

# Nurses with Disability: Transforming Healthcare for All

[Beth Marks, PhD, RN, FAAN](#)

[Jasmina Sisirak, PhD, MPH](#)

---

## Article

---

### Abstract

Disability is a natural part of the human experience and nurses with disability add greatly needed value as our colleagues. People with disability represent the largest marginalized group, making up more than 15% of the global population. Recognizing the value of nurses with disability requires an understanding of the ongoing systematic exclusion of students with disability entering the nursing profession and nurses with disability maintaining employment. Nurses with disability can offer patient-provider concordance, supporting a shared experience, valuing disability, and modeling positive expectations. In this article, we first discuss [disability, ableism, and nursing](#). Also included is information about [universal design structures for access](#) that can be useful to support students and nurses with disability in academic and clinical settings. Lastly, we provide [recommendations for nursing education and practice](#) to include and value people with disability in these environments. Because systemic barriers can be easy to fix but often ignored, employing nurses with disability who directly experience these barriers provides an opportunity and incentive to advocate for change. Nurses with disability have enormous potential to expand healthcare from a medicalized view of disability as an inherently negative trait to a marker of diversity and the hallmark of equitable care.

**Key Words:** Nurses with disability, marginalized groups, ableism, universal design, universal design for instruction, Americans with Disabilities Act, nursing education

What qualities make a nurse and have the potential to impact nursing care for every patient? How can Maria, who was born with one hand, be a nurse? In what ways can Nushi, who has lifting restrictions, provide nursing care? How will Anthony, who is hard of hearing, impact the care of all patients?

---

**People with disability represent the largest marginalized group...**

People with disability represent the largest marginalized group, making up more than 15% of the global population ([Villines, 2021](#)). Recognizing the value of nurses with disability requires an understanding about exclusion of both students and practicing nurses with disability. In this article, we aim to recognize the value-added of “disability visibility” and describe anti-ableist

approaches in nursing practice for improved healthcare and health outcomes for all patients. We discuss approaches to improving nursing practice through Universal Design (UD) and Universal Design for Instruction (UDI). Lastly, we offer recommendations to include and value people with disability in nursing education and practice.

### Disability, Ableism, and Nursing

Ongoing systematic exclusion of students with disability entering the nursing profession, and nurses with disability securing and maintaining employment, impacts our ability to recognize their value. Disability is a part of diversity, equity, and inclusion (DEI) efforts in the healthcare workforce. However, the unique contributions of nurses with disability are not included in the functional abilities for nursing practice and nursing education programs ([NCSBN, 1997](#); [Yocom, 1996](#)). Excluding the functional abilities that nurses with disability possess, those non-domain specific activities and attributes, compromise every nurse’s ability to provide safe, effective care for patients.

---

**Disability is a part of diversity, equity, and inclusion efforts in the healthcare workforce.**

Incorporating a value-added disability perspective demonstrates the impact of nurses, such as Maria, Nushi, and Anthony, to provide quality nursing care for everyone. Maria has a unique capacity to teach patients to function effectively with one hand. Nushi can lead the implementation of ergonomic safe lifting and handling, and Anthony can demonstrate the value of lip reading to enhance communication for everyone. Many of these added skills can be universally beneficial.

As a profession, we must challenge the requirement that nursing students and nurses do all items listed in the 1996 functional abilities domains and corresponding activities and attributes document (e.g., pick up objects with hands, push and pull 25 pounds, hear faint body sounds) ([Yocom, 1996](#)). These requirements favor able-bodied people, diminish safety and quality of care for nurses and patients, and potentially exclude more than 15% of the population. Research data continue to document the strengthening and reinforcement of student biases toward disability throughout health sciences curriculums ([Brillhart et al., 1990](#); [VanPuymbrouck, 2021](#)) and suggest a much needed role for nurses with disability and allies to dismantle structural and systemic discrimination and ableism.

---

**...we must challenge the requirement that nursing students and nurses do all items listed in 1996 functional abilities domains and corresponding activities and attributes document...**

A 2020 study documented that 83.6% of healthcare professionals implicitly preferred people without disability ([VanPuymbrouck et al., 2020](#)). Nurses with disability can offer patient-provider concordance, while supporting a shared experience, valuing disability, and modeling positive expectations. This perspective is often absent in the lives and healthcare of many people with disability. Concordance is most often defined as a similarity, or shared identity, between healthcare provider and patient based on various demographic variables ([Shen et al., 2018](#)) and is an important dimension of the healthcare relationship that is linked to healthcare disparities. Increasing patient-provider concordance for people with disability has the potential to extend patient visits by improving trust; satisfaction; participatory decision-making styles; healthcare processes and outcomes; and adherence to treatment recommendations ([Cooper & Powe, 2004](#); [Cooper et al., 2003](#); [Hilton et al., 2020](#); [Traylor et al., 2010](#)).

A greater need exists to diversify our nursing workforce as the United States (U.S.) becomes increasingly multicultural and diverse ([Togioka et al., 2022](#)). Ongoing research documents the link between increasing diversity in the healthcare workforce and improvements with healthcare delivery, especially for underrepresented segments of the population ([Bristow et al. 2004](#); [IOM, 2002](#); [Jackson & Gracia, 1974](#)). Increasing data suggest that implicit bias (i.e., attitudes or stereotypes that unconsciously affect our understanding, actions, and decisions) leads to poorer healthcare outcomes for patients of color and disability ([Ailey, 2022](#); [Hoffman et al., 2016](#)). In addition, people with disability have increasing fear that the COVID-19 pandemic will and has worsened medical biases, as it is easy for healthcare providers to internalize biases of a system that views people with disability as "the problem" or "less than a whole human" ([Shapiro, 2020b](#)).

---

**...people with disability have increasing fear that the COVID-19 pandemic will and has worsened medical biases...**

### **Disability Visibility**

Just under one in four people in the United States lives with a disability (about 26% of adults) ([NCBDDD, 2020b](#)). For people with disability, equitable access to healthcare, or the right to receive the same healthcare one would receive if one were not disabled, is as important as equitable access to housing, education, and employment. As the nursing profession aims to reflect population demographics, increasing the visibility of nurses with disability is critical. Togioka et al. ([2022](#)) reported that people within a group may have a unique potential to solve healthcare issues that are more prevalent within that group by incorporating individual patient perspectives and developing accessibility and inclusiveness approaches. Nurses with disability have the potential to add their customs, experiences, and problem-solving methods to innovate and test model approaches to systems-based healthcare problems ([Togioka et al., 2022](#)).

---

**Unfortunately, despite the removal of legal barriers, discriminatory practices persist in healthcare.**

Increasing the visibility and promotion of students and nurses with disability, as healthcare professionals, can shift the view of disability as a negative attribute to a positive, value-added characteristic within nursing practice. Seeing disability-related accommodations as a civil right can support equitable access to healthcare education, facilities, and practice ([Powell, 2021](#)). With equity, people with disability are increasingly visible and can access the same facilities, programs, and services across all community sectors (e.g., healthcare, housing, education, employment). Recognizing disability as another human characteristic creates an opportunity to include accessibility for people with disability within diversity, equity, inclusion, and accessibility efforts. In the US, with Section 504 of the Rehabilitation Act of 1973, Education for All Handicapped Children Act of 1975 (reauthorized Individuals with Disabilities Education Act in 2004), and the Americans with Disabilities Act ([ADA, 1990](#)), people with disability can no longer be legally excluded from government services and employment, attending public schools, and buying goods and services in our communities ([Pulrang, 2020](#)). Unfortunately, despite the removal of legal barriers, discriminatory practices persist in healthcare.

As nurses with disability gain more visibility, nurses and allies can implement practices and structures that support equity for people with disability and/or chronic conditions in their healthcare and improve health outcomes. Practices and policies that include a central tenet of the ADA assertion that discriminatory treatment is "based on characteristics that are beyond the control of such individuals and resulting from stereotypic assumptions not truly indicative of the individual ability ..." ([ADA, 1990](#), section 2.a.7) can support employment and contribution of nurses with disability. Additionally, inclusion of the guiding premises of the ADA ([1990](#)) and the ADA Amendment Act (ADAAA) of 2008 can reverse the conscious negative attitudes and the unconscious prejudice reported by healthcare professionals ([VanPuymbrouck et al., 2020](#)).



