

Work Experiences of Nurses with Self-Identified Disabilities

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Abstract

Globally and in Canada, meaningful participation of disabled people in the labour market is a relatively new occurrence. While the literature about disabled people's experiences and perceptions related to employment is established, very little is known about disabled nurses' work experiences. The aim of this study was to produce a rich descriptive account of the practise experiences of disabled registered nurses (RNs) from their perspectives.

The research aim was addressed through a qualitative descriptive study that explored the perspectives and experiences of study participants. In-depth, semi-structured interviews were conducted with 12 female RNs residing and working in the province of Ontario. Data was analyzed using conventional content analysis and presented as textual summaries organized under categories.

The study found that participants' experiences of practising with a disability were a mix of positive and negative aspects strongly influenced by factors relating to workplace milieu such as interactions with others in the work environment. Participants identified a greater number of facilitators to practising with a disability than barriers; however, the barriers identified corresponded with actual or desired facilitators.

The findings of this study contribute meaningfully to knowledge on the topic of disabled nurses' work experiences by confirming the findings of previous studies and addressing the scarcity of detailed accounts on the topic. Additionally, the study lends support to a more universal understanding of nurses' work experiences that is not US-centric.

The findings signal that the organizations and institutions that employ disabled nurses need to be more responsive to their situations and address barriers impeding

their success. In the context of education, the findings encourage self-reflection and actions that will support the success of disabled students and inculcate positive attitudes and behaviours towards disabled nurses. Lastly, the findings highlight several areas where further research could be undertaken to inform policy, educational curricula, and attitudes and behaviours related to disabled nurses.

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Table of Contents

Abstract	ii
Acknowledgements	iv
Table of Contents	vi
List of Tables	xi
Chapter 1: Introduction	1
Introduction	1
Disability and Work in Canada	2
Disability Policy in Canada	4
Disability Legislation in Ontario.....	5
Disability and Nursing in Canada.....	7
Nursing Practice in Canada	7
Registered Nurses Practice Trends and Issues	9
Disability and Nursing Regulation	11
Disabled Nurses in Canada.....	13
Disability Research and Disabled Nurses.....	13
Purpose and Aims	14
Research Question	15
Significance of the Research	15
Terminology and Definitions.....	16
Definition of Disability.....	19
Summary.....	20
Chapter 2: Literature Review	21
Introduction.....	21
Constructions of Disablement	22
Individual vs. Social Approaches to Disability	24
The Social Model of Disability	26
Embodiment and Impairment.....	27
Identity and Identity Politics	29
Disability in the Context of Nursing	31
Portrayals of Disability in Nursing Practice and Scholarship	32
Portrayals of Disability in Nursing Education.....	33
Nurses' Attitudes Towards Disability and Disabled People	35
Work Experiences of Disabled Nurses.....	37

Studies of Others' Experiences with Disabled Nurses.....	39
Studies of the Practice and Work-Life Experiences of Disabled Nurses	40
Gaps and Limitations of the Literature	49
Summary.....	51
Chapter 3: Methodology.....	52
Introduction.....	52
Approach to the Research.....	52
Philosophical Assumptions.....	53
Approach to Inquiry.....	54
Positionality and Research Topic	55
Research Methodology and Methods	56
Research Methodology	57
Table 3.1 Basic Beliefs of Constructivist Inquiry Approach (cont'd)	60
Methods	60
Sampling and Sample Size.....	61
Data Generation.....	62
Positionality and Data Generation	64
Data Analysis	65
Ethical Considerations.....	67
Trustworthiness	71
Trustworthiness Criteria.....	72
Credibility	72
Transferability.....	74
Dependability.....	74
Confirmability.....	76
Reflexive Approach to Research	77
Reflexivity as Introspection	79
Reflexivity as Intersubjective Reflection	81
Reflexivity as Critique of Social Position and Power	84
Gender and Power	86
Thoughts on Doing Reflexivity	89
Summary.....	91
Chapter 4: Participant Interviews.....	93
Introduction.....	93
Study Participants.....	93
Participant Demographics	93
Participant Vignettes	96
Participant 1: "Dorothy".....	96
Participant 2: "Sophia"	98
Participant 3: "Rose".....	100

