Faculty Beliefs Related to Admitting and Educating Nursing Students with Disabilities

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Abstract

This study described the views of nursing faculty related to admitting and educating nursing students with disabilities. Participants consisted of 10 nursing faculty from baccalaureate nursing programs with experience either admitting or educating nursing students with disabilities. Two semi-structured open-ended interviews were conducted, audio-taped, and transcribed for each participant. Young's framework of oppression and Oliver's medical/individual model and social model of disability informed this interpretive study. Findings revealed that a medical/individual model of disability informed nursing faculty's decisions and actions in relation to admitting and educating nursing students with disabilities and that nursing faculty lacked awareness of resulting oppressive behaviors. The findings should encourage nursing faculty to examine their beliefs related to educating nursing students with disabilities and change them if those beliefs endorse or actively support the oppression of students with disabilities.

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Chapter One: Overview and Review of Literature

Background

Imagine that a college student with a physical disability has applied for admittance to a nursing program. She has been accepted based upon admission criteria that were written by nursing educators who have limited knowledge of the Rehabilitation Act of 1973 or the Americans with Disabilities Act (ADA, 1990). Soon the questions, the concerns, and the attitudes of faculty related to educating a student with disabilities begin to surface. Weatherby and Moran (1989) posed early questions related to admitting students with disabilities to nursing programs: "How much will a physical handicap interfere with a person's ability to perform as a nurse? How can the needs of the handicapped student be met without compromising the quality of the educational program? At what point does the right of a handicapped student to pursue a meaningful career conflict with the public's right to safe care?" (p. 179).

Watson (1995) raised the following questions regarding the obligations of nursing programs to accept and accommodate qualified applicants with disabilities. What are the essential functions required of nursing students to complete degree requirements? Under which circumstances would an individual's disability preclude becoming a nurse? How do you determine appropriate services for students with disabilities? How do you clarify what constitutes a reasonable accommodation? What is the appropriate response to complaints filed by students under the ADA? In later research, Maheady (1999) voiced a concern about potential threats to patients' health and safety when cared for by a student with a disability. Persaud and Leedon (2002) surveyed nursing schools asking about

methods and practices of assessing or recognizing a disability and of establishing reasonable accommodations. More recently, Moore (2004) raised what she believed to be the ultimate question in need of answering, namely, "What is the core and essence of nursing, held by all nurses, in all settings, in all roles, and in all parts of the world"(p.201)? Nursing programs continue to raise questions and concerns related to admitting and educating nursing students with disabilities. Early questions remain unanswered and new questions are raised related to admitting and educating nursing students with disabilities.

In what follows, I discuss the purpose of the study and the importance of this study to nursing and nursing education. A review of the literature concludes this chapter.

Purpose of Study

The purpose of this research is to explore faculty beliefs related to admitting and educating nursing students with disabilities. Little qualitative research examines this issue. This study will contribute to the discipline of nursing by facilitating contemplation of beliefs by nursing faculty related to admitting and educating nursing students with disabilities. Awareness of these beliefs may lead to review and revision of admission and curricular policies for nursing students with disabilities, resulting in appropriate and fair policies.

Most studies related to faculty members working with students with disabilities have been quantitative using Likert-type scales. Past attitude studies have measured the attitudes of faculty members regarding working with students with disabilities. French (1996), in *Beyond Disability: Towards an Enabling Society*, reviewed the literature on the

attitudes of health professionals towards disabled people. She reviewed data obtained in quantitative studies using the Attitudes Towards Disabled Persons Scale (ATDP). French classified the attitudes from these studies as either positive or negative. She concluded that although the research evidence was conflicting, there was room for improvement in the attitudes of health professionals towards disabled people. She found it disturbing that most of the research related to disability focused on the disabled person's impairment rather than social and environmental barriers. Brillhart, Hazel, and Wyers (1990) compared attitudes held by nursing faculty, beginning nursing students, graduating nursing students, registered nurses, and people with disabilities also using ATDP scale. Faculty members were found to have the most negative attitudes of the groups measured. Christensen (1998) measured nurse educators' attitudes toward applicants with physical disabilities using the Interaction with Disabled Person Scale (Gething, 1991), the Contact with Persons with Disabilities Scale (Yuker & Hurley, 1987), and the Nurse Educators Information Survey developed by the author. Like French, Christensen classified attitudes as either positive or negative. Nurse educator's attitudes towards people with disabilities were generally more positive in this study than they were in previously published studies.

Sowers and Smith (2004) studied nursing faculty members' perceptions, knowledge, and concerns about students with disabilities. This study surveyed nursing faculty to obtain a clearer picture of faculty attitudes and knowledge regarding individuals with disabilities who wish to be or are nursing students. Using a Likert scale related to attitude, the researcher inquired about and explored two issues: "Students who experience the following types of disabilities (disabilities listed) can be successful in my

program" and "Students who experience each of the following types of disabilities (disabilities listed) can be successful in my profession." Sowers and Smith found that many faculty doubted the capacity of individuals with disabilities to successfully complete a nursing program and practice nursing as professionals.

Chubon (1992) addressed concerns related to disability research using attitude studies. He stated,

> The fact that the essential knowledge and tools on which to base attitudes toward disability research are, at best, only crudely developed should serve as a restraint. Researchers are a long way from developing attitude measures that have sufficient reliability and validity to be acceptable for personnel screening. . . . The lack of theoretical referents, standardized definition, independent variables and measures predominate the attitude toward disabled person research, and weigh heavily against drawing substantial conclusions. (p. 307)

Nursing researchers have examined quantitatively whether faculty members believe students with disabilities can be successful in nursing schools, in the nursing profession, and concerning related issues. Researchers have not addressed this question from a qualitative perspective, giving faculty the opportunity to express their experiences or concerns related to admitting and educating nursing students with disabilities.

I believe this study is important to nursing and nursing education. The issues surrounding admitting and educating nursing students with disabilities are complex, and they are not well understood based on past quantitative research. Solutions, such as an in-service training program (Sowers & Smith, 2004) and the development of essential

functions for nursing student admission (Christensen, 1998), are being proposed based on data from this quantitative research. Until beliefs are fully explored, I believe the admission criteria and curriculum proposed may not benefit students, faculty, or the nursing profession. I believe this study will help nursing to discover the beliefs on which faculty base their actions related to admitting and educating nursing students with disabilities. The results should lead to a deeper understanding of an important area in nursing and may encourage nursing faculty to contemplate their own beliefs. The development of curriculum is based on beliefs and guided by a mission and philosophy. Understanding beliefs is where nursing faculty must begin.

Questions

The questions addressed in the lightly structured interviews asked participants to explore their personal definition of disability; relate their definition to a medical or social model framework of disability; describe personal experiences from the faculty perspective related to admitting and/or educating a student with disabilities; and to discuss admission criteria related to functional abilities, if used by their programs.

Review of Relevant Literature

Increasingly, both traditional age students entering college as well as adults considering second careers find a baccalaureate degree in nursing attractive. Job access, stability, and opportunities for career mobility and advancement are drawing students to nursing programs in increasing numbers. With the passage of the Americans with Disabilities Act (ADA) of 1990, disabled students are "entering institutions of higher learning at rates that are consistent with the extent to which the disabled are present in the

population at large" (Watson, 1995, p.147). As part of this pattern, nursing programs are accepting and enrolling students with disabilities.

The numerous articles and studies completed in the past 25 years related to nursing students with disabilities focus on admission criteria, the essential elements of a nursing program that students must be able to complete, and the reasonable accommodations students with disabilities need to meet concerning these essential components (Davidson, 1994; Fritsma, 1996; Helms & Weiler, 1993; Swenson et al., 1991; Weatherby & Moran, 1989). When the program in which I presently teach admitted a student with physical disabilities several years ago, this was the literature available to me as I tried to answer the many questions that the student's admittance raised, including this: How could I teach a student that could actually "do" so little? The articles were either very prescriptive giving suggestions of admission criteria that would eliminate the possibility of ever having a student with disabilities in a nursing program or very vague. The vague articles tried to apply the unclear ADA guidelines to nursing education. My program contracted consultants who only sympathized, recognized the issues, and wished us luck. We, as did most programs' faculty, were reacting to educating a student with disabilities instead of being proactive.

The review of the literature includes data related to nursing students with disabilities entering nursing programs; discussion of position papers from national nursing organizations; studies involving nursing educators and students with disabilities; and articles and a symposium discussion of nursing students with disabilities that emphasize the oppression nursing students experience.

Magilvy (1995) randomly selected two baccalaureate and two associate degree nursing programs from each state to review the extent to which nursing schools have admitted students with visual, hearing, mobility, or learning disabilities. Eighty-six surveys (40% response rate) were returned, with most reporting contact with a student with special needs. A majority of these students were learning disabled. Approximately half of those disabled students who were admitted graduated. The results of the analysis indicated limited experience with accommodations for most programs. Watson (1995) completed a similar study surveying 247 baccalaureate nursing programs (59% response rate). Forty-five percent admitted new students with disabilities, and learning disabilities were the most prevalent disability. Watson discussed types of service programs provided for nursing students with disabilities as well as pre- and post-admission strategies.

More recently, the American Association of Colleges of Nursing (AACN) and the Minnesota Nurses Association (MNA) published discussion/position papers related to admitting and educating nursing students with disabilities. In December of 1999, the American Association of Colleges of Nursing (AACN) e-mailed a survey to 540 AACN member schools concerning the ADA. Of the 145 schools that responded,

> 91% indicated that the school or parent institution had policies and support systems in place to deal with ADA issues. Eighty-seven percent of the respondents have had experience with students having either a physical or mental disability or both. Seventeen schools reported having experiences with a lawsuit involving the ADA. Only 12% indicated they have had no experience with such students. If this sample is representative of schools of nursing, it is clear that this

> is an issue of concern to the vast majority. In fact, all but eight schools responded that some materials specific to schools of nursing would be helpful to them. (2002, p.1)

The ACCN published the results in a discussion paper entitled "*Guidelines for Accommodating Students with Disabilities in Schools of Nursing*" (2002). The paper has been removed from the ACCN site because it is considered outdated.

The Minnesota Nurses Association developed a position paper in 2000 entitled *Nursing Education and the Americans with Disabilities Act*. According to the MNA, nursing education programs have responded in diverse ways when complying with the ADA. Nursing programs' practices vary when it comes to admitting students with disabilities; many programs admit students with a wide range of disabilities, while others have been more restrictive. In addition, nursing programs struggle with understanding their roles in disability determination, identifying and implementing reasonable accommodations, and determining the essential components of their courses and programs. In response to these struggles, as well as to a general scarcity of information, the variability of current program behaviors, and professional values of diversity and high standards, the MNA developed a position statement to begin to establish clarity and uniformity among programs (MNA, 2000).

Persaud and Leedom (2002) published results from a descriptive survey (50% response rate) that examined the effect of the ADA on admission and retention practices in nursing schools in California. The authors specifically examined methods used to recognize a disability and practices related to establishing reasonable accommodations.

The majority of responding schools had student applicants with identified disabilities. Nineteen percent of the respondents stated that the school had applicants for which they could not make an accommodation; 16% felt they had to make accommodations that were not reasonable; and 15% stated that they made accommodations that they would not repeat.

Scullion (1999) interviewed nursing faculty and students as part of a larger study that examined the nature and influence of a pre-registration nursing curriculum on the preparation of student nurses to work with disabled people. The purpose was "to explore how disability was conceptualized by student nurses and their teachers; to offer insights into how curriculum may influence approaches towards disabled people who find themselves in receipt of nursing care; and to provide nurses and nurse educators with insights into the potential impact of conceptualizations of disability, adding to the debate concerning their role in promoting or challenging disablism" (p. 650). Scullion identified three themes concerning the conceptualization of disability: "a form of deviation from norms; a phenomenon characterized by dependency; and a notion that is inherently ill-defined" (p. 652).

Carroll (2004) discussed nurse educators' questions about the ability of nursing students to perform certain skills required by the curriculum, the safety of both students with disabilities and patients, and the ability of nurses with disabilities to get nursing jobs. She discussed shifting the focus of nursing curricula from the technical to the humanistic, stating "People with physical disabilities surely can deliver humanistic care to their patients" (p. 207).

Three articles in particular have discussed nursing students with disabilities and the oppression they experienced as nursing students (Maheady, 1999; Marks, 2000; Northway, 1997). Maheady (1999) interviewed nursing students with disabilities, including graduate, undergraduate, and recent graduates. Maheady found that nursing students with disabilities encountered more attitudinal barriers than physical barriers. She stated, "Often, negative attitudes had an impact on the students' self esteem and confidence, adding more stress to the experience" (Maheady, p. 166). Students in this study reported perceiving negative attitudes from faculty, staff members, physicians, employers, and patients' family members. Marks (2000) authored a commentary of Maheady's (1999) research study. While she was pleased that journals were beginning to publish research that addressed the experiences of nursing students with disabilities, she believed that Maheady's study was flawed since Maheady used the medical model to conceptualize and define disability. Marks stated that "despite participants' repeated efforts to convey the horrific types of attitudinal barriers, the researcher continually shifted the focus back to the individuals' impairment and safety issues related to their disability" (p. 207). This demonstrates oppression experienced by nursing students with disabilities at another level, namely as participants in a research study. Northway (1997) stated that the nursing profession has failed to conceptualize disability in terms of oppression. This lack of conceptualization has resulted in the disabled community identifying the nursing profession as playing a role in its experience of oppression.

Disabled nursing students' perceptions of negative attitudes from faculty, the use of the medical model to frame disability in nursing research, and the disability

community's view of the nursing profession as oppressive are three distinct, but related examples of oppression experienced by nursing students. Furthermore, Maheady (1999), Marks (2000), and Northway (1997) suggested that nursing faculty as educators should recognize what values, beliefs, and attitudes they have about disability before they begin thinking about admitting and educating students with disabilities.

Brillhart et al. (1990) maintained that, although research findings conflict, evidence suggests that health professionals' attitudes are not very different from those of the general public, and they may become more negative as professional education proceeds. Paris (1993) concluded that the negative attitudes of health professionals towards disabled people must be examined for the following reasons: "(a) Health professionals may influence the attitudes of the general public towards disabled people. (b) Negative attitudes may adversely affect the self-image and recovery of recently injured or disabled people. (c) Negative attitudes may affect the delivery of services to disabled people. (d) Negative attitudes may influence funding decisions. (e) Negative attitudes may influence the attitudes of health care students, thus perpetuating a negative image of disabled people" (p. 820).

In the spring of 2003, Rush University College of Nursing and Rush University Medical Center sponsored a conference entitled "Students with Disabilities: Nursing Education and Practice." A select group of nursing educators, health care administrators, legal and health policy experts, and representatives of national disability rights organizations and advocacy groups were invited to address the issues related to the recruitment of people with disabilities into the nursing profession. Audience participant

Catherine Ellyin (Marks, 2003), master's prepared nurse, Abbott Contract Labor Services and *Nursing Spectrum* advisor stated,

> After the panel discussion today, I spoke with Dr. Bronwynne Evans. My concern was the lack of insight and rigidity from faculty about how to reach the outcome of a successful nursing student. Some faculty at WSU were still having concerns about Victoria Christensen (a disabled nursing student/graduate), even after she had a successful nursing school experience. I question whether or not faculty have insight into their attitudes and if they have insight into how they might teach students regarding maximizing their full potential if they (the faculty) have some barrier mentalities. I am concerned that faculty may not have this insight. I think we have a wonderful, challenging opportunity here before us to help faculty think more broadly based in terms of how they perceive students and how the students are as individuals and honor their uniqueness. If students experience this in school, they can honor the uniqueness in the patients and families they will serve. (p.105)

In the symposium summary, Katherine A. Pischke-Winn (2003) expressed that "faculty attitudes towards accepting and working with qualified students with disabilities can be the greatest barrier. In many cases, necessary accommodations don't go beyond accepting, open-minded attitudes by college faculty and clinical sites" (chap.10, p. 1−2).

A review of the relevant literature shows that students with disabilities are applying to nursing programs (Magilvy & Mitchell, 1995; Persaud & Leedon, 2002; Watson, 1995). Many nursing programs are reacting by setting specific admission

guidelines that would restrict these students from being admitted to their programs (Davidson, 1994; Katz et al., 2004). Other programs are struggling to provide accommodations that don't affect the essential elements of the curriculum. In addition, students with disabilities describe detecting negative faculty attitudes as part of their educational experiences. Most of these studies were quantitative. In fact, there is a lack of research that looks at this issue from a qualitative perspective.

Chapter Two: Theory and Method

Theoretical Framework

In this chapter, I discussed theoretical and methodological frameworks, followed by research methods. Under theoretical frameworks, the framework of oppression, the medical/individual model of disability, and the social model of disability are described as supporting frameworks for this study.

Framework of Oppression

Several frameworks support the rationale and purpose of this study. The framework of oppression, developed by Young (1990), has been discussed in nursing literature (Northway, 1997) as a means to better understand the oppression experienced by disabled people. Using Young's framework as a basis for reflection, Northway gives examples of various forms of oppression found in nursing literature.

Young described oppression as a concept or a framework: "Its [oppression's] causes are embedded in unquestioned norms, habits, and symbols, in the assumptions underlying institutional rules and the collective consequences of following those rules" (p. 41). In the 15 years that I have been teaching nursing, the admission standards have changed little and are similar to the admission criteria used when I was admitted to nursing school 30 years ago. This is an example of the unquestioned norms, habits, and rules for admitting and educating students that are based on tradition. Young stated that some groups suffer injustices as a result of people's often unconscious assumptions and reactions, many of which are based on the media's and cultural stereotypes and the structural features of business mechanisms. Young noted, "The conscious actions of

many individuals daily contribute to maintaining and reproducing oppression, but those people are usually simply doing their jobs or living their lives, and do not understand themselves as agents of oppression" (p. 42).

