

CHAPTER 5

Nursing Education Curricula Position Paper

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The purpose of this meeting is to examine the feasibility of recruiting individuals with disabilities into nursing. My task is to assess the educational curricula and hopefully, generate discussion regarding whether or not an otherwise academically qualified individual with a disability can successfully complete a nursing program.

When Kay (Andreoli) called and invited me to give this presentation, I was reminded of a situation that I encountered during the first few weeks of my deanship at Ohio State. The situation was this. An RN student who was legally blind as a result of severe diabetes had been admitted to the program but had been unable to complete the skills test. As a result, she was not able to advance very far. This skills test was a laboratory, timed test that required students to go from one "station" to another and complete the skill such as taking blood pressures, temperatures, changing dressings and the like. When I think about it, it makes me laugh. Well, she couldn't see well enough to do that so she kept failing this test. Needless to say, she was getting quite frustrated and questioned the necessity of this particular test (as did I). At some point she did go to see a lawyer---she was very smart, you know. She figured, "Enough of this." I wasn't

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getting very far. That's how it came to my attention. Literally, this was my third week on the job. So I contacted the university attorney, we sat down with the faculty and said, "Now look, gang, this is the deal. This woman's been admitted to this program, so you are obliged to make reasonable accommodations to provide her with the opportunity to succeed, not fail."

Well, they were not sure this could be done and they offered all kinds of reasons for this including that if she were to earn a degree from OSU that it would devalue the degree because she couldn't meet the same requirements as everyone else. I tried to impress upon them that she never could do what they were asking - that she would continue to fail if they didn't make any accommodations. At last they relented - and there's a happy ending to this story - they did make the necessary accommodations. They consisted primarily of verbally testing the student's knowledge of the procedures focusing on the theory and principles rather than requiring her to perform the skill within a specified period of time. The faculty were then obligated to consider how they would make accommodations for her when she was enrolled in the required clinical courses. They did and the student completed the program and went to work as a counselor for a diabetes association.

That is just one example of how making reasonable accommodations allowed a student with a significant disability to be successful. To begin the dialogue as to whether or not students with a disability can be accommodated without compromising academic or professional standards—that's what everybody's talking about, what they're worried about--I will discuss the standards that guide the development of nursing curricula. I will start with the accreditation process and standards that are used in that process since the purpose of accreditation is to assure that education programs are of sufficient quality. Basically, accreditation is an assessment process to determine whether programs achieve what they identify they want to achieve. That is, how successful are they in producing products of their program that meet their explicit mission and goals and how well do those graduates measure up to the standards for professional practice.

The Commission on Collegiate Nursing Education (CCNE) is one of two accrediting bodies for nursing education and focuses exclusively on baccalaureate and graduate programs in nursing. The accreditation process is guided by a set of standards (Commission on

Collegiate Nursing Education, Standards for Accreditation of Baccalaureate and Graduate Nursing Education Programs, 1998) designed to foster continuous improvement, a valuing of innovation accompanied by an expectation of a high level of accountability to the publics served, including consumers, students, employers, programs and institutions of higher education.

The self-study and on-site evaluation require programs to address four standards. Three of those relate to Program Quality as it pertains to

- Mission and Governance
- Institutional Commitment
- Resources and Curriculum and
- Teaching-Learning Practices.

The fourth standard addresses Program effectiveness as measured by: Student Performance and Faculty Accomplishments. The Standard that is most relevant to our discussion is Standard III, Program Quality: Curriculum and Teaching-Learning Practices.

This standard requires that the curriculum:

- Build on a liberal arts and science foundation,
- Possess a clearly stated mission and set of goals,
- Identify student expectations,
- Be guided by professional standards and expectations of the communities of interest, and
- Be sequentially and logically organized.

Furthermore, this standard requires that learning experiences be designed to provide students with the opportunity to meet the expectations of the curriculum. In other words, students must be given the opportunity—the learning experiences—to meet what the program expects. The standard applies to both undergraduate and graduate programs with the expectation that the master's curriculum will prepare graduates to function in an advanced practice role. So, basically, accreditation requires that the program identify the set of standards that have guided the curriculum. At this point those standards are not articulated—in other words, there isn't a specific set required—but this issue is currently under review by CCNE as it undergoes its first revision of these standards.

