Cultural Competence Revisited: Nursing Students with Disabilities

Beth Marks, PhD, RN


ABSTRACT

The demographic profile of students in nursing schools is changing in relation to many different cultural backgrounds. Despite the potential for students with disabilities to enrich the nursing profession, nurse educators may be perpetuating historical attitudes, values, and practices that exclude students with disabilities from gaining admission or identifying themselves as people with disabilities. Educators in nursing schools continue to ask whether people with disabilities have a place in the nursing profession, while the more salient question is, “When will people with disabilities have a place in the nursing profession?” More important, as we create environments that welcome students with disabilities into the nursing profession, how does the quality of nursing care improve and become more appropriate for people with different cultural experiences? The purpose of this article is to present the value of recruiting students with disabilities into nursing schools in order to enhance culturally competent nursing care.

Data from the U.S. Census Bureau, Population Division, Population Estimates Program (1999) and Housing and Household Economic Statistics Division (1999) confirm our nation’s growing ethnic and racial diversity and predict that this trend will continue during the next century. While educators continue to prepare the nursing workforce to meet the needs of this growing trend, diversity remains a challenge in nursing education (Lester, 1998a). As the profession becomes more culturally diverse, the demographic profile of students recruited and enrolled in nursing schools is changing in relation to cultural backgrounds. Today’s nursing students have cultural backgrounds shaped by many influences, collectively described as sociocultural factors (Betancourt, Green, & Carrillo, 2002). In addition, students have more sophisticated expectations for their education because of diverse sociocultural factors (e.g., ethnicity, race, nationality, gender, language, sexual orientation, age, physical and mental abilities, socioeconomic status, life experiences).

Despite the potential for students with disabilities to enrich postsecondary education, the academy supports: intellectual, sociocultural, ethical, political, and policy conclusions about disabled people without examining the ignorance, fear, and prejudice that deeply influence [their] thinking. (Longmore, 2003, p. 3)

Nurse educators, as members of the academy, may also perpetuate historical attitudes, values, and practices that exclude students with disabilities from gaining admission or identifying themselves as people with disabilities (Doe, 2003; Evans, 2005; Maheady, 1999; Marks, 2000b). Educators in nursing schools continue to ask whether people with disabilities have a place in the nursing profession, while the more salient question is, “When will people with disabilities have a place in the nursing profession?” More important, as environments that welcome students with disabilities into the nursing profession are created, how does the quality of nursing
care improve and become more appropriate for people with different cultural experiences?

The purpose of this article is to present the value of recruiting students with disabilities into nursing schools in order to enhance culturally competent nursing care. Disability culture and identity will be discussed, cultural competence will be defined, and strategies for implementing culturally competent care for people with disabilities will be reviewed.

**DISABILITY CULTURE AND IDENTITY**

People often associate “disabilities” with an apparent physical impairment, such as paraplegia, quadriplegia, blindness, or deafness. However, the most common chronic conditions causing activity limitations are rarely visually apparent, such as back problems (5.9 million), heart diseases (4.0 million), arthritis (3.7 million), lung or respiratory diseases (3.3 million), orthopedic impairments of extremities (2.7 million), psychiatric conditions (1.5 million), learning disabilities and mental retardation (1.5 million), diabetes (1.2 million), and cancer (0.9 million) (LaPlante & Carlson, 1996).

Conditions commonly viewed as disabling have a much lower prevalence. For example, paralysis is the main cause of activity limitation for 547,000 people (42,000 have quadriplegia and 47,000 have paraplegia) (LaPlante & Carlson, 1996). Hearing impairment is reported as a primary cause of activity limitation for 654,000 people (127,000 report being deaf in both ears), and visual impairment, including blindness, is a main cause of limitation for 727,000 Americans (LaPlante & Carlson, 1996).