Participant 4: “Blanche”	101
Participant 5: “Helen”	102
Participant 6: “Louise”	104
Participant 7: “Jenny”	105
Participant 8: “Mary”	107
Participant 9: “Sondra”	108
Participant 10: “Florence”	110
Participant 11: “Heather”	112
Participant 12: “Natalie”	113
Summary	115
Chapter 5: Findings – Participant Experiences and Perceptions	116
Introduction	116
Practising Nursing with a Disability	116
Experiences	117
Practising nursing with a disability	117
Content Areas.....	117
Practising with a disability.....	117
Perceptions of others	117
Facilitators of practice	117
Barriers to Practice	117
Categories.....	117
Experiences Interactions Exposures.....	117
Uncertainty Perceptions of abilities Perception of person	117
Facilitating factors Factors that would facilitate	117
Nature of disability Nature of nursing Work Work environment factors	117
Changes.....	117
Changes in the Amount of Time Spent Practising.....	117
Changes in Ability to Practice	120
Poor Practice Conditions	124
Reactions.....	126
Embodied Responses.....	130
Negative Emotional Responses	131
Cognitive Responses	134
Physical Responses	138
Interactions.....	139
Negative Interactions.....	140
Positive Interactions	142
Negative Perceptions	143
Positive Perceptions.....	145
Negative Outcomes	146
Positive Outcomes.....	150
Exposures.....	151
Being Visible	152
Degree of Visibility.....	152

Consequences of Being Seen.....	154
Disclosing.....	155
Decision to disclose.....	155
Consequences of Disclosing.....	159
Perceptions of Others.....	161
Uncertainty about Perceptions	161
Perceptions about Competence	162
Perception Towards Person	166
Attributed Characteristics.....	166
Feelings and Attitudes	168
Behaviour Towards	169
Summary.....	171
Chapter 6: Findings – Barriers and Facilitators of Practice	173
Introduction.....	173
Barriers to Practice	173
Nature of Disability.....	173
Mental Embodiment.....	174
Physical Embodiment.....	175
Person-environment Interactions	176
Nature of Nursing Work	177
Work Environment Factors	179
Interpersonal Interaction	179
Workplace Culture	180
Facilitators of Practice	182
Facilitating Factors	183
Support	183
Resources	185
Relational Factors.....	185
Intrapersonal factors	186
Work Environment Factors	187
Factors that Would Facilitate	188
Support	188
Resources and Strategies	189
Work Environment Factors	190
Work Characteristics	191
Culture and Climate.....	191
Additional Thoughts	192
Insights	193
Insights about Self	193
Insights about Nursing	194
Forethoughts.....	195
Concerns	196
Addressing Issues	196

Summary.....	199
Chapter 7: Discussion.....	201
Introduction.....	201
Summary of Findings.....	201
Discussion of Findings.....	203
Understanding Findings in Relation to the Research Question.....	203
Practice Experiences and Perceptions.....	204
Perception of How Others Perceive Participants.....	209
Barriers and Facilitators of Practising with a Disability.....	210
Relationship of Findings to Previous Research and Literature on Disability.....	211
Experience of Change and Emotionality.....	212
Disclosure and Visibility.....	215
Disability climate in the workplace.....	219
Barrier and Facilitators of Practice.....	222
Work Productivity.....	225
Self-concept and Managing Identity.....	227
Accommodating Disabled Nurses' Needs.....	232
Knowledge and understanding of disabled nurses' experiences.....	236
Study findings in Relationship to Theorizing Disability.....	237
Evaluation of the Research.....	238
Strengths of the Study.....	238
Limitations of the Study.....	240
Contributions to Knowledge.....	243
Contribution to Critical Disability Studies.....	243
Contribution to Existing Knowledge.....	244
Implications and Recommendations for Practice.....	245
Workplace Policies and Programs.....	245
Disability Climate and Disclosure.....	246
Implications for Education.....	249
Recommendations for Future Research.....	250
Summary.....	253
References.....	255
Appendices.....	304
Appendix A: Interview Guide and Reference list.....	304
Appendix B: Study Consent Form.....	306