The process does not prescribe any particular content or courses that must be present in the curriculum or program. Rather, it depends on the program directors knowing what the professional standards are, designing curricula to meet those standards and then engaging in ongoing processes that evaluate outcomes and guide changes for continuous quality improvement. The process hinges on the existing professional standards—in other words, the various curricular elements that are deemed essential to produce either an entry-level or advanced practice professional nurse.

The first professional standard to be considered is the requirements for licensure. For the entry level, the first consideration is that an individual must pass the NCLEX examination, which is a cognitive test. So, for example, if a student with a disability has successfully completed a program, he or she may need accommodations to take the exam. A student with a visual impairment may need adaptive technology and so on. For example, one of our students with a learning disability needed to be alone in a quiet room when she took examinations. In this case she was accommodated by our state board, but not without some hassle. The board required a whole new set of documentation on her disability, even though she had been accommodated throughout her four years of college. I wrote a letter certifying to that extent, that that was the case. Licensure is granted upon successful completion of the NCLEX examination. Beyond that, once licensed, Registered Nurses are expected to perform in accordance with each state's practice act. So the only ability needed to pass the NCLEX is a cognitive one.

The other standards that guide the development of curricula are those promulgated by professional organizations. I am going to focus primarily on three sets of standards for purposes of today's discussion. They are *The Essentials of Baccalaureate Education for Professional Nursing Practice* (American Association of Colleges of Nursing, 1998) and *the Essentials of Master's Education for Advanced Practice Nursing* (American Association of Colleges of Nursing, 1996). *Nurse Practitioner Primary Care Competencies in Specialty Areas: Adult, Family, Gerontological, Pediatric, and Women's Health* (U.S. Department of Health and Human Services, Bureau of Health Professionals, Division of Nursing, 2002) developed the National Organization of Nurse Practitioner Faculties and the American Association of Colleges of Nursing.

The Essentials of Baccalaureate Education identifies five components of a professional education. These are liberal education, professional values, core competencies, core knowledge, and role development. The liberal education component consists of those courses taken outside of the nursing major directed at providing students with the ability to, for example, develop problem-solving skills, integrate concepts from the basic sciences, interpret quantitative data. These courses differ from school to school and are frequently influenced by local requirements. The nursing major consists of a series of courses, some with required clinical practica that provide the student with learning information to function as a professional nurse.

The nursing major consists of a series of courses, some with required clinical practice, that provide the student with the clinical opportunity to learn information needed to function as a professional nurse.

The curriculum is expected to provide students with the opportunity to learn the core values of the profession—altruism, autonomy, human dignity, integrity and social justice. These are typically interwoven throughout the nursing major, but some of the stories I heard this morning make me think that perhaps the faculty need to revisit the learning of these core values themselves.

Nursing's core competencies are critical thinking, communication, assessment and technical skills. As with core values, these competencies are woven throughout the curriculum and typically increase in sophistication as the student advances through the required course work.

Let me say a little bit about technical skills, because I think this is something very relevant. Some examples of what's on the technical list are vital signs, personal hygiene and so on and so forth.

Professional nurses are expected to possess core knowledge of health promotion, risk reduction and disease prevention; illness and disease management; information and health care technologies; ethics; human diversity; global health care; and health systems and policy. And finally, graduates are expected to possess knowledge of

their roles as providers of care, designers/managers/coordinators of care and members of their profession.

When these were being developed by the organization there was much debate surrounding the inclusion of technical skills as a core competency and it is just this that today and tomorrow we need to discuss and debate. The issue boils down to whether a student who possesses a physical disability that limits the capacity to, for example, provide ostomy care or respond to a Code Blue or start an IV can successfully complete the required course work? Or, would it be sufficient for a student to learn *how* to do these skills and understand the scientific principles behind the skill but not be able to perform it?

