as a very strong option. I went to CHOP* [Children's Hospital of Philadelphia] *for a second opinion. They took over most of my care. They took her three weeks early so that I wouldn't have a spontaneous delivery. The birth was not something that I thought would be. I had a birth plan written to have a natural birth and this very natural hippie, no drug, no intervention type stuff. I had a C-section which I didn't want but it was not optional and she came out and she needed to be intubated right away. The baby was put on life support basically right at birth and started getting surgeries at day two of life.*

But during that time, I continued to follow all the pumping recommendations. She couldn't take food of any kind by mouth or otherwise for several weeks so I just continued to pump and freeze. When her surgeries were finished, she was finally able to start taking in milk. Thankfully, I had a surplus supply. I was able to actually donate my extra milk to other babies who were sick. I met my goal of pumping and providing milk for the whole year which she had a NG tube. She was never able to take by mouth so I pumped exclusively for a year. It [pumping] *crushed me quite a bit. I never got the experience that mothers imagine – I never got to even hold her for three whole weeks, and ultimately even when I did hold her, she could never breastfeed and she had terrible reflux issues. It was just incredibly crushing and sad and I felt really alone.* (Personal communication, February 13, 2018)

When asked on how her partner could contribute, Lindsay stated her partner was a support system but was not interested in induced lactation but found ways to help Lindsay by cleaning the pump and making sure that the milk was stored properly. In regards to their relationship at the time, Lindsay shares in her own words:

We decided to make our marriage legal while pregnant because we knew she [the baby] *was sick and needed a lot of medical attention. My partner would have had no right to the baby if we didn't have a commitment, and so we went through all these legal proceedings. Very shortly after her birth, we did a second parent adoption so that all the legal requirements were met to provide health insurance to make sure that all of our rights were protected under the law which they are now federally but they were not back then.*

There's probably an assumption that because the other person is a woman, that she will understand what you're going through as a person who gave birth. And that did not feel that way to me. It still felt very isolating. It could be a correct assumption for some people but it wasn't correct in my case. I think it's just impossible for another person who didn't give birth to the baby to understand all the emotions that come hormonally. When you're carrying the baby, you can never escape that feeling that they're apart of you. So that was kind of frustrating. The assumptions that people would make. "Oh it must be nice to have another mom." That's not always a good assumption. (Personal Communication, February 13, 2018)

Case Two: Katie

Katie and her partner Abby have been together for about 12 years with 6 of those years as a married cou-

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ple. Together for a long time, Abby always pictured herself as the one to give birth and was ready before Katie to conceive a child. Despite multiple attempts, Abby failed to get pregnant. The disappointment and emotional reality hit Katie at that point with her realization that being a birth mother was something she desired. She went through many intrauterine inseminations before finally conceiving with in vitro fertilization. Katie's pregnancy over the course of the months showed normalcy, and after 29 hours of labor, she gave birth to a healthy baby boy. Their son is almost 16 months now and is still currently breastfeeding more for comfort than for nutrition. Katie's breastfeeding experience happened immediately after birth, recounting the experience in her own words:

They put him on my chest so that [breastfeeding] *happened immediately. Then, once we got into the postnatal room, breastfeeding became really challenging. I started having a lot of pain. I eventually told the lactation consultant that I didn't think I could do it anymore. She* [lactation consultant] *recommended that I pump. They gave me a pump to use and then I ended up pumping and scheduling an appointment with a lactation consultant outside the hospital in the hopes that I could sort of pump for a while and eventually get back to breastfeeding when my nipples healed.* (Personal Communication, April 5, 2018)

When asking how her partner contributed to these milk feedings, Katie stated that she [her partner] was the one doing all the bottle feeding while she pumped due to the pain felt by direct breastfeeding. Once Katie started direct breastfeeding again, her partner became less involved. On the topic of induced lactation for her partner, Katie responded:

I don't think she was interested in that at all. I mean there's a couple of things. One is that I was able to do it so it didn't really seem necessary. I think also gender identity comes into it in an extent. I mean she definitely identifies herself as female but I think that she's less excited about those changes to her body, and I feel totally comfortable with that. I think she also wouldn't have been super eager to have her boobs get bigger and then have milk come out of them. (Personal Communication, April 5, 2018)

With regard to healthcare professionals, Katie felt that she was supported throughout her breastfeeding experience with only terminology misuse at times. She describes:

The only thing was terminology sometimes. Like in one of the prenatal classes we took, I think she [instructor] *had a hard time with terminology. I think she just wanted to say mom and dad all the time. But she tried so I think it's really a matter of people getting accustomed to using the right terminology, you know inclusive terminology.*