With the expansion of nursing practice, nurses are uniquely qualified to examine and address structural healthcare practices that impede nurses with disability in clinical settings. As nurses we might consider several questions:

- Will we, as nurses, do our own work to raise our consciousness about disability issues and avoid placing the burden on people with disability to “teach” us?
- Should we continue our sole focus on “treating” issues located within individuals and their disabilities while overlooking the myriad socially constructed barriers (e.g., physical, attitudinal, or policy) that prevent or exclude people with disability from participating in and contributing to society? ([VanPuymbrouck, 2021](#))
- Can we implement innovative nursing practices to provide equitable healthcare?

As the largest group in the professional healthcare workforce worldwide, and in some instances, the only available healthcare professional, nurses have an enormous capacity and opportunity to welcome nurses with disability as valued peers.

### **Unmasking Ableism**

Ableism refers to bias, prejudice, and discrimination against people with disability. For people with disability, ableism starts with the attitude that people with disability are ‘less than.’ Prejudice and discrimination against people with disability limits what they can do and become. While differences in ability are a normal part of human experience, ableism is one of the most common forms of prejudice ([Villines, 2021](#)).

---

**...ableism starts with the attitude that people with disability are ‘less than.’**

Ableism can be based on physical or mental abilities and occur in a variety of spaces, including in-person and digital spaces and on individual or systematic levels ([Murphy, 2021](#)). Examples can include the following: building structures or websites without accessibility; ridiculing people with disability; refusing reasonable accommodations for people to access public spaces; lacking compliance with disability rights laws like the ADA; and assuming that people with disability want or need to be “fixed” ([Eisenmenger, 2019](#)). Use of terminology referring to disabilities and conditions can also perpetuate ableist assumptions. The terms “wheelchair-bound,” “victims,” or “suffering” from various disabling conditions, and “I don’t think of you as disabled” can present disability as a tragedy and/or evoke pity. For example, the continued use of “wheelchair bound” implies that a wheelchair is a restraint instead of a vehicle. “Wheelchair user” is more accurate and respectful, and does not have an ableist connotation ([Cherney, 2020](#)).

Forms of ableism include hostile, benevolent, and ambivalent ([Villines, 2021](#)). Hostile ableism includes openly aggressive behaviors or policies, such as bullying, abuse, and violence. Benevolent ableism views people with disability as weak, vulnerable, or in need of rescuing. This form of ableism undermines one’s individuality and autonomy and reinforces an unequal power dynamic. Ambivalent ableism combines both hostile and benevolent ableism. For example, a person might start a social interaction by treating someone in a patronizing way, and then switch to being hostile if the person objects to their behavior.

---

**Ableism can also vary based upon perception of different disabilities.**

Ableism can also vary based upon perception of different disabilities. For example, discrimination against those with visible impairments may differ from treatment of those with non-apparent impairments. Whether or not the disability is physical or cognitive, or is a condition that is well known, may result in different types of biases and discrimination. Disabilities with a long history of stigma (e.g., people with intellectual disabilities, severe mental health conditions, albinism, facial differences) also have resulted in specific myths, stereotypes, or slurs.

Ableism impacts acceptance to nursing school for people with disability and employment for nurses with disability. Although data is limited on the numbers of students with disability in nursing education, in medical education less than one percent of all students have a disability ([Eickmeyer et al., 2012](#); [Zazove et al., 2016](#)). While many students with and without disability learn about different forms of discrimination, recognizing ableism is often excluded during any educational program, including nursing education. Additionally, education of healthcare providers in the United States remains strongly informed by the medical model. Within a medical model, disability is often viewed as bad and/or sad and that those living with a disability should work to overcome their disability and/or try to avoid it or cure it at all costs ([VanPuymbrouck, 2021](#)). Precise employment rates for nurses with disability are not known, but as of July 2021, the unemployment rate for people with disability was 12.1% compared to 5.4% for people without disability ([Murphy, 2021](#)).

---

**Ableism impacts acceptance to nursing school for people with disability and employment for nurses with disability.**

---

**...nurses have an enormous capacity and opportunity to welcome nurses with disability as valued peers.**

### **Anti-Ableism on the Job**

Ableism results in various maltreatments, disadvantages, and injustices, including disability-based health inequities and poorer health outcomes. Discrimination or ableism is often portrayed as benign, unintentional, or caused by lack of “awareness” ([Pulrang, 2016](#)). Prejudiced remarks may be disregarded as people do not perceive people with disability as either hurt or disadvantaged enough by disability prejudice ([Pulrang, 2016](#)). Discrimination experienced in healthcare settings is seen more as a social etiquette issue than a social justice or equity issue. Healthcare professions are traditionally perceived as

benevolent disciplines in which every human life is valued equally, without any form of prejudice or discrimination (Janz, 2019). While many providers consciously have good intentions and positive attitudes toward people with disability, they actually have implicitly negative attitudes (VanPuymbrouck, 2021). Although the value of every human life is the ideal among healthcare providers, the influence of dominant societal understandings and attitudes toward individuals and groups of people deemed to be ‘others’ places an individual ‘worth’ on human life.

For people with disability, evidence documents the same levels of implicit disability bias among healthcare professionals as with the wider population (FitzGerald & Hurst, 2017). Moreover, data document that biases are likely to influence diagnosis and treatment decisions and levels of care provided to people with disability. The danger and insidious nature of ableism in healthcare is that it often presents as ‘common sense’ and denies its own rhetoricity (Cherney, 2011; Janz, 2019).

---

**The common sense milieu of ableism in healthcare increases the vulnerability for both nurses and patients with disability.**

The common sense milieu of ableism in healthcare increases the vulnerability for both nurses and patients with disability. For example, the COVID-19 pandemic highlighted the application of a utilitarian approach based on ableist tendencies to defining extraordinary, heroic, and futile measures to preserve or prolong human life among people with various types of disability (Janz, 2019). Ableism was exposed in a variety of settings, as noted by disproportionately higher morbidity and mortality rates for people with disability during the pandemic (Shapiro, 2020a, 2020b). An increased understanding about the impact of discrimination in healthcare can include anti-ableist policies to better serve people with disability in healthcare.

Ableism, like ageism, can be considered an important social determinant of health that shapes the conditions of daily lives for people with disability and influences health outcomes (Mikton et al., 2021). Table 1 below describes examples of ableism across three levels: institutional, interpersonal, or internalized.

**Table 1. Levels of Ableism**

Level	Example
<b>Institutional Ableism</b>	An example of <i>institutional ableism</i> is medical ableism, which is rooted in the idea that disability of any kind is a problem that needs fixing. When part of medical teaching and health policy, it affects the entire healthcare system and the well-being of patients, creating physical and attitudinal barriers that form policies, laws, regulations, and practices that exclude people with disabilities from full participation and equal opportunity.
<b>Interpersonal Ableism</b>	On an <i>interpersonal level</i> , ableism permeates social interactions and relationships. For example, a parent of a child with a disability might focus solely on a “cure” for the disability at the expense of understanding disability from a value-added perspective.
<b>Internalized Ableism</b>	<i>Internalized ableism</i> is when a person either consciously or unconsciously believes and incorporates the harmful negative messages they hear about disability and applies them to themselves. With the lack of shared identity with family members or friends with disability, people may have had no opportunity to learn about disability civil rights, advocacy skills, and disability pride, including nurses who acquire disability later in life.

---

**...implicit and explicit biases related to disability remain embedded across healthcare structures, policies, and practices.**

While one’s words and actions significantly impact healthcare and health outcomes experienced by people with and without disability, implicit and explicit biases related to disability remain embedded across healthcare structures, policies, and practices. Recent research continues to document the reinforcement and strengthening of disability biases among students during their healthcare education (VanPuymbrouck, 2021). Despite longstanding and stereotypic assumptions, disability status is not indicative of an individual’s ability (ADA, 1990) and the

internalized sense of shame with a “disabled body” is both a product and a tool of injustice (Lehrer, 2020). Instead, disability is a beautiful part of human diversity to be accepted, honored, and shared in its richness and capacity, bringing pride to members within this community.

### Universal Design Structures for Access

Having a nurse with a disability with lived experience can model excellent nursing care, pride in one’s disability, and can mitigate patients’ feelings of inferiority; hesitation to request accessible healthcare and reasonable accommodations; or perception of being a burden. Accessibility laws, such as, the Architectural Barriers Act (1968), Section 504 of The Rehabilitation Act of 1973, the Fair Housing Act Amendments (1988), and the Americans with Disabilities Act (1990) establish minimum requirements to prevent discrimination of people with disability healthcare built environment (Maisel & Ranahan, 2022). The impact of these laws is evident throughout most communities in the US, as many people experience the benefits of accommodating one person with a ramp.