The question can also be asked as to whether or not, in today's health care environment, is it the professional nurse who does or should do all of these tasks or can and should many of them be delegated? Put another way, are the other domains of professional practice such as problem solving, assessment, and critical thinking more important than the performance of a particular skill for professional practice?

Turning now to the *Essentials of Masters Education*. This document identifies the core content that is deemed essential for all masters' students irrespective of the advanced practice role for which the student is preparing. The document assumes that this core knowledge provides the base upon which the clinical knowledge is built and allows that the content of the clinical portion of the program will be driven by standards developed by various specialties.

And the graduate core consists of content such as research, policy, ethics, professional role development and so on. The essentials of masters education also identifies that students should have advanced health assessment, advanced physiology and advanced pharmacology.

Basically, the core content is didactic content obtained in a classroom or through reading and comprehension. *The Essentials* does not dictate specific courses but rather limits the discussion to content. It is then the responsibility of the program director to configure this content however he or she chooses. But, the accreditation self-study will ask the program director to identify where the content is located in the curriculum.

Turning now to an example of professional standards that should guide master's programs. The National Organization of Nurse Practitioner Faculties (NONPF), in partnership with the American Colleges of Nursing (AACN) developed a set of standards for the preparation of nurse practitioners—*Nurse Practitioner Primary Care Competencies in Specialty Areas: Adult, Family, Gerontological, Pediatric, and Women's Health*. The standards delineate core as well as specialty competencies. I will limit this discussion to the core competencies; they are:

- Management of Patient Health/Illness Status
- Nurse Practitioner-Patient Relationship
- The Teaching-Coaching Function
- Professional Role
- Monitoring and Ensuring the Quality of Health Care Practice and
- Cultural Competence

Of relevance to today's discussion is that competence in assessment is the requirement to "perform a complete system, or symptom-specific physical examination." The question must be asked if certain physical disabilities would preclude meeting this requirement. Or, put another way: Are there reasonable accommodations that would allow students to meet this objective?

In reviewing existing professional standards, it is safe to say that cognitive skills and critical thinking dominate. Yet, technical skill development is not non-existent. The question before us is whether or not a student with a disability who is otherwise academically qualified can successfully complete a nursing curriculum.

A variety of disabilities can affect students and they may be otherwise stellar candidates for admission to our programs if we are willing to make accommodations. For example, you may have students with mobility impairments due to conditions such as cerebral palsy, MS or spinal cord injury. Some students have medical impairments—often invisible—caused by arthritis, asthma, or seizure disorders. And, learning disabilities are fairly common. All of these would require the program to make *reasonable accommodations* once a student was admitted. For example, making accommodations in the taking of examinations by allowing for more time, or utilizing the services of a

scribe. Some students may need a note-taker; others need faculty to be patient if they are late for class due to their mobility limitations. Still others need special seating **in an accessible classroom**, so they can hear the instructor or see the blackboard. Others need assistance in their laboratory courses or flexibility in meeting requirements they might have missed because of illness.

A student with a learning disability may need more clinical time to meet the objectives of the course. A student with a hearing impairment may need special equipment to hear heart or breath sounds. A visually impaired student may need lab assistance, or print material in an alternative format and preferential seating in the classroom.

Accommodations in taking examinations including the NCLEX are commonly needed. Depending on the nature of the disability, a student may need additional clinical experiences to meet the objectives of the course. There is simply a wide range of disabilities requiring various accommodations. So, for me, the answer to the question as to whether or not a student with a disability is a reasonable candidate for admission to a nursing program is a qualified "Yes." Qualified in the sense that some disabilities may, by their very nature, exclude students from pursuing a nursing curriculum. But not all disabilities do that. The challenge for faculty is to give this topic careful thought and to open up their minds, shake off old conceptions and prejudgments of what it takes to be a nurse and determine how and if a student with a disability can be successful in the program. Certainly, there is not much in the national standards driving nursing curricula that would preclude admitting students with disabilities.