I mean the hard thing about breastfeeding is that there's a lot of judgment around it either way like either you're breastfeeding or you're not breastfeeding and people are judging you. You're breastfeeding too much or you're breastfeeding too long or oh, you're still breastfeeding? I felt like when he turned a year suddenly we fell off a cliff where it was like okay he doesn't need to breastfeed anymore. I felt like the message changed which is like "You don't need to do this anymore, and if you do, there's a little bit of judgment." I think that mothers get so many mixed messages, and I think that's what's really hard. It's like you want to do the right thing for your baby, and I think there's different opinions on what the right thing is and I think compassionate practice is a lot more helpful than a judgmental attitude. Because everybody is trying to do their best. (Personal Communication, April 5, 2018)

Table 2. Practice Recommendations

Display nondiscrimination signs and brochures with pictures of same-sex couples and families in the waiting area.
Review medical history and registration forms for inclusion of gender-neutral options such as "spouse" or "unmarried partner" in addition to an option for "husband" or "wife."
Recruit healthcare professionals trained in LGBT competent care especially International Board Certified Lactation Consultants (IBCLC) who specialize in communicating with same-sex mothers to equip these mothers with the skills they need to promote lactation.
Visit LGBT-centered health clinics for guidance and training sessions.
Offer referrals for other local LGBT family planning agencies and lactation services if unable to meet the couple's needs.

Case Three: Nicole

Nicole is a 31-year-old mother living with her wife in the Lehigh Valley area. After being together for 7 years and having been married for 4, the two of them decided to have a child once they were emotionally and financially ready. The decision to choose who would be the birth mother was simple as Nicole always pictured herself as

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Suggested Clinical Implications

- Continue to encourage same-sex mothers during their lactation experience by cheering them on to help them meet their pumping goals.
- Avoid labeling the relationship status or sexuality of two women as they may identify in different ways.
- Actively listen to same-sex couples to personalize their breastfeeding experience.
- Present a positive and nonjudgmental attitude to create an atmosphere of inclusivity.
- Be familiar with standardized guidelines available for same-sex couples interested in family planning and lactation including those from ACOG (2012) and IOM and NRC (2011).
- Know the guidelines and best practice recommendations, recruit healthcare professionals trained in LGBT competent care, and display resources and brochures for same-sex families in the waiting area to ensure that optimal care is provided.

the one, especially because her wife wasn't interested in that position and just wanted to be the parent. All was well until Nicole received worrisome news at her 32-week routine ultrasound that her son had a brain defect. Hearing the health concerns for her son, Nicole decided to switch from her original healthcare network to a children's hospital where she gave birth to her son at 37 weeks. She began breastfeeding immediately but found it difficult as her son wasn't latching on. To maintain her milk supply, she has been exclusively pumping since his birth on February 5th with the goal to continue for a year. The nurses have continually been helping her son with his motor skills so that he could latch properly and attempt direct breastfeeding again. Nicole's wife has been a great support system while Nicole pumps—offering verbal encouragement, cleaning the bottle and equipment, and talking to the nurses to make sure the milk is stored properly. When asked if Nicole's wife would be interested in induced lactation, Nicole replied:

My wife isn't interested in induced lactation or providing non-nutritive sucking but if she had been, it would have been nice to know. Induced lactation was something that we didn't know existed until coming to the children's hospital. We would've missed that opportunity with our former provider. (Personal communication, April 6, 2018)

Implications for Nursing Practice

The case exemplars illustrated key themes of heteronormativity in healthcare, feelings of isolation, and inappropriate judgments or assumptions. They highlight the role of nonbiological partners as a support system in the form of encouragement and technical help. Based on these themes, nurses must adapt the healthcare setting to ensure a welcoming environment for same-sex mothers and families. There is a need to show outward and visible symbols of inclusion and support (Table 2). Nurses need to be receptive to this patient population and continue to develop skill sets that facilitate open communication. It is vital for nurses to not make assumptions on a patient's gender or sexual orientation. Nurses must avoid assuming that both women in female-partnered couples understand the emotional process of pregnancy, birth, and lactation or want to participate in the process of lactation. These assumptions may damage the trusting and understanding relationship between this patient population. Information literacy is vital to competent care so nurses must excel in acquiring and distributing this knowledge to support same-sex couples in their journey to motherhood. Acting as a resource by knowing the guidelines and best practice recommendations, recruiting healthcare professionals trained in LGBT competence care, and displaying resources and brochures for same-sex families in the waiting area will ensure that optimal care is provided.

Limitations

There are several limitations to our study. Only three women were interviewed and of these three women, two mothers were patients of the second author as their child spent time in the N/IICU. The experience of vulnerable infants in the N/IICU differs completely from children not in the N/IICU, indicating that the information presented is skewed and not necessarily representable of a general population. In future studies, focus will be placed on healthy term infants to better reflect the general population. This case series was completed to inform us of the current atmosphere of breastfeeding same-sex mothers and the preparation needed to conduct a formal qualitative study.