The concept of inclusive design began in the 1950s with Universal Design (UD) emerging in the 1960s as a design philosophy for inclusive products and environments for all, regardless of age, ability, size, or background. UD “enables and empowers a diverse population by improving human performance, health and wellness, and social participation” (Maisel & Ranahan, 2022, para. 3). By integrating UD within nursing practice, students and nurses with disability have greater potential to innovate and enhance patient care. For healthcare facilities, UD reduces the economic impact of segregated programs and services and enhances the impact of universal designed healthcare that can benefit everyone (Maisel & Ranahan, 2022).

---

**By integrating UD within nursing practice, students and nurses with disability have greater potential to innovate and enhance patient care.**

Incorporating the eight goals of UD supports every nurse in the workforce (Matt, 2015). For example, with an aging nursing workforce, injuries and disabilities are more prevalent. By recognizing and accommodating nurses with disabilities in the design of nursing work environments, we can meet future needs of students and nurses. The eight UD goals listed in Table 2 can be incorporated into innovative nursing practices to meet an increasingly diverse workforce with a range of ways to support employees (Halligan et al., 2019).

**Table 2. The Eight Goals of Universal Design** (Matt, 2015)

<p><b>Body Fit</b> – accommodating a wide a range of body sizes and abilities</p> <p><b>Comfort</b> – keeping demands within desirable limits of body function</p> <p><b>Awareness</b> – ensuring that critical information for use is easily perceived</p> <p><b>Understanding</b> – making methods of operation and use intuitive, clear, and unambiguous</p> <p><b>Wellness</b> – contributing to health promotion, avoidance of disease, and prevention of injury</p> <p><b>Social Integration</b> – treating all groups with dignity and respect</p> <p><b>Personalization</b> – incorporating opportunities for choice and the expression of individual preferences</p> <p><b>Cultural Appropriateness</b> – respecting and reinforcing cultural values and the social, economic and environmental context of any design project</p>
--

UD promotes an inclusive process that is open to, and encouraging of, input that challenges and accommodates different and conflicting points of view.

With origins in the built environment, a UD approach incorporates potential support needs at the planning stage, lessening costs associated with individual accommodations by ensuring that buildings and infrastructure are designed to accommodate differences from the start (Clarkson et al., 2003). UD promotes an inclusive process that is open to, and encouraging of, input that challenges and accommodates different and conflicting points of view. Simply knowing about issues is useful, but pointless if nothing is done about them. The following subsections will describe how emotional engagement with the issues leads to a greater acceptance of the need for inclusivity, whilst at the same time improving design. The nursing workforce of the future population will have a much more diverse profile of capabilities (e.g., physical, sensorial, and cognitive) than that of nurses today. The eight goals noted above are opportunities to foster cultural competency and cultural humility through inclusive design to meet changing population demographics.

### **Cultural Competency and Humility**

Incorporating cultural competency to provide equitable and quality patient care is challenging in the absence of colleagues with disability (Marks, 2007). Achieving cultural competency and cultural humility in nursing practice requires lifelong learning and critical self-reflection to be fully knowledgeable about cultures other than your own. With these pieces one can build cultural competency. As nursing education incorporates the value of various disabilities in nursing care within the curriculum, students with and without disability can appreciate the value of colleagues with disability in their nursing practice.

Fostering cultural humility requires understanding differences between cultural competence and humility (Moreland, 2021). Cultural competency implies a discrete endpoint where one can function with a thorough knowledge of the mores and beliefs of another culture and an intellectual understanding of culture. Cultural humility acknowledges that it is impossible to be adequately knowledgeable about cultures other than one's own and necessitates commitment for active engagement in life-long learning and critical self-reflection. Nursing care must move from cultural competency. But without colleagues who have disability, cultural humility cannot be achieved. Disability culture is unique; the presence of colleagues with disability will contribute to nursing care and cultural humility.

---

**...without colleagues who have disability, cultural humility cannot be achieved.**

Integrating fundamental concepts of the *American Disabilities Act* (ADA, 1990) within nursing education and practice is imperative. Cultural humility can be enhanced by incorporating an understanding that “...individuals with disabilities are a discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful

unequal treatment...”within nursing practice ([ADA, 1990](#), section 2.a.1.7). Moreover, deconstructing the systemic processes that have “...relegated [people with disability] to a position of political powerlessness in our society” (section 2.a.1.7) can create opportunities to advocate for people with disability.

Achieving cultural humility for people with disability necessitates inclusion of UD principles to promote communication and architectural access for full participation within healthcare. Today, the seven principles of UD guide development of spaces and instruction designs in healthcare structures and systems that are equitable, flexible, simple and intuitive, easily usable with perceptible information, tolerant of errors, and appropriate size and space for approach and use to the greatest extent possible by the greatest number of people.

---

**UDI is an educational framework to apply universal design principles to learning environments with a goal toward greater accessibility for all.**

Incorporating Universal Design for Instruction (UDI) in nursing education and practice is another way to improve communication access and achieve disability cultural humility ([Levey, 2018](#)). UDI is an educational framework to apply universal design principles to learning environments with a goal toward greater accessibility for all. By designing learning modules with UDI for people with various learning styles, designs are often substantially more usable for all learners. UDI can enhance effective communication for diverse learners across learning environments between nurses and patients. For example, building UDI awareness and developing faculty roles have been cited as integral parts in building successful inclusive practices and teaching effectiveness in postsecondary education and can be included in patient education. Practicing proactive, versus reactive, approaches to UD uses a holistic approach; reduces the stigma of disclosure; saves time when accommodations are requested; and reduces marginalization by peers and faculty due to perceptions of differential treatment ([Levey, 2018](#)).

### **Access and Equity in Nursing**

Accessibility is giving equitable access to everyone along the continuum of human ability and experience ([AAM, 2022](#)). Access includes physical environment; access to and representation in content for everyone; and inclusion of legal definitions and provisions of the *Americans with Disabilities Act* ([ADA, 1990](#)). Inclusive design expands access beyond compliance. As equity is not the natural state, achieving equity, or fair and just treatment of everyone, requires deliberate attention to more than matters of recruitment, hiring, compensation, promotion, and retention of nurses with disability ([AAM, 2022](#)). Deliberate consideration, including time, resources, and consideration, is necessary to recognize past exclusion and achieve genuine inclusion to develop relationships of trust and understanding.

Consistent evidence demonstrates the need for equity with respect to gender, race, and ethnicity in our healthcare workforce ([Hilton et al., 2020](#)). Equity encompasses policies and practices used to ensure fair treatment, access, opportunity, and advancement for all people, while at the same time trying to identify and eliminate barriers that have historically prevented full participation by some individuals or groups ([Indiana Arts Commission, 2022](#)). Organizations that embrace access within Diversity, Equity, Inclusion, and Accessibility (DEIA) initiatives can foster cultures that minimize bias and recognize and address systemic, structural inequities for nurses with disability.

---

**Inclusive design expands access beyond compliance.**

---

**For nurses with disability, essential functions for employment and struggles to obtain accommodations often prohibit working in clinical settings.**

For nurses with disability, essential functions for employment and struggles to obtain accommodations often prohibit working in clinical settings ([Clarkson et al., 2003](#)). In a 2011 study, nurses with hearing disability reported need for minimal accommodations. However, many either left or contemplated leaving employment in hospital settings because their accommodations were either not provided or were ignored ([Neal-Boylan, 2011](#)).

[Levey \(2014\)](#) reported that many faculty lacked experience and knowledge to work with students with disability in classroom and clinical settings, resulting in the requirement for students with a disability to perform activities that their non-disabled peers were not required to perform. Additionally, faculty also reported using the medical/individual model for admitting and educating students with disabilities and perceiving that students with vision disability were the least likely to succeed in their program and the profession. Eliminating the pedagogy of oppression for students with disability in nursing education may prevent overt and covert discrimination experienced by nurses with disability in clinical settings.

With the COVID-19 pandemic, UD has emerged as a key approach to create spaces for equitable access ([Lanteigne & Oram, 2020](#); [Levey et al., 2021](#)) to healthcare in services, buildings, and community spaces in a post-pandemic world ([Lanteigne & Oram, 2020](#)). Students and nurses with disability struggle to articulate discrimination that they experience due to their disability, both with nursing colleagues and in clinical settings. Because systemic barriers tend to be “hidden in plain sight” ([Pulrang, 2014b](#)) and easy to fix but often ignored, employing nurses with disability who directly experience the barriers provides an opportunity and incentive to advocate for change.