Addition to Position Paper Presentation

Carole Anderson. Over the years, I have learned how to deal with physical facility issues in making some accommodations, which is no small matter at OSU because the campus is huge. When you make these accommodations you really improve the learning environment for all students. You make accommodations for some but most of those accommodations are very sensible and good teaching-learning practices. I think it is important to keep this in mind and it certainly does not lower standards.

A student with a learning disability may need more clinical time to meet objectives. Faculty struggle with this, trying to discern if this means the student is getting some advantage that other students do not have. They may need special equipment, or more time and so on. In my own experience, I found that mental disabilities seem to be the most difficult for faculty to understand and accommodate. Typically, if it became apparent that a student was, for example, struggling with depression, the first response is to try to insist that the student withdraw from the program until he or she had the depression treated. Well, that may not be the best thing for the student.

As we heard this morning, reducing the student load may be a better option than making some sort of accommodation. In my experience, faculty have a great deal of difficulty doing this because they think they are giving the student some sort of special treatment.

Another disability is one caused by drug and alcohol use or abuse. Faculty have a great deal of difficulty with this. Nursing faculty tend to be very puritanical and some still want to see it as a sin if you drink too much, which means the world is full of sinners.

As I mentioned before, accommodations may be needed to take the National Council Licensure Examination (NCLEX). Depending on the nature of the disability, a student may need additional clinical experiences to complete the course objectives. There is a wide range of disabilities requiring many different accommodations.

An interesting project is under way at the Oregon Health Sciences University, called the Health Science Faculty Education project. Sponsored by the Oregon Health Sciences Center on Self-Determination, it is one of twenty-two federally sponsored projects to assist health science faculty in meeting the educational requirements of students with disabilities. The web site is: www.healthsciencefaculty.org; and www.exceptionalnurse.com is a resource for student nurses and practicing nurses. It contains a lot of information about legal aspects of your career and accommodations.

As I said, the answer for me, as to whether or not a student with a disability is a reasonable candidate for admission to a nursing program, is a qualified "Yes." It is qualified in the sense that some

disabilities may by their very nature exclude students from pursuing a nursing curriculum. Marca Bristo said this morning that most people, 99.9 percent of individuals, do not want to deliberately set themselves up for failure. I think we can assume that if someone has a significant disability that would preclude that person from being a nurse or working as a nurse in a certain area, he or she is probably not very likely to attempt to do that. You have to trust the ultimate wisdom of the individual.

Again, the challenge for the faculty is to give this topic careful thought and to open up their minds, shake off old conceptions and judgments of what it takes to be a nurse, and determine how and if a student with a disability can be successful in our programs. Certainly there is not much in the national standards driving nursing curriculum that would preclude many students with disabilities. Thank you.

Nursing Education Curricula Response

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ADD), Research Assistant Professor, Department
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Thank you to Dr. Anderson, who presented several nice examples of how students with disabilities have been able to achieve success in nursing school. Additionally you also addressed the importance of maintaining academic and professional standards, which I think most of us want to see happen.

As Dr. Anderson mentioned, nursing's core competencies continue to evoke controversy in the ongoing debate. Dr. Anderson gave us a qualified "Yes" in response to the question as to whether or not a student with disabilities is a reasonable candidate for admission to nursing programs. This is "qualified" in the sense that some disabilities by their very nature exclude students from pursuing a nursing curriculum. I think that no student should be excluded on the basis of disability.

In nursing education, the hidden curriculum drives academicians to ask the question, "Is there a place in nursing education for individuals who do not meet the traditional requirements of an academic program, such as the disabled student"? From a disability perspective, a more appropriate question might be the following one,

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“How can we recruit and retain persons with disabilities into the nursing profession?” Second, we might ask, “What do individuals with disabilities bring to the relationship with healthcare recipients”? Third, “What do individuals with disabilities bring to the nursing profession”? Last, “How can we provide an educational program that creates an accepting environment for all students, not just those with disabilities?”