**Cultural Minority**

Like race and gender, disability is now considered a natural part of the human experience. People with disabilities are disentangling socially constructed determinants, from those attributable to physiology, identifying themselves as members of a sociocultural group that crosses diagnostic boundaries. In addition, social, political, and economic barriers are considered a large part of daily concerns, not just intrinsic limitations of disability. People with disabilities increasingly report a sense of identity with other disabled people. In a national survey, 45% of disabled people felt that people with disabilities are a minority group in the same sense as racial/ethnic minorities (Louis Harris & Associates, Inc., 1998). The 1998 N.O.D./Harris national survey data also documented that 84% of disabled people (compared to 81% in 1994 and 74% in 1986) feel some sense of identity with others who have disabilities (Louis Harris & Associates, Inc., 1998).

Because people with disabilities have frequently grown up in isolation from each other, they often have not had an opportunity to develop a sense of subculture or shared experiences of social stigma, isolation, and second-class citizenship. Consequently, many people with non-apparent and apparent disabilities do not identify themselves as having a disability due to shame and fear of negative treatment from others.

Currently, people with disparate disabilities are sharing a common identity and a need to claim their human and civil rights. Similar to other minority groups, during the past 20 years, people with disabilities are gaining more control over definitional issues by renaming themselves in accordance to their own perspective. This process serves to reclaim a sense of individual identity and empower a sense of group identity. As people share their experiences of stigma and isolation, attitudinal and architectural barriers, not the intrinsic limitations related to the disability, are viewed as central to disablement. People no longer want to be viewed merely as a “pathological” condition.

**Reclaiming Disability**

As disparate groups of people with disabilities, including parents of children with intellectual disabilities, shared their experiences of second-class citizenship, they came together to demand enforcement of the first civil rights law for people with disabilities to enjoy basic human and civil rights: the Americans with Disabilities Act of 1990 (ADA). The ADA, similar to the Civil Rights Act, attempts to bring fundamental rights and equality to all Americans. As a civil rights law, the ADA focuses on arbitrary, unjust, and outdated societal attitudes and practices that prohibit and/or restrict access for people with disabilities, and seeks to eliminate practices that make people unnecessarily different.

The ADA is not an extension of disability benefits designed to create opportunities for disabled people or to identify a particular group of individuals who are entitled to special treatment. In addition, the ADA is not a legal framework to guide educators in preparing professional nurses who will provide safe and effective care. Instead, the ADA seeks to end discrimination in the areas of employment, state and local governments, public accommodations, commercial facilities, transportation, and telecommunications (U.S. Department of Justice, Civil Rights Division, Disability Rights Section, 1998).

**Culturally Competent Care**

The emergence of “cultural competence” in health care attempts to address the factors that contribute to disparities in health care services (Betancourt et al., 2002). As defined by Betancourt et al. (2002), the construct of cultural competence describes the ability of health systems to provide care to people with diverse values, beliefs, and behaviors, as well as tailor services to meet consumers’ social, cultural, and linguistic needs. Although educators, researchers, and administrators are still trying to define and implement cultural competence in academic settings, the workforce, and health care systems (Betancourt et al., 2002), the primary goal is to deliver high-quality, equitable health care to people, regardless of cultural background.

People with disabilities often state that people’s reactions toward them are more difficult to cope with than their disability (Marks, 2000a). Many of these reactions come from health care professionals who do not understand and have not received any education regarding dis-
ability issues from a social model perspective (Scullion, 1999b). Unfortunately, this creates a cultural conflict, which translates into ableist (discrimination based on disability status) care for patients. Unlike the Civil Rights Act, which passed after tremendous amounts of consciousness-raising and demonstrations, the ADA passed very quietly with little understanding of what disability discrimination (i.e., ableism) entails (Johnson, 1999).

Consequently, discrimination and oppression related to disability status has received little attention in nursing literature (Northway, 1997) and may be widespread in a variety of health care settings (Scullion, 2000). Obstacles range from inaccessible offices and equipment to negative attitudes toward people with disabilities. People with disabilities state they are often treated as a “diagnosis” and not as people (Gill, 1996). Because nurses are often the first health care professionals that people with disabilities or their families meet, they have a tremendous influence on how people are treated and how people with disabilities view themselves. In this way, increasing the number of health care providers with disabilities can only improve health care for people with disabilities.

