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Learning Health Equity Frameworks within a Community of Scholars

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Abstract

Scholars in nursing science have long espoused the concept of health equity without specifically using the term or dialoguing about the social determinants of health and social justice. In this paper, we describe the development, implementation, and evaluation of a doctoral and post-doctoral seminar collective entitled Health Equity: Conceptual, Linguistic, Methodological and Ethical Issues. The course enabled scholars-in-training to consider the construct and its nuances

and frame a personal philosophy of health equity. We offer an example of how a group of emerging scholars can engage in the important, but difficult discourse related to health equity. The collective provided a forum for debate, intellectual growth, and increased insight for students and faculty. We posit that the lessons learned by all participants have the potential to enrich doctoral and post-doctoral scientific training in nursing science and may serve as a model for other research training programs in the health sciences.

Doctoral and post-doctoral study is a time of introspection and discovering new ways of knowing. The complexities of mastering the basic scholarship of a discipline and the inevitable soul searching about unfamiliar perspectives require a great deal of psychic energy and intellectual honesty. The American Nurses Association's *Social Policy Statement* (Neuman & Dixon, 2010) aims to illuminate nursing's disciplinary obligations to operate within a framework of values which reflect the society it serves. This social contract, though narrow in scope, provides a starting point from which to launch discussions about disciplinary knowledge development and the creation of the next generation of nursing scholars.

With respect to the body of nursing scholarship, students need to incorporate social values that recognize diverse life-styles (Bevis & Watson, 1989) and consider the concepts of social justice and health equity. Almost twenty years ago, Baldwin and Nelms (1993) recommended that students engage in "difficult dialogues" about race, ethnicity, and sexuality. In their own classroom, Baldwin and Nelms encouraged inclusion of the experiences of "white women, women of color and men of color" and introduced diversity topics within a racialized and gendered context. They noted that while learning was enhanced, students and faculty were uncomfortable discussing these topics (Baldwin & Nelms, p. 343).

While difficult and complex issues about health extend far beyond race, ethnicity, gender, and sexuality, discussion on the broad array of topics that detract from health equity can present challenges to emerging scholars. Dialogue about sensitive topics is best accomplished in a learning environment where faculty and students openly acknowledge and confront the existence of bias, judgment, power differentials and prejudice. Finding or creating this environment can be difficult but necessary if we as nurses are to take an active role in promoting health equity of individuals and communities. A fundamental understanding that human experiences are contextually and culturally defined can aid us in this quest (Neuman & Dixon, 2010).

Herein, we describe the development and implementation of a doctoral and post-doctoral seminar collective examining theories, concepts, and methods related to health equity. We first introduce the setting for the course, Health Equity: Conceptual, Linguistic, Methodological, and Ethical Issues. Within this context, we explore the concept of health equity and the development of the classroom seminar itself. We also explore the lessons learned in developing and implementing the course, and provide suggestions to doctoral students and faculty about how others might replicate and build upon this innovative model. We have merged faculty and students voices in this paper as co-authors unless we explicitly indicate otherwise.

The Concept of Health Equity

In 1992, Whitehead defined health equity as a concept and principle that everyone should have a fair opportunity to attain her or his full health potential; no one should be at a disadvantage to achieve this potential; and all individuals should have equal access to available care for equal need, equal utilization for equal need, and equal quality of care for

all. The principles of health equity integrate social justice and the social determinants of health. Social justice holds that every individual and group in the world is entitled to fair and equal rights so that each receives just treatment and an impartial share of the benefits of society (Gostin & Powers, 2006; Roberts, 2006). The World Health Organization (Birch, 2009) defines the social determinants of health as those conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources, including healthcare, at local, national, and global levels. “The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries” (CSDH, 2008).