Systemic barriers include policies, practices, or procedures that result in unequal access or exclusion of a particular group. For example, systemic barriers may include a physical environment that is not accessible; lack of relevant assistive technology (e.g., assistive, adaptive, and rehabilitative devices); and, negative attitudes of people towards disability ([NCBDDD, 2020a](#)). These barriers compromise the active participation of students, nurses, and patients with disability with barriers, such as high counters; inaccessible bathrooms and examination tables; lack of large-print material; videos that do not include captioning for health messages; and use of technical language, long sentences, and words with many syllables.

Access and equity within nursing is also impacted by words and actions misguided by good will and unexamined assumption rather than hostility ([Pulrang, 2014a, 2016, 2020](#)). With the lack of disability training in nursing education and employment, nurses often perpetuate beliefs or practices that can be offensive to colleagues and patients with disabilities. People often think that their beliefs about disability are progressive, when in fact they may be two or three decades out of date ([Pulrang, 2014a](#)). For example, while euphemistic language such as ‘differently abled’ or ‘handi-capable’ may be used because “disability sounds too negative,” these terms primarily serve to eliminate uneasiness of the group doing the labeling and can cause more harm than good ([Pulrang, 2014a](#)). Terms like ‘differently abled’ can further stigmatize and marginalize nurses with disabilities, as it suggests that disability is an individual problem and denies the interaction between an individual’s body, and the social, cultural, and political structures.

---

**People often think that their beliefs about disability are progressive, when in fact they may be two or three decades out of date.**

---

**Disability assumptions are deeply-rooted in societal norms.**

Including conversations about ableism within DEIA efforts in nursing education and practice can dismantle negative assumptions about disability. Disability assumptions are deeply-rooted in societal norms. People with disability believe that ‘well-meaning ableism’ is due to misinformation, honest mistakes, or lack of proper ‘disability awareness’ rather than hostility ([Pulrang, 2014a](#)). Words do matter and the persistence of anti-disability language in day-to-day lives can erode self-esteem and prevent delivery of nursing care. With continued adherence to outmoded ‘functional abilities’ in nursing education and job descriptions based on erroneous assumptions about people with disability, we effectively exclude many who could ensure and innovate accessible and equitable nursing practice.

### **Who is at Risk?**

The absence of nurses with disability in practice creates an incubator of risk for patients. The lack of disability cultural competency and cultural humility perpetuates the ongoing research that documents experiences of discrimination among nursing students and nurses with disabilities ([Neal-Boylan & Miller, 2020](#)). Unfounded issues of safety often preclude nurses with disability in practice. With ongoing misconceptions as to the abilities and innovations that nurses with disability can bring to patient care, nurses with disability working in clinical settings are significantly underrepresented.

---

**The absence of nurses with disability in practice creates an incubator of risk for patients.**

According to the 1999 Institute of Medicine (IOM) *To Err is Human* report, no relationship has connected disability status and medical errors or patient safety ([IOM, 1999](#)). The IOM report further noted that when people make mistakes, it is most often caused by faulty systems, processes, and conditions (e.g., basic flaws in how the health system is organized) and not the result of individual recklessness or actions of a particular group. Redesigning environmental and structural interventions beyond individual level practices can support nurses with disability to provide nursing care and encourage all nurses to provide anti-ableist, equitable nursing care, and healthcare ([Brown et al., 2019](#)).

---

**Students and nurses with disabilities can challenge negative stereotypes and support colleagues and patients to adopt disability-positive approaches.**

Similar to other marginalized communities, nurses with various disabilities and their allies can effectively advocate for systemic or institutional accessibility (e.g., ramps, elevators, healthcare interpreters for patients with limited English proficiency and deaf and hard of hearing). Advocating for dismantling physical and communication barriers, along with ableist policies, laws, regulations, and practices that exclude people with disability from full participation in their healthcare ([Finkelstein, 2020](#)), can improve employment of nurses with disability and nursing care. By including core values of equity, participation, and empowerment within accessible, disability-friendly systems, everyone can receive support to enjoy their full health potential and have control over their health and healthcare ([WHO, 1986](#)).

Nurses with disability can also ameliorate the internalized sense of shame and discriminatory ideas and prejudices from our healthcare structures, culture, and society ([Finkelstein, 2020](#)). Students and nurses with disabilities can challenge negative stereotypes and support colleagues and patients to adopt disability-positive approaches. Ensuring that nurses are competent in dismantling ableism and implementing UD for structural and environmental access benefits all patients who receive nursing care in our healthcare system.

### **Recommendations for Nursing Education and Practice**

Ernest Grant, PhD, RN, president of the American Nurses Association, reported that as working conditions declined during the pandemic, and nurses also reported the negative impact on their mental health with burnout and job termination (Nelson, 2021). Grant's report of the three most pressing issues in nursing included: 1) mental health and well-being of nurses (including stigma related to seeking care for mental health issues); 2) workforce; and, 3) social justice issues is timely. Moving forward from the COVID-19 pandemic is an opportunity to develop improved worksite environmental structures and policies to support nurses who experience various permanent or temporary disabilities, including mental health disabilities, occupational stress, or aging related concerns. Stigma can be dispelled by appreciating the strengths and weaknesses of all nurses and the role of collaborative practice to create an inclusive work environment (Matt, 2015).

Many individual accommodations can benefit all nurses, whether or not a disability is identified (Matt, 2015). Accommodations such as shorter workdays or nights; welcoming break rooms; scheduled wellness breaks; and stress management techniques are approaches that can benefit everyone (IOM, 2008; Milliken et al., 2007). When purchasing new equipment (e.g., feeding, intravenous, and patient-controlled analgesia pumps; blood glucose monitors), include colleagues with low vision on the purchasing team to consider readability of screens with enlargeable text displays or audio output (Matt, 2015). Flexibly designed equipment and information models accessibility for patients and benefits everyone. Healthcare organizations can highlight these accomplishments to provide accessible environments and accommodations that change practices and improve patient outcomes.

---

**Many individual accommodations can benefit all nurses, whether or not a disability is identified.**

---

**A social model of disability views limitations as a mismatch between a person and the environment...**

The COVID-19 pandemic provided a unique opportunity for disability activists and scholars to amplify their shared goal to eliminate unjustified assumptions inherent in the medical model by empowering people with disability through their slogan "Nothing About Us Without Us" (Beaudry, 2016; Charlton, 2000). It also allowed for alternative frameworks to incorporate into healthcare education and practice. For example, the social model of disability views disability as a social phenomenon caused by social oppression and prejudices (Beaudry, 2016). A social model of disability views limitations as a mismatch between a person and the environment (e.g., in a world without stairs, being unable to climb them is not a problem) (Peppar et al., 2021).

As nurses expand the framing of disability beyond a medical model to include a social model perspective, disability is seen as a difference and not a deficiency or abnormality (Gill, 1994). Within the social model, disabling qualities reside in the environment that limits opportunities (i.e., access and attitudinal barriers). Colleagues with disability have a unique perspective to bring to the nursing profession, not a deficit.

### **Valued Colleagues**

Legislative decisions continue to focus on the need to improve community participation and employment among people with disability as valued colleagues. On June 25, 2021, President Biden signed Executive Order (EO) 14035, "Diversity, Equity, Inclusion, and Accessibility in the Federal Workforce," for a coordinated government-wide initiative to promote diversity, inclusion, and equity in the federal workforce and to expand its scope to include accessibility (Exec. Order No. 14035, 2021). EO 14035 advances equity for employees with disability with the leadership of the federal government to model employment of individuals with disability. We have a renewed opportunity to advance equity for nurses with disability, assess current hiring practices and equity in employment, and improve processes to request reasonable accommodations for all.

Students and nurses with disability continue their reluctance to self-identify as people with disability due to stigma; lack of awareness and knowledge regarding disability rights/responsibilities under the law; and feelings or perceptions that they can handle it without accommodations (Ali et al., 2013; Elcock, 2014; Neal-Boylan & Smith, 2016). A 2022 survey of 714 U.S. physicians in outpatient practices noted the following results: 1) 21% could not identify who pays for needed accommodations; 2) 36% reported little or no knowledge about their legal responsibilities; 3) 68% felt at risk for ADA lawsuits; and, 4) 71% did not know who determines accommodations (Iezzoni et al., 2022).

---

**Disability is, in fact, a natural part of the human experience.**

---

**Nurses with disability add greatly needed value as our colleagues.**

The need to expand our healthcare talent pool to eliminate gender, ethnicity, and race-based discrimination is becoming more evident in the research literature (Hilton et al., 2020). Including healthcare providers with heterogeneous disabilities would likely create innovative "ways of knowing." As we embrace students and nurses with disability as colleagues, the nursing profession has a unique potential to both recognize the needs within the disability community as a marginalized or discriminated-against group and address the pervasive structural and systemic ableism within nursing education, nursing practice, and healthcare. Disability is, in fact, a natural part of the human experience. Nurses with disability add greatly needed value as our colleagues.