Organizational Cultural Competence

As our society becomes increasingly multicultural and multilingual, health care administrators are recognizing the need to design organizational systems that provide culturally appropriate care to diverse populations. Studies have linked quality of care with racial and ethnic diversity in the health care workforce (Betancourt et al., 2002). Specifically, research has documented that improvements in cross-cultural communication and racial concordance between health care providers and patients may lead to greater patient involvement in care, higher levels of patient satisfaction, more preventive care, and better health outcomes (Cooper-Patrick et al., 1999; Morales, Cunningham, Brown, Liu, & Hays, 1999). Saha, Taggart, Komaromy, and Bindman (2000) found that African Americans and Hispanic Americans sought care from physicians of their own race because of personal preference and language, not solely because of geographic accessibility. These findings have implications for developing targeted strategies to increase the supply of minority health care providers, including health care providers with disabilities. Unfortunately, although data have not been systematically collected on health care leaders and professionals with disabilities, the literature shows an underrepresentation of racial and ethnic minorities in the health care workforce (Evans, 1999).

In a dialogue with nurses about cultural competence, Lester (1998b) documented the importance of having a diverse nursing workforce in providing long-term, culturally competent care. While this dialogue among nurses did not include nurses with disabilities or disability as a cultural issue, nurses did report enhanced learning from working in diverse environments and working with coworkers of different cultural backgrounds (Lester, 1998b). Nurses also reported enhanced cultural competence learning when they interacted with faculty and fellow students who had diverse cultural backgrounds. This parallels reports of educational environments being enriched when students and nurses without disabilities have the opportunity to work alongside others who have disabilities (Evans, 2005).

Systemic Cultural Competence

While many Americans face obstacles to obtaining quality health care services, people with disabilities are especially vulnerable to the inadequacies of the existing health care system. Similar to racial/ethnic minorities, people with disabilities are sharing their concerns related to disparities in health status, as well as inequitable and inaccessible health care delivery systems (Blumberg, 1994; Rosen, 1994). According to disability rights activist and scholar Margaret Nosek (1996):

Although we are experiencing some progress in removing discrimination on the basis of disability in education, employment, and public services, the mind-set of medical professionals is more deeply rooted in tradition and has been slower to respond. (p. 17)

Barriers to accessing health care services are often related to attitudinal, programmatic, physical, and communication issues (Marks & Heller, 2003), along with inadequate professional education regarding disability issues (Gill, 1991, 1996). Studies show that barriers result in reduced access to health education, preventive health screenings, and health promotion activities (Rimmer, Rubin, & Braddock, 2000).

Attitudes are often the greatest barrier reported by people with disabilities. Attitudinal barriers are experienced by people with disabilities when health care professionals view and treat them as if they were deficient, abnormal, or sick, and in need of prevention, correction, or assimilation (Gill, 1997). Scullion (1999b) reported that “The experiences of disabled people suggest that their contact with nurses is demeaning and disempowering” (p. 648). The definitions and assumptions nurses have about disability are likely to influence the care they provide to people with disabilities. Reportedly, attitudes can change the most when people with disabilities work side-by-side in an equal status with their non-disabled peers (Evans, 2005).

People with disabilities experience programmatic barriers with inflexible appointments that fail to accommodate transportation availability, underinsured or lack of health insurance coverage, geographical unavailability of health services, or lack of assistance in clinic settings (Marks, 2000a). Physical barriers for people with disabilities include inaccessible examination tables, lack of accessible restrooms, and lack of written, pictorial, and Braille signage regarding access information within the facility (Marks & Heller, 2003).

Communication barriers may prevent people with visual, hearing, or learning disabilities from receiving information in an understandable format. For example, inappropriate presentation of teaching materials, such as the
lack of sign language interpreters, large-print formats for health education materials, and materials appropriate for the patient's level of intellectual functioning, may inhibit learning. Discordant communication between health care providers and people with disabilities has the potential to decrease health care parity and reduce quality of care.

**Clinical Cultural Competence**

People with disabilities report that health care professionals often lack knowledge and sensitivity about their disabilities, and focus more on patients' disabilities than their immediate health problems (Gill, 1996). Because many health care providers have not had the necessary training or experience to provide health care services for people with disabilities, they have a tendency to objectify people with disabilities as a “disease” (Gill, 1996) or “defective machine” (Blumberg, 1994) that needs to be cured or fixed. This perspective fails to construct health within a person's own conceptualization and can negatively affect a person's ability to obtain health care services.