With the disability perspective in mind I would like to advance the debate from the question, “Do persons with disabilities have a place in the nursing profession?” to the more salient question, “When will persons with disabilities have a place in the nursing profession?” I invite you to challenge the nursing profession to move beyond what is legally mandated to persons with disabilities and to consider the moral and ethical imperative for enhancing cross-cultural concordance between healthcare providers and healthcare recipients. Specifically, I would like to offer the social model of disability as a framework that will sponsor the recruitment and retention of persons with disabilities into nursing. The use of this model will enhance cultural competence among nursing students and nursing professionals. Within a social model of disability, as nurse educators, we must first address our prejudices toward persons with disabilities and recognize the value and the viability of the hard-won rights of people with disabilities.

Second, we must expand our understanding of disabilities beyond abnormalities and deficiencies. Dr. Carol Gill at the University of Illinois at Chicago states, that “the social model distinguishes an individual’s impairments or differences from the social consequences or social oppression.” Within a social model, attitudinal and architectural barriers are seen as central to disablement, not merely the intrinsic limitation of the disability. Dr. Gill further states that while nature can impair, only society can disable. It is society that must be fixed; to ameliorate disability, not people.

Third, we must accept and accommodate people with disabilities. We will discover that a student’s success is highly dependent on the availability of accommodation and not on the type or a severity of disability.

Fourth, the social model of disability encourages us to recognize the intrinsic value that persons with disabilities bring to the nursing profession to enhance culturally competent nursing care.

I want to revisit culturally competent care. This is a concept that was brought up years ago by one of our nurse theorists, Leininger, and I think we need to revisit the concept and think about including people with disabilities. A couple of months ago I did a literature review just to see where people with disabilities fit into the concept. I found that there were several disability task forces and not one article mentioned disability as a culture, not one article included a person with a disability as even a minority person who might want to talk about cultural competence.

So, the concept of cultural competence helps to address the factors that contribute to disparities in healthcare services. The primary goal is to deliver high quality, equal healthcare to people regardless of cultural background, including persons with disabilities.

Dayton and Corrello define cultural competence as the ability of health care systems to provide care to systems with diverse values, beliefs and behaviors. In addition, it tailors services to meet consumer, social, cultural and linguistic needs.

Every year Rush Medical Center holds an award ceremony named the Eugene J-MA Thonar, PhD Award. The award is given to someone who has contributed to advancing the rights of persons with disabilities, specifically in healthcare. Beverly Huckman, Associate Vice President for Equal Opportunity and Chairperson of the Rush ADA Task Force, was presenting at the award's ceremony and talked about a patient who was deaf and was receiving dialysis. During the first week of treatment, all the hospital funds allocated to pay for interpretive sign language for this patient were used. Ms. Huckman's question to the audience was, "How can we think about being able to accommodate patients with disabilities?" My thought was that if we start to include in nursing schools students who are deaf and who are proficient in sign language, we would be able to accommodate not only this patient, but other patients who use sign language. Rather than relying on interpreters to interpret nursing care, patients and the nursing profession would benefit from having nurses who used ASL as

their first language. Moreover, we would not need to spend money for interpreters.

When we think about cultural relevance and we think about educating a lot of people, if we include someone who uses sign language as their primary or native language, I think we will broaden the services we can provide to patients. We know the intrinsic value students and professionals from different backgrounds add to and enrich the nursing profession. Unfortunately the values and practices that exclude students with disabilities continue in nursing education. What attitudes and values are conveyed to the public when we maintain and perpetuate the message, "You can be our patient, but you cannot be our peer?" Attitudes change the most when people with disabilities work side by side and in equal status and partnership with their non-disabled peers.

How can we attain cultural competence for healthcare recipients with disabilities who are receiving nursing care? First and foremost, educators must challenge out-moded professional perceptions that nursing students with disabilities impose an inherent threat to the public distinctly different than other students. Within the social model, disability status is more a liability than one's ethnic, gender or racial background. We need to be open to nontraditional ways in which the criteria for achieving the core competencies can be met. 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.