Young believed that many groups experience oppression, but those contributing to the oppression may not be aware of their contribution. I believe nursing faculty may unconsciously contribute to the oppression experienced by nursing students with disabilities. My initial reaction was to pose a question: How can faculty members, who are socially conscious about many groups, *not* consider students with disabilities as belonging to an oppressed group? I believe the answer to this question is complex and needs to be explored. An initial basis for reflection is asking faculty about their beliefs related to educating nursing students with disabilities.

Young believed that oppression is a symptom of groups. She defines a social group as a "collective of persons differentiated from at least one other group by cultural forms, practices, or way of life" (p.43). She states "A social group is defined not primarily by a set of shared attributes, but by a sense of identity" (p. 44). Group membership includes identification with a certain social status, the common history that social status produces, and self-identification that defines the group as a group. Young also maintains, "For our identities are defined in relation to how others identify us, and they do so in terms of groups which are always already associated with specific attributes, stereotypes, and norms" (p. 46). Finally, she claims that all persons have multiple group identifications.

Forms of Oppression

Young posited five faces or forms of oppression−exploitation, marginalization, powerlessness, cultural imperialism, and violence−that groups experience. Only one form of oppression needs to occur for the group to experience oppression.

Exploitation refers to "oppression [that] occurs through a steady process of the transfer of the results of the labor of one social group to benefit another" (p. 49).

Marginalization is perhaps the most dangerous form of oppression and refers to a situation in which groups of people are excluded from useful participation in society. This may take the form of exclusion from work or exclusion from other societal roles. Marginalization has been reported in the nursing literature related to the concern expressed by nursing faculty to what role disabled nursing students will have in the nursing profession (Carroll, 2004).

Members of oppressed groups are usually in situations in which power is exercised over them, and thereby they often experience Young's third face of oppression, namely powerlessness. The workplace is one such situation. This imbalance of power, however, also extends beyond the workplace to other areas such as a person's academic experiences. Indeed, the power imbalance between students and faculty is well documented in educational literature. Bevis (2000) described this power imbalance based on the roles a teacher can take, as for example, "information provider; arbitrator of validity and truth; establisher of the rules and regulations of the classrooms; and [the one] responsible for making the connections, analogies, explanations, assumptions, and implications around ideas and theories . . .,the teacher is the power" (p. 169). She states,

"When the teacher is the sole critic, evaluator, marker−the teacher is the power" (p.169). The power imbalance Bevis described could be even greater between faculty and non-dominant groups of students such as disabled students.

Cultural imperialism, another of Young's faces of oppression, is universalization of a dominant group's experience and culture, and its establishment as the norm. Social groups that do not conform to such norms are marked as "other" and their difference is viewed negatively. In schools of nursing, one dominant group is female nursing students without disabilities. Non-dominant groups in nursing include students with disabilities as well as male students in general. Curricula are written and clinical experiences developed based on the abilities, needs, and experiences of the dominant group: white female nursing students. This becomes the norm for any nursing student's educational experience. Students who are not members of the dominant group are admitted, educated, and evaluated using these same norms. Thus, cultural imperialism often shapes nursing curricula.

Examples of cultural imperialism can be found both in how a curriculum is taught and what is included in that curriculum. Not only do nursing curricula often neglect the needs and experiences of disabled nursing students, but programs also tend to neglect to educate students about caring for people with disabilities.

Violence, the final face of oppression is defined by Young as random and unprovoked attacks of a person physically or of their property. While disabled people have historically and still experience violence, I do not believe nursing students have

experienced actual violence in the admission or education process so have decided to not include this category in the study.

Medical/Individual Model of Disability

According to Marks (2000), "A common myth held by health care professionals is that disability is primarily a medical/illness issue. In the context of the medical model, disability is perceived as an individual and/or a medical phenomenon" (p. 205).

Michael Oliver (1983) was one of the original writers who identified disability models, specifically the individual and social models of disability. He stated, "The idea of the individual and the social model was taken quite simply and explicitly from the distinction originally made between impairment and disability by the Union of the Physically Impaired Against Segregation (UPIAS) in the Fundamental Principles document" (1976). In the Fundamental Principles document, the meaning of disability was radically redefined as being socially created. Oliver identified this interpretation as the social model of disability and contrasted this with what he called the dominant medical model.

Oliver (1990) believed that under capitalism, disability became an individual pathology. He claimed, "Disabled people could not meet the demands of individual wage labour and so became controlled through exclusion" (p. 47). In Oliver's view, the "medicalising" of disability was connected to the rise of the medical profession: "In the twentieth century, we have seen an increasing medicalisation of society; medicine has acquired the right to treat a whole range of conditions and problems that would have previously been regarded as moral or social in origin" (p.48).

Of course, people with disabilities often require medical attention, such as the intervention needed after a disability-causing accident or the intervention required to treat physical or emotional complications related to having a specific disability. Further, the involvement of the medical field in the treatment of disabilities often shifts from intervention to rehabilitation as the physical conditions associated with a disability shift from acute to chronic. Oliver notes, "The aim of returning the individual to normality is the central foundation stone upon which the whole rehabilitation machine is constructed" (Oliver, 1990, p. 54). Medicine also continues to search for a cure for many chronic conditions−for example multiple sclerosis, muscular dystrophy and spinal injury.

This relationship between medicine and disability often places the emphasis on disability as a disease in a need of a cure, however. Disability under the medical model is thus viewed as a deficiency or abnormality and considered negative. That is to say, according to the medical model, disability resides in the individual and the remedy is cure or normalization of the individual. The agent of remedy is the professional (Blacklock, 1995).

Oliver (1996), in *Understanding Disability*, stated two fundamental points about the individual model of disability. He said, "Firstly, it locates the problems of disability within the individual and secondly it sees the causes of this problem as stemming from the functional limitations or psychological losses which are assumed to arise from disability" (p. 32). He continued, "Many of the newer professions such as physiotherapy, occupational therapy, health visiting, nursing and even teaching, either work in

organizations hierarchically dominated by doctors or have their professional practice structured by a discourse based upon the medical model" (p. 48).

Social Model of Disability

Oliver (1996) also developed the social model of disability. He views it as a model, not a theory, since it does not connect with all of the experiences of disabled people and can only partially explain the social oppression experienced by members of the disabled community. In the social model of disability, the problem of disability exists; however, it does not reside in the individual, but within the society. The definition of the social model of disability is stated within the original UPIAS (1976) document:

> In our view it is society which disables physically impaired people. Disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society. Disabled people are therefore an oppressed group in society. (p. 14)

The social model does not deny that disabled people experience illnesses that require medical intervention. The model does not support doctors focusing their treatment on the disability instead of the illness that accompanies the disability. Medicine's aim is to restore the disabled person to normality or to a state as near to normal as possible, often through whatever means are available. The medical profession locates the disability in the person, rather than in the social environment that does not fully accommodate the person's abilities.

According to Oliver (1996), proponents of the social model of disability would argue the following:

> It is society that has to change not individuals and this change will come about as part of a process of political empowerment of disabled people as a group and not through social policies and programmes delivered by establishment politicians and policy makers nor through individualized treatments and interventions provided by the medical and para-medical profession. (p. 37)

When addressing nursing education, this position would require that a nursing curriculum be developed collaboratively with the disabled community so that it is accessible to all individuals. In this case, the environment would change, and there would be no reason for an individual with a disability to request accommodations.

Experts have suggested that in order for nursing programs to successfully admit and educate students with disabilities, admission criteria and curriculum needs to be developed based on the social model of disability (Marks, 2000; Moore, 2004). This model would encourage faculty to develop both theory and clinical courses that allow all students to participate without the need for accommodations. This would eliminate the need to prescribe skill-based admission criteria as well as the need to decide what essential elements are required in a nursing program as a reaction to applicants with disabilities. This would be a paradigm shift for schools of nursing.

Nursing educators have become much more socially aware when developing curricula. Common courses found in baccalaureate nursing curriculum address cultural diversity, global health, public health, ethics, and leadership. Within these courses, content includes the social, economic, and political factors related to the quality and cost

of health care, as well as access to health care. This same social awareness has not been transferred to working with students with disabilities.

The framework of oppression, the medical model, and the social model of disability have been used to describe nursing education as it relates to educating nursing students with disabilities. My work draws on this, as I believe that oppression occurs, that defining disability from a medical model contributes to the oppression, and that the social model could be part of the solution. My work, however, differs from past studies related to admitting and educating nursing students with disabilities which have primarily used quantitative measures (Brillhart et al., 1990; Carroll, 2004; Christensen, 1998; Davidson, 1994; Persaud & Leedom, 2002; Sowers & Smith, 2004; Swenson et al., 1991; Watson, 1995; Weatherby & Moran, 1989). Past studies have not explored, either quantitatively or qualitatively, the basis of nursing faculty attitudes or the beliefs on which these attitudes may be based. I believe nursing faculty cannot proceed to make decisions about admitting and educating nursing students with disabilities until faculty truly understand why and/or how oppressive beliefs and attitudes arise.

Methodological Framework

My research process was guided by the discipline of nursing, feminist beliefs, and interpretive research commitments and perspectives. I discuss these in the following sections.

How the Discipline of Nursing Informs My Methods

Nursing is a profession that touches many lives, but it is not well understood by those outside of the discipline. In what follows, I give a brief history of nursing as an

academic discipline as it relates to research. When I graduated with my four-year degree in nursing in the early 1980s, nursing theorists were beginning to challenge the quantitative paradigm of nursing research. The quantitative paradigm had remained strong during the earlier years of nursing research, as nursing struggled to be recognized as an academic discipline, nursing professors modeled research on the medical model, and academic and governmental institutions failed to provide support and funding for qualitative research.

A shift began in the mid-1980s, when Madeline Leininger, a well-known nursing theorist, authored one of the first comprehensive qualitative research books developed by and for nurse researchers. In it she stated, "Over the past three decades, the majority of nurse researchers have been strongly socialized to value and use quantitative types of research as the only legitimate method for 'scientific' nursing research" (1985, p. 3). Nursing had been building its professional status; quantitative research legitimized nursing as an academic discipline. Because nursing is a discipline and a profession that involves providing care for patients, quantitative research related to outcomes of this care had been needed. During this same time period, nursing students received a brief introduction to qualitative research, which was described as soft and non-scientific. There was little faculty support for graduate students to pursue qualitative research. In fact, few nursing faculty were able to mentor graduate students in qualitative research. According to Leininger, in 1985, there were approximately 50 nurse research experts proficient in anthropological, phenomenological, philosophical, and historical methods.

Leininger believed that nursing knowledge could be advanced using qualitative research. She maintained that

> Nurse anthropologists and nurse philosophers recognize that people are cultural beings with broad and divergent views of life, of living, and of experiencing. Accordingly, health and illness states are embedded in the cultural values, religious views, economic conditions, and social environments of human expressions. Indeed, the real meaning and quality of life, health, and care are best known from a holistic and social structure frame of reference. (1985, p. 2)

Leininger gave four reasons why qualitative research methods were important to nurses. She stated that "nursing has philosophical, historical, and epistemological beliefs that are deeply rooted in humanistic services to humankind, and these roots can best be discovered by qualitative methods more than by quantitative 'scientific' ones" (1985, p. 22). She also discussed the importance of defining the hidden and culturally based values of nursing care using qualitative methods. According to Leininger, nursing had been defined as caring for the human response of illness. Qualitative research could assist with looking beyond this definition. Lastly, Leininger noted that "nursing is a humane field of study and practice, and this means that humanistic patterns of care and lifestyles must be identified and studied" (1985, p. 22).

In the mid 1970s, as part of her dissertation research, Barbara Carper (1978) identified four fundamental patterns of knowing based on an analysis of the conceptual and syntactical structure of nursing knowledge. These patterns of knowing influenced nursing faculty views related to qualitative research. Wainwright notes that "Carper's

(1978) discussion of ways of knowing in nursing ranks as one of the most influential pieces of nursing writing of the twentieth century" (2000, p. 750). Carper states, "The four patterns are distinguished according to logical type of meaning and designated as: (1) empirics, the science of nursing; (2) aesthetics, the art of nursing; (3) the component of a personal knowledge in nursing; and (4) ethics, the component of moral knowledge in nursing" (1978, p. 14). Empirics supports knowledge generated from within a framework based on quantitative principles of research. It is "empirical, factual, descriptive and ultimately aimed at developing abstract and theoretical explanations" (p.15). Aesthetics, personal knowing, and moral knowing, on the other hand, support qualitative methodologies. The art of nursing is the creative, subjective side; personal knowing is the nurse's subjective knowledge, her ability to know herself and thus to move toward self-actualization; and the ethics of nursing involves knowing what is just and right. All three ways of knowing can be explored using the qualitative methods that are well known today.

In any attempt at research, it is important to match the research question with methodology used. In the early 1990s, I completed my master's thesis analyzing the concept of caring. For this study, I explored what patients defined as nurse caring behaviors. I replicated a quantitative study using a Q-sort methodology. The results demonstrated that patients believed that the most caring nurses were the ones who were the most technology competent. Today, thinking about the concept of caring from a holistic perspective, I believe I would have obtained richer data researching this concept using qualitative methodology. I believe the concept of caring is part of what Carper

would define as the aesthetics of nursing, namely, part of the creative, subjective side of nursing that may be better researched using qualitative methods.

Even as late as 2001, concerns about academic support for qualitative research were still being raised. In one study, for example, Munhall (2001) asked the following questions:

1. If you are enrolled in a Ph.D. program, for what method does your required courses program you? (There are exceptions!)
2. If you are seeking a faculty position, how will you get the evidence of extramural funding that is required to be demonstrated?
3. Peruse the list of recent NINR (National Institute of Nursing Research) grants and ask, which paradigm is most rewarded? (p. 46)

Munhall implies through these questions that many Ph.D. nursing programs require their students to take courses that focus on learning quantitative research methodology. Research using quantitative methodology is more readily funded by the NINR. To obtain a faculty position, especially in a research university, it is necessary to obtain extramural funding, which is difficult unless it is a quantitative study. All of these factors support nursing research that is quantitative.

As an academic as well as a practical discipline, nursing continues to develop within a tension between qualitative and quantitative research. Clinical research resulting in improved patient outcomes will continue to be funded and remain largely quantitative.

Research related to aesthetic aspects of nursing or to personal and moral knowing has stepped out of the quantitative boundaries and requires qualitative methodology.

How Feminist Beliefs Inform My Methods

In my previous research on disability, I was drawn to feminist theory including Young's (1990) framework of oppression as it relates to disability. I was drawn to feminist theory because of the epistemological stance feminists take regarding the recognition of and opposition to oppression, not only on a class level but also on an individual level. As I explored feminist theory, I found connections to qualitative methodology and disability. I considered how feminist theory affected my beliefs that informed my methods.

Feminist researchers do not subscribe to one particular method. The research question, not the method, moves a feminist research project forward. I believe, as Campbell and Bunting (1991) stated, that "methods themselves are not bound to a philosophical stance. Consequently they can be used from any world view; thus the methods do not drive the assumptions" (p. 3). My research question leads to the qualitative method of interviewing from a feminist perspective. My research involved interviewing individuals in order to hear their voices. Interviewing offers researchers access to people's ideas, thoughts, and memories in their own words rather than in the words of the researcher (Reinharz, 1992). My focus was on understanding and listening to each interviewee rather than focusing on getting questions answered. I completed a second interview to verify, or member-check, and to obtain further understanding of the participants' beliefs.

Feminist theory discusses the importance of leveling the power structure of an interaction such as an interview. This can be difficult because of academic differences between a researcher and a participant. This type of power differential did not exist in this study, as the participant may have a higher degree than the researcher. Other actions I took to reverse the power differential included maintaining continuous relationships with the participants through multiple interviews, allowing participants to member-check the transcripts and make any alterations in the transcribed data, and interviewing participants in neutral environments or an environment of their choosing.

Feminist research at its inception involved the study of women's experiences. Some current feminist research focuses on the individual's experience of oppression, especially as it relates to class, race, and gender. Harding (1987) believed it was important to examine critically the sources of social power in order to understand women's experiences. I have chosen in my study to focus on one source of social power: nursing faculty members. I interviewed nursing faculty not because the majority of nursing faculty are women, but because they are in a position of social power, and thereby are as a group a potential source of oppression.

Oppression is a complex topic in nursing and in education. Research on the gender oppression of male nurses/students in a female profession (Ellis, Meeker, & Hyde, 2006; Smith, 2006; Stott, 2007) and research related to students' experience of oppression by faculty (Mooney & Nolan, 2006; Rather, 1994; Roberts, 2000) is important and would fit with feminist perspectives of qualitative research. I am aware that this oppression exists and was conscious of discriminating between types of oppression

during the research process. I remained alert to the fact that it is often difficult to discern disability oppression from gender oppression or other instances of oppression such as age, race, or sexual orientation.