We used the concept of health equity to grow as scientists. We sought to understand how definitions, culture, historical trauma, social constructions of gender, and structural violence shape every aspect of the research process. Scientists often approach the investigation of the health status of social groups by examining a sample population’s difference from an arbitrary or normed population; the sample population is often described as “vulnerable” or “minority.” However, the evaluation of difference, disparities, or deficits alone does not address the root causes of inequity and often fails to examine what is fundamentally fair and just for all people to reach their full health potential. As a caring discipline rooted in tenets of communal responsibility, scholars in nursing science are well-positioned to shift the focus from a one-dimensional approach that examines the outcomes or byproducts of a multitude of inequities to one of probing the root causes of health disparities. Our investigations should be aimed at illuminating the social determinants underpinning global inequities and developing interventions to promote health equity. Development of nursing knowledge in this manner guides scientists toward different solutions and requires rigorous examination of causes. Additional scrutiny involves judgment of ways to avoid health inequities and fundamental injustice. With careful attention to societal context, value orientations, assumptions, and health determinant framing, our approach to nursing science using health equity concepts may prove challenging.

Center for Health Equity Research

The setting for the course was the Center for Health Equity Research (CHER) at The University of Pennsylvania School of Nursing. The mission of CHER is to: 1) Improve, through research, health among those who have experienced social or economic disadvantage; 2) Reduce or eliminate disparities in health outcomes and healthcare access through scientific inquiry; 3) Support changes in public policy to maximize health equity for disempowered, marginalized, vulnerable, and underrepresented populations; and 4) Mentor the future cadre of scientists who will develop independent programs of funded research in the area of health equity and health disparities. By its very nature, attainment of health equity requires facilitating the highest level of health possible for all individuals, communities, and societies around the globe. Center scientists focus on reducing or eliminating disparities in health outcomes and healthcare access through descriptive and interventional programs of research. The knowledge generated by Center scientists helps us to understand, address, and promote health equity.

The focus on health equity in CHER helped guide the conceptualization of the course. In the Center, fellows (doctoral students and post-doctoral fellows) and faculty members work in close proximity. The environment was conducive to informal scholarly dialogue about the doctoral curriculum and the need for advanced conceptual coursework to build on first-year theoretical doctoral content. These discussions provided the context for dialogue about health equity and the request by doctoral students for course development.

Health Equity: Conceptual, Linguistic, Methodological, and Ethical Issues

Conceptualization of the course happened during a time of substantive change at the Center. Previously called the Center for Health Disparities Research, CHER had just undergone a name change when the leadership and affiliated faculty agreed to change the Center's focus from health disparities research to one of health equity research. This conceptual shift allowed Center members to communicate a global perspective to promote and achieve health equity that seemed in concert with the Center mission. Within the new Center framework, students began to engage in informal conversations about language used by clinicians, educators, scholars, and scientists surrounding health differences, the importance of the social determinants of health, and how often, even as doctoral students, there is little opportunity to engage in difficult discussions about the root causes of health inequities. Discourse, it seemed, was often constrained by implied rules that disallowed the scholarly exploration of challenging and sensitive topics. Students yearned for a defined space that incorporated tenets of respect and honesty balanced with intellectual discovery and self-awareness, or a "safe place" for learning.

A faculty member responded to these concerns, drafted a syllabus that seemed synergistic with the students wishes, and asked interested students to offer feedback and revisions to the syllabus early in 2009. We chose the term, "collective," because the course was designed to empower students to embrace peer-learning and peer-teaching in conjunction with a faculty member who would relate to collective members in a non-authoritarian way. The course, therefore, was intended as a place for safe discussions of sensitive issues. We defined our collective as a group of learners who shared common interest in health equity and agreed to work together to meet course objectives openly by honestly acknowledging our biases and desiring to learn from one another. After the course was approved by the Graduate Group in Nursing (our curricular oversight body) and listed as an official offering by the School of Nursing, 15 students registered for the course. The student and faculty creators of the syllabus presented it to course participants during the initial class meeting and revised it through group consensus (see Course Outline, Appendix 1).