List of Tables

Table 2-1 Summary of Literature Review	44
Table 3-1 Basic Beliefs of Constructivist Inquiry Approach	59
Table 3-2 Data Analysis Process	68
Table 3-3 Trustworthiness Criteria and Strategies	75
Table 4-1 Participant Demographics	95
Table 5-1 Major Categories from Analysis of Participant Narratives	117
Table 5-2 Sub-categories, Sub-sub Categories and Codes under the Category of Experiences	119
Table 5-3 Sub-categories, Sub-sub Categories and Codes under the Category of Interactions	139
Table 5-4 Sub-categories, Sub-sub Categories, and Codes under the Category of Exposures	151
Table 5-5 Categories, Sub-categories, and Codes of Content Area: Perception of Others	161
Table 6-1 Categories, Sub-categories, and Codes of Content area: Barriers to Practice .	174
Table 6-2 Categories, Sub-categories, and Codes of Content Area: Facilitators of Practice .	183

Chapter 1: Introduction

Introduction

With the emergence of the contemporary disability rights movement in the late 1960s, disabled people in the workplace has become a topic for discussion and debate (Williams, 2006). Over the last several decades, a corpus of literature about disability and labour market participation has developed from the field of disability studies and other areas of the academy such as sociology, law, and organizational studies. This interdisciplinary body of literature includes work focusing on disability human rights, comparative analyses of disabled and non-disabled workforces, and employment equity legislation and its impact in the workplace (e.g., Burns & Gordon, 2010; Goss, Goss, & Adam-Smith, 2000; Lunt, & Thornton, 1994; Parker, Owens, & Gould, 2012; Robinson, 2000; Shier, Graham, & Jones, 2009).

The literature on disability in the workplace also provides information and insight into disabled peoples' experiences and perspectives of employment/unemployment in various labour market industries and occupations; however, there is a relative paucity of information about the practice and work-life experiences of disabled nurses (this despite that nursing is the largest healthcare profession in North America). Disabled nurses' work experiences have been understudied. The preponderance of research evidence available focuses on the experiences of nursing students with disabilities rather than nurses in practice and does little to engage with disability discourses. This research addresses this knowledge gap by

examining the perceptions and experiences of disabled registered nurses (RNs)¹ practising nursing in Ontario, Canada, to produce rich descriptions of these experiences.

In this introductory chapter, I contextualize the research by reviewing the literature that explores the connections and relationships between disability, work, and nursing in Canada. The chapter also outlines the significance of the study, identifies the research aims and question, addresses terminological issues, and operationally defines key terms.

The remainder of this document is divided into six chapters. In Chapter 2, I build on Chapter 1 by reviewing the literature that specifically examines the workplace and practice experiences of disabled nurses. In Chapter 3, I outline the research methods of the study and discuss related considerations. Chapters 4, 5, and 6 present the results of the study, Chapter 4 providing detailed biographical sketches of the participants, and Chapter 5 and 6 explicating the findings of the qualitative content analysis undertaken in the data analysis phase. Finally, in Chapter 7, I discuss the results of this qualitative descriptive study in the context of the literature, the study's strengths and limitations, and implications for practice, education, and research. In the last section of Chapter 7, I present a conclusive summary of the study and revisit its main aims.

Disability and Work in Canada

“Participation in the labour market is an important part of life for Canadians seeking personal independence and long-term financial security” (Statistics Canada,

¹ In Ontario, there are three categories of nurses: Registered Nurse (RN), Registered Practical Nurse (RPN) and Nurse Practitioner. While some commonalities exist (particularly between RNs and RPNs), key distinctions in their educational preparation, legislated authority and scope of practice, and level of autonomous practice and responsibility differently influence their practice experiences (Boblin, Baxter, Alvarado, Baumann, & Akhtar-Danesh, 2008; College of Nurses of Ontario (CNO), 2011; Huynh, Alderson, Nadon, Kershaw-Rousseau, 2011). Such differences warrant separate study of each group.

2008, p. 6). Yet, for a sizable number of the nearly 3.8 million adult Canadians with disabilities (aged 15 years or older) (Statistics Canada, 2012)² who could potentially participate in Canada's labour force, this basic right is not possible or achievable. Statistical data suggests that disabled peoples' participation in the labour market is strongly tied to demographic characteristics and associated socio-economic variables. The likelihood that a disabled person in Canada will find work and be continuously employed depends on factors such as the nature of their impairment (e.g., type, severity, origin, and trajectory of their impairment), level of education, occupation and labour industry, and geographical location (Galarneau, & Radulescu, 2009; Statistics Canada, 2008; Williams, 2006).