## **Inclusion and Accessibility Solutions**

Legislative decisions, policies, and practices can positively shape the diversity of the nursing profession within its workforce. Including marginalized populations and welcoming students and nurses with disabilities can equalize opportunities by incorporating universal accessibility approaches in education and practice. While Yocom's (1996) functional abilities have had a wide and long term impact on preventing students and nurses with disability from entering and remaining in nursing practice, nurses have a unique opportunity to include accessibility solutions within the nursing profession.

Following more than two decades of work by the American Association of Medical Colleges (AAMC), nurse leaders in national organizations can also initiate widespread efforts to educate and employ nurses with disabilities (Matt et al., 2015) and to recognize the value of practicing nurses with disability toward patient care. As the 'Voice of Disability in Nursing,' the National Organization of Nurses with Disability (NOND, n.d.) works to promote equity for people with disabilities and chronic health conditions in nursing. NOND board members collaborate with national organizations to implement best practices in education and employment to ensure inclusion and access.

---

**...nurse leaders in national organizations can also initiate widespread efforts to educate and employ nurses with disabilities...**

Nurse leaders have a critical role to make similar changes advanced by the AAMC within the nursing profession through the following actions: providing education and retraining; changing stakeholder attitudes; implementing practice changes; and creating policy change (Evans & Marks, 2015). The future of nursing practice will be shaped by ongoing changes in the workplace, work, and workforce. The National Institute for Occupational Safety and Health (NIOSH) notes that shifting workforce demographics will support changes through opportunities and challenges (Syron et al., 2020). For example, imbalanced power relationships that often occur by race/ethnicity, gender, sexual orientation, age, class, disability, and/or neurodiversity can be addressed to prevent various occupational health inequities. Neurodiversity in the workforce can include variations in brain function, such as autism, attention deficit/hyperactivity disorder (ADHD), and dyslexia.

For nurses with disability, the following inclusion and accessibility solutions can address many workplace and work issues:

- Reviewing policies and practices to identify and correct institutional bias
- Improving data collection to better understand disparities
- Implementing policies and programs to reduce occupational health inequities
- Fostering workplace inclusivity and worker empowerment
- Developing inclusive technology

The most recent significant regulation impacting nurses with disability in the healthcare is the Office of Federal Contract Compliance Programs (OFCCP) revisions to the current regulations implementing the nondiscrimination and affirmative action regulations of section 503 of the Rehabilitation Act of 1973, effective March 24, 2014 (Affirmative Action, 2013). The OFCCP rule establishes a nationwide 7% utilization goal for qualified workers with disability, resulting in more outreach by healthcare organizations wanting to hire and retain nurses with disability (Marks & McCulloh, 2016).

---

**A critical need exists for nurse educators and human resource managers to proactively recruit, educate, and employ nurses with disabilities...**

A critical need exists for nurse educators and human resource managers to proactively recruit, educate, and employ nurses with disabilities and chronic health conditions. To hire more people with disability, the Society for Human Resource Management (SHRM) recommends creating an inclusive culture, broadening your talent practices, fostering wider awareness, and prioritizing access for all (Stadtler, 2019).

## **Advocating for Innovation in Nursing**

Advocating for change in healthcare institutions and nursing practice requires a roadmap of measurable, tangible actions to achieve disability equality. First, ensure that diversity, equity, inclusion, and accessibility (DEIA) and systematic efforts to remove ableist language and structural barriers are put in place to support individual healthcare practices for patients and healthcare providers. Second, collaborate with the American Nurses Credentialing Center (ANCC) Magnet Recognition Program® to integrate disability pride and removal of ableist structures and practices. Third, achieve recognition for your DEIA efforts to promote full inclusion of people with disability, to inspire accessible innovation for all, and to foster cultures of inclusion through Disability:IN's "Best Places to Work for Disability Inclusion" (Disability:IN, n.d.). Collaborating with NOND can also influence the provision of culturally responsive nursing education and practice to create systemic improvements.

As we reframe perspectives about people with a wide range of different needs, we can ask the following questions:

- What about this space is disabling someone (e.g., chairs, absence of visual or auditory cues)?
- Who is unable to access this service or program?
- How can we accommodate you to best meet your needs?

We can also incorporate resources noted in Table 3

### **Table 3. Resources to Develop a Diversity, Equity, Inclusion, and Accessibility Strategic Action Plan**

Strategy	Resources
<p><b>ENCOURAGE</b> conversation between access and equity and worksite about the potential for discrimination that may preclude hiring, retention, and employment for nurses with disability.</p>	<p><b>National Organization of Nurses with Disabilities (NOND)</b> (<a href="http://www.NOND.org">www.NOND.org</a>). NOND promotes best practices in education and employment through the dissemination of resources to individuals, nursing and disability organizations, and educational and healthcare institutions.</p>
<p><b>DISSEMINATE</b> information and examples on developing accommodations to facilitate knowledge and self-efficacy among employers and clinical sites. Create collaborative partnerships with clinical sites to increase accessibility.</p>	<p><b>State Board of Nursing (BON).</b> Employees should know what their state BON says about employees with disability and required accommodations and work with the BON to develop inclusive regulations for nurses with disability.</p>
<p><b>UNDERSTAND</b> the unique role of essential functions for employment and develop clear guidelines for recruiting, retaining, and promoting nurses with disability .</p>	<p><b>ADA National Network</b> (<a href="http://www.adata.org">www.adata.org</a>). ADA National Network provides information, guidance and training on the Americans with Disabilities Act (ADA). Regional Centers can tailor information to meet the needs of education, business, government, and individuals at local, regional and national levels.</p>
<p><b>CREATE</b> training hubs for advocacy skills, adaptive technology, and disability resources within nursing employment to inform all nurses, including those with disabilities, so that healthcare providers and nurses will be able to provide these resources to patients.</p>	<p><b>The Association of Medical Professionals With Hearing Losses (AMPHL)</b> (<a href="http://www.amphl.org/">www.amphl.org/</a>). AMPHL promotes advocacy and mentorship, along with the development of products (e.g., see-through surgical masks).</p>
<p><b>ADOPT</b> policies that are uniformly applied to guide advocacy for and support of nurses with disability in recruiting, hiring, and promoting in nursing careers. Adhering to rigid essential functions can promote inconsistencies across nurses.</p>	<p><b>JAN's Workplace Accommodation Toolkit</b> (<a href="https://askjan.org/toolkit/The-JAN-Workplace-Accommodation-Toolkit.cfm">https://askjan.org/toolkit/The-JAN-Workplace-Accommodation-Toolkit.cfm</a>) is a free, comprehensive online resource for employers seeking to move beyond basic compliance with the Americans with Disabilities Act (ADA) in order to create more disability-inclusive workplaces.</p> <p><b>4 Ways to Hire More People with Disabilities - Society for Human Resource Management</b> (<a href="https://www.shrm.org/resourcesandtools/hr-topics/behavioral-competencies/global-and-cultural-effectiveness/pages/4-ways-to-hire-more-people-with-disabilities.aspx">https://www.shrm.org/resourcesandtools/hr-topics/behavioral-competencies/global-and-cultural-effectiveness/pages/4-ways-to-hire-more-people-with-disabilities.aspx</a>)</p>
<p><b>TRAIN</b> employers, nurses, clinical sites, and disability student services on strategies to integrate the social model of disability and disability history within existing curricula.</p>	<p><b>Disability Studies Degrees</b> (<a href="http://dsq-sds.org/article/view/963/1147">http://dsq-sds.org/article/view/963/1147</a>). Collaborate with disability studies programs to develop interdisciplinary coursework that provides information regarding disability history, culture, arts, and identity, along with dual degrees.</p> <p><b>Disability History Museum (DHM)</b> (<a href="http://www.disabilitymuseum.org">http://www.disabilitymuseum.org</a>). DHM is a virtual project, it has no bricks or mortar. It aims to provide all site visitors, people with and without disability, researchers, employers, and nurses with disability, with a wide array of tools to help deepen their understanding of human variation and difference, and to expand appreciation of how vital to our common life the experiences of people with disability have always been. A variety are available aimed at changing cultural values, notions of identity, laws and policies have shaped and influenced the experience of people with disability, their families and their communities over time.</p> <p><b>Bodies of Work</b> (<a href="http://www.ahs.uic.edu/dhd/bodiesofwork/">www.ahs.uic.edu/dhd/bodiesofwork/</a>). Incorporate "bodies of work" to explore innovative forms of artistic expression to explore the disability experience and advance the rights of people with disability.</p>
<p><b>ENSURE</b> data collection is being undertaken related to the participation and successes of employees with disability.</p>	<p><b>Rush University Medical Center</b> (<a href="http://www.rushu.rush.edu">http://www.rushu.rush.edu</a>). Rush has been at the forefront of institutions promoting disability rights, the Americans with Disabilities Act (ADA), and Section 504 of the Rehabilitation Act of 1973. Rush ADA Task Force to oversee their ADA Transition Plan to develop "Programs Related to Disability Rights and Accommodations" (<a href="http://tinyurl.com/nns4eak">http://tinyurl.com/nns4eak</a>) that make their university and medical center more accessible for improved access and services, outreach, and education. Developing questionnaires that capture the qualitative and quantitative success of students and nurses with disability, along with the impact on their patients, peers, faculty, and employers.</p>