Course Beginnings

I think it will take some time for the group to gel, trust each other and learn together how best to participate in the course. With time, I anticipate a greater willingness to engage in uncomfortable conversations about gender, race, class, etc. It is my hope that this group can be a safe place to develop ideas, take risks, and eventually improve our scholarship. - Course Participant

During the group's first meetings together, a shared goal emerged: to create a space that would allow students to acknowledge and celebrate diverse social locations. This objective was foundational for meaningful class discussions. Members entered the collective from different racial, socioeconomic, class, sexual orientation, and educational backgrounds and had diverse personal stories contributing to their educational development within the nursing discipline. We set out to establish equality and reduce power differentials in our approach to learning. We agreed to blur the teacher/student boundaries of the traditional classroom and have the faculty member be an equal member of the collective. Our group held that diversity of thought would aid each other in moving our thinking and inquiry forward without the need for traditional faculty power and leadership. Students at varied stages of doctoral study as well as tenured faculty members made up the health equity learning circle. We met weekly in a seminar-style conference room and communicated between classes through a discussion board. Students volunteered to facilitate, lead, or moderate sessions based upon their interest and with a format that was comfortable for them. All members assumed a leadership for at least one class.

The collective decided that the syllabus was a fluid document and added or deleted pertinent topics as weekly discussions drew out questions and curiosities that invited further exploration. The concept of “whiteness,” for example, emerged from our discussion about race. Two members of the class who did not have prior experience with the topic decided to research and co-facilitate a future class on the topic. The syllabus addition served to deepen the collective’s understanding of how racial discussions emerge from within a dominant standpoint and subsequently influence research. Alternatively, health policy appeared on the original syllabus as a topic of inquiry; however, the collective decided that instead of dedicating a specific class period to this discussion, it would be infused in all topics throughout the semester. One to three students, depending on the level of interest, facilitated topics for discussion. These included: 1) Ethics and Conflicts, 2) Gender, Sex and Sexuality, 3) Race, Racism, Ethnicity, and Ethnocentrism, 4) Special Populations, 5) Methods and Measurement Considerations, 6) Whiteness, and 7) Revisiting Models and Frameworks

The collective agreed upon the course deliverables and outcomes. As a contribution to the Center and the School of Nursing, participants supported the development of a position paper that was meant to catalyze discussion about the place of health equity in nursing science. Additionally, individual or group submission of an original manuscript, grant, or development of individual work was an acceptable option for students taking the course for a grade but not for those auditing. Members developed a grading system in which all participants, upon class entry, had an A. The collective agreed to be accountable to one another for leadership in class sessions, class preparation, and weekly participation. A collective decision about a person who was not meeting the expectations of the course would result in a decrease in grade, although this would be mediated by the influence and feedback from the group. We agreed that if it became evident that any members were not adhering to their commitment, we would discuss the situation within the group meeting. Students enrolled in the class shared a common interest in a goal of eliminating health disparities and, as scientists-in-training, learning new ways to move toward health equity. However, there were also diverse, pre-conceived notions among the collective members and a variety of reasons for taking the course, as illustrated by the themes described in Table 1 taken from commentary from collective members.

Lessons Learned

All members of the collective exited the course with lessons learned, new insights, and sensitivity to critical issues affecting nursing scholarship. While the intent of the course was a safe and equal space for all in a non-authoritarian classroom, we were perhaps naïve in thinking that the journey would be easy and uneventful and the goal achievable. We failed to consider the ramifications of a de-centered classroom (faculty teaching from the sidelines without authority and students sharing equal responsibility for course activities and outcomes) and a syllabus filled with sensitive topics. We recognized that our goal more realistically might have been a safe space to acknowledge our biases and take the first small steps toward disclosure and insight. Herein we provide more details about our journey.

Accountability and Productivity

Members valued the opportunity to contribute to the group learning experience by presenting topics of interest to health equity frameworks. As one member stated, the “... curriculum development was a process that engaged an intellectual level of thought.” While the intensity of thought required in the course collective was celebrated, several members were discouraged by the group’s inability to move from the theoretical to the practical level, which was often ignored in classroom conversations. Variables associated with gender, sexuality, sexual orientation, and socioeconomic, for example, were scrutinized for their descriptive values; however, the class did not come to a consensus on how best to

incorporate the variables into their projects nor how to deal with a commonly accepted binary world view of gender and sexuality.