Despite a push to increase disabled people in the labour pool beyond the current level (Williams, 2006) and longitudinal data indicating improvements in the employment rates and work-life conditions for disabled Canadians, many continue to be prevented from participating in the labour market (Human Resources and Skills Development Canada [HRSDC], 2010). A significant number of disabled Canadians remain unemployed, despite being qualified and ready to work. Additionally, those employed continue to experience discrimination in the workplace and when trying to secure employment (HRSDC, 2010). Out of fear of being discriminated against, many disabled people in the labour force also refuse to self-identify as disabled and/or ask for the accommodations they need (HRSDC, 2010; Statistics Canada, 2008).

² As reported by Statistics Canada's 2012 Canadian Survey on Disability (CSD), this represents 13.7% of the cohort of Canadians aged 15 years or older. The CSD estimates that 4.3 million (14.3%) of Canadians are disabled. Worldwide, an estimated 1 billion people (15% of the world's population) have some form of disability (World Health Organization, 2014).

Disability Policy in Canada

The available literature about disability in Canada suggests that disability-related legislation and policy in this country has been a “hit or miss affair” (Prince, 2004) resulting in marginal progress in all aspects concerning disabled Canadians including employment (Burns & Gordon, 2010). Canada’s current standing regarding the welfare of disabled people results, in part, from inconsistent and non-integrated federal, provincial, and territorial approaches to removing barriers to employment and addressing other challenges for disabled people. Like many countries, Canada has developed a disability policy framework consisting of laws, policies, and principles that attempts to ensure that disabled people have equal rights and freedoms. At the national level, this framework consists of 38 federal statutes explicitly pertaining to disability. These include the United Nations Convention of the Rights of People with Disabilities (UNCRPD), broad human rights and discrimination legal instruments (i.e., Canadian Charter of Rights and Freedoms, Canadian Human Rights Act), the Federal Employment Equity Act, and federal public service policies and principles (e.g., Government of Canada public service employment equity policy and duty to accommodate principle). Additionally, other federal statutes have implications for disabled people although they are not explicitly indicated (McColl, Jaiswal, & Roberts, 2017). Federal disability-specific legislation that addresses the societal and systemic barriers faced by disabled Canadians does not exist.³ Instead, provincial and territorial governments are responsible for ensuring that the rights of disabled people living in their jurisdiction are safeguarded.

³ In 2016, the Government of Canada announced plans to propose federal accessibility legislation. Under the direction of Canada’s first-ever minister responsible for persons with disabilities — the Hon. Carla Qualtrough — the federal government has completed cross-country consultation with individual Canadians and stakeholders such as disability organizations (Government of Canada, 2017).

Each government must also comply with all federal legislation relating to disability (Law Commission of Ontario (LCO), 2009). Specific to employment and workplace conditions for disabled people, each jurisdictional government in Canada has developed its own system aimed at ensuring disabled people have access to employment and work accommodations, and work in barrier-free environments. Within the literature is a strong suggestion that Canada needs national disability legislation “to protect and ensure that appropriate services and programs are in place for persons with disabilities regardless of where they live in Canada” (Gordon & Burns, 2010, p. 207). Evaluation data from the United States’ experience with national disability legislation indicates that comprehensive, universal disability legislation in Canada would hasten the progress of Canada’s disability equity agenda (Gordon & Burns, 2010). However, Bond and McColl (2013) point out that a national and/or integrated network of disability policy is unlikely to emerge without answers to difficult and contentious questions, and sound evidence to base policy upon. Such barriers are further confounded by the rights’ rhetoric and highly polarized ideological tensions and disagreement between disability policy stakeholders (Bickenbach, 2006).