The work of Jenny Morris (1993), a disabled woman, feminist and freelance writer and researcher, stems from two characteristics of feminism:

> Firstly, the way in which disability is generally invisible in terms of feminism's mainstream agendas; secondly, the way in which, when disability is a subject for research by feminists, the researchers fail to take on the subjective reality of disabled people, instead objectifying us so that the research is alienated from our experience. (Morris, 1993, p. 67)

Morris believed that feminist disability research must create space for the "absent subject," in the way that feminist research has focused on non-disabled women and she noted areas ripe for feminist disability research. An example of research that needs to be done concerns the experience of abuse within institutions. According to Morris, such research should seek to do three things:

1. Name the experience as abuse;
2. Give expression to the anger, pain and hurt resulting from such experiences;
3. Focus on the perpetrators of such abuse, examining how and why it comes about (Morris, 1993, p. 64).

Morris might state that some nursing faculty members are perpetrators of the suffering experienced by nursing students with disabilities. I believe nursing students

with disabilities experience abuse and research is needed to examine how and why such abuse, with its resultant suffering, comes about. One way to examine how and why this abuse comes about is to explore faculty members' beliefs about disability. Hence my research project. In preparing for my research, I found several quantitative studies specific to nursing that addressed faculty attitudes toward people with disabilities (Brillhart, et al., 1990; Christensen, 1998; French, 1996; Sowers & Smith, 2004). However, I found no qualitative studies that explored faculty members' positive and/or negative attitudes towards students with disabilities, what these attitudes might be based on, or why they occur.

Disability researchers discuss the difficulties researchers have when they are not members of the community, culture, or group that they study. Those who research particular cultures or specific social issues, such as poverty or HIV/AIDS, are often not members of those groups. Some critics view research done under such conditions as limited. I am not a disabled person. Because of this, I was hesitant, initially, to attempt disability research. However, my research focuses on nondisabled educators (in particular, nursing educators) of disabled persons (in particular, disabled nursing students); as such, my research seeks to understand a group of which I am a member.

Morris (1993) believed that it was imperative that non-disabled researchers analyze their own attitudes towards disability. In addition to interviewing members of a group to which I belonged, I also felt it was important to explore my own beliefs about admitting and educating students with disabilities and to include this information as part of my research. As part of the interview process, I chose to include my experiences

educating a disabled student. Reinharz (1992) defined this as researcher self-disclosure. According to Reinharz,

> Researchers who self-disclose are reformulating the researcher's role in a way that maximizes engagement of the self but also increases the researcher's vulnerability to criticism, both for what is revealed and for the very act of self-disclosure. Receiving feedback from the interviewees, on the other hand, enables the self-disclosing researcher to continuously correct the interview procedure. (1992, p.34)

Interpretive Research

As a literature review shows, qualitative researchers disagree about the application of theory and the specific use of methods. I find this lack of consensus both freeing and disconcerting. There is no one definitive handbook that specifies how one should complete a qualitative study. A number of handbooks, however, offer multiple suggestions related to qualitative methodology and methods, and I reviewed these guides to explore the meaning of qualitative research. I felt drawn to the interpretive approach of qualitative research as I more specifically defined my research questions. Erickson (1986) in the *Handbook on Research on Teaching*, used the term *interpretive* to refer to the whole family of approaches to participant observational research including ethnographic, qualitative, participant observational, case study, symbolic interactionist, phenomenological, constructivist, and interpretive approaches. He believed that, although there are differences among these approaches, "each bears strong family resemblance to the others" (p.119).

Erickson (1986) distinguished between research based on the natural sciences and interpretive research. He stated that “through culture, humans have learned systems for defining meaning, and in given situations of practical action humans often seem to have created similar meaning interpretations” (p. 126). He noted that these are surface similarities, and we cannot assume that the interpretations of meanings between two individuals are the same: “Thus a crucial analytical distinction in interpretive research is that between behavior, the physical act, and actions, which is the physical behavior plus the meaning interpretations held by the actor and those with whom the actor is engaged in interpretation” (p. 126−127). This is not true in the natural sciences. Research in the natural sciences does not need to take into account the meaning from the point of view of the actor. As Erickson explained, “The nature of cause in human society becomes very different from the nature of cause in the physical and biological world” (p. 127). In interpretive research, it is important to explore the actor’s interpretation of what his or her action means to him or her.

Munhall (1994), an author of qualitative nursing research texts, noted that the greatest aim of interpretive research was to understand particular meanings “in pursuit of understanding what it means to be human” (p. 32). The interpretive researcher asks “(1) how being is created or transformed through experiences and (2) how social or environmental forces structure human experiences” (Munhall, 2001, p. 443). She stated that the research methods used by traditional science cannot guide the scholarly endeavors of caring professions. The focus on reliability and validity objectifies persons

and phenomena. The knowledge gained from scientific studies tends not to benefit those being studied.

Research Method

In this section, I discuss the researcher role and research design. In the research design section, I include descriptions of the settings and participants, the method of data collection, the framework for the interviews, and an overview of data analysis.

Researcher Role

I assumed the role of the interviewer, and with it, certain necessary responsibilities. As stated earlier, it was important to understand and listen to the interviewee and not have as the main focus getting my questions answered. I chose to include researcher self-disclosure by including my own experiences educating a disabled student. This was a way for me to "maximize engagement of the self" as a researcher (Reinharz, 1992, p. 32).

I chose to interview faculty and not students with disabilities so there were not ethically problematic power differentials in this study. With the small sample size, however, another ethical issue arose: I needed to be careful about how I presented the data to maintain participants' anonymity. Finally, my research involved looking at disability, but not focusing on the voice of the oppressed. While I acknowledge the moral and practical importance of listening to and hearing the voice of students with disabilities, I know there is an explicit need for my study.

As a researcher, I recognized that I have biases related to my role as a nursing faculty member, my past experiences working with a student with disabilities, and my

ethnicity, religious framework, and gender. I was continuously aware of these biases as I formulated follow-up questions and interpreted data. Member-checking was a part of the interview process, as I strove to understand my participants through their lenses and not my own.

Research Design

Settings/Participants

I obtained a purposeful sample of participants consisting of 10 full-time nursing faculty from institutions located in the greater metropolitan area of Minneapolis/St. Paul. In order to be included, participants must have been at institutions that offer a bachelor's degree in nursing. I obtained this sample from four private institutions and three state institutions. Differences in mission statements were evident among institutions. Interviewing faculty from several institutions allowed voices that represent these different mission beliefs to be heard. Faculty had to have taught both clinical practice and theory to undergraduate nursing students and been nursing instructors for a minimum of five years, a period that hopefully gave nurses enough experience as faculty to form beliefs about educating nursing students. Faculty must have had experience with either admitting or educating a nursing student with disabilities. Because of student privacy laws, if faculty members were not involved in either of these processes, their knowledge of working with a student with disabilities would be limited and second hand. Actual experience, I believed, would lead to richer data.

Data collection

I conducted two audio-taped, open-ended interviews of about one hour with each participant. After analyzing data obtained from the first interview, I conducted a second audio-taped interview for member-checking and for clarification as needed. I interviewed nursing faculty either in their settings or in mutually agreed upon locations. Because I taped these interviews, the settings had to be private and quiet.

Framework for interviews

My purpose for this study was to explore beliefs nursing faculty have about admitting and educating nursing students with physical disabilities. Most studies reported in the literature are quantitative and describe faculty members' attitudes toward admitting and educating nursing students with physical disabilities (Brillhart et al., 1990; Christiansen, 1998; Chubon, 1992; French, 1996; Sowers & Smith, 2004). These studies measured attitudes using a Likert scale and reported results, indicating that faculty members were either positive or negative about admitting and educating nursing students with disabilities. I propose that these results, while important, are incomplete. I hoped through this study to learn about the beliefs nursing faculty had related to admitting and educating a nursing student with physical disabilities.

The interviews were semi-structured, with the primary purpose to better understand nursing faculty members' beliefs about admitting and educating nursing students with disabilities. All participants chose their faculty offices as the location for their interviews. We sat across from each other at a desk or table with the tape recorder between us and the door to the office closed. I began the interview with collecting

demographic data related to rank, position, and total number of years teaching. The questions posed in the semi-structured interview asked participants to explore their personal definition of disability; to relate their definition to a medical or social model framework of disability; to describe their own experiences as faculty admitting and/or educating a student with disabilities; and to discuss admission criteria related to functional abilities if used by their programs. I listened carefully to responses; asked questions based on these responses, and clarified statements when needed. I ended the interview within the hour time frame I had given each participant during the consent process.

Data Analysis

Immediately after the first interview, I took field notes describing my initial impressions of the interview. I included thoughts related to my interviewing style such as, "I did better with questions, I think." I noted initial impressions of the participant, for example, "Her nursing background was evident in what she talked about." I noted their emotions and mine as well. I listened to each interview's audio tape immediately after the interview, and at that time I took notes about my subjective perceptions related to the interview. Wengraf (2001) describes this as "instant post-interview debriefing in order to lose as little as possible of your experience of the interview" (p. 209).

Ricoeur's theory (1976) of interpretation guided my data analysis. After having the interviews transcribed, I performed a first reading of each interview. As part of the first reading, I listened to the taped interview while reading along with the transcript. The purpose of this first reading was to gain a better understanding of what was expressed and

I believe hearing the participant's voice contributed to this understanding. As an interpreter, I drew upon past experiences and knowledge as I strove to understand the data. During this initial analysis, I formulated written questions for the second interview to increase understanding. I used a second interview to gain further understanding of the data gleaned from the first interview. During the second interview, I asked participants for clarification of the transcript as needed.

After the first reading, I constructed meaning units using the actual data and wrote them in the margins of the transcript. From these meaning units, I created labels on the actual transcript and used these labels to discover common themes. After the second interview, I continued this process and either accepted or rejected the labels, created new labels, and continued to construct themes. I created an electronic data analysis folder which contained subfolders of the constructed themes. I electronically placed transcribed data that I believed represented the themes into these folders. As I analyzed this data, I made electronic interpretive comments in the margins. I then printed these transcripts, placed them in a notebook using themes as dividers. I again analyzed the supporting transcripts, the meaning units, the labels, and themes created. I summarized my interpretations in each section of this notebook. During the analysis, I considered parts of the text that seemed significant, as well as the relationship of significant parts to each other and to the text as a whole. I returned to the original transcribed data to review supporting data in its original context to assure accurate understanding. Those who read this study should be able to understand how I arrived at my interpretations, although readers may not necessarily agree with those interpretations.

Chapter Three: Stories and Definitions

I asked each participant to share his or her story of admitting and/or educating a nursing student with disabilities. Many published quantitative studies deny participants' their "voices"; both faculty and students voices are absent in these studies. During my interviews, faculty members were given a voice to talk about their experiences and their beliefs. Through these stories, I heard about successes as well as failures; students with disabilities have graduated, and students with disabilities have failed to graduate. Faculty members have expressed excitement with successes and frustration related to failures, both working with the students and working within the educational system. To participate in this study, faculty all had to have experiences admitting and/or educating at least one student with a disability and a few had experiences with several students. Their stories were diverse relative to their experiences, but similar themes emerge. As I conveyed participant's stories, I used pseudonyms to provide autonomy.

As part of their stories, faculty described personality characteristics that the students with disabilities possessed. They described students that were proactive about obtaining assistance; perceptive and aware of their needs as they were able to manipulate the environment to be able to adapt to their disability; assertive in obtaining adaptive equipment; and as having previous experience with adapting to their environment. Descriptions were also of students who chose not to take "ownership" of their disabilities. This lack of ownership affected their abilities to be successful. One student was described as having a "defeatist attitude" and believed accommodations were needed for

everything. Some students self-disclosed their disabilities, while other students chose not to disclose their disabilities. Faculty participants also described counseling prenursing students about the role of the nurse and their ability to be successful in this role, given their disabilities. Participants expressed concern about litigious students and family members and described how this concern affected both admission and teaching practices.

Stories

Prenursing majors typically have many questions and concerns about the admission criteria for a nursing program. Student questions include the following: How many students are accepted each year in the nursing program? What is the minimum grade point average needed for acceptance? What are the required courses? Other concerns about admission criteria included worries about the physical exam, immunizations requirements, and other criteria on the application. The faculty in this study described the concerns that disabled prenursing students had.

Because of the complexity of requirements, many nursing programs advise their majors as freshman, before those students receive acceptance into the nursing program. One faculty member described a student's early concerns:

> Susan: We currently have a student here involved with having a disability. The student came to see me when she first came to the college to find out if she could still pursue nursing with the hearing loss, so it was more information gathering on her part. Can I even choose this career . . . and [She] came to see me . . . to find out if that was even feasible because she was doing some fact-finding. And then she came to meet with me again as a sophomore student at the time of the

application process into the program and asked some of the same questions again to be sure that she should go through with the application and you know, the rules were still the same or the information was the same. I think she wanted reassurance.

Diane: **. . .** what did you tell her when you met with her; what did you say?

Susan: Well, first I asked her to tell me a bit about her disability. How significant was her hearing loss? How did she have accommodations now in classes, or you know, what had she done to that point? And her hearing loss was as an infant so the majority of her life she has dealt with this. She's the only one in her family, so she had a lot of experiences to share about how the family learned to work with her or school. And the accommodation is amplification, which from our perspective was easy to solve−an amplified stethoscope, another nurse to verify information should there be a question. I guess in my mind that was a pretty limited issue to deal with and there was no reason she couldn't pursue nursing, or this program, or apply or be successful. So it was kind of easy to solve, in my mind. And it has been easy to work with her.

This student with a hearing loss was concerned whether she could be successful as a nurse; she asked, in essence, if she could pursue a nursing career. I believe she was also asking if she could meet curriculum requirements. Could she be successful in the nursing program? She asked these questions as a freshman and then posed many of the same questions as a sophomore. Could she still apply to the program? Were the rules the same? She wanted reassurance. As nursing program advisors, faculty participants

described meeting with many students in the pre-program period in order to reassure them and different students had different concerns. All students, able bodied or not, wondered if they meet academic admission criteria and, if they had turned in all of the required forms. The student with the disability that Susan described, however, added the concern of meeting the "rules" related to the physical ability requirement. This student considered not just her ability to be admitted to the nursing program, but also her success in the nursing curriculum and profession. She was also concerned about physically being able to meet the requirements that this program outlined as necessary of a professional nurse.

Another faculty member discussed her experiences formally counseling prenursing majors about the role of the nurse and the expectations, both physical and academic, of this career. She reported saying the following when counseling a student with deafness:

> Alice: I think I've been involved in three different levels−I would say my level with disabilities−one would be in a prenursing course where sometimes−I can think of two people. One person had severe deafness that even as we tried to make accommodations and tried to get new technology, even tried to do surgery, still wasn't able to differentiate well enough to listen to heart sounds, listen to lung sounds, listen to some of those basic nursing skills that a person would have to do so re-counseling and re-advising that person into a different profession−that would be one level before they even get into the admission process.
>
> Diane: So this person, this is just all pre-admission−

Alice: Yes, she was wondering if she would be able to move through the nursing program−something that she wanted to do. She came into the prenursing course and we began working with her right away. And I think the stress of her experience and knowing that there was such a large gap between what she felt comfortable and confident in doing, versus what the expectation level is with somebody who is a nurse−I think that's probably a big influence on her as to how she chose to go into a different profession.

Diane: Okay, how did you help her to become aware of what the nurse's role would be or how did she learn about it?

Alice**:** Well, she had an aunt who was a nurse and then the prenursing course−we bring a lot of different nurses in−who talk to, tell their stories about the nurse because it's kind of an experiential type of experience. And she also got to follow a nurse and shadow them in the clinical setting and so I think that was a big eye-opener for her. And she, we made a special person attempt−an interpreter was with her and when she shadowed the nurse I think that's when she really became clear to her kind of where that gap is.

Alice described the many efforts that her program made on behalf of the student to help her hear at the level Alice believed was necessary to perform well as a nurse. The basic skills (listening to lung and heart sounds with a stethoscope−an amplifying instrument) she described are psychomotor skills and would be required of students by nursing programs to successfully pass an assessment or skills course. These skills are not

required for all nursing roles for which a graduate could be employed, but are required by nursing curricula.

Given the student's inability to hear at a level judged necessary for success, Alice's program counseled this student to consider a career other than nursing. Was the nursing curriculum's requirement, rather than the student's inability to hear, the real barrier preventing the student from becoming a successful nurse? I believe the faculty felt they were making a special effort to help this student succeed by researching accommodations such as special technology and even surgical options. I don't believe they would have considered that, in fact, they may have contributed to the oppression of this student, a young woman who may have experienced marginalization and cultural imperialism as a result of their actions (Young, 1990). I believe, as Young (1990) states, that these faculty were just doing their jobs; in fact, they went beyond what most faculty would do by exploring accommodation options, and would never consider themselves as agents of oppression.

Alice stated that the student, because of her experience participating in a prenursing course, had a better understanding of the role of the nurse which led her to self select out of the profession. In this prenursing course, nurses shared stories and the student was able to shadow a nurse in a clinical setting. I am uncertain which stories were shared by the nurses in the prenursing course. The shadowing experience in a clinical setting, which would have involved the student observing a nurse using many complex psychomotor skills, would have given this student only one example of a nursing role. I wonder if it would have been helpful for this student to shadow a nurse with a disability

and hear her story, or to shadow nurses in roles that do not require complex physical abilities.