All group members contributed to class discussion, scholarly preparation, and knowledge advancement, but participation was unequal. Collective members expressed the concern that the course may have fallen short on rigor as we settled on group-produced deliverables. While several students liked having the ability to choose individual projects and engage in a model of “enrichment and learning,” there was little accountability on the collective as a whole because we “removed” grading concerns. Toward the end of the semester, the collective discussed the imbalance of burden and responsibility during a class meeting and several members volunteered to share the workload by taking on some responsibility for manuscript preparation. We ultimately decided that each class member should work with the faculty member to decide what grade best reflected his or her efforts. In most cases, the class members reflected on their contributions and wrote a short email to the faculty member describing the personal outcomes of the course, and faculty and student collaborated on determining the final grade.

Difficult Discourse

Several members of the collective acknowledged a sense of discomfort with difficult topics. Specifically, the topic of race/ethnicity presented unique challenges because some students had not explored this issue in a racially diverse group. Some members expressed surprise that points of view they assumed were common among students on a liberal campus were not shared. While the collective worked hard to maintain the safe space, members found themselves censoring their comments in order to minimize the perception of “finger-pointing” or “blaming” of social groups. Other students felt vulnerable and censored themselves out of fear of appearing “dumb,” “biased,” or “racist.” Individuals in the collective dodged discussing issues of sexuality, sexual orientation, and sexual desire despite having reading materials about these issues.

Logistical Challenges

The number of weekly reading assignments became burdensome to students. Some members felt their personal schedules would not allow them to fully participate in class preparation and hindered their learning experience. Several members were uncomfortable with the structure, or lack thereof, of the class periods; one noted that it felt as if the class were on a “path to nowhere”. Some key terms or concepts were left undefined as the group struggled to come to consensus but had to leave actionable examinations in amorphous form. This occurrence may have several root causes: 1) lack of class devotion - as the semester progressed; students became busier with outside priorities that are an inevitable structure of academic life, 2) class cohesion several, but not all students had the opportunity to attend an out-of-town conference together which may have influenced an unintended marginalization of other class members, and 3) meeting continuity the class did not meet weekly because of previous commitments and conferences, which may have ruptured some levels of rapport that would have built during weekly contacts.

Confronting Power Differentials: Student Perspective

Nursing education is most often situated within institutions where patriarchal structures of power prevail (Romyn, 2000). Within these institutions, the student functions as an empty vessel that absorbs the academic content the teacher is offering and this learning structure perpetuates an unequal balance of power. As scholars of nursing science, who are also committed to the tenets of health equity, we intentionally sought to align our learning process with the same values that were the subject of our inquiry. Although we knew it impossible to do across the entire university community, we wished to abolish institutional

hierarchies and establish an egalitarian space for learning, even if only within our small health equity collective. We desired to achieve a safe space for members to discuss their personal experiences and viewpoints and believed that removing power differentials was necessary in order to create and maintain such a space. Now with the benefit of hindsight, we offer our thoughts regarding our experiences confronting power differentials in order to create a “safe” space.

While many initially felt eliminating power differentials was an obtainable and worthwhile objective, the collective could not easily ignore existing faculty-student power structures. Although well-intentioned, we have come to believe that trying to create such a “safe” space free of power differentials was not a realistic objective within the context of our academic environment. Some students believed that the attempt to have a non-authoritarian classroom “...put another elephant in the room to dance around”. For example, several collective members found that “the first two classes were awkward,” due to difficult decision-making around how the collective should function on a week to week basis. Student members were timid about how to move things forward when developing rules and regulations in a collegial way. Even though the faculty member clearly laid out the expectations for the collective members to engage in negotiation for the outcomes, given our varied experiences, personalities, expectations and skills, we found obstacles to making choices and reaching conclusions. As students and scholars educated within the hierarchical academic structure, it was challenging to create an environment that looked so different from what was familiar. Although, as one member said, “...we were all trying to be as open to each other and act as much like a collective as possible,” the presence of a tenured faculty member in the room and the perceived power differentials among group members made the uneasiness more acute during our discussions.