Moreover, people should be permitted to use a range of technologies and strategies to carry out the essential functions of their jobs. Persons with disabilities have the potential to improve nursing care and to advance culturally relevant care with their unique understanding of disability issues.

In summary, while the content and methods of nursing curricula influence the nature and quality of patient care, professional education concerning disability has been harshly criticized for promoting and failing to challenge negative stereotypes associated with disabled people. The hostility and abuse that is routinely experienced by students with disabilities from their peers, faculty and potential employers is illustrated in Dr. Carol Maheady's 1999 article. In her

study, a nursing student with a back injury reported that other students teased her a lot while she was in a body cast. She was in a geographic area where it snowed a lot and fellow students would push her over snow banks; they would razz her and say, "She's a turtle, she can't get out of her shell." To label students with disabilities in nursing school as needing to jump through hoops negates and re-imposes society's ablest devaluation and sanctions discrimination.

If we expand the nursing curriculum beyond the medical definition of disability, students and faculty will share an understanding of the social determinants that impact the disability experience. This will transform professional relationships with healthcare recipients who have disabilities by providing culturally sensitive care. By using the social model, nurses with disabilities will be perceived as valuable professionals whose skills and talents are not only needed but highly desired by the nursing profession.

In a 1976 article about nursing education, Ashley La Bell wrote, "We cannot continue to spend so much time teaching bed-making while the need to understand problems of the aged go unmet. To do so is surely an instance of misplaced priority. Strategies for helping the aged cannot be developed with our heads lowered while tucking in corners of sheets." Are nurses afraid of the internal chaos that might be released if their heads were raised and they looked about to really see?

To make Ashley La Bell's comment relevant for today's presentation, we cannot develop nursing care strategies for healthcare recipients with disabilities with our heads lowered tucking in corners of sheets and focusing on other technical skills. Are we also afraid of the internal chaos that might be released if our heads are raised and we look about to really see?

Audience Participation

Julia Cowell, PhD, RN, Rush University College of Nursing. I really appreciate the presentation both speakers gave. I wonder if we need to look at the opportunity to expand employment opportunities and educational opportunities for people with disabilities beyond the

care of individuals. For example, in public health nursing programs — which are not guided by the standards for advanced practice from the American Academy of Colleges of Nursing (AACN) —we have skill guidelines from our professional groups that allow really any person who can critically think, problem solve and draw on theoretical frameworks to have a very rich career. I think in our effort to standardize nursing education, which we have to do to make sure that we share a high level of preparation to guarantee successful care for the public, in some sense we have narrowed the practice of nursing for other people who are interested in other kinds of advanced education.

Carole Anderson. I do not disagree with you. My intention was to use those standards as one example. I think you are right; there are other examples and yours is a good one.

Sheila Dugan, MD, PT, Rush University Medical Center. I am a physical therapist and a physician, not a nurse. My question in terms of getting advanced degrees in public health nursing as your entry point is still, what about basic nursing preparation? I think that is where we need to make a statement or at least critically analyze it. I think that is the crux of the issue for our work.

Carole Anderson. That is true. The bachelor's degree is prerequisite. But there are lots of people out there with undergraduate degrees already who then may suffer a disability, who could then go on for an advanced degree. Which, by the way, is a very reasonable approach to career advancement. Maybe a career in public health might be more gratifying after a certain kind of disability.

I think the issue at the entry level is one where we really have to think about more broadly than to say how can we accommodate students. There are some sacred cows in nursing as there are in every profession. One of them is that you have to meet the objectives in a certain clinical course in a specific period of time; either 10 weeks, 12 weeks, 16 weeks. And if you don't meet the objectives in that specific timeframe, you will fail. I think there are people with certain disabilities who might need 20 weeks or 22 weeks to be successful. Can we give them that time and let them succeed? I think it's those kinds of things we need to think about and open up the possibility.

There's a fair amount of rigidity in any profession about how to get to the end point. We have a difficult time saying there are lots of different roads to reach that end point; we want to say there is only one road to that point. I think that's also true of medicine and they have struggled with the same thing.