Would this have made a difference in the student's decision? I believe decisions about which nurses students should shadow and which stories students should hear could influence students' beliefs about who can be a nurse. Such selections show a valuing, whether conscious or unconscious, of the dominant group: able-bodied nurses working in clinical settings. Citing their experience as the norm is, again, an example of cultural imperialism. This is not uncommon in nursing programs. Nursing faculty teach and create learning experiences for the dominant group: white, able-bodied females. I can think of many reasons why this happens: traditional educational practices, the complex demands already placed on nursing faculty, the lack of experience/exposure to students with disabilities, or perhaps the fact that some faculty have not thought about it. Deciding how to counsel a student, what content to include in the curriculum, and what clinical experiences to offer demonstrates a belief by faculty of what a nurse needs to know and perform.

In their stories, participants discussed the ethical complexity of allowing a student to pursue a nursing major when faculty believed either that the student would not be successful in the nursing program or the student would be unable to find employment, given the amount and type of accommodations the student would need as a practicing nurse. One faculty stated the ethical issues this way:

> Alice: So you have to kind of, because there's no sense moving somebody through a nurse education program, and if you've made dramatic

> accommodations for somebody but you ethically know that the employer would not be able to make the same types of accommodations to allow the student or then the nurse to work in that same capacity. I guess that has an ethical component to be evaluated and kind of project out−what would be reasonable for an institution or the employer to be able to make.

Pre-admission counseling was one means by which Alice felt that students were given the opportunity to recognize whether they could be successful. Participants stated that not all students received this kind of formal counseling, and not all students were perceptive enough to understand the role of the nurse and the barriers the job would present.

Alice described in the above scenario a form of marginalization. Young (1990) discussed marginalization in her framework of oppression referring to a situation in which groups of people are excluded from useful participation in society. Carroll (2004) discussed marginalization occurring by nursing faculty when they expressed concern as to what role disabled nursing students will have in the nursing profession. Participants in this study expressed similar concern, but they labeled this concern an ethical issue and did not see it as an issue of oppression, specifically marginalization. Participants worried that admitting and educating students who they believe will not be able to obtain a job as a nurse could be an injustice. Young and Carroll would see the injustice as a nursing program not admitting a student because of a worry that the student might not get a job, given the student's disability. Young and Carroll on the one hand, and faculty participants on the other, are both concerned for the student with a disability, but from different beliefs and perspectives.

The faculty interviewed often vacillated between statements that demonstrated a social beliefs framework and those demonstrating a medical model framework (Oliver, 1990). Ethical concern for and/or about a student represents a social view, but framing ethical concerns in terms of the need for accommodations changes the basis of the statement from a social beliefs framework to a medical model framework.

Another participant described the student she worked with as having a defeatist attitude.

> Diane: Was she trying to say, because she had a disability she couldn't do the activity?
>
> Jane: She would pull that in kind of with every conversation, and then what I would do is I would pull her letter out. And I would say, "Okay, in your letter it says these are the things that you have accommodations for." And I just had a sense that she was so used to kind of not being able to do things or having barriers that maybe everything in her life felt like a barrier . . . that's the way she framed everything. . . . I just found that the strategy of sticking to her letter was very helpful, because I think she was so overwhelmed by the things that she couldn't do that everything was a barrier.

According to Jane, this student believed the accommodations granted fell short of meeting the need her disability generated. To be successful and to complete an activity in a course, she needed a faculty member's encouragement and a reframing of the situation, one that drew on her accommodation letter. The faculty member expressed that she believed the student perceived everything as a barrier.

Young would describe this student's defeatist attitude as expressing powerlessness (1990), another face of oppression. Those who are oppressed have power exercised over them rather than exercising power over other people. This student felt powerless in the face of course activities that she actually could do and that she successfully completed. It was not evident if the power imbalance between a student and faculty member also contributed to her defeatist attitude. The faculty member believed that the powerlessness that the student expressed was related to past experiences, and did not reflect the student−faculty relationship. The faculty member also believed that the student would find all tasks to be barriers. It is uncertain whether the student believed this herself or if this was just the faculty member's belief. It is also uncertain how this belief affected their interactions.

Another faculty member in her story expressed her concerns about students not disclosing their disability or being unable to accept their disabilities.

> Wendy: . . . difficulties surface because the individuals are not able to−have not come to the point where they−I don't know if *acceptance* is the word−but they have been able to say, "Okay, that's who I am. This is what I need to let people know about me in order for me to be successful" . . . so it is somehow getting at their perceptions and so that they come in with an accurate perception −not just an accurate perception but willingness to share that perception and see that we are here to help them be successful.

Wendy desired success for students with disabilities. She discussed that students need to have accurate perceptions of their academic needs and need to share those perceptions.

Prenursing students have had little physical ability expectations prior to the nursing program. Typically, prenursing students don't know what nursing will require of them physically until they are in the laboratory or clinical situation. The complexity of a nursing curriculum may make it difficult for a student to have an accurate perception of their disability in relation to what is required for a student in a nursing program. It may not be possible for a student with a disability to have an accurate perception of their academic needs as Wendy desires because of this complexity.

Wendy reported hearing the following statements from those who did not want to disclose their disabilities: "I wanted to be like my classmates for one time in my life," and "I want to be like my peer group and I am not."

The desire of the student with a disability to "be like my classmate" could be explained using Young's (1990) definition of cultural imperialism. Students with a disability believe they will be perceived negatively by the dominant group, which in nursing is comprised of white, female, able-bodied students and/or faculty; the desire that these students with disabilities express to be the same seems understandable based on the belief that nurses are or should be white, female, and able-bodied. The faculty expressed understanding of, but also frustration in working with students who did not disclose their disabilities. When Wendy's students did not disclose their disabilities, she was frustrated, I believe, by not being able to offer timely accommodations to help those students be successful.

Another faculty member discussed her experience when a student was admitted with a non-disclosed disability to the nursing program.

> Vicki: I don't think anyone was aware of the disability or how much of a disability she had . . . I think after our experience with her, which she did not successfully complete the first semester, we came up with all these, like you said, reactive rules that you needed to be able to stand for this number of times in clinical, you need to be able to sit for classes for this long of a period of time, etc., etc., so it was kind of reacting to the situation. . . . Up to that point we've always had individuals with physical disabilities such as hearing loss and then we tried to figure out, you know, how to adapt those, and now with those stethoscopes and stuff like that, you know, that became a lot easier to invite those people into the program….And so finally when we got this student that wasn't able to master it, you know is when we all of a sudden stepped back and thought, "Okay, now what do we really want or require of our students?"

This program reacted to the experience of non-disclosure by creating admission criteria addressing physical abilities. These criteria suggest that this program would likely restrict students with certain disabilities from being admitted to the program. Many nursing programs have developed admission criteria in response to working with a student with disabilities (Swenson et al., 1991; Weatherby & Moran, 1989) including some schools represented by participants. I believe this reflects certain beliefs held by members of nursing programs, beliefs related to admitting students with disabilities, such as the conscious belief that failing to admit students with disabilities is not an instance of oppression.

In actual practice, marginalization may result from setting admission criteria that reflect the abilities purportedly required of anyone fulfilling the position of a professional nurse. Such criteria, however, may bar students with disabilities from entering a nursing program, even if those students would be hired as nurses, had they received the appropriate training. The tension here is between the physical skills a student must demonstrate to enter or pass a nursing curriculum and those physical skills necessary for employment as a nurse. I believe the admission criteria are related specifically to the physical abilities needed to be successful in nursing school and are related to many of the roles, but not all of the roles, of nursing.

Unlike the non-disclosure experience, two faculty members' stories described student characteristics who chose to disclose their disability. The students described were perceptive, assertive, and successful when adapting to their environment or using adaptive equipment.

> Marcia: She was an excellent student to begin with and I think that probably helped a little bit also−very perceptive, able to communicate well with clients, very okay with her disability . . . manipulating her environment to meet her needs and so she did very well, very well.
>
> Kay: She . . . was quite assertive in coming and talking to people and saying, "This is what I need to have done." She needed assistive equipment−adaptive equipment . . . and she had no trouble hearing with that stethoscope.

These academic experiences are much different from those related in the previous stories of students not wanting to disclose their disabilities, lacking awareness of their

disabilities, and/or having defeatist attitudes about their abilities to complete educational tasks. The experiences related by Kay appeared to be positive because the students were perceptive, assertive, and could adapt to their environments. I believe this is an example of success because a student adapted to the environment. Seeing the students' success as the result of adapting to their environments reinforces the idea that the disability resides in the individual, and hence supports the medical model framework, which couples success with adaptation.

In contrast to the positive faculty experiences described previously, a faculty member discussed her frustration with the lack of information she received about the type of disability a student had.

> Beth: We're never told if it's cognitive or psychological−what their disability is−we're not even told if they're hearing impaired−because that is considered confidential. So, I'm only told how I have to modify things. I'm never told why, which I find very frustrating. I think I find it very frustrating because, you know, as nurses you're used to doing an assessment and now they're saying−"No, you can't assess, you just have to do what we tell you to do." So that's been frustrating, although I have adapted. You know, okay you can't tell me, that's fine.

Beth expressed her frustration with the lack of knowledge of the disability requiring the accommodations that needed to be made, which caused tension between her nursing role and her role as an educator. Her nursing role required her to base her initial actions and thought processes on an assessment of the situation followed by diagnosis of

the problem. Typically, it is only after a nurse like Beth identifies the problem through assessment that she and others develop, implement, and evaluate interventions. Beth stated that with a student with a disability under her program's current guidelines, she has to start with the interventions without completing an initial of assessment and diagnosis, which is counter to way nurses think and practice.

Beth also described an experience with a student and family member, which was litigious in nature. She admitted that a negative experience with a student with disabilities has impacted the way she views these students as a whole.

> Beth: Every time I think of students with disabilities, unfortunately, I go back to this one student whose behavior was so bizarre and so unpleasant, but you know again you think of all the modifications you've had to make for different students, and how it worked and what you might do differently. . . .

She admitted how a past negative experience affected how she worked with students with disabilities, especially when there were legal implications. She then tried to balance this account by noting the times she was successful with modifications when working with students with disabilities.

The stories that participants shared were unique involving different types of course experiences, different types of disabilities, and different expressions of students. Faculty reflections were also very individualized. As I analyzed the stories, I thought about Young's (1990) framework of oppression, and found I could visualize the faces of oppression he described woven throughout these stories. As I predicted, most faculty had not thought about their beliefs about admitting or educating nursing students with

disabilities, and were also not aware that their actions could be described as oppressive, although one participant volunteered to be a part of this study because of her beliefs. She said the following:

Joanne: Well, I have to say the reason I answered your e-mail was because I thought, "Oh, I've gotta get my belief out there to make sure that other nursing instructors of other nurses know that−that people with disabilities can really contribute to our profession," and hoped that I could−hoping your research can get out there, and other people will think about it over time and say, okay, you know, maybe I should think about it.

Personal Definition of Disability

During the initial interview, faculty members were asked to give their personal definition of disability. Most participants stated they hadn't thought much about how they would define disability. Because of these statements, I brought each participant's transcribed definition to the second interview for the participant's review. I noted any changes in the definitions in the second transcribed interviews, although most faculty members made little to no change from their original definitions. When reviewing these definitions, I was able to see themes or similarities in how faculty understood the meaning of disability. I grouped these definitions together. In the following sections, I describe themes, and then provide actual supporting statements given by the participant that define their understanding of disability.

Outside of the Normal

Several faculty members defined disability as being different than normal. Other phrases they used included “keeps you from being in the mainstream”; “cannot complete the skills”; “cannot complete the expectations.” Some faculty described disability from a broad perspective; others described disability from a nursing student framework. These participants focused on what students were not able to perform related to skills required in a nursing program.

Definitions

Jane: I think I’d probably define it broadly that it’s any physical, emotional, mental problem or focus area that keeps you from being in the mainstream, and do things like people who do not have those types of issues.

Marcia: Well, you know that’s a tough one because there are so many definitions of what normal is. I guess probably−a disability in my definition would include somebody who cannot complete the skills that are expected of them, whether that means communication or the physical skills or the learning, like we talked about the learning disabilities, so someone who cannot complete the expectations that are outlined within whatever program that they are in.

In the second interview, Marcia added,

I believe it truly is someone who is outside of the norm in completing skills. And I hate using that word *norm−normal*−but it is someone who wouldn’t be able to complete the expectations that are expected of anybody else in the program.

Kay: I would say a disability is a difference in some ability compared to the total say general population−physically, psychologically, learning disabilities, physical disabilities−not necessarily visible but somehow it impacts human function in some way.

Vicki: I guess I think of disability as being a deficiency in some physical or mental capacity.

In the second interview, Vicki expanded on her original definition.

Well, I guess the one thing I would react to in that definition is the word *deficiency* because it seems like it has a negative connotation. But when I think of disability, I'm trying to think that if there's any examples that I can think of where it's normal−where there isn't something that's lacking like vision, hearing, dexterity, so yeah, you know I'm not sure if I can come up with a different word that's not−not negative. I guess, well alteration, alteration could be non-negative sounding−instead of a deficiency, an alteration.

Alice: I am using a disability a lot, but maybe you don't ever really think of what the term is or how to define it, but to me, a disability is something that causes you to be or feel less than the population that surrounds you. So to me, a disability doesn't really have to be something that gets labeled, but sometimes people feel that they are disabled in comparison to other people around them. And I guess that's the definition I would use.

The definitions of *deficiency* either imply or include the words *normal* and *difference*. These faculty members define *disability* as different from normal. Marcia and

Vicki seemed to struggle with the words *normal* and *deficiency* and felt these terms sounded negative, but they had difficulty changing their definition. I believe this is because of the desire they have to work with students with disabilities and have them be successful, and the above definitions created tension with their desire. They didn't want to sound negative, but recognized that they were.

Most participants stated that they had not thought about a definition of disability. Their definitions emerge from or support what Oliver (1990) identifies as the medical model of disability. A disability resides within the individual, and, as stated earlier, the remedy is cure or normalization of the individual. This is evident in the definitions as participants used the words *normal*, *mainstream*, and *deficiency*.

Nursing curricula have at their origins underpinnings of the medical model (Bevis & Watson, 2000; Clark, 2005). A focus on a patient's disease process with the desired goal of wellness for the patient is a common theme in nursing curricula. A foundational area of prenursing curricula is science courses, which are typically medical in origin and emphasis. Minimally, most nursing students take five science courses as a pre-requisite to a nursing program (I personally took eleven science courses) and then often take more at the graduate level in preparation for an advanced nursing degree. These courses are often taught by non-nursing faculty, which keeps the material within a medical model framework. Could this foundation in the sciences taught from the medical model shape participants' beliefs that disability denotes different or not normal?

One focus of nursing curricula is teaching students to care for individuals and families holistically across the life span. Nurses believe that the concepts health and

illness are defined by the individual patient and are subjective concepts. Textbooks still give standard definitions of health and illness, but these must be individualized to each patient based on the patient's personal definitions. The Nursing Process, which describes how nurses think and care for patients, emphasizes the nurse's role as caring for the response of the individual to illness (Potter & Perry, 2009). For example, a physician would order an antibiotic to treat the infection of a patient with pneumonia. The nurse would treat the individual's response to the pneumonia. If such a patient has difficulty breathing, the nurse would raise the head of the bed, assess the respiratory status, encourage fluids, and administer oxygen as needed.

But not every patient with pneumonia reacts in the same way; each individual response is unique and has value. These responses to an illness by a patient are not considered abnormal by nurses, but nursing faculty have defined what it means to be a person with a disability, which is often a response to an illness or injury, objectively as not normal; the response to the disability is not necessarily seen as unique or as having value. There is a difference between how nurses view patients as unique individuals and how nurses view persons with disabilities when *disability* is defined as different or abnormal.

Very few to no nursing curricula address individuals that experience disabilities and the nurse's role caring for the response of the individual to the disability. In a widely used textbook used in nursing curriculum, the concept of disability is mentioned briefly in the chapter related to rehabilitation concepts (Ignatavicus & Workman, 2010). Framing disability in terms of rehabilitation suggests that any particular disability is not normal

and needs to be cured or at least regarded as a deficit. Nurses have not been educated from a nursing process perspective or from any perspective that emphasizes caring for persons with disabilities. These nurses are now nursing faculty and continue to have curricula available to them that de-emphasize caring for patients with disabilities.

Nursing faculty, through education or career experiences, have not been required to reflect on their beliefs about disability, from either a nursing practice or faculty perspective. This was evident in my interviews.

Unable to Perform/Function

In their definitions, faculty mentioned expectations related to skills required for students to perform well in a nursing program. During the interview, faculty often referred to psychomotor skills related to the Minnesota State Board of Nursing Ability (MBNA) requirements. To be licensed by the State Board of Nursing, nursing programs must evaluate students with respect to many different abilities. Abilities are defined broadly and the successful demonstration of these abilities is believed to be essential and is a graduation requirement. Nursing programs can choose the evaluation method that each believes best meets the ability in question; often psychomotor skills are used as a measure. An example of an ability is "to promote oxygenation." In order to accomplish this task, students could teach patients how to cough and breathe deeply.

Programs are encouraged to measure such abilities using learning activities already present in the curricula, and traditionally, nursing programs include many psychomotor skills that can conveniently be used to measure these abilities. The MBNA requirements may be why participants focused on nursing skills in their definitions.

Participants were questioned about designing curricula around MBNA requirements so that those requirements could be met without using psychomotor skills to measure ability. I felt resistance to this suggestion that was related to the need for faculty buy-in and the amount of work this would take for the small number of students with disabilities.

Definitions

Susan: . . . any physical, intellectual, psychological entity that may interfere with the person's ability to perform something.

Marcia: . . . somebody who cannot complete the skills that are expected of them, whether that means communication or the physical skills or the learning, like we talked about the learning disabilities, so someone who cannot complete the expectations that are outlined within whatever program that they are in.