Having said this, we do not mean to imply that the seminar was not a valuable learning experience, or that power differentials precluded our ability to engage in difficult discourse. On the contrary, there were many instances during our time together that student members shared personal experiences of grappling with marginalized social locations and this activity informed the group’s ability to process sensitive situations. Nonetheless, while many collective members were delighted to engage in sensitive conversations at a theoretical level, we had difficulty applying the concepts to our own work if challenged by others in the group. Practical discussions at times resulted in hurt feelings and highlighted how power intertwines with every aspect of our social position, scholarship, and learning. Ultimately, the faculty role as mediator, guide, and decision-maker was missing. The lack of structure afforded by the decentered classroom detracted from our learning experience and left many of us wanting more.

Confronting Power Differentials: Faculty Perspective

When doctoral students approached me about this course, I was uncertain that I had the mastery of related knowledge to lead a seminar based on health equity content even though philosophically I work from a health equity perspective. I offered to be the faculty of record if we developed and implemented the course together on an equal footing so that we might learn the content together. I anticipated a decentered classroom with me teaching from the sidelines without authority and the students empowered to organize the course. Had I performed a literature search on the decentered classroom, I would have found many articles like Judy Segal’s (1996), entitled *Pedagogies of Decentering and a Discourse of Failure*. She explained that students in a decentered classroom will either resist decentering by not engaging or resist it “with their feet” by not coming to class. While we all had lofty expectations of the class, both occurred. Quite a few students came to class without reading the materials assigned by their peers. One of the students who helped develop the syllabus missed four of fourteen classes. While the urgency to grapple with difficult topics remained

a consistent theme, other competing activities pushed the course down the priority list, and the more engaged students seemed understandably uncomfortable about challenging their less engaged peers.

The course caused me to rethink my role in the classroom. In the initial weeks of class I likely abrogated my responsibility to make sure the discussion was constructive, make sure burdens of work were equally shared, and make sure course outcomes were met. Several scenarios arose when I should have intervened in order to make sure that participant's wishes about being heard or not heard occurred. But I hesitated because I had agreed to be non-authoritarian. The first situation was when the class struggled to determine the products of the course. Other scenarios included ignoring the wish of one member to end a conversation about her own experiences with respect to race/ethnicity, and another ignoring the wish of one member to end a conversation critiquing her research methods. All these situations needed a leader to intervene, and the student leaders did not have the pedagogical experience to do so. After approximately 6 weeks of class, I made the decision and shared with the collective that I would continue to teach from the sidelines but would enter the conversation if I needed to with authority to protect the integrity of the learning experience. I came to understand that a completely decentered classroom is not the best model for a class on sensitive topics, or likely any topic.

Two personal principles have evolved from this experience that I will take into the classroom in the future: 1) Institutional authority is unavoidable at times because some things are not allowable in class; 2) Awareness and reflexivity about the classroom experience are faculty responsibilities and enrich the student learning experience. Perhaps the best advice comes from bell hooks (1994, p. 13): "To teach in a manner that respects and cares for the souls of our students is essential if we are to provide the necessary conditions where learning can most deeply and intimately begin."

Next Steps

The collective writing of this manuscript provided a valuable forum for additional discourse among faculty and students about the course. We circulated several drafts and had the opportunity to discuss the course among collective members with the perspective that distance allows. The faculty member and two original class members, a doctoral student and post-doctoral fellow, plan to serve as co-teachers for the course during Fall Semester, 2011 using a reconstructed syllabus taking into account these experiences. Likely changes in the course will include: 1) a more formal course deliverable that can be negotiated as either a joint or individual project; 2) equal, shared leadership and decision-making among the three-person leadership team; 3) initial background readings on power, class, gender, race/ethnicity, and sexuality during the first third of the class, followed by more open discussions of personal perspectives after completion of foundational readings.