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

Carol Anderson. I think nursing faculty have a more challenging job today than they have ever had for a variety of reasons. One of the challenges they face is that the student body is really very heterogeneous. For example, at the Ohio State University we developed a program for second-degree students that's a master's program. This caused a great dilemma. Faculty asked how can these people with different academic backgrounds, who have never worked as nurses, not need the entire undergraduate nursing program. Faculty have really struggled with these students. And yet these are very bright, very capable students. They come with lots of different kinds of experiences and add a lot of richness. We've told faculty, "Don't worry about what they come in with, worry about what they're going to go out with." Worry about how you are going to get them from here to there. You do not want to convey to the students that they don't know anything. In the meantime, of course they don't know much because they are students and they're here to learn.

Jim Williams, PhD, Department of Cell Biology, Research Scientist, Rush University Medical Center. Of those faculty who struggle with students with disabilities or change, do you have any sense of how many of those faculty have significant exposure to someone with a disability in or out of the workplace, or have a disability themselves?

Carol Anderson. I think we heard this morning that probably all of us have exposure to a lot of people with disabilities whether we know it or not. And if you are a nurse, it would be hard to have avoided exposure to people with disabilities. What we know from the literature is that people with disabilities are isolated, segregated in society. Maybe this happens less frequently now because increasingly more people have a social kind of exposure than ever before; public places are more accessible now. But it is my understanding that persons with disabilities still tend to live segregated lives, so in all likelihood, faculty don't have much exposure to people whose disabilities are visible.

Judge Jean DiMotto, JD. You must be wondering what a felony judge is doing here. I spend most of my time in felony court, but a couple times a month I speak to nurses and nursing faculty around the country about legal issues. So I'm listening to the kind of issues that have come up. It seems to me that most people who are attending this symposium today are either advocates, very open-minded about the issue of disabilities and accommodations, or want to be more open-minded and informed about the issue. As a judge, I am use to hearing both sides of issues. Let me pick out just one thing you said, Carol, because this is something I hear about as I teach nursing faculty about the legal aspects of failing unsafe clinical students and they are not talking about students with disabilities. We know there are not many of these students in nursing programs.

Say there is a student with a disability in an eight-week or ten-week clinical rotation who cannot meet the objectives in that time frame, but could meet the objectives with double the time. I would hazard a guess that many faculty would say those students whom we don't identify because their disability is not visible, or who have not self-identified, could also meet the course objectives if we double the time. So taking this another step, it suggests that we need more clinical time for all our students on the premise that it seems most of

us agree that accommodations for people with disabilities would often benefit everyone. I would think the counterpoint to this is that it would expand the time to graduate a nurse to double, and there are cost/time issues and lots of other issues around this.

Can I hear a response to: If another student who would otherwise fail with no known or self-identified disability fails at ten weeks, but twenty weeks would help, how would faculty deal with this?

Carol Anderson. I think most faculty would fail them at ten weeks. I think that the majority of students can meet the objectives in the time that is given to them; we're not talking about a lot of people. In my experience in working with students, it becomes pretty apparent that there are some students who with just a little more time are able to succeed. And I would say, give the time to them. That time does not have to be cost-free. It doesn't have to be free to the students; they may have to pay additional tuition. What is so wrong with giving them a little more time? But, I think faculty would struggle with this.

Judge Jean DiMotto. I do hear them struggle with that. They would say if a student without any known or disclosed disability has missed three clinical dates out of an eight-week rotation, that's a substantial period of time to miss. If they allow make-up time, even if the student paid for the make-up time, it is the faculty's additional burden, if you will, to accommodate that make-up time for the student who has not been there.

If you say it is no cost – not that the student wouldn't bare some extra cost for the extra accommodation – it seems the framework of the structure of the curriculum would make that difficult. As I've listened to nursing faculty around the country, that's the response.

Carole Anderson. You mean that there are some structural kinds of pragmatic problems to be able to make this accommodation. And that may be true. Resources are getting to be a bigger issue. There is a huge shortage of nursing faculty. So I do think there are some pragmatic problems; you're right. If we really want to do this I think we have to try to do it; have to try to extend the time and figure out how to get it done. There are ways to get it done.