Kay: . . . it's some difference in function.

Beth: I tend to think of it more an impairment of physical abilities, although with teaching here I would say it is any cognitive, psychomotor impairment that affects the ability to function in the role of a person that's selected.

These definitions imply the inability to function, perform, or complete the expectations or skills required by the curriculum and/or the nursing faculty. Individual faculty expectations are transferred to curricular expectations and may affect admitting and educating students with disabilities. These faculty members define disability using performance as criteria. Typically, nursing curricula are heavily performance or skills based, so I am not surprised that performance would be included in a definition. Nursing curricula include the refinement and demonstration of skills required for successful

performance in labs and clinical settings; they have been developed for the able-bodied student who can perform or function under what is considered normal circumstances.

Once again, these definitions refer to a medical model belief system. Disability is described as a condition of the student that makes her unable to perform or function. The reason a student with a disability cannot perform or function in a nursing program is that the curriculum has been developed for, and suits an environment that supports the able-bodied student. I believe that much of this is related to tradition. Historically, nursing programs have always been performance based. I believe part of it is related to how faculty decided to define and evaluate state board abilities. Programs have not considered how to change their curricula and environment to allow access for all students, but instead consider disability an individual problem, such as an inability to perform or function.

Broad-based definitions

Many participants defined disability broadly, including physical, intellectual, and psycho-social impairments. Participants may have included these in their definitions since traditionally the nursing role has required that nurses be of sound body, mind, and spirit. The nursing role requires a level of intellect that allows students to be successful in course work, to think critically, and pass the national nursing exam to become a licensed practitioner. All participants believed that cognitive ability was necessary to be a nurse. Many participants also discussed the difficulty faced when working with students that had undiagnosed or untreated psychological impairments. This came up in every interview as an area of concern for nursing faculty. All participants believed that nurses

need to be mentally healthy in this professional role. They also noted the ability to physically care for patients and all that this entails. The definitions related below support a holistic view of disability which as defined by nursing considers the body, mind, and spirit of an individual.

Definitions

> Susan: . . . any physical, intellectual, psychological entity that might interfere with the person's ability to perform something.
>
> Jane: . . . it's any physical, emotional, mental problem or focus area that keeps you from being in the mainstream and do things like people who do not have those types of issues.
>
> Wendy: So there's some variety of factors or characteristics that together says that it requires more effort and accommodations in order to achieve the same goals as somebody who has been determined to be (and I hate to use this word) but a whole person or a physically, emotionally, spiritually, psychologically well person.
>
> Kay: I would say a disability is a difference in some ability compared to the total say general population−physically, psychologically, learning disabilities, physical disabilities−not necessarily visible but somehow it impacts human function in some way.
>
> Beth: I tend to think of it more an impairment of physical abilities, although with teaching here I would say it is any cognitive, psychomotor impairment that affects the ability to function in the role of a person that's selected.

Beth added psychological barriers in her second interview:

Beth: . . . might be barriers to learning which could be physical, cognitive, and psychomotor or I'd say psychological.

Vicki: I guess I think of disability as being a deficiency in some physical or mental capacity.

Students are also exposed to holistic terminology in nursing curriculum when learning about holistic care of patients. Nurses are not only expected to care for patients' bodies, but their minds, relationships, and spirits as well. The above definitions would imply that same holism is needed by a nurse to care for a patient holistically. Nurses would need to have a sound body, mind, and spirit to care for a patient's body, mind, and spirit. How does this belief intersect with the actual practice of nursing? The nursing profession and health care institutions are aware of the benefits of having a practitioner that understands that patients need to be cared for at more than a superficial level. So nurses not only need to have sound bodies, minds, and spirits, but they also should be similar to the patient for whom they care.

This is evident in the desire of nursing programs to recruit diverse nursing students to care for the increasingly diverse patient populations with their unique needs based on their cultural heritage. This is also evident in the desire by healthcare institutions to hire bilingual nurses. Would it not also be helpful for the population of patients with disabilities to have a nurse who understands what it is like to live with a disability, a nurse with a shared disability identity? There are reports of educational environments being enriched when students and nurses without disabilities work

alongside others who have disabilities (Evans, 2005). Environments may be even richer when nurses with disabilities work with peers and students who share their experiences. Nursing programs have not made an effort to recruit students with disabilities in the way they have students diverse in other ways; in fact, admission criteria would suggest just the opposite.

Link Disability with Requiring an Accommodation

The below definitions include requiring an accommodation as part of the participants definition of disability.

Definitions

Susan: . . . that might require an accommodation to perform or accomplish something.

Joanne: . . . the first thing I think of is in relation to education and particularly nursing education that a disability is something that requires some sort of accommodation or assistance in learning.

Wendy: So there's some variety of factors or characteristics that together says that it requires more effort and accommodations in order to achieve the same goals as somebody who has been determined to be (and I hate to use this word) but a whole person or a physically, emotionally, spiritually, psychologically well person.

These are interesting definitions, as not all students with disabilities require accommodations. Many have self-adapted to the learning environment and are able to function independent of accommodations. This may not have been part of the

participants' experiences, and this may be why their definitions include references to accommodations. The belief in the need for accommodations could also affect beliefs about a nursing student with a disability being successful (or unsuccessful) in the nursing role.

The following definition notes that a person with a disability could use an accommodation to make an adaption to his or her environment. This puts the responsibility on the individual to adapt to the environment.

> Mary: . . . I think that there are physical and hidden disabilities, and I think that there's lots of accommodations out there now that a person that has one of these could probably make an adaptation to their personal and work life so that they would be able to set some really nice goals and suit them very effectively.

Disability is defined by most participants as being outside of the normal population, unable to perform or function in some way, and requiring accommodations, and is defined broadly, including physical, intellectual, and psycho-social issues. These definitions support a belief in the medical model, in that the disability resides within the individual; it is an individual's problem. These definitions supporting the medical model may inform nursing faculty practices and may result in the oppression of nursing students with disabilities.

The Social and Medical Models

During the second interviews, I explained briefly to the participants what it meant to define *disability* based on a medial model as well as based on a social model. In this

section, following the explanation of the models, I discuss the participants' responses to these models as it relates to their definitions of disability.

> Diane: The medical model looks at disability as disability resides within the individual. So the individual has a disability because they can't see or they can't hear and that's the individual's issue. They have the disability and it resides in them. The social model would look at it and say, yes the students have some type of impairment, they can't see, they can't hear, they don't have fingers or whatever, but the reason why they're having difficulty is because of their environment. So they would say I would do fine in this society if the environment was set up as such so I could be a participant, but it's not my disability, it's the environment that's causing the issue. Do you resonate more towards one of those models or another – do you think your definition resonates towards one of those types of models?

I waited until the second interview to introduce the models, since I didn't want to affect the participants' definitions of disability based on the model with which they felt aligned. I anticipated that most nursing faculty would like to believe that they are socially conscious and would desire to resonate with the social model both as nurses and as faculty members. Eight of the 10 participants were not aware of the two models I described to them.

When disability is defined using a medical model, the underlying belief is that the disability resides within the individual; the cause of the problem is a functional limitation. If disability is defined from within a social model framework, the problem of disability

exists, but does not reside in the individual; rather, it lies within the environment (Oliver, 1990). This framework assumes that the environment in which a person with a disability evolves and acts is not barrier free. After reviewing and revising if desired their definition of disability given during the first interview, I briefly explained the models and asked the participants to discuss which model they thought their definition of disability supported.

After reflecting on their definitions, some participants believed that their definitions were closer to the social model, some to the medical model, and some saw their definitions as a combination. For example, Susan felt her definition sounded more medical:

> Well, I think the definition sounds more medical because I think it emphasized that the disability resides with the person as you just described it, and that person needs some kind of an accommodation to do something. So if I'm in a wheelchair, the problem is that you have to put in a ramp−accessible doors. I, I mean I guess I talked about it, I think about it first from the individual's perspective. . . . it's a whole different−it's a reframing of how you look at it. . . . Then your assumption is the work or whatever the activity is to be performed can be performed by anyone. You know, if you take it from the social side, it doesn't matter that you're blind. How would I reframe the environment to allow you to do X to be successful when you can't see? That's where I am having a little difficulty, without having someone else do that in that example. . . . That's interesting. And, and I think we do come from a medical model−nursing is linked to healthcare. We think about the function, the delegated medical task, or you know whatever

you define them at−the work that nurses do−that's our world and so you know, as you're talking, I'm immediately thinking about examples of work in nursing. . . . So, could that person do X, Y or Z and it's−my images are nursing work.

Diane: . . . do you think personally your definition resonates with the medical model?

Susan: I don't think entirely they do. Because I think when we talked in March, I don't know, I think I'm pretty open-minded about who could be a nurse and how accommodations could be made having another person to do something. I don't see that as being unreasonable or impossible. . . . Yeah, that's interesting, I mean maybe I−maybe I responded that way not knowing that there was a social definition and a medical definition or whatever.

Susan recognized her definition was more closely aligned with the medical model. She also immediately began thinking about how the application of a social model would work for nursing. She thought about a blind person and what might have to be adapted in the environment for a blind nurse to be successful. She had difficulty, but I believe this difficulty came from her thinking about the work of nursing in a traditional framework, and not in the many jobs a blind nurse could perform.

She appeared troubled by her definition resonating with the medical model stating that in our initial interview she was quite open-minded about who could become a nurse and how accommodations could be made. This statement implies her belief that working in a medical model framework may limit nursing students with disabilities. She wondered if the reason her definition sounded more medical was because of her lack of knowledge

of a social model. It seems that her definition of disability and her belief about her openness to working with students with disabilities are in tension. Would this lack of awareness of the social model affect how Susan would consider admitting and educating nursing students with disabilities? Would Susan consider the nursing school environment and curriculum to be barriers and work to change these environments if she was not aware that doing so might help students with disabilities succeed? I believe that, if nursing programs teach nursing using a medical model framework of disability, the nursing program environment and curriculum would be considered barriers for a student with a disability.

Kay believed that her experiences at work resonated with the medical model, but her personal beliefs align more closely to the social model.

> Kay: I think my experience has been definitely more towards the medical model. Um−and specifically my experience here.
>
> Diane: Like your personal experience or your experience with students?
>
> Kay: Yes, both, both that um−yeah−it's your problem and you have to figure out a way to deal with it and it's your responsibility to, like, if a student needs to have accommodations with testing then it's the student's responsibility to let us know about that. It's not our responsibility to find out to make any sort of changes.
>
> Diane: What do you believe−do you have a belief that it should be one way or the other?
>
> Kay: I think it should be more social model. I have spent time in a disability community and have observed that is their perspective. And I didn't understand

> that at first and then I went out there and then it made sense to me. But um, yeah, that's, that's the thing that if you're aware of the disabilities and I think the social model downplays the difference, and the medical model emphasizes that that individual is different from anybody else. So it's much more ostracizing and then you get into who do you tell about and who do you not tell about your disability. So it's a, I think by and large there's, what I've seen is definitely much more medical model.

Kay described the medical model as being the mode of operation for both her as a nursing faculty and for nursing students. Her personal experience with disability in her work environment required her to come up with solutions to the physical issues that impacted her in her role as faculty member−she had a disability; she was responsible for coming up with the solution. Students are also required to initiate a meeting with the disability coordinator before accommodations can be made; faculty cannot make accommodations without this. The disability resides within the student; the obligation to seek accommodation for the disability lies fist with the student. She also talked about being different and how the social model would neutralize the "difference" that disabled people experience. The experience of feeling different, she maintained, has an effect on disclosure. Kay was not alone in her concern; other faculty discussed disclosure and how difficult it is when students do not disclose their disabilities.

Because of the design of nursing program curricula, the possibility of complex accommodations exists for each student with a disability. This would not be true if nursing curricula were designed from the beginning using a social model framework.

Accommodations such as making equipment available and providing licensed personnel take time and money to implement. Modifying a nursing curriculum and program to allow those with disabilities to be successful without complex accommodations would also require an enormous amount of work and effort. The faculty I interviewed wondered if this would be cost effective given the few students with disabilities presently interested or enrolled in nursing programs. Is the non-disability-friendly educational nursing environment the reason why students with disabilities are not choosing nursing for a career?

In the mid 1980s, early in my nursing career, I worked as a public health nurse on the East Coast and one of my clients was a quadriplegic attending and living at a state college. This college chose to be environmentally accessible so that even quadriplegics could live on campus and attend classes. Many students with disabilities attended this college because it implemented the social model framework. I believe this would happen in nursing as well. If a nursing program's curriculum was known to be designed using a social model framework, I believe nursing students with disabilities would choose to attend this university.

Vicki described what she believed as insurmountable barriers to adapting the environment and felt a stronger connection to the medical model.

> Vicki: Yeah, I think I'd probably resonate with the medical model because when you say that social I'm thinking, "Okay, so what in the environment for someone who's visually handicapped−what would that look like if the environment needed to respond to that so that, you know, every let's say stop sign would have let's say

> a sound so that the people that weren't able to see the stop sign would have an auditory, do you know what I mean and just um, yeah, I don't know if I could go there. It sounds like chaos.

Vicki viewed the social model framework as applying very broadly and possibly involving the environment outside of the academic setting. I had asked her to consider her definition of disability, but she moved from her definition of disability to stop signs. I did not redirect her to consider the nursing curriculum environment when considering the two frameworks so I am not sure how she would respond to such redirection. She was very certain that this model would not work in the day-to-day environment that a person with a disability has to maneuver−that it would be chaos. She would support the medical model, identifying disability as an individual issue not an environment issue.

Jane felt her definition resonated with the social model, but believed that nursing professionals, especially the hospital-based nurse were closer to the medical model.

> Jane: Yeah, I, I think probably a little closer to the social model. It's a little, I mean when you talk about context of things and it's almost like the world−I mean, I think if you think back historically it was the survival of the fittest. And so society was formed around the strong people without disabilities because that's what survived, you know . . . the animals that were weaker and the people that were weaker would die; they wouldn't survive. And so now we have the medical capability to help people, you know, live a lot longer and help people, you know, survive and that kind of thing. So it seems like, and it makes sense to me, that when you look at it from a social context that because the great masses have−you

know, don't have that hearing or the seeing disability−that's the way the world is and it's kind of like, deal with it, you know.

Jane contemplated about the historical absence of people with disabilities because of the survival of the fittest. Advances in medicine changed survival rates so those with disabilities did survive. Most people are still able bodied and this dictates how disability is viewed−from a medical model. The individual with the disability needs to deal with it.

Diane: But you would resonate more towards that the environment should−

Jane: I think I do, uh-huh, uh-huh.

Diane: −be adjusted to have people with disabilities be able to be more active participants in society. Is that what you think?

Jane: And I think when we talk about nursing as well, you know, nursing a lot of times, um, resonates through the medical model. A nurse is a bedside nurse, an ICU nurse, takes care of the patients with all the critical care−all the−you know a nurse is not a parish nurse or a community health nurse or a−you know when you think about nursing in that kind of realm so then of course people are like, well nurses can't work as a nurse if they're disabled because they think of nurses. . . . Nursing is the medical model.

Jane believed that when the public thinks about nursing, they commonly have the hospital-based nurse in mind. The Johnson and Johnson advertising campaign pictures a nurse with scrubs and a stethoscope around his/her neck which is representative of hospital based nursing. Television shows depict nurses in highly technical roles. Often print and electronic media focus on the hospital-based nurse. The public's image of

nursing shows an able-bodied nurse working in a hospital environment. This image has shifted over the last decade to include men as well as racially and ethnically diverse nurses. However, this image has not shifted to include a nurse with a disability portrayed as successful in the nursing role. The public's narrow definition of who a nurse is and what a nurse does could impact a student with a disability considering a nursing career, patients being comfortable with a nurse with disabilities caring for them, and perhaps the faculty of a nursing program believing that a nurse with a disability has value in the nursing profession.

Joanne believed her definition resonated more with a social model.

> Joanne: I think more of a social model because I think, like I told you before, that just because someone has a disability doesn't mean that they can't be a nurse but the way that most nursing programs are set up, it doesn't allow for people with those disabilities to become nurses because we continually say they have to be able to do X, Y and Z. Even though people who are already nurses who then become disabled and can't do X, Y and Z, they can still stay nurses. So to me, yeah it's more of a social definition where the environment needs to be "tweaked" in order for them to achieve that goal.

She expressed that the foundations of nursing programs are barriers for students with disabilities. She argued that if practicing nurses who became disabled were allowed to continue practicing nursing, the environment in nursing programs would likely change to allow students with disabilities to be successful as well.

Marcia, Wendy, Beth, and Mary felt their definitions were related to both models.

> Marcia: I think the definition that I have there is probably closer to a medical model−not being able to complete the skills−and yet we adapt our environment. We do things like provide amplified hearing for people who don't hear as well for the stethoscope. And so, those are pieces of the environment that we are changing or modifying so we realize that there is a social piece to that−that environmental piece−probably strictly if you just look at the definition that I gave you, its probably more a medical model, but I do think that there is an extensive amount of that social piece, that environmental piece that plays into people with disabilities. I don't think we can get around it, especially with the American Disabilities−the American with Disabilities Act−because they know that−they definitely say the environment is a key piece in a disability.

Marcia included in her response the ADA's mandate to consider environment when thinking about disabilities. Ramps, elevators, and curbs were constructed based on ADA laws. Specific laws, such as those that have made spaces accessible to people with disabilities, have an environmental focus. Institutions are required to manipulate the environment for accessibility, but not necessarily for success. For example, a nursing student may be given access to an elevator to reach a nursing laboratory, but then there may be no further altering of the environment; only able-bodied student can function well in the space and fulfill lab work.