Because of our previous experience, the 2011 course leadership recognizes the challenges of creating a safe space for dialogue. We will acknowledge to course participants that no space is always safe and bias free, but with their help, we will create a learning environment conducive to disclosure, creativity, and at times, risk taking. As leaders we will be open and honest in our attempts to recognize our own biases and how they affect our scholarship. Future course assignments will include readings about conscious and unconscious bias.

An unexpected benefit from the class has been the collective acceptance that we need to explore the philosophical underpinnings of health equity from a variety of perspectives. Within the context of a T32 training grant from the National Institute of Nursing Research directed by the faculty involved in this course, many of us in the original collective have ongoing weekly contact in a formal group setting. In our weekly T32 sessions we have

begun to read and discuss one book a month. These texts, such as *Gender Trouble* and *Undoing Gender* by Judith Butler and *Where We Stand: Class Matters* by bell hooks, allow us to circle around again on sensitive topics with more substantive discussions. They likely would not have occurred had we not taken those initial, stumbling steps in the health equity course.

Conclusion, Discussion, and Suggestions

We created a course focused on conceptual, linguistic, methodological, and ethical issues in health equity with a desire that emerging nurse scientists critically examine how education, practice and research in nursing can improve. Though not without its limitations, the course served the purpose to allow doctoral and post-doctoral students to begin engagement in difficult, yet necessary conversations about health inequities and the barriers to helping individuals and communities attain their full health potential. The process of developing this course and the lessons learned demonstrate how such a course can be altered, tailored, and improved to meet the needs of students at various stages in their education and to improve faculty understanding of classroom dynamics and pedagogy.

We recommend that such a course not be focused solely for doctoral and post-doctoral students. The topics regarding health equity need to be addressed at both the baccalaureate and Master's level. We chose to engage in this learning process in a collaborative, fluid seminar but we acknowledge that this method may not be appropriate for all program levels and class sizes. The sensitive nature of topics that require levels of self-awareness and critique as well as disclosure in a safe learning environment may lend itself to mature discourse in intimate settings. These ideal conditions should not preclude discussions from occurring at the undergraduate level with care about the context and should push educators to think creatively about how to infuse health equity tenets in a variety of classroom settings.

Ongoing opportunities for further discussion are critical over time to keep the dialogue open and allow others into the circle of discussion. Most importantly, we do believe, that in order to promote health equity and social justice, nurse scientists must engage in reflective discourse, develop a self-awareness of their personal biases, and be prepared to be challenged in how they view their own research and practice.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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References

- Baldwin D, Nelms T. Difficult dialogues: Impact on nursing education curricula. *Journal of Professional Nursing*. 1993; 9(6):343–346. [PubMed: 8300971]

- Bevis, EO.; Watson, J. Toward a caring curriculum: A new pedagogy for nursing. New York: National League for Nursing Press; 1989.
- Birch M. Implementing equity: The commission on social determinants of health. Bulletin of the World Health Organization. 2009; 87:3. [PubMed: 19197394]
- Bradbury-Jones C, Sambrook S, Irvine F. Power and empowerment in nursing: a fourth theoretical approach. Journal of Advanced Nursing. 2008; 62(2):258–266. [PubMed: 18394038]
- Commission on Social Determinants of Health. Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization; 2008. Closing the gap in a generation: health equity through action on the social determinants of health.
- Gostin LO, Powers M. What does social justice require for the public's health? Public health ethics and policy imperatives. Health Affairs. 2006; 25(4):1053–1060. [PubMed: 16835186]
- hooks, b. Teaching to transgress: Education as the practice of freedom. New York: Routledge; 1994.
- Neuman, C.; Dixon, J. Nursing's social policy statement: The essence of the profession. American Nurses Association; Washington DC: 2010.
- Roberts DE. Legal constraints of the use of race in biomedical research: Toward a social justice framework. The Journal of Law, Medicine and Ethics. 2006; 34(3):526–534.
- Segal J. Pedagogies of decentering and a discourse of failure. Rhetoric Review. 1996; 15:174–191.
- Whitehead M. The concepts and principles of equity and health. International Journal of Health Services. 1992; 22(3):429–445. [PubMed: 1644507]

Appendix: Course Outline

Title: Health Equity: Conceptual, Linguistic, Methodological, and Ethical Issues.