---

Nurses with disability who advocate for systems change can effectively address systemic healthcare discrimination and accelerate equitable healthcare for everyone. A first step is to acknowledge the existence of discriminatory practices and implicit bias that result in inequities related to the intersectionality of disability, race, gender, ethnicity, and sexual orientation in healthcare settings (Togioka et al., 2022). It is important to recruit, retain, and promote people with disability in nursing. Educators, students, and practitioners need resources to learn about the impact of structural ableism in healthcare on patient outcomes. Nurses with disability and allies can create welcoming environments by including disability-positive messaging to improve the quality of nursing care for everyone. Such actions can potentially eliminate indirect, subtle, and possibly unintentional macroaggressions and microaggressions.

---

**It is important to recruit, retain, and promote people with disability in nursing.**

## Conclusion

Following Thorne's (2020) advice, it is time "...to shake our collective selves free of that convenient illusion that we are off the hook because we know ourselves to be kind, compassionate, and professional in all of our patient interactions regardless of race, [disability], or privilege. That is simply no longer enough" (p. 1-2). Nurses with disability bring a unique and innovative set of nursing skills that can transform and improve healthcare and health outcomes, increase universal design for equitable access, and foster accessible and acceptable learning for everyone. Our disability and our nursing care matters. As highlighted by the pandemic, 'typical' care is not always best.

---

**...we must examine all barriers that impact nurses with disability and nursing care recipients.**

When assessing equity, we must examine all barriers that impact nurses with disability and nursing care recipients (Wallon et al., 2022). To realize a more inclusive and equitable healthcare environment, we have a unique opportunity to create a 'new normal' that develops and implements universally accessible structures for all healthcare providers and recipients. Creating this new normal of care requires building leaders among students and nurses with disability to incorporate their lived experience and reframe disability and illness beyond the medical model viewpoint.

Disability, like any other minority group, contains its own community whose members often view it as a source of pride dependent upon their individual experiences with that part of their identity. Integrating a social model approach into disability education in pre- and post-licensure training programs will foster deeper understanding of the meaning and nature of disability and intersectionality with social, cultural, interpersonal, and political contexts. Including the social model perspective within nursing practice can de-stigmatize disease, illness, and disability; eliminate systemic and historic discrimination; and, challenge the view of disability as an individual deficit or defect. Disability is more than a condition to fix or cure solely through medical intervention and/or rehabilitation. Given the historical roots of the profession of nursing in activism and social change, nurses such as Maria, Nushi, and Anthony can expand healthcare from a medicalized view of disability as an inherently negative trait or societal burden to a marker of diversity and the hallmark of equitable care.

---

**Disability is more than a condition to fix or cure solely through medical intervention and/or rehabilitation.**

## Authors

### Beth Marks, PhD, RN, FAAN

Email: [bmarks1@uic.edu](mailto:bmarks1@uic.edu)

ORCID ID: 0000-0002-8243-5643

Beth Marks is a Research Associate Professor in the Department of Disability and Human Development, University of Illinois at Chicago and Past President of the National Organization of Nurses with Disabilities (NOND); and, she co-produced a documentary film entitled, *Open the Door, Get 'Em a Locker: Educating Nursing Students with Disabilities*. Beth directs research programs related to the empowerment and advancement of people with disabilities through health promotion initiatives and primary health care. She has also published numerous articles and books related to health promotion, health advocacy, and primary health care including the *Health Matters: The Exercise and Nutrition Health Education Curriculum for People with Developmental Disabilities* and *Health Matters for People with Developmental Disabilities: Creating a Sustainable Health Promotion Program*.

### Jasmina Sisirak, PhD, MPH

Email: [jsisirak@uic.edu](mailto:jsisirak@uic.edu)

ORCID ID: 0000-0002-3389-5651

Jasmina Sisirak is a Research Assistant Professor, Department of Disability and Human Development, University of Illinois at Chicago. She directs health promotion research projects related to nutrition and health promotion for persons with intellectual and developmental disabilities. She has published articles, chapters, and research briefs in the areas of disability,

health, and nutrition and has co-authored two books, *Health Matters: The Exercise and Nutrition Health Education Curriculum for People with Developmental Disabilities* and *Health Matters Creating a Sustainable Health Promotion Program*.

## References

Affirmative action and nondiscrimination obligations of contractors and subcontractors regarding individuals with disabilities, 41 CFR § 60. (2013). <https://federalregister.gov/a/2013-21228>

Ailey, S. (2022, January 20). *Are we equipped to care for people with intellectual, developmental disabilities? Low accreditation standards are contributing to health disparities*. Medpage Today. <https://www.medpagetoday.com/opinion/second-opinions/96768>

Ali, A., Scior, K., Ratti, V., Strydom, A., King, M., & Hassiotis, A. (2013). Discrimination and other barriers to accessing health care: Perspectives of patients with mild and moderate intellectual disability and their carers. *PLoS One*, *8*(8), e70855. <https://doi.org/10.1371/journal.pone.0070855>

American Alliances of Museums. (2022). *Definitions of diversity, equity, accessibility, and inclusion*. <https://www.aamus.org/programs/diversity-equity-accessibility-and-inclusion/facing-change-definitions/>

Americans With Disabilities Act of 1990, 42 U.S.C. § 12101 et seq. (1990).

Beaudry, J. S. (2016). Beyond (models of) disability? *Journal of Medicine and Philosophy*, *41*(2), 210-28. <https://doi.org/10.1093/jmp/jhv063>

Brown, A. F., Ma, G. X., Miranda, J., Eng, E., Castille, D., Brockie, T., Jones, P., Airhihenbuwa, C. O., Farhat, T., Zhu, L., & Trinh-Shevrin, C. (2019). Structural interventions to reduce and eliminate health disparities. *American Journal of Public Health*, *109*(S1), S72-S78. <https://doi.org/10.2105/AJPH.2018.304844>

Brillhart, B. A., Jay, H., & Wyers, M. E. (1990). Attitudes toward people with disabilities. *Rehabilitation Nursing*, *15*(2), 80-85. <https://doi.org/10.1002/j.2048-7940.1990.tb01439.x>

Bristow, L. R., Butler, A. S., & Smedley, B. D. (2004). *In the nation's compelling interest: Ensuring diversity in the health-care workforce*. National Academies Press. <https://doi.org/10.17226/10885>

Charlton, J. I. (2000). *Nothing about us without us: Disability oppression and empowerment*. University of California Press.

Cherney, J. L. (2011). The rhetoric of ableism. *Disability Studies Quarterly*, *31*(3). <https://dsq-sds.org/article/view/1665/1606#top>

Cherney, J. L. (2020). *Best practices for avoiding ableist terminology*. Nevada Today. <https://www.unr.edu/nevada-today/blogs/2020/avoiding-ableist-terminology>

Clarkson, P. J., Keates, S., Coleman, R., & Lebbon, C. (Eds.). (2003). *Inclusive design: Design for the whole population*. Springer.

Cooper, L. A., & Powe, N. (2004). *Disparities in patient experiences, health care processes, and outcomes: The role of patient-provider racial, ethnic, and language concordance*. The Commonwealth Fund.