Disability Legislation in Ontario

Ontario has an array of laws that explicitly or indirectly address disability (LCO, 2009). Within this framework, laws that promote the removal of barriers and provide access to benefits, services, support, and accommodations, such as the Accessibility for Ontarians with Disability Act (AODA), have the most impact on the labour market participation of disabled Ontarians. For example, under the Ontarians with Disability Act (ODA) and subsequently the AODA, employers in the public and private sector are required to take proactive steps to systematically remove barriers preventing disabled

people from gaining employment, being treated equitably at work, and fully participating and feeling included in the work environment. Additionally, the AODA sets standards of accommodation that are enforced through random government inspection. Mechanisms to ensure these rights are provided through the Ontario Human Rights Code (OHRC).⁴ Laws in Ontario also recognize that the disadvantages and barriers disabled people face when seeking and maintaining employment often result in lower income levels and limited opportunities for training and education (LCO, 2009). Further, there is recognition that some people with impairments may be prevented completely from working. These circumstances are addressed under the Ontario Disability Support Program Act, which provides a social assistance program for eligible persons with disability and by the Workplace Safety and Insurance Act, which provides income and re-employment support for individuals who experience disability because of work-related adverse events.

Although Ontario's system of legislation and regulations is among the best in Canada, it is not without its problems or criticisms. A comprehensive review of the AODA (Beer, 2010) highlights several concerns such as the slow pace of implementation, felt absence of leadership from the government, and lack of public awareness. Disabled people and advocacy organizations, such as the AODA Alliance, have also criticized the Ontario government, arguing that it has unjustifiably failed to effectively enforce the AODA (AODA Alliance, 2014).

⁴ A fulsome accounting of the relationship between the OHRC and AODA is available through the OHRC Commission website: <http://www.ohrc.on.ca/en>.

Disability and Nursing in Canada

Nursing Practice in Canada

In Canada, registered nurses (RNs) comprise the largest healthcare workforce.⁵ Nursing practice is generally categorized into four main areas (clinical practice, administration, education, and research), and is typically structured by three organizational bodies: the professional regulator, the professional association, and the employee union. Professional regulators are the governmentally appointed bodies that regulate RNs. A key role of the regulatory body is to protect the public interest by ensuring that quality nursing services are delivered. In most Canadian provinces and territories, a single organizational body functions as both professional regulator and professional association. However, in Ontario, RNs are regulated by one body, the College of Nurses of Ontario (CNO), and represented by another, the Registered Nurses Association of Ontario (RNAO). The CNO accomplishes its mandate through 1) establishing entry to practice requirements, 2) articulating and promoting standards of practice, 3) administering a quality assurance program, and 4) enforcing practice standards and the conduct of nurses (CNO, 2015a). Through legislation, the CNO controls entry into the profession in Ontario and determines the parameters of each member's practice. The CNO also exercises disciplinary authority through practice restrictions, suspensions, and membership revocation.

Whereas the regulator functions to benefit the public interest, the professional organization and the union's role is to advance the interests of the profession, and provide support and information for workplace issues, respectively. As the official

⁵ The 2016 Canadian Institute of Health Information (CIHI) (2017b) *Nursing Workforce Report* indicates that in 2016 298,743 RNs were eligible to practise nursing in Canada. Of this population, 95.6% were employed. By comparison, in 2015 there were 84,063 physicians in Canada (CIHI, 2017a).

professional nursing association in Ontario, the Registered Nurses Association of Ontario (RNAO) works through political and other levels to 1) influence decision-making impacting nurses and the public they serve, 2) increase nurses' contributions to shaping healthcare in Ontario and across Canada, 3) lobby for healthy public policy, and 4) promote excellence in the profession (RNAO, 2015). Membership in the RNAO is voluntary. Approximately 30% of Ontario's RNs are members of RNAO (RNAO, 2015).

By comparison, unions represent approximately four out of every five nurses in Ontario (Canadian Federation of Nurses Unions (CFNU), 2017). The Ontario Nurses Association (ONA) is the trade union representing the largest number of RNs in the province. According to ONA (2015), most of its 60,000 members are RNs; however, the exact number of RN members is unpublished.⁶ The ONA mission is to "improve the economic welfare and quality of work-life of [its] members, [and] enable them to provide high-quality health care" (ONA, 2015, "Mission"). Membership in ONA is compulsory in workplaces where the union is the legal employee representative. ONA engages in collective bargaining on behalf of its members with employers, such as hospitals, to set wages and working conditions. ONA also provides its members with protection against unfair practices and unsafe work environments, and information and support related to workplace issues. These role functions are met through the various services ONA provides such as assisting members in legal proceedings related to their employment (ONA, 2015).