Wendy: I would think it's a combination. I think it resides within the individual, but it is not unique to, I mean that individual isn't the only one that has to take that disability into consideration. Other individuals that they interact with have to take that in so in terms of socially with other people it's going to have an impact on their relationship. The environment, how the environment is set up is going to come back and have an impact on that individual. And perhaps even that individual is going to, in the ultimate, is going to have an impact on the environment because the environment is going to need to change in order for that individual to be most successful. So I don't think it's a pure model. I don't think it's pure medical or purely social. I think it's a combination. And I do believe that a certain amount is within the individual. That's not to say that it's the individual that has to deal with it only. Everybody has to be aware of it to help the communication−two-way communication, to have whatever the working environment is to be successful, not only for that individual but for the organization that the individual works with. So I think it's a combination of the medical view and the social view.

Diane: Yeah, in the current model.

Wendy: There's nothing−I think it's partly because I come at nursing from−it's a lot of shades of gray. There is so little in nursing and healthcare that is purely black and white. And if we were to say that it's purely a medical model than we're saying it's truly black and white. There are certain parameters that are−they're just there−but if you look at it in terms of what happens in terms of

> how the individual is having to adapt or live with it, then that−that kind of like the dropping a water−or something into a pool and it just kinds of spreads out. That disability or that limitation or whatever way you want to call about it, that alteration from what we consider the standard norm is going to have an impact out there and then it also kind of reverberates and comes back so it's kind of like an echoey-type thing.

Wendy believed in a combination of the two models, that disability resides within the individual, and that faculty and the environment have roles in responding to the disability. The environment may impact the student's ability to be successful and may have to change based on student's needs. She pictured the student with the disability having an impact on the environment, and this impact having a corresponding effect on the student with the disability. For this process to occur successfully, Wendy stressed the importance of communication between the student, the faculty, and the organization.

Unlike Wendy, Mary resonated with a particular model depending on the disability issue.

> Mary: You know, when I used to have to work with the head of the disabilities office, I mean, she was really good at presenting those two models and I think sometimes, depending on the disability and what kind of issue was at hand I might swing between those two models. So maybe I'm a little bit more of a hybrid, but I do think that there are times that sometimes the disability creates such a deficit that certain types of work might not be possible for the student. And, and I'm willing to say that. And I really said if you come slowly out of this

> more social model that, that can make you cringe. But I think that you have to be able to use both those things because sometimes you meet students that, you know, if you have a student that's had a severe head injury and they no longer had a memory, short-term memory, they're probably not going to be able to have enough critical decision-making skills to be placed into an acute patient care environment.

Mary had a good understanding of the two models; she had heard them presented at her place of employment. She stated that her beliefs would vary depending on the type of disability involved. For example, she would believe a student with a severe head injury would not be successful in nursing, even if the environment were accessible and designed using a social framework model. I agree with Mary; nurses must have certain cognitive abilities in order to think critically and do their jobs safely. Schools of nursing ensure this by requiring that applicants have a minimum grade point average for admission to the program. I believe that brain injury is complex, and that some brain-injured students succeed as nurses and some cannot. I don't think implementing or designing a curriculum around a social model framework would allow all students with disabilities to succeed. Interestingly, nursing programs that are designed around a medical model do not guarantee that all able-bodied students will be successful either.

Beth believed, like Mary, that not all students with disabilities could succeed even if the nursing program environment was modified.

> Beth: In many ways, I think I would give them equal play. Um, the environment is not necessarily friendly to disabled people. I remember when I worked for the

> American Rehab Foundation back in the late 60s; that was when they pushed through the legislation to get curb cuts and bathrooms accessible to handicaps and the whole issue then was the environment, needs to be modified, you can't assume, you know that it's a−it will fit the needs or the abilities of everybody. So, but I think, I think if you from a perspective of barriers that don't need to be there which could be insurance, it could be all sorts of things, I think the environment plays a huge part−I'm thinking socio-political. You know, just thinking of where we just had Minnesota had cut funding for people for electric wheelchairs and it was like−well they can't pay for them themselves so if you don't allow them to have that, they're not really mobile out in the community. So you then, you make the person more disabled, or the environment is more disabled, that could, you could say. So in many ways, I think that they have an equal place because it's both internal and external.

Beth viewed environment from a systems level; she agreed that barriers exist, but noted that barriers go beyond the internal environment of a nursing curriculum and extend to the socio-political arena. She also believed that manipulating the environment would not necessarily allow access to all those with disabilities, a belief similar to the one Mary voiced.

If I had not asked participants to consider their definitions in terms of both the medial and the social model, their definitions would have largely reflected the medical model. Even though some participants were able to state that their definitions seem more aligned with the medical model, most had difficulty stating this, and added the social

aspect within their explanation. I believe this is because nursing is evolving and striving to become a more socially conscious profession. Globalization has increased nurses' awareness of social issues that affect the health care of individuals such as poverty, race, and gender. I think nursing faculty struggled with thinking about disability from the social model because disability has not been included as part of this discussion.

Using a model to frame beliefs helped participants think more deeply about disability than they did when offering their original definitions. As stated previously, prior to participating in this study, most had not heard of these models, or even thought much about their definitions of disability. Perhaps the time between the two interviews allowed for reflection; it may have been the models introduced that encouraged participants to contemplate beliefs. Perhaps just taking some time to think about disability intentionally facilitated participants to move beyond their initial responses and to think about disability more broadly.

Chapter Four: Admission Criteria, Educational and Faculty Experience

In this chapter, I review program admission criteria statements with participants. I have included themes that were discovered during the analysis of transcribed data. Themes related to safety, both students and patients; the national licensing exam; discussion of post graduation employment; and nursing faculty aging and disability are discussed in this chapter.

Admission Criteria Statements

As noted in the review of the literature, many schools of nursing have developed admission criteria statements related to functional ability either in response to working with a student with disabilities or to avoid the possibility of a student with disabilities meeting the criteria and applying to the nursing program (Davidson, 1994; Fritsma, et al., 1996; Katz, et al., 2004; Persaud & Leedom, 2002; Weatherby & Moran, 1989). Statements included phrases such *essential qualifications, essential behaviors,* or *essential functions*. I asked participants if they had any documents that discussed specific admission criteria or statements related to functional abilities that they give to students during the admission process for nursing. The participants' responses varied. If participants' programs did use criteria, documents were not readily available and most were obtained post interview. Most programs had written statements, but they were used quite differently. I obtained specific program documents after the first interview and brought them to the second interview for participants to review and respond to.

Susan stated that her program developed a statement of attributes or activities that nurses need to demonstrate. It is given to students that declare nursing as a major. The statement ends with a request for students to seek accommodations if there is anything they believe they may have trouble completing. The statement is designed to encourage students to be proactive; it is not to be used as a screening tool for admission.

Susan was the only participant who discussed using an attribute or activities statement as a means of helping students be proactive in seeking accommodations. During their interviews, many participants discussed how helpful it was to know in advance that a student would need accommodations, especially in the clinical setting where faculty need to use creative methods to give students with disabilities similar experiences. From personal experience, I know that the Office of Disabilities is very helpful with accommodations in a classroom setting. Nursing faculty were left to design and create the accommodations needed in a nursing lab or clinical setting. Depending on the type of disability, this could be a time-consuming process. Examples include finding and ordering modified equipment; researching and purchasing computer simulations to offer similar experiences to those students unable to manipulate equipment; meeting with the institution's management to make them aware of the student with disabilities coming to their unit; looking closely at clinical assignments to be able to give a student with disabilities the best learning experience possible; researching literature to see what other nursing programs have done; reviewing the ADA and asking once again, "Is this a reasonable accommodation?"; and calling "experts" from nursing for assistance in all of the above.

Being proactive allows the nursing program time to accomplish any or all of the above activities. Proactive programs like this one may be viewed positively, not simply as reacting to students with disabilities. The efforts of the program to be proactive and giving itself time to create accommodations demonstrates a positive attitude toward working with students with disabilities. The program, however, still operates under the medical model of disability; that is, it focuses on developing accommodations rather than modifying the environment. The school did not use the title "admission criteria" for their statement, which to some may seem disability friendly. It might be argued that having any statement referring to functional abilities is a barrier; I believe the intentions of the statement were meant to encourage student success, and the faculty did not perceive it as a barrier.

Marcia researched the ADA as well as other nursing programs for assistance in formulating new admission criteria. She stated these sources offered little information about or assistance with creating these documents. In response to a student with a hearing disability interested in the nursing program, Marcia's program created a limited policy stating what was required of the student physically to be admitted into the program. Marcia described the process this way:

> Marcia: You know, it had come about−I think the majority of it had come about, we had the conversation about students with a hearing disability and it was a very minor hearing disability, but we were concerned about them not being able to hear blood pressures or you know, monitors, or something. And it wasn't even a student that we had admitted. It was

> someone that had been interested in the program. And so we, just faculty came together, and there were only two of us that came together and said, "Well these are some concerns that we have. These are some skills that must be completed. And mostly it's the physical disability component of the listings−must be able to walk or stand−those kinds of things. It's a very limited policy, but, you know, it was very interesting to me because we did some research on it at that point and looked at the American with Disabilities Act as well as looking for any research or what other nursing programs were doing, and there's very limited information out there.

Marcia stated that all of the program's syllabi gave expectations of the types of skills that students would need to master in order to complete the courses. The syllabi also states the department will work with the student on a documented disability.

> Marcia: We really fortunately, knock on wood, wherever the wood is, we really haven't come across students who have had significant physical disabilities that wanted to come into the program that we have had to use that as a gatekeeper. But I'm sure that we would, I mean, if at a certain point students are not able to fulfill some of those skills, we would use it as either something to steer them away or something to say to them that this is going to be very difficult for you and you really need to think about this as a piece of your future life.

Marcia stated that part of the admission process entailed getting a statement from the applying student's physician indicating that the student could lift a specified weight and was in good physical health. Marcia's statement "That would be something that we

would fall back on−that you cannot lift; that mobility is much less, and we're not sure that we can accommodate that" referred to progression issues if a student were to become disabled during the program.

Marcia's program developed a statement in reaction to the possibility of a student with a hearing disability applying to the program. Program faculty looked for help developing this statement and found very little. This seems to be a frustration for many nursing educators. For example, while attending a national nursing conference, I sat in on a session whose topic was nursing students with disabilities. During the question and answer period of one session, nursing faculty conference participants asked numerous questions related to educating nursing students with disabilities. I was disappointed with the lack of clarity of the panel members' responses, as was the audience. Even though the percentage of nursing students with disabilities is relatively small, each program that works with these students has many questions, concerns, and is asking for information and direction. If they cannot find help, one response is for them to create reactionary admission policies that can be used as gate-keeping tools to screen out students with disabilities.

During the initial interview, Jane mentioned that she did not know if her program had an admission criteria policy. She believed that, were a student with a disability to apply, the admissions committee would have a discussion about admitting this student and would address how they were "going to manage that and is it in our mission or philosophy to do that."

During the second interview, after reviewing her program's admission criteria that I had found, Jane stated that it was good, insofar as it covered the program and reduces the need to deal with an applicant with a disability, "but it is a very huge block for people who have a disability." She felt it was a reactionary document put in place to protect the facility.

Jane hadn't been aware that her program had such a document, even though she was a member of the admissions committee for the nursing department. This document had been developed in response to working with a student with disabilities in this nursing program. She felt the document was incomplete, since it did not encourage students to seek accommodations if they are unable to meet the performance criteria. She wished the document included such encouragement.

Vicki referred to her program's admission criteria statement and the responsibility of students to be aware of the accommodations that they would need.

> Vicki: It gives both of us direction but it gives the individual whose coming in direction about what the expectations are and then obviously, you know, if they can meet the expectations or can find accommodations about how to you know, get around the objectives, you know, that's kind of on them.

During the second interview, Vicki reflected on the origin of the document. Admission to her nursing program was based on grade point average only, and a student with a significant physical disability had been admitted based on this criterion. The program then developed an admission criteria document that enumerated physical ability requirements to avoid having another student advance through the admission process as

far as this student had. Vicki's colleagues developed an admission criteria document in response to working with a student with disabilities in their nursing program.

Wendy stated that she did not believe that her program had such a statement, and then said, "I think that could circumvent some issues in terms of the admission process." She went on to say that a statement like that would be helpful if a student, once accepted, was not able to perform to the criteria listed on the statement. Wendy described what the program might say to the student:

> Wendy: This is what you came in under and we're noticing that you go beyond that. You're able to do more than what we said, or we're seeing that there are some limitations that perhaps were not clear at the time of the admissions.

According to Wendy, the program would not use the admission criteria as a gate-keeper, but would use it to list capabilities the student would need to hone to be successful. Wendy noted that they could then tell a student ". . . like you need to have a certain level hearing acuity, whether without aids or with aids you need to have that kind of thing in order to be successful." She stated if a student could not be successful after obtaining some type of assistance, her program would inform the student that the program might not be the right place for this student.

I believe Vicki and Wendy were referring to students who choose not to disclose their disabilities when applying to a nursing program. Many programs admit students based on grade point average only, and faculty may physically never meet a student prior to admitting him or her to the program. Having an admissions criteria document would give these kinds of programs some power after the admission process to deny or rescind

acceptance based on the admission criteria statement. Furthermore, while students are not required to disclose that they have disabilities when applying for a nursing program, programs can require that they state whether they can meet certain physical mobility and sensory requirements that are part of the admissions criteria. Establishing these requirements as normal or necessary for admission is a form of oppression−cultural imperialism. By using an admission criteria statement, such programs in essence require students to disclose that they have physical disabilities.

In response to questions related to admission criteria, Alice stated, "I think they self-select. I think my experience with those students who have a disability−I think they would self-select out." This participant had experience working in another nursing program that had specific physical requirements as part of their admission criteria. Alice went on to describe the following:

> Alice: So what they had as part of their admission process was they put everyone through a physical ability set of things, so you had to do so many things with weights, you had to crawl on the floor, you had all these different tests that were done with the admissions process. I never liked it, myself, because I always went back to what my own beliefs are in it, and I guess if it doesn't−I think people can still be nurses and they can be tracked into different areas of nursing, even if they can't lift or even if they have a knee disability that they're not able to do certain things. So, doing those physical exams in order to get admitted to the school of nursing always went into contradiction as to my belief system of people and their

> capacity to provide nursing care, and so I've worked really hard over the last three years and we finally got rid of that.

Alice held beliefs about the role of the nurse that led her to create system changes in a nursing program. She believed some nursing roles do not require the physical abilities that nursing admission criteria and nursing curriculum often require. This system change would admit students with physical disabilities to this nursing program. I wonder if this change in admission criteria also changed the beliefs of program faculty about educating a student with physical disabilities.

Unlike Alice, many participants did not report encountering students who self-selected out of nursing or were self-aware enough to know what accommodations they would need to succeed in a nursing program. It might be that student self-awareness is only part of the issue; student's lack of awareness of the requirements of the nursing curriculum and lack of knowledge about the nursing role may contribute to not understanding what accommodations would be needed in a nursing program.

After reviewing the admission document of her program, Joanne stated that it was quite outdated and didn't reflect the industry at this point.

> Joanne: It's old−this is old−it's still in place, but it's old because as far as I know the Board of Nursing does not have anything anymore related to being able to lift up to 50 pounds. . . Because, I have a student who's not doing anything and she's still being successful. So, I would say by looking at it, yes I think that is outdated and doesn't reflect the industry at this point.

The admission criteria document guiding students into Joanne's program lists physical requirements that could be used as gate-keepers for admission or progression in nursing programs and do not match industry requirements for physical ability.

I obtained admission criteria documents related specifically to nursing from four out of the six schools that the participants represented. The other two schools had disability documents that applied generally to all programs. Several participants were not aware a document existed, or were unsure of what the document said or how it was used. One faculty member felt the document was outdated and did not reflect industry standards related to physical requirements of a nurse. Faculty who were aware of the existence of a document felt the admission criteria had a range of effects, from acting as gate-keepers to encouraging student success. After reviewing these documents with participants, only half of the participants responded with further reflection regarding the document.

What really is the purpose of functional ability or performance requirement statements? Why had participants' nursing programs felt the need to develop such statements? I believe the statements were reactive, developed in response to admitting and educating a nursing student with disabilities. Educating a nursing student with disabilities in a medical model framework of disability creates tension in the following ways. Nursing faculty who think and teach from this framework are responsible for the education of this student. The educators need to create accommodations that are individualized to the student and to the situation. This process is costly, both with respect to time and resources. Disability services at colleges and universities often have difficulty

with understanding appropriate accommodations for the laboratory and clinical setting, so faculty must design these. Minnesota Board of Nursing Abilities requirements are usually written with a physical component requirement−programs need to create accommodations so that students can meet these requirements. The program or institution might need to purchase costly equipment, adding to the sense that accommodating students with disabilities amounts to a burden.

A functional ability statement and a performance requirement are specific examples of nursing curricula defining disability from the medical model. Because this is how faculty members have been educated, it is understandable that this would be their response to admitting and educating nursing students with disabilities. However, this response perpetuates the medical model, positing that the disability resides within the individual. It does not encourage movement toward a barrier-free environment of social framework view of disability. I believe these functional ability statements used as admission criteria can discourage students with disabilities from considering nursing as a career.