Credit: 1 cu, 3 hours per week of theory and seminar

Catalog Description

The course focuses on advanced analysis and evaluation of theories, concepts, and methods related to health equity. Topic areas include models and frameworks of health equity; linguistic choices related to equity, disparity, and vulnerability; role of economics, class, gender, sex, sexuality, race, and ethnicity; health equity in special populations; and issues in health policy, research ethics, and research methods. Emphasis is on advanced discourse and analysis of health equity theory and research.

Prerequisite

Doctoral program matriculation or permission of professor

Overview

Participants will investigate current issues and controversies about health equity, health disparities, and health vulnerability. Discussions will center on the role of language, ethics, and social vulnerability in our conceptualization of health equity. Participants will question and evaluate research strategies for generation of new knowledge among scientifically under-represented populations. The class will emphasize diversity of thought grounded in the literature of health equity, health disparity, health vulnerability, healthcare access, and healthcare ethics.

Course Objectives

The objectives of this course are designed to allow participants to:

1. Analyze current ethical and linguistic controversies about health equity definitions, concepts, and theories.
2. Consider the role of gender/sex/sexuality, race/ethnicity, and economics/class in healthcare access, outcomes, policy, and research.
3. Examine health equity as a concept when applied to special populations such as prisoners, people with disabilities, children, pregnant women, immigrants, and older people.
4. Develop advanced research methodological skills associated with studying populations with social vulnerability.
5. Determine a personal, ethical, and rigorous model of knowledge development for the study of health equity in a specific population.

Course Content

- I. Models, Frameworks, and Language: Health Equity, Health Disparity, and Vulnerable Populations
 - Definitions, concepts, and linguistics: health equity, health disparity, social justice, environmental justice, social determinants of health
 - Competing and complementary frameworks and perspectives
- II. Ethics and Conflicts
 - Insider/outsider dilemmas
 - Issues of economics and class
 - Research enterprise in a global environment
 - Exploitation and colonialism versus knowledge development about under-represented groups
 - Post-colonialism: theories and methods
- III. Gender, Sex, and Sexuality
 - Equity in women's health
 - Equity in men's health
 - Equity for gender-identity based cultures and LGBT populations
- IV. Race, Racism, Ethnicity, and Ethnocentrism
 - Definitions and linguistics
 - Role of diversity: stereotyping, prejudice, and group diversity
 - Issues of discrimination
 - Whiteness
 - Partnership versus empowerment
- V. Special Populations
 - Prisoners
 - People with disabilities
 - People with serious mentally illness

- Children
- Pregnant women
- Immigrants, migrants, and undocumented people
- Older people

VI. Health Policy

- Healthcare access
- Healthcare economics
- Healthcare legislation
- Evaluation of policy and unintended consequences

VII. Methods and Measurement Consideration

- Measuring health outcomes disparities and health access disparities
- Payment for research participation
- Access versus coercion to participate in research
- Unit of study: individuals, dyads, families, communities, nations

VIII. Revisiting Models and Frameworks: Health Equity, Health Disparity, and Vulnerable Populations

- Cultural competency
- Cultural humility

Teaching Methods

Seminar and discussions.

Evaluation Methods

Leadership in class sessions: 20%

Weekly participation: 10%

Development of a collaborative position paper on a topic chosen by participants: 20%

Submission of original manuscript for publication: 50%

Required Text

Articles and readings as posted on Black Board

Table 1

Themes from Collective Participants Discussing Reasons for Taking a Health Equity Course

Theme	Description
Fulfilling a need	Collective members were looking to fill a gap in the nursing curriculum. There were students expecting uncomfortable conversations and hoping to create a safe space in which to have them
Collegiality	Collective members looked forward to becoming part of a community of scholars and to deepen their exploration of health equity principles within a diverse group of colleagues. Building trust was key to developing this ideal.
Workload	Students expected to put forth efforts toward reading and synthesizing new materials through a different lens befitting doctoral level studies.