<https://www.commonwealthfund.org/publications/fund-reports/2004/jul/disparities-patient-experiences-health-care-processes-and>

Cooper, L. A., Roter, D. L., Johnson, R. L., Ford, D. E., Steinwachs, D. M., & Powe, N. R. (2003). Patient-centered communication, ratings of care, and concordance of patient and physician race. *Annals of Internal Medicine*, *139*(11), 907-915. <https://doi.org/10.7326/0003-4819-139-11-200312020-00009>

Disability:IN. *Home Page*. <https://disabilityin.org/>

Eickmeyer, S. M., Do, K. D., Kirschner, K. L., & Curry, R. H. (2012). North American medical schools' experience with and approaches to the needs of students with physical and sensory disabilities. *Academic Medicine*, *87*(5), 567-73.

<https://doi.org/10.1097/ACM.0b013e31824dd129>

Eisenmenger, A. (2019). *Ableism 101: What it is, what it looks like, and what we can do to fix it*. Access Living.

<https://www.accessliving.org/newsroom/blog/ableism-101/>

Elcock, K. (2014). Supporting students with disabilities: Good progress, but must try harder. *British Journal of Nursing*, *23*(13), 758.

<https://doi.org/10.12968/bjon.2014.23.13.758>

Evans, B., & Marks, B. (2015). *Assisting students with disabilities to enroll in allied health programs and secure jobs*. Western Interstate Commission for Higher Education.

Exec. Order No. 14035, 3 C.F.R. 34593-34603 (2021). <https://www.federalregister.gov/documents/2021/06/30/2021-14127/diversity-equity-inclusion-and-accessibility-in-the-federal-workforce>



Finkelstein, R. (2020, August 20). *Disability discrimination 101 and ways to be anti-ableist*. Diversability. <https://mydiversability.com/blog/2020/8/20/what-you-need-to-know-about-ableism>

FitzGerald, C., & Hurst, S. (2017). Implicit bias in healthcare professionals: A systematic review. *BMC Medical Ethics*, 18(1), 19. <https://doi.org/10.1186/s12910-017-0179-8>

Gill, C. J. (1994). A bicultural framework for understanding disability. *Family Psychologist*, 10(4), 13-16.

Halligan, P., Martyn, K., Pace, K., Pace, A., & Gee, N. (2019). Universal Design for Learning to support nursing students: Experiences in the field. *The AHEAD Journal*. <https://www.ahead.ie/journal/Universal-Design-for-Learning-to-support-nursing-students-Experiences-in-the-Field>

Hilton, E. J., Lunardi, N., Sreedharan, R., Goff, K. L., Batakji, M., & Rosenberger, D. S. (2020). Two sides of the same coin: Addressing racial and gender disparities among physicians and the impact on the community they serve. *Anesthesiology Clinics*, 38(2), 369-377. <https://doi.org/10.1016/j.anclin.2020.01.001>

Hoffman, K. M., Trawalter, S., Axt, J. R., & Oliver, M. N. (2016). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between Blacks and Whites. *Proceedings of the National Academy of Sciences of the United States of America*, 113(16), 4296-4301. <https://doi.org/10.1073/pnas.1516047113>

Iezzoni, L.I., Rao, S. R., Ressler, J., Bolcic-Jankovic, D., Agaronnik, N. D., Lagu, T., Pendo, E., & Campbell, E. G. (2022). US physicians' knowledge about The Americans With Disabilities Act And accommodation of patients with disability. *Health Affairs*, 41(1), 96-104. <https://doi.org/10.1377/hlthaff.2021.01136>

Indiana Arts Commission. (2022). *Inclusion diversity equity and access (IDEA)*. <https://www.in.gov/arts/programs-and-services/resources/inclusion-diversity-equity-and-access-idea/>

Institute of Medicine, Committee on Quality of Health Care in America. (2000). *To err is human: Building a safer health system* (Kohn, L. T., Corrigan, J. M., Donaldson, M. S., eds.). National Academy Press. <http://doi.org/10.17226/9728>

Institute of Medicine, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. (2002). *Unequal treatment: Confronting racial and ethnic disparities in health care* (B. D. Smedley, A. Y. Stith, & A. R. Nelson, Eds.). National Academies Press. <https://doi.org/10.17226/12875>

Institute of Medicine, Committee on the Future Health Care Workforce for Older Americans. (2008). *Retooling for an aging America: Building the health care workforce*. National Academies Press. <https://doi.org/10.17226/12089>

Jackson, C. S., & Gracia, J. S. (1974). Addressing health and health-care disparities: The role of a diverse workforce and the social determinants of health. *Public Health Reports*, 129(Suppl 2), 57-61. <https://doi.org/10.1177/003335491412915211>

Janz, H. L. P. (2019). Ableism: The undiagnosed malady afflicting medicine. *Canadian Medical Association Journal*, 191(17), E478-E479. <https://doi.org/10.1503/cmaj.180903>

Lanteigne, V., & Oram, M. (2020, September 1). *Universal Design: A tool for creating equitable spaces after COVID-19*. Well. <https://resources.wellcertified.com/articles/universal-design-a-tool-for-creating-equitable-spaces-after-covid-19/>

Lehrer, R. (2020). *Golem Girl: A Memoir*. 2020. Penguin/Random House.

Levey, J. A. (2014). Attitudes of nursing faculty towards nursing students with disabilities: An integrative review. *Journal of Postsecondary Education and Disability*, 27, 321-332. <https://files.eric.ed.gov/fulltext/EJ1048784.pdf>

Levey, J. A. (2018). Universal Design for Instruction in nursing education: An integrative review. *Nursing Education Perspectives*, 39(3), 156-161. <https://doi.org/10.1097/01.NEP.0000000000000249>

Levey, J. A., Burgstahler, S., Montenegro-Montenegro, E., & Webb, A. (2021). COVID-19 Pandemic: Universal Design creates equitable access. *Journal of Nursing Measurement*, 29(2), 185-187. <https://doi.org/10.1891/JNM-D-21-00048>

National Center on Birth Defects and Developmental Disabilities. (2020a). *Common barriers to participation experienced by people with disabilities*, in *disability & health home disability inclusion*. Centers for Disease Control and Prevention. <https://www.cdc.gov/ncbddd/disabilityandhealth/disability-barriers.html>

National Center on Birth Defects and Developmental Disabilities. (2020b). *Disability impacts all of us*. Centers for Disease Control and Prevention. <https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html>

National Council of State Boards of Nursing. (1997). *Guidelines for using results of functional abilities studies and other resources*. Nursing Practice & Educational Committee: NCSBN.

Maisel, J. L., & Ranahan, M. (2022). *Beyond accessibility to universal design*. Whole Building Design Guide. <https://www.wbdg.org/design-objectives/accessible/beyond-accessibility-universal-design>