Safety

The participants often discussed student and patient safety and employment although I did not pose a direct question that referred to these themes. These became interrelated themes as faculty discussed the safety of patients, the safety of nursing students, employment requirements of safe care, and the ability of students to be aware of environments in which they could safely work.

Patient Safety

All participants referred to patient safety at some point in one or both interviews. This concern centered on the fact that, during their academic programs, nursing students spend significant time caring for patients from different populations and in different situations in courses that provide practical experience. A concern for patient safety is a priority for schools of nursing while students are in the clinical setting. "Ultimately our concern is for the safety of patients that our student encounters" stated Susan. Marcia articulated a similar point:

> Marcia: I think that my concern is for the client, I mean ours is two-fold really when we're in education, we're concerned about the student. We advocate for the student. But we also have to think about the safety of our client, and if they are in a position where they are not safe and able to care for their client, I don't feel okay with that.

This statement refers to not only the safety of the patient, but the safety of the student who has a disability. Faculty may demonstrate concern for safety based on several factors. Nurses are taught to not harm patients, and to care for them. Because nursing involves human error, this does not always occur. Malpractice insurance exists for this reason and our litigious society reinforces the need for insurance. State boards of nursing that approve nursing programs exist to protect patients. Safety issues occurring with students or patients could threaten program board approval. In my study, participants discussed safety often when referring to students with physical disabilities caring for patients.

> Wendy: My first response is this gut thing−I don't think it would be in the best interest of the clients that we're trying to serve, and I don't mean the students but ultimately the patient population or the people out there that would be our clients. I don't think it would be in the best interest for them and saying that we can clearly say that we have prepared a safe, practicing individual if we did not take those into consideration. Knowing full well that all of the abilities, that if an individual chooses a practice environment, he or she may not have to use all those abilities in that practice environment, but if that individual is called upon to do that ability, they I believe have to be able to do it. They have to have been able to do it at some point in time and be able to do that.

Wendy was responding to a question related to rewriting Minnesota Board Nursing Abilities (MBNA) requirements so that all students could complete them without needing accommodations and designing them to be barrier free. In this statement, Wendy expressed the belief that the MBNA requirements should stand as presently written to ensure safe care of patients. If a nursing student could not complete the MBNA requirements, it does seem like she is referring to without accommodations, then the student should not care for patients. Making accommodations or designing MBNA requirements to be barrier free could lead to the unsafe care of patients.

Beth responded to the question related to beliefs about what should be considered appropriate accommodations for a student as follows:

> Beth: Well, you know, I think the question is always going to be safety. So, if with this accommodation the student could be successful in clinical and safe in

> clinical, I think, I don't know that we would ever think about sending somebody's sister to clinical with her. I mean, this was just when she was−the student was returning.

Again, safety was a concern. Could a student with a physical disability be safe in the clinical setting? In their stories of working with students with disabilities, faculty discussed accommodations that had been made for students with physical disabilities to ensure patient safety during clinical training in the academic setting.

I have not found studies that document that students with disabilities have more unsafe episodes with patients or that they have harmed themselves at a greater percentage than do other nursing students. I have personally witnessed many near breaks in safety in the clinical setting, instances during which I as a faculty stopped the error before it occurred. These near errors did not involve students with disabilities, but rather involved students in a new learning situation and were errors that are common in the particular setting. I believe that nursing program faculty assume rather than know that the safety risk with students with disabilities is higher because of the disabilities. This assumption may be an example of how nursing faculty unconsciously contribute to the oppression of nursing students with disabilities.

National Licensing Exam/Disclosure/Self-Awareness

Participants voiced concerns about the licensing exam. The exam is a cognitive test only; there is no physical component. The license granted when students pass the exam is the same for all graduates whether they have a disability or not. "Our license

doesn't say they have a limited scope of practice−it's any kind of practice," stated Marcia. She went on to say the following:

> Marcia: . . . there's not anything on your license that says that you cannot practice in this field, and with the American with Disabilities Act the way it is now, if you are discriminated against in the hiring process, there are significant repercussions to that.

I believe some participants would have been more comfortable having students with disabilities apply for a special license allowing them to have a limited scope of practice. A school would distinguish the capabilities of graduates with disabilities especially related to performance of specific skills, and the licenses could be based on these distinctions. Mary stated ". . . Maybe you are limiting the license of that person. . . . Where they could only function within certain patient groups or certain clinical settings and have a restriction on the license."

Marcia continued discussing safety issues and the degree to which students had insight about their strengths when choosing what role to practice in nursing.

> Marcia: It's both−I think that my concern is for the client, I mean ours is two-fold really when we're in education, we're concerned about the student. We advocate for the student, but we also have to think about the safety of our client and if they are in a position where they are not safe and able to care for their client, I don't feel okay with that. I mean, I think most students intuitively figure out where they belong and their strengths, but there are the odd few that don't have that insight, and I can name probably a handful within the last couple of

> years where I think, "Boy, I'm really concerned about that student and I'm very concerned whether they'll choose to practice and these weren't students with disabilities." So, extrapolating from there, I would think that if there were some method that we could use to not discriminate against the student with the disability, but to help them perform in a job where they were doing well and we can send them out into the work force saying, "These are the things that we qualify them for," or "These are the things that we've checked them off and they do a fine job at this and if you're an employer, look at the skill list or look at the communication list, set of communication."

Marcia believed that not all nursing students are aware of their strengths in nursing and may choose roles that may involve safety issues for clients. It is interesting that she did not suggest a limited license for these students, but maintained that educators should be very clear with employers about the abilities of graduating students.

Wendy also expressed concern related to students' self-awareness and their ability to choose appropriate practice settings based on their strengths and limitations.

> Wendy: And the other thing is they may not be self-aware of what their limitations are going to be and what kind of practice settings that they should even be going and interviewing for. So that could very well be. And again setting them up, just because, it's kind of like, not exactly but just because we taught it didn't mean they got it. We think about that. But just because we taught it and they got it doesn't mean they're going to be able to use in the real world.

The interviews imply that nursing faculty would like to be assured that students with disabilities are not allowed to choose roles that may jeopardize patient safety. Having a degree means that a nursing student has graduated from a generalist program, has met the graduation requirements for this program, and has successfully completed the state nursing board abilities requirements enumerated by the relevant state. A student's diploma does not indicate the accommodations that were implemented in order for that student to fulfill the requirements of the degree. A nursing license does not state what accommodations a student needed in order to complete a nursing program. Nursing faculty are concerned that students with disabilities may not have the insight to know which nursing jobs they can safely perform or that students may choose to non disclose. Nursing faculty are concerned that students will be not able to gage their abilities to perform well in certain positions and that employers will not be aware of the nurse's disability, not recognize accommodations that would be needed, and hire graduates, putting the safety of patients at risk.

Nursing faculty described interacting with students who did not disclose their disabilities and with students in general who lacked insight related to their strengths and weaknesses. Students like these may continue this non-disclosure and lack of insight when seeking employment. I believe this may be a significant concern for nursing educators especially when disabilities are hidden. The competition to be admitted to a nursing program and the desire not to be labeled as different has reinforced the tendency not to disclose a disability. If nursing curricula were developed using a social model framework, the focus would not be on the "difference" of students with disabilities. Such

curricula might encourage the disclosure of disabilities; disclosure in most cases would not even be necessary. Students then might begin to view their disabilities as not individual problems, but as environmental challenges that need resolution.

Post-graduation Employment

Faculty voiced a concern related to students who have graduated and passed the national licensing examination and are now considered registered nurses. Would they be able to safely practice nursing? Would their employer recognize the accommodations needed for the new nurse to practice nursing safely? Would students with disabilities be able to find employment?

> Wendy: . . . in terms of working with students who have disabilities is that, we can make a lot of accommodations to get them through the academic expectations, but ultimately it's going to be who is going to be willing to employ that individual and are they going to be willing to provide them with same accommodations and so if there's going to be those barriers are we doing them a service by getting them to the point where they have a degree and not be able to use it . . . ?

Wendy expressed a concern that nursing programs may provide accommodations in the academic setting that employers will not be willing or financially able to provide. She discussed employment barriers and the ethics of graduating a student who would not be able to find employment because of her level of accommodation would be considered excessive. Should the ability of employers to provide accommodations inform academic institutions of the level of accommodations that they should provide? Wendy believed

that faculty should work with the practice arena when making decisions about types of accommodations. The difficulty with this is the complex situation of individuals with disabilities and the many roles and possible employers that students with disabilities could have.

I believe Wendy was thinking about a student with a disability choosing a role in an acute care setting, a setting in which new graduates often find themselves employed. Alice had similar concerns as Wendy.

> Alice: Um, as a nurse educator you have to kind of project what would be a reasonable accommodation that an employer could put into motion for a person within their work site.
>
> Diane: You mean after the student would graduate?
>
> Alice: Right. So you have to kind of, because there's no sense moving somebody through a nurse education program and if you've made dramatic accommodations for somebody and then you ethically know that the employer would not be able to make the same types of accommodations to allow the student or then the nurse to work in that same capacity. I guess that has an ethical component to be evaluated and kind of project out−what would be reasonable for an institution or the employer to be able to make.
>
> Diane: So that's for a nurse, for a student after they graduate.
>
> Alice: Yeah, so you try to figure out an equal accommodation here because it wouldn't, I mean, I've seen it happen sometimes where a school will take the students' money and make these grandiose accommodations but once they're out

> the employer can't do that. The employer has to have−they can make some accommodations ones that are reasonable−but kind of large-scale accommodations are very difficult for that employer to make. That's where my mind keeps going, uh, thinking about what is a reasonable accommodation and what kind of strategies should we use because you have to kind of figure out what the institution that they're going to be employed by can do as well. Otherwise you're setting them up, you know?

Faculty expressed the ethical dilemma of students with disabilities being unable to find employment as nurses after graduation. The type of accommodations needed post graduation for employment and the employer's willingness or ability to provide these accommodations could affect Wendy's and Alice's beliefs about the type of accommodations that should be provided to nursing students. Their beliefs could limit who gets accepted to the nursing program. If nursing faculty believe employers would not accommodate graduates with disabilities, then ethically the nursing program should not graduate such students. The oppression occurring in this situation is that the nursing faculty decide who the employer will be and the type of accommodations that the employer would be willing to provide. Nursing faculty can only make assumptions in this area; their beliefs are not necessarily grounded in facts.

In contrast, Beth stated, "You cannot consider whether they're not−whether they are employable−that is not your job. The job is can you educate−you know, the question is can you educate them and can they be safe." Vicki stated that programs need to focus on student success and on course objectives and criteria, and "not look at the endpoint

about what they actually can do." From what participants related, faculty members continue to feel a responsibility for student success and patient safety after students graduate.

A high percentage of nursing graduates begin their careers in a hospital setting (Kenward & Zhong, 2006). Although this remains a common practice, employers do not require it, and, according to the most recent survey available, 12% of students begin their practice outside of the hospital setting (Kenward & Zhong). Many students feel comfortable starting in the hospital setting, where most of their clinical education occurred, but this is no longer required, as nursing practice is shifting outside of the hospital setting. The accommodations a student needed in the academic clinical hospital setting may not be needed in a non-hospital setting after he or she graduates. The baccalaureate degree is a generalist degree, and the work done to achieve this degree could be applied to many professional nursing roles. Some nursing roles do not require the use of arms, legs, eyes, and ears. Wolffe (2003), a career counseling consultant, addressed employment and accommodation issues for individuals with disabilities who wished to enter the field of nursing. Wolffe gives examples of nursing positions that are viable for individuals with visual impairments including case management, data collection and management for insurance companies and hospitals, research, intake, outpatient education and counseling, health management presentations, risk management, legal consulting, areas of public health, pre-op and post-op patient education, psychiatric nursing in-service training, and nursing education.

Students with disabilities may experience marginalization due to faculty beliefs that nurses must be able-bodied and work in the hospital setting. Nursing curricula may have developed in response to and in support of these beliefs. The barrier for students with disabilities, therefore, may not simply be related to obtaining a nursing job; I believe students face earlier barriers in performance-based nursing programs whose criteria are designed to meet and measure needs and abilities of able-bodied students.

Nursing Faculty

Throughout the course of interviewing, several themes emerged related specifically to nursing faculty. One concerned the faculty members' lack of experience working with nursing students with disabilities. All involved in the study had had at least one experience working with a nursing student a disability, and several faculty members had multiple experiences. However, most felt that they lacked experience, or that their nursing programs in general did not work with students with physical disabilities on a regular basis. In response to the question of the possibility of changing the nursing program environment to a social framework model, Susan stated, "And yet, we haven't had a student on our doorstep that forced me to work through that and how would we change that."

Expressing a similar situation, Kay stated, "I don't have that much experience with students with physical disabilities. You know, even in a non-nursing class that I teach, I've not had students with physical disabilities." Indeed, most students in nursing programs are able bodied. Because of the design of programs, only small numbers of faculty may teach and need to make accommodations for a student with a physical

disability in a classroom, clinical, or laboratory setting. Given student privacy acts, conversations about the process of developing accommodations are limited to those involved. This limits faculty exposure to these conversations, and may even limit faculty members' abilities to form and reflect on beliefs about working with students with disabilities.

Another theme that emerged was faculty members' lack of knowledge about working with students with disabilities. Alice stated,

> And I think the bottom line is−faculty, we haven't really been forced to take a look at our assumptions of disability−we don't do a good job of it when it comes to our nursing education programs. Our nurse educator programs spend no time on disability education.

In addition to lacking knowledge about working with students with disabilities in general, faculty noted the difficulty of not knowing that they would be teaching a student with a disability until the course began. They received no advance notice. Alice found these two issues especially problematic.

> Alice: Well, you can't have a buy-in too close because you can't talk to everybody about everything of a student's private information so you can't have−so you're screwed sometimes. . . . I was between a rock and a hard place and it's difficult to know who needs to know and then how to move from there−you know, in looking at the case and as they go through different rotations you're dealing with totally different players that bring totally different beliefs of philosophies and judgments about a disabled students one course at a time.

Receiving no notice left little time for faculty to prepare the necessary accommodations especially in skills- and clinical-based courses. Faculty seemed to assume that if all faculty working with the student with a disability were involved from the beginning of the student's career in the nursing program, improved outcomes would result. For example, faculty could discuss their beliefs about educating students with disabilities, come to a consensus, and collaborate together on accommodation development.

If the process remains as Alice describes, I believe the buy-in would occur only if the student were successful. If faculty struggled when working with a student, frustration would likely result, yielding a negative impact on this student's future learning. Working collaboratively to develop accommodations, I believe, would help decrease the likelihood of frustration, since most faculty have little experience in this area and would benefit from the input of colleagues. However, this scenario still supports the medical model framework, as accommodations would still need to be developed on a course-by-course and student-by-student basis. The individual student's need for accommodations remains the focus. A nursing curriculum developed using the social model would make the environment accessible, which would then limit the number of accommodations, if any, that a student might need.

Many participants also discussed the fact that faculty base their teaching practices on tradition. Susan said "Faculty are typically older and have a longer history of not being open-minded in terms of admitting students with disabilities because this was not the norm." Alice stated, "Tradition is a barrier and tradition is how we have put our nursing education together." Typically, faculty teach the way they were taught. Nursing

curricula does not differ much from the nursing curriculum I was educated under in the early 1980s. Faculty often struggle to incorporate new pedagogy. They are aware of the confining box created by accrediting bodies, state boards of nursing, and licensing exams. Course descriptions, laboratory exercises, and clinical requirements usually change only related to advances made in nursing and medical knowledge, not in expectations related to performance. Nursing educators move glacially related to change.

Alice also expressed the risk she felt advocating for a student with disabilities.

> Alice: It's just going to take some practice and it's going to take some real valuing of learning to measure how we think in a different way. It's going to take some value as to what our assumptions are, and the problem with it is when you lay out what your assumption is then there's threat of judgment.
>
> Diane: Yeah, okay, yeah, to be honest with what you−to be honest about your beliefs in any area you risk being judged is what you're saying.
>
> Alice: So that's why with disability if you have someone who's out there and supportive in trying to make as many accommodations that we can reasonably appropriate to the situation, then we risk being side-swiped−broadsided by the differences of faculty. And you've got a little−it's not a very comfortable thing because there's always the area of risk as you end up trying to support and move forward. And who gets caught in that is not only the student with the disability, but would be whoever is the advocating faculty that's in alignment. Because every, to me, it seems like, as we were talking about different stories, every time you have the student with a disability, you need an aligning faculty which can

> offer support and can help in advocacy for whatever is reasonable accommodation.

Alice implied that faculty take risks when working with students with disabilities, especially faculty who advocate for the student. In her statement, she refers to differences in faculty. I believe she was referring to differences in faculty's beliefs related to admitting and educating nursing students with disabilities.

A faculty member working with a student with a disability often works in isolation, making what she believes are appropriate accommodations for the clinical situation. If the student passes the course, she or he advances to the next clinical course with a different faculty member who, similar to the first faculty member, likely has no to little experience working with a student with disabilities and who lacks knowledge of this student due to privacy laws. This faculty member may have never considered her beliefs related to educating a nursing student with a disability and may react to the situation based on teaching practices embedded in the medical model.

Alice described tension that occurred in a student situation when a faculty member disagreed with the accommodations that had occurred in the previous semesters.