Incongruent cultural views of health may result in people with disabilities refusing to access health care services because of fear or health care professionals refusing to provide health care services. In their study examining attitudinal and health care system variables related to accessibility and availability of gynecological and reproductive services for women with disabilities, Kopac, Fritz, and Holt (1996) found that several basic services were not provided by agencies, such as prenatal care (79%), counseling or treatment related to sexually transmitted diseases (45%), health education for sexual and reproductive knowledge (17%), and mammograms (9%).

**STRATEGIES FOR ATTAINING CULTURALLY COMPETENT CARE**

The real goal and spirit of the ADA (1990) is “to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities” and “to assure equality of opportunity” (as opposed to creating opportunities) for all Americans (Section 2.b.1, Section 2.a.8). Nurse educators must challenge outmoded perceptions that nursing students with disabilities pose an inherent risk to the public that is distinctly different from that posed by any other student. From a minority perspective, disability status is no more a liability than one’s ethnic/racial background or gender. To date, no research study has systematically documented a relationship between disability status and medical errors or patient safety. In addition, according to the Institute of Medicine’s 1999 report, 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). The majority of mistakes are not the result of individual recklessness or the actions of a particular group. Unfortunately for nursing students with disabilities, the preoccupation of some faculty with the issue of safety “even in the face of repeated demonstrations of safe practice, [seems] to be a veiled attempt to prevent” the progression of students with disabilities in the nursing program (Evans, 2005, p. 14).

Nursing students with disabilities will foster a new set of knowledge, skills, and abilities in the nursing profession. Essential functions need to be redefined accordingly. People with disabilities have the potential to improve nursing care and advance culturally relevant care with their unique understanding of disability issues. Nurse educators need to move away from the notion that they are attempting to identify a particular group of individuals (students with disabilities) who are entitled to some type of special treatment. People should be permitted to use a range of strategies and technologies to perform the essential functions of their jobs.

Educators need to expand their conceptualization of disability beyond the medical model definition and incorporate more comprehensive models of disability, such as a social model or interface model (Goodall, 1995; Scullion, 1999a), into nursing education. Curricula restricted to using only a medical definition of disability will fail to recognize the social determinants of the disability experience. Consequently, graduating nurses will continue to be limited in their ability to provide culturally responsive care for people with disabilities. By exploring and adopting a broader definition of disability, nurses will be able to consider the distinction between “impairment” and “disability,” and reflect on their own attitudes, beliefs, and values regarding disability-related issues (Scullion, 1999a).

The use of more comprehensive models of disability will also promote the perception of nurses with disabilities as valuable professionals whose skills and talents are needed and wanted by the profession. In addition, policies and procedures that include the perspectives of people with disabilities can be developed and implemented. By incorporating disability into discussions of diversity, disability-friendly language and inclusive photographs and art representing positive images of people with disabilities can be integrated into syllabi, student handbooks, and lectures.

**SUMMARY**

As nurses, we must attend to several issues. First, we must expand our view of disability beyond our understanding of disability as physical, sensory, psychological, and cognitive abnormalities or deficiencies to include a more comprehensive model of disability. For example, the social model of disability incorporates the minority group model and the independent living model and defines disability as a social status, rather than merely a physical or cognitive attribute (Gill, 2001). A primary focus of the social model is on external factors, with an explicit rejection of the notion that “impairment” creates disability (Scullion, 1999a). According to Gill (2001), the social model distinguishes individuals’ “impairments” from their social consequences or social oppression. In addition, while nature can impair, only society can disable, and it is society that must be fixed to ameliorate disability.
Second, we must address our prejudices toward people with disabilities and recognize the value and viability of the hard-won rights of people with disabilities to access basic human and civil rights. Lastly, as we accept and accommodate people with disabilities as nursing students and professional nurses, we will discover that a student’s success is highly dependent on the availability of accommodations, not the type or severity of disability. In this way, students with and without disabilities will enhance culturally competent nursing care.

REFERENCES