- Marks, B. (2007). Cultural competence revisited: Nursing students with disabilities. *Journal of Nursing Education*, 46(2), 70-74. <https://doi.org/10.3928/01484834-20070201-06>
- Marks, B., & McCulloh, K. (2016). Success for students and nurses with disabilities: A call to action for nurse educators. *Nurse Educator*, 41(1), 9-12. <https://doi.org/10.1097/NNE.0000000000000212>
- Matt, S. B., Fleming, S. E., & Maheady, D. C. (2015). Creating disability inclusive work environments for our aging nursing workforce. *Journal of Nursing Administration*, 45(6), 325-30. <https://doi.org/10.1097/NNA.0000000000000208>
- Matt, S. B., Maheady, D. C., & Fleming, S. E. (2015). Educating nursing students with disabilities: Replacing essential functions with technical standards for program entry criteria. *Journal of Postsecondary Education and Disability*, 28(4), 461-468. <https://files.eric.ed.gov/fulltext/EJ1093588.pdf>
- Mikton, C., de la Fuente-Núñez, V., Officer, A., & Krug, E. (2021). Ageism: A social determinant of health that has come of age. *The Lancet*, 397(10282), 1333-1334. [https://doi.org/10.1016/S0140-6736\(21\)00524-9](https://doi.org/10.1016/S0140-6736(21)00524-9)
- Milliken, T. F., Clements, P. T., & Tillman, H. J. (2007). The impact of stress management on nurse productivity and retention. *Nursing Economic\$, 25(4)*, 203-10.
- Moreland, C. L. (2021). *Fostering cultural humility in disability services*. Fostering Cultural Humility Workshop. <https://fisafoundation.org/wp-content/uploads/2021/04/Fostering-Cultural-Humility-Workshop-04-07-2021.pdf>
- Murphy, C. (2021). *What is ableism? Here's what you need to know about this form of discrimination*. Health. <https://www.health.com/mind-body/health-diversity-inclusion/what-is-ableism>
- Neal-Boylan, L., Fennie, K., & Baldauf-Wagner, S. (2011). Nurses with sensory disabilities: Their perceptions and characteristics. *Rehabilitation Nursing*, 36(1), 25-31. <https://doi.org/10.1002/j.2048-7940.2011.tb00062.x>
- Neal-Boylan, L., & Miller, M. (2020). How inclusive are we, really? *Teaching and Learning in Nursing*, 15(4), 237-240. <https://doi.org/10.1016/j.teln.2020.04.006>
- Neal-Boylan, L., & Smith, D. (2016). Nursing students with physical disabilities: Dispelling myths and correcting misconceptions. *Nurse Educator*, 41(1), 13-18. <https://doi.org/10.1097/NNE.0000000000000191>
- Nelson, R. (2021, December 30). *Year in review: Reflections on nursing in 2021 with an eye to the future*. Medscape. <https://www.medscape.com/viewarticle/965789>
- National Organization of Nurses with Disabilities. (n.d.) *Home Page*. <https://nond.org/>
- Peppar, E. P., Cyr, M., & Agrawal, R. K. (2021, August 31). *Health equity requires anti-ableism*. American Academy of Pediatrics. <https://publications.aap.org/aapnews/news/15488?autologincheck=redirected>
- Powell, K. (2021). Academia's ableist mindset needs to change. *Nature*, 598, 693-695. <https://media.nature.com/original/magazine-assets/d41586-021-02907-7/d41586-021-02907-7.pdf>
- Pulrang, A., (2014a). *3 ableisms: Part 1 - Well-meaning ableism*. Disability Thinking. <https://disabilitythinking.com/disabilitythinking/2014/04/3-ableisms-part-1-well-meaning-ableism.html>
- Pulrang, A. (2014b). *3 ableisms: Part 2 - Systemic ableism*. Disability Thinking. <https://disabilitythinking.com/disabilitythinking/2014/04/3-ableisms-part-2-systemic-ableism.html>
- Pulrang, A. (2016, January 22). *Disputing "ableism."* Disability Thinking. <https://disabilitythinking.com/disabilitythinking/2016/1/22/disputing-ableism>
- Pulrang, A. (2020, October 25). *Words matter, and it's time to explore the meaning of "ableism."* Forbes. <https://www.forbes.com/sites/andrewpulrang/2020/10/25/words-matter-and-its-time-to-explore-the-meaning-of-ableism/?sh=72b9af87162d>
- Shapiro, J. (2020a). *Oregon hospitals didn't have shortages. so why were disabled people denied care?* NPR. <https://www.npr.org/2020/12/21/946292119/oregon-hospitals-didnt-have-shortages-so-why-were-disabled-people-denied-care#:~:text=Press-,People%20With%20Disabilities%20Were%20Denied%20Care%20In%20Oregon%20Hospitals%20Amid,of%20ventilators%20or%20other%20care>
- Shapiro, J. (2020b, April 15). *People with disabilities fear pandemic will worsen medical biases*. NPR. <https://www.npr.org/2020/04/15/828906002/people-with-disabilities-fear-pandemic-will-worsen-medical-biases>
- Shen, M. J., Peterson, E. B., Costas-Muñiz, R., Hernandez, M. H., Jewell, S. T., Matsoukas, K., & Bylund, C. L. (2018). The effects of race and racial concordance on patient-physician communication: A systematic review of the literature. *Journal of Racial and Ethnic Health Disparities*, 5(1), 117-140.



- Stadtler, D. (2019, February 21). *4 ways to hire more people with disabilities*. Society for Human Resource Management. <https://www.shrm.org/resourcesandtools/hr-topics/behavioral-competencies/global-and-cultural-effectiveness/pages/4-ways-to-hire-more-people-with-disabilities.aspx>
- Steinfeld, E., & Maisel, J. L. (2012). *Universal design: Creating inclusive environments*. 2012. Wiley.
- Syron, L., Rosemberg, M. S., Flynn, M.A., Siven, J., Steege, A., & Tamers, S. L. (2021, October 20). *The Role of Demographics in the Future of Work*. Centers for Disease Control and Prevention. <https://blogs.cdc.gov/niosh-science-blog/2021/10/20/demographics-fow/>
- Thorne, S. (2020). On privilege and fragility. *Nursing Inquiry*, 27(4), e12386. <https://doi.org/10.1111/nin.12386>
- Togioka, B. M., Duvivier, D., & Young, E. (2022). Diversity and discrimination in healthcare. *StatPearls*. <https://www.ncbi.nlm.nih.gov/books/NBK568721/>
- Traylor, A. H., Schmittiel, J. A., Uratsu, C. S., Mangione, C. M., & Subramanian, U. (2010) Adherence to cardiovascular disease medications: does patient-provider race/ethnicity and language concordance matter? *Journal of General Internal Medicine*, 25(11), 1172-1177. <https://doi.org/10.1007/s11606-010-1424-8>
- VanPuymbrouck, L. (2021). Clinicians who report low disability bias score high for ableism at an unconscious level. *Bloom Blog*. <https://hollandbloorview.ca/stories-news-events/BLOOM-Blog/clinicians-who-report-low-disability-bias-score-high-ableism>
- VanPuymbrouck, L., Friedman, C., & Feldner, H. (2020). Explicit and implicit disability attitudes of healthcare providers. *Rehabilitation Psychology*, 65(2), 101-112. <https://doi.org/10.1037/rep0000317>
- Villines, Z. (2021). *What is ableism, and what is its impact?* Medical News Today. <https://www.medicalnewstoday.com/articles/ableism>
- Wallon, R. C., Gossett, J., & Meeks, L. M. (2022). It took a pandemic: Enduring lessons for improving accessibility in medical education. *Disability Compliance for Higher Education*, 27(11),1-15. <https://doi.org/10.1002/dhe.31292>
- World Health Organization. (1986). *The Ottawa Charter for health promotion*. <https://www.who.int/teams/health-promotion/enhanced-wellbeing/first-global-conference>
- Yocom, C. J. (1996). *A validation study: Functional abilities essential for nursing practice*. National Council of State Boards of Nursing, Inc.
- Zazove, P., Case, B., Moreland, C., Plegue, M. A., Hoekstra, A., Ouellette, A., Sen, A., & Fetters, M. D. (2016). U.S. Medical schools' compliance with the Americans With Disabilities Act: Findings from a national study. *Academic Medicine*, 91(7), 979-86. <https://doi.org/10.1097/ACM.0000000000001087>

---

September 30, 2022

DOI: 10.3912/OJIN.Vol27No03Man04

---

**Citation:** Marks, B., Sisirak, J., (September 30, 2022) "Nurses with Disability: Transforming Healthcare for All" *OJIN: The Online Journal of Issues in Nursing* Vol. 27, No. 3, Manuscript 4.

---

## Related Articles

---

**ARTICLE** September 30, 2022

[Faculty Scholarship Addressing Health Disparities with Persons with Intellectual and Developmental Disabilities: A Case Study Based on Boyer's Model of Scholarship](#)

Sarah H. Ailey, PhD, RN, FAAN; Tanya R. Friese, DNP, RN, CNL, USN (Retired)

---

**ARTICLE** September 30, 2022

[Finding the Right Words: Cohesion and Divergence in Inclusive Language Guidelines](#)

Miriam R. B. Abbott, MA

---

**ARTICLE** September 30, 2022

[Care of Students with Disabilities in Schools: A Team Approach](#)

Kathleen Johnson, DNP, RN, NCSN-E, PHNA-BC, FNASN, FAAN

---

**ARTICLE** September 30, 2022

[Access to Secondary Healthcare for People with Intellectual Disabilities: The Role of Community Learning Disability Nurses in Wales](#)

**ARTICLE** September 30, 2022

Adults and Seniors with Autism Spectrum Disorder: Implications for Person Centered Care

Connie Kartz, PhD, RN; Munira Wells, PhD, RN; Sara Muñoz

---

**ARTICLE** September 30, 2022

International Nursing Actions to Reduce Health Inequities Faced by People with Intellectual and Developmental Disability

Kathleen Fisher, RN, MSN, CRNP, PhD; Melissa L. Desroches, RN, CNE, PhD; Daniel Marsden, MSc, SCLD, RNLD, FHEA; Stacey Rees, PhD, MSc, BSc (hons), RN(LD); Ruth Northway, PhD, MSc(Econ), RN(LD); Paul Horan, MA, MA(j.o.), PGDipCHSE, RNID, RNT; Judy Stych, DNP, RN, CDDN; Sarah H. Ailey, PhD, RN, FAAN; Henrietta Trip, RN, DipNS, BN, MHealSc(NURS), PhD(Otago); Nathan Wilson, RN, BSS, MSc, PhD, GCertSc(Statistics)