> Alice: I was comfortable with them, but we ran into−after the accommodations had been put in place one, two, four semesters−the fifth semester the faculty who got the student was not comfortable with what had gone on in the previous four semesters and so when the student had a chance to−well she always thought that she was abusing it−you know she did want to come on certain days−she said the student was going to opt out and do that with a preceptor for that day−or felt like

> we had just a little psychologically−coddled the student through the program and so what's going to happen when she goes to work. Well, I guess whoever hires her will know what her limitations are and allow for that as well. And as far as I know she's working in a nursing home setting, she's been doing all the MDS reports, which gives her flexibility so when she has these severe days she has that flexibility.

Accommodations are made each semester in isolation in response to student privacy laws. The faculty member for the last semester course for this student disagreed with the previous accommodations, felt they were excessive, and was concerned about this student's ability to work as a nurse. This student was able to find employment in a job that offered her the accommodations needed for her disability.

According to participants, faculty do not discuss beliefs about working with students with disabilities in faculty meetings. Faculty members tend to work in isolation when working with students with disabilities and risk having their credibility as faculty members questioned as they struggle to make appropriate accommodations. When a student with a disability is admitted, nursing programs react. Reacting is part of the medical model framework and can lead to tension among faculty members. A social model framework would encourage faculty members to work proactively by discussing beliefs. This model would also require department mission statements to spell out faculty beliefs about working with students with disabilities. To do this, faculty members would need to consider and answer clearly the following kinds of questions: Who is our student and, who are we serving? Does the faculty believe that a student with disabilities can be a

nurse? What are the assumptions related to admitting and educating a nursing student with disabilities?

These discussions would best occur at faculty meetings supported by leadership in the department. For a student's experience to be positive and the student to be successful, faculty should be in full agreement about their beliefs or should reach a consensus in these beliefs. This would eliminate a faculty member feeling judged or side-swiped when working with a student with disabilities.

Many participants expressed their awareness of the feelings that students with disabilities experienced when participating in nursing programs. Susan stated, "The perception of not wanting to be different; then to be in a place where you're reminded that you're different because the environment creates barriers for you, so even if you'd like to blend in, you can't." I believe Susan was referring to an academic environment designed for able-bodied students. Many accommodations that are required for a physical disability would be obvious to other students in the laboratory or clinical setting. For example, a stethoscope designed for the hearing impaired looks different than a non-hearing-impaired stethoscope. Furthermore, nursing programs are heavily based on the performance of specific skills. An accommodation that is needed to perform those skills would make the student using them look different. For example, a student who needed a faculty member's assistance to open a sterile package would stand out from her peers. Because classroom, laboratory, and clinical environments are usually not accessible, it is difficult if not impossible for a student with a disability to feel that she is the same as

others. This reinforces the perception that the disability resides within the individual, perpetuating the medical model framework of disability as defined in nursing education.

Alice felt that it was important to make the environment safe for a student with a disability to come to faculty to acknowledge her disability. Alice said "Students are fearful about putting out their disability. It is a burden for the student who is putting forth all the time and effort not to disclose." Alice believed this lack of disclosure occurs preadmission and is related both to the competiveness of admission to nursing and competition among students after they are admitted. She added, "Yeah, from what I've seen, they try to muddle through as best they can until something falls apart." Nondisclosure may also be related to a student's desire not to feel different or fear of faculty's reaction if she discloses her disability. Faculty have the main share of the balance of power in a faculty-student relationship. In a clinical setting, a faculty's performance-based evaluations of students are often subjective; grading can occur using anecdotal accounts and grades of satisfactory/unsatisfactory. Subjective grading, I believe, gives even more power to faculty and causes more fear in students, especially the student with a disability in a performance-based setting.

Several faculty discussed their own personal experiences with disabilities as well as aging nursing faculty issues and how these might influence beliefs about working with nursing students with disabilities. Three participants, Alice, Beth, and Kay, disclosed personal disabilities and how they affected working with students with disabilities.

> Alice: So I think maybe that's why I will go the extra effort to try to do something that's reasonable because I know and have experienced how a person struggles

> and tries to figure out their worth because of having to deal with something that's not up to standard or meets what other people are able to do. . . I've experienced it now so maybe this experience has made me a little more wiser, and concerned because I'm a young faculty member and I look at my peers out here−what will happen as they age and go through the aging process and have different disabilities that creep up into their lives.

Alice described her personal experiences with having a disability and how she questioned her self-worth measuring herself against what she considered the normalcy. She views her disability as her problem, an individual problem, defined and embraced as such by her professional lived environment, namely nursing. She believed her experience has made her wiser, perhaps more knowledgeable about resources, and that she will make an extra effort to find accommodations that will help a student be successful in the courses she teaches in.

The experiences she described had both an emotional and an epistemological component. She had become a member of the "group." I discussed earlier the mandate from national nursing organizations stating the nursing population needs to represent the culture of the patients for whom they care. This issue, as it relates to recruitment of students of diversity to care for the increasingly diverse patient population, arises often. Any conversation about it should expand to include a discussion of nurses with disabilities who can care for the ever present population of patients with disabilities. Universities also desire to employ diverse faculty. Yet, diversity tends to be limited to race and often does not extend to disability. The aging of nursing faculty may force

universities to embrace faculty with disabilities as a diverse group. I wonder if this may have an effect on faculty's beliefs about educating nursing students with disabilities. For Alice, it made her wiser and more accepting although she still defined her personal disability from the medical model.

As an aging group, nursing faculty increasingly experience disabilities. Beth, who is on the downward slope of the faculty age bell curve, stated that she didn't want to request the extra assistance needed for teaching because "you don't want to be labeled as having a disability." Beth did not want to be labeled as having a disability. She did not want to be labeled as different. Through our conversion, I learned that she would benefit from certain accommodations. I wonder if she is afraid that other faculty or the administration will decide that she cannot perform in her role as a faculty member if she receives these accommodations. The label *disabled* may have a stigma in her department and it may be negative. If a faculty member is concerned about the label, I believe a nursing student with a disability would be concerned as well.

Kay described both personal and family experience with disability. Unlike Beth, Kay requested support for her disability. She stated,

> When you have personal experience or family experience, you learn from that, you understand what the struggles are, and I think you're both more creative when it comes to ways to overcome problems that people have−students have. But I think it increases your awareness. You look for it as opposed to being surprised when it shows up.

Kay also discussed a personal experience with a disability. She expressed the difficulty she experienced in her faculty role, the lack of university administrative support, and how she was insulted and disheartened though her own experience of trying to obtain accommodations. Her personal experiences have helped her to be more aware of, proactive about, and creative with accommodations. She also described the emotional side of having a disability. I believe a faculty member's personal experience with a disability and the affective response drives the desire for these faculty to push the boundaries and work towards the success of nursing students with disabilities.

The lack of experience of working with students with disabilities, the lack of knowledge related to the disability itself, educating based on tradition, an awareness of the fear students with disabilities experience, and aging/disabled faculty were themes discussed by several participants. The participants also expressed mistrust, disheartenment, and insecurity about their jobs when relating their personal experiences about their disabilities and their work environments.

Faculty members, as previous nursing students in both undergraduate and graduate education, did not have formal educational exposure related to caring for patients with disabilities from a social perspective. As noted previously, this likely influenced their teaching and dealing with their own students; nursing curricula do not typically discuss the oppression a person with physical disabilities experiences as a patient. To further entrench educator's beliefs based on their personal educational experiences, nursing care as discussed in present textbooks focuses on acute, rehabilitative, and preventive care within the medical model framework of disability. For

example, a typical textbook, when addressing the care for someone with a spinal chord injury, discussed the acute phase and rehabilitative phase. Such a text would also discuss preventative care for the chronic phase. Textbooks tend not to address how this person will now maneuver through a medical system that views disability as an individual problem with the goal of normalcy, something that person may never approximate. Nor do such texts usually address the issues of oppression that affects a person with a disability as a patient or as a student.

These issues are often what bring a patient with disabilities back into the medical system. Exploitation, marginalization, powerlessness, cultural imperialism, and violence that people with disabilities experience can have major impacts on a person's work and career opportunities, potentially leading to decreased income and poverty. Poverty and morbidity are directly related. Faculty in this study stated they hadn't thought about their beliefs related to admitting and educating nursing students with disabilities. I am not surprised by this, in that they had had limited educational exposure as both undergraduates and graduate students that might have challenged them to begin formulating beliefs on which they might base their future practice as faculty members.

The way nursing curricula presents certain health issues occurring in cultural groups is similar to the way they tend to address disabilities. For example, textbooks often present statistics related to the increased frequency of high blood pressure and diabetes in African Americans. Yet the discussion either in nursing texts or by nursing faculty about the causes of high blood pressure and diabetes for this ethnic group from a social perspective remains limited. In a widely used medical surgical textbook

(Ignatavicius & Workman, 2010), one paragraph is devoted to environmental factors that may contribute to increased blood pressure in African Americans. The text devotes *one sentence* to address issues related to poverty, the inability to purchase medication and healthy foods, and the ability to access health care. The cultural experience of oppression can be found behind the statistics, but the nursing profession does not yet systematically discuss oppression as it relates to the health-care of this group.

Faculty discussed fear during their interviews in a number of forms; fear about how the faculty member who tries to make accommodations will be treated by other faculty; fear related to faculty self-disclosure of personal disabilities as it relates to job security in their academic work environments; and the fear they perceive students experience about disclosing their disabilities to nursing faculty. It seems as if these faculty participants experience a face of oppression, namely, powerlessness, related to their attempts at either working with students with disabilities or dealing with their own disabilities. The participants who had had personal experiences with disabilities and voiced personal experience of oppression also discussed how they had made extra efforts and were more creative when working with students with disabilities. Yet as faculty members, the participants were not wholly powerless. These faculty members had experienced power before acquiring their disabilities; were able to maintain some power in their positions; and were in the position to have a positive impact on students with disabilities.

Chapter Five: In Conclusion

In this chapter, concluding thoughts are followed by implications for nursing, limitations of the study, and suggestions for further research.

Concluding Thoughts

The participants of this study all had experiences admitting and/or educating at least one nursing student with a disability. They appeared to be passionate about their work with these students and in their desire for them to be successful. They also expressed frustration with their experiences, both personal and professional.

The stories they told about working with students with disabilities described personality traits of students with disabilities; their and their program's efforts to find and offer appropriate accommodations; frustration over students' non-disclosure of their disabilities; functional criteria that they and their programs developed in response to working with students with disabilities; pre-admission counseling for students with disabilities; the ethics related to admitting students with disabilities; and the fear related to potential litigious situations. Embedded in these stories, as discussed in the analysis, were words, descriptions, actions, and behaviors that could be perceived as oppressive by students with disabilities. I believe the faculty in this study were not aware that they may be contributing to oppression. As Young (1990) states, "The conscious actions of many individuals daily contribute to maintaining and reproducing oppression, but those people are usually simply doing their jobs or living their lives, and do not understand themselves as agents of oppression"(p. 42).

The definitions of disability contained the following thematic phrases: “outside of the normal”; “unable to perform or function”; “broad based including physical, intellectual, and psycho-social impairments”; and “linking disability with an accommodation.” These definitions would mirror what Oliver (1990) would state as defining disability from a medical model framework. In this model, the problems related to a disability are located in the individual, stemming from the functional limitations that are assumed to arise from the disability. Most faculty were not aware of models that defined the disability experience. They were not aware that they were defining the concept of disability using a medical model framework or even that there were other frameworks to consider, such as the social model that would be less oppressive to students with disabilities.

Participants reviewed admission criteria that contained functional abilities that were developed in response to past experiences of admitting and educating nursing students with disabilities. The purpose of the functional criteria statements varied from helping students with disabilities become aware of the physical demands of the nursing curriculum to acting as a gate-keeper in the admission and progression processes. Many nursing roles require specific physical abilities, and other roles do not. Nursing programs have chosen to require a broad range of physical abilities as part of the curriculum requirements. By designing curricula based on the establishment of norms from the dominant group−able-bodied students and nurses who work in physically demanding roles−students with disabilities can experience a form of oppression defined by Young (1990) as cultural imperialism. Students with disabilities become the “other” and their

differences are viewed negatively. By including functional abilities as part of the admission process, faculty make a statement about who can be a nurse. Students with disabilities may feel marginalized by these statements, as they may feel excluded by not being able to meet these abilities.

Themes related to nursing faculty emerged during the interview process. Lack of knowledge and experience related to working with students with disabilities; basing teaching practices on tradition; the risk faculty take when advocating for disabled students; awareness of students' feelings; and experiencing disability themselves. Faculty have had little to no education about disability, tend to teach how they were taught, and the cycle continues. Faculty who advocated for disabled students and who had experienced personal disability described experiencing incidences of oppression. Although these faculty did not use the term *oppression*, the emotions they expressed when telling their stories suggest this was what they were describing.

Implications for Nursing

I hope that, through the dissemination of this study, nursing faculty will understand the importance of taking time to contemplate their personal beliefs related to admitting and educating a nursing student with disabilities. Do they believe a student with a disability or multiple disabilities can be a nurse? I would like them to consider assumptions they make about who their students are. I would like them to understand how disability is presently defined in nursing using the medical model and consider the implications of using this definition when developing and implementing curricula. I would ask nursing faculty to explore the social model of disability and the potential

impact of implementing this model in a nursing curriculum. I would ask nursing faculty, as a group, to dialog about their beliefs and come to a more inclusive consensus about their beliefs as they relate to the mission and philosophy of their departments, programs, and institutions.

Nursing faculty who volunteered to participate in this study put much energy into helping students with disabilities succeed in their nursing programs. The faculty members in this study had experiences and views about admitting and educating nursing students with disabilities, although as they admitted, these views were not well thought out. I believe they were working under the medical model framework of disability and, unbeknownst to them, participated as agents of oppression. I believe that the faculty members who participated in this study, as well as other faculty members through dissemination of this work, may begin to recognize their admission processes and curricula design as oppressive. This may lead faculty to more aggressively dialog about their beliefs and actions, and it will hopefully lead to discussions about implementing the social model of disability in the design of their curricula.

As a faculty member of a university that has encouraged contemplation of social justice issues as they relate to racism, I find myself drawing parallels between race and disability. Even though I have stated these parallels in my work setting, my colleagues and institution have not welcomed such a discussion. Some educational systems that presently exist have been developed historically on social inequities. Thankfully, many colleges and universities, both those with troublesome pasts and those with less troublesome histories, dialog about the effects of racism. But conversations about this

kind of injustice often remain limited to racism and do not extend to other areas of social inequities, specifically disability. I had hopes that the conversation about racism would expand to include other social justice issues. In a required anti-racism workshop I attended, I brought up these issues, but was told that we were going to focus only on racism. I support and agree with forums related to anti-racism and understand that anti-racism work can be disrupted when people suggest working on other forms of oppression. But in defense, I have found little work being done related to these other forms of oppression and nothing related to disability. This may be the reason some faculty, like some participants in this study, have not felt supported in their personal experiences of disability. More generally, faculty have not been encouraged institutionally to contemplate their beliefs about disability and their response to these beliefs, even though both have social justice implications.

Limitations

As I analyzed my data after the second interviews, I recognized a few questions I could have asked that would have helped me gain more depth of understanding. For example, in relation to the ADA environmental requirements, I wondered if participants felt it was also an individual and/or educational role to create accessible environments. Do educational systems modify environments because they are required by the ADA or could it be perhaps a belief that is the right thing to do that creates a change? I believe my lack of developing an exhaustive list of relevant questions had limited impact on my findings.

In addition to not including all of the pertinent questions I could have included, I chose to have limited member checking due to time constraints. I did bring back to participants their definitions of disability, and asked for clarification during the second interview when I was unsure of the meaning of statements transcribed.

Faculty who volunteered to participate in this study had an interest in this topic. The faculty voices that emerged were from teachers who cared deeply about admitting and educating nursing students with disabilities. I found that this group applied the medical model of disability when admitting and educating nursing students and contributed to the oppression students with disabilities were experiencing. These results would not have surprised me if I had interviewed faculty that I expected not to be sympathetic.

This study did not include the voices of others, however. This study does not draw on the view of faculty who chose not to respond to my request to participate in this study. These faculty may have similar, different, or more oppressive perceptions of students with disabilities who are either applying to programs or were admitted to programs.

Suggestions for Further Research

As noted in the literature review, a small amount of research related to admitting and educating nursing students with disabilities, a majority of which was done from a quantitative perspective exists. I believe these studies omitted an important first step. Beliefs of nursing faculty related to admitting and educating nursing students have not been explored from a qualitative perspective. My sample size was small and limited to one Mid-western state. I believe it would be helpful to hear more voices from faculty in

different parts of the country. I also think it would be helpful to hear students' voices related to their admission and educational experiences. I would hope that faculty as a group would begin discussions about their beliefs and that students' experiences, as well as those of faculty, would inform these discussions. These beliefs should inform the mission and philosophy of nursing programs and departments, and should be put into practice in admission and curricular decisions.

If programs choose to move to a social framework for admission and curricular design, I believe it would be important to research the effects of this change. Are there an increased number of students with disabilities applying to a program that uses a social framework design? How does the social framework design affect the learning experiences for all students in the nursing program? Are students well prepared to practice in the profession of nursing? I think it would be important to hear both faculty and student's voices in this research.

I believe that any change in practice must start with an examination of beliefs. Most faculty in this study stated they had never thought about their definition of disability, and during the interview, they often remarked that our discussions caused them to think more about their educational practice related to students with disabilities. Nursing programs have created policies and curriculum environments in reaction to working with students with disabilities. I propose that nurse educators step back, examine their beliefs, and change them if those beliefs endorse or actively support the oppression of students with disabilities.

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