Judge Jean DiMotto. Would you suggest we try to do this for students with known or identified disabilities, or students without known or identified disabilities?

Carole Anderson. I think the accommodation is one thing. I think allowing all students the opportunity to succeed is another thing. If a little bit more time will help a student succeed, I'm suggesting you should probably give it to them, rather than cutting them off at some arbitrary term time.

I say the same thing about tenure now in my position. What's the magic in six or seven years? We have had that time-frame for 100 years. Why do we have to make some sort of career-breaking decision in six years? Seven years? What's so sacred about the time? Except for some of the pragmatics, which I admit are very real.

New Speaker. I spent some time in nursing service, but I've been in education for a long time. I just want to say that when our students graduate there is some notion that they can probably be employed somewhere. I'm from downstate Illinois and I do not see the gates of most hospitals opening their doors to people with physical or mental disabilities. I think it would help if service and education once again would try to work together and create work environments where the students' during summer, weekends, breaks, holidays, etc., could transition into the workplace and help education and help service.

Carol Anderson. I think there are a lot of projects going on like that across the country.

Nancy Hogan, PhD, RN, Professor, University of Miami School of Nursing, Florida. I think there is another thing that I've thought about for a long time and none of us want to talk about. We're in a place here where we're talking about nearly everything. It is not uncommon to have clinical rotation of six hours where the first hour is spent in pre-conference, the last hour in post-conference, one to two 15-minute breaks during that six hours, and a half-hour to hour lunch.

Carole Anderson. That's one of those dirty little secrets.

Karen Ward, JD, Civil Rights Attorney. I would like to respond to the judge's question. If what she's saying is that the faculty are using the difficulty of extending these special things to all people as a reason not to do it — they're just not following the law. If they're saying we will try to give it to people without disabilities because we ought to have a goal for everybody's seat filled—that is a good thing.

But the duty is to accommodate the person with the disability. And how you deal with the rest of the people has got to do with your philosophy, your resources and lots of things. If you use the latter to get around doing the former, you're not doing what you are supposed to do.

Paul Jones, MD, Assistant Dean of Students' Services, Rush Medical College, Chicago. One of the things we have been doing on the medical college side is accommodating students with extra time to help them through our curriculum and to level the playing field. What we didn't bank on was when we successfully degreed those students, they ended up with the mark of extra time on their transcript. This is then viewed by residency program directors as a student perceived as having some kind of trouble during his or her education. So I would very much warn you that one of the things that you need to begin to look at and think about is the aftereffects of bringing students in, graduating them, and making sure that it isn't an nursing degree with an asterisk on it. It needs to be a full degree.

Carole Anderson. Yes, absolutely.

Paul Jones. I think there is a court case exactly on this topic, but it pertained to the legal profession in terms of the bar exam having asterisks on them for extra time. And it was found to be illegal. So if this is happening in your profession, I'd really question the legality of it.

Carole Anderson. You're saying that metaphorically, aren't you?

Paul Jones. I'm saying it metaphorically. Even so, it sounds like a standard practice; it may not be an official policy.

Carole Anderson. I think what Dr. Jones is saying is that when you look at a transcript where the student did not finish in four years, it looks like they had academic difficulty.

Andrew Imparato, JD, President and CEO, American Association of People with Disabilities (AAPD). I had a comment responding to Dr. Mark's point about cultural competence. I think that's a really good way to think about why the folks who train nurses should incorporate some disability issues into their training; to increase their awareness and sensitivity. I also wanted to add the notion of empowerment and independent living as something that could be taught/trained as part of cultural competence. Again, from my perspective, it would help with all patients, not just patients with disabilities.

I think it's possible to make it part of cultural competence that people would have a basic understanding of an independent living philosophy of disability. It is an independent living philosophy of life in general, self-advocacy, those types of skills and why those skills are particularly important for disenfranchised groups, whether they are people with disabilities or others. I just wanted to throw that out to you.