Conclusion

Heterosexual assumptions have isolated same-sex couples to feel vulnerable in a healthcare setting that lacks inclusivity in healthcare encounters. The cases emphasize the structural barriers and facilitators to motherhood and the need for sensitivity and encouragement in promoting lactation. Perinatal nurses who engage firsthand with these women need to stand as a voice and define the underlying needs of the mothers. By creating this trusting relationship, perinatal nurses challenge commonly held and systemic judgments and create a foundation of understanding for other healthcare professionals, reducing stigmatization. They are a vital force in fostering this welcoming community and advocating for the success of lactation care for same-sex mothers. ✤

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References

American College of Obstetricians and Gynecologists. (2012). Health care for lesbians and bisexual women (Committee Opinion No. 525). *Obstetrics and Gynecology*, *119*(5), 1077–1080. doi:10.1097/AOG.0b013e3182564991

Auerbach, K. G. (1981). Extraordinary breast feeding: Relactation/induced lactation. *Journal of Tropical Pediatrics*, *27*(1), 52–55. https://doi.org/10.1093/tropej/27.1.52

Bryant, C. A. (2006). Nursing the adopted infant. *Journal of the American Board of Family Medicine*, *19*(4), 374–379. doi:10.3122/jabfm.19.4.374

Chapman, R., Wardrop, J., Zappia, T., Watkins, R., & Shields, L. (2012). The experiences of Australian lesbian couples becoming parents: Deciding, searching and birthing. *Journal of Clinical Nursing*, *21*(13–14), 1878–1885. doi:10.1111/j.1365-2702.2011.04007.x

Farrow, A. (2015). Lactation support and the LGBTQI community. *Journal of Human Lactation*, *31*(1), 26–28. doi:10.1177/0890334414554928

Goldberg, A. E., & Scheib, J. E. (2015). Why donor insemination and not adoption? Narratives of female-partnered and single mothers. *Family Relations*, *64*(5), 726–742. doi:10.1111/fare.12162

Hayman, B., Wilkes, L., Halcomb, E. J., Jackson, D. (2013). Marginalised mothers: Lesbian women negotiating heteronormative healthcare services. *Contemporary Nurse*, *44*(1), 120–127. doi:10.5172/conu.2013.44.1.120

Hayman, B., Wilkes, L., Halcomb, E. J., & Jackson, D. (2015). Lesbian women choosing motherhood: The journey to conception. *Journal of GLBT Family Studies*, *11*(4), 395–409. doi:10.1080/1550428X.2014.921801

Institute of Medicine and National Research Council. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. Washington, DC: The National Academies Press.

Lawrence, R. A., & Lawrence, R. M. (2015). *Breastfeeding: A guide for the medical profession* (8th ed). Philadelphia, PA: Elsevier.

Lofquist, D. (2011). Same-sex couple households. In *ACSBR/10-03*. Washington, DC: U.S. Census Bureau. Retrieved from https://www.census.gov/prod/2011pubs/acsbr10-03.pdf

Marques, A. M., Nogueira, C., & de Oliveira, J. M. (2015). Lesbians on medical encounters: Tales of heteronormativity, deception, and expectations. *Health Care for Women International*, *36*(9), 988–1006. doi:10.1080/07399332.2014.888066

Sabin, J. A., Riskind, R. G., & Nosek, B. A. (2015). Health care providers' implicit and explicit attitudes toward lesbian women and gay men. *American Journal of Public Health*, *105*(9), 1831–1841. doi:10.2105/AJPH.2015.302631

United States Department of Health and Human Services. (2011a). *The Surgeon General's call to action to support breastfeeding.* Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General. Retrieved from https://www.surgeongeneral.gov/library/calls/breastfeeding/calltoactiontosupportbreastfeeding.pdf

United States Department of Health and Human Services. (2011b). *How nurses can help the Surgeon General call to action to support breastfeeding*. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General. Retrieved from www.cdc.gov/breastfeeding/pdf/actionguides/nurses_in_action.pdf

Wahlert, L., & Fiester, A. (2013). Induced lactation for the nongestating mother in a lesbian couple. *American Medical Association Journal of Ethics*, *15*(9), 753–756. doi:10.1001/virtualmentor.2013.15.9.ecas2-1309

Wilson, E., Perrin, M. T., Fogleman, A., & Chetwynd, E. (2015). The intricacies of induced lactation for same-sex mothers of an adopted child. *Journal of Human Lactation, 31*(1), 64–67. doi:10.1177/0890334414553934

Wittig, S. L., & Spatz, D. L. (2008). Induced lactation: Gaining a better understanding. *MCN. The American Journal of Maternal Child Nursing*, *33*(2), 76–81. doi:10.1097/01.NMC.0000313413.92291.0f

Wojnar, D. M., & Katzenmeyer, A. (2014). Experiences of preconception, pregnancy, and new motherhood for lesbian nonbiological mothers. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, *43*(1), 50–60. doi:10.1111/1552-6909.12270

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