⁶ ONA does not publish a membership categorization analysis indicating the exact number of members that are RNs. ONA reports it has 60,000 members who are working nurses (RNs, RPNs, and NPs) and allied health professionals (ONA, 2015). ONA also reports that it has over 14,000 nursing student affiliates.

Registered Nurses Practice Trends and Issues

Nursing practice in Canada is impacted by several nursing workforce trends and issues. These trends include healthcare spending cuts (CFNU 2013a; CIHI, 2014) amidst a national nursing shortage (CFNU, 2013a; Canadian Nurses Association (Tomlin et al., 2009),⁷ slow growth in the number of RNs, and decline in proportion of RNs among regulated nurses⁸ (CIHI, 2011, 2017), and a shift into an accelerated period of population

⁷ Globally, there is a health profession shortage, particularly nursing, which typically accounts for one-third of a healthcare workforce (CFNU, 2007, 2013a; Kuehn, 2007; Lane, Fernandes Antunes & Kingma, 2009). Concurrently, governments have been implementing austerity measures and policies in response to the recent economic downturns. In Canada, healthcare spending has declined since 2010 coinciding with the global recession of 2008 (CIHI, 2014). One perspective is that such cuts to spending weaken the nursing workforce and its ability to support the health and safety of patients (International Council of Nurses, 2011, 2016). In Canada, the Canadian Nurses Association estimates a shortfall of 60,000 full-time equivalent nurses by 2022 (Tomlin et al., 2009). Many argue that the current shortfall is masked by heavy workloads, overtime hours, and delayed retirements (Gormanns, Lasota, McCracken, & Zitikyte, 2011; Winsten, 2011). Despite this shortfall, the number of students admitted to entry to practise RN programs has been decreasing since 2009/2010 (CIHI, 2015). In 2014, the average age of a RN in Ontario was 46.2 years (CIHI, 2017b). Approximately one in five RNs (22.7%) currently practising are eligible for retirement at age 55 (CIHI, 2017b). On average, nurses retire much earlier compared to the overall Canadian workforce (age 56 vs. 62) (Aiken, 2001). Since 2007, there has been an overall increase in the proportion of RNs younger than 35. At the same time, the number of RNs age 60 and older increased between the years 2005 and 2014 (from 8.1% to 13.5%) and then held steady (CIHI, 2015, 2017c). This population represents the largest percentage of nurses who leave the profession each year (one-third of the outflow of nurses in 2013) (CIHI, 2014). While the exact reasons are unknown, this outflow may signal that these nurses have retired. Beyond the loss in sheer numbers, this outflow represents a potential loss in expertise and leadership in the profession that may have implications for patient care (Hill, 2010).

⁸ According to CIHI's (2016) health expenditure report, since 2011, the growth rate of health spending has lagged the rate of inflation and population growth combined. During the same period, per-capita spending has decreased. Cuts to healthcare spending at the provincial and federal government levels to address growing deficits and economic downturns in the last decades have directly impacted the supply of registered nurses (Alameddine, Baumann, Laporte, & Deber, 2012). And while recent measures have been implemented to improve the number of registered nurse graduates, the supply of registered nurses across Canada remains well below what is needed to sustain the nursing profession and meet the growing demands on the healthcare system (CFNU 2012, 2013a). Despite the rate of RNs per 100,000 population recently, again reaching the peak highs of the early 1990s, the growth in the supply of RNs has slowed down since 2012. There were more new RN graduates in 2011 than in 2016 (11,044 in 2013 vs. 10,022 in 2016). Additionally, since 2007, the proportion of RNs among regulated nurses has declined across multiple care settings (CIHI, 2017b).

The CNA (2009) predicts a shortfall of 60,000 RNs by 2022. Others speculate that the shortfall is greater but is masked by delayed retirements and overtime hours (Winston, 2011). Between 1992 and 2010, the nursing overtime rate in Canada almost tripled (from 10.2% to 29%). In 2016, both the unpaid and paid overtime public-sector nurses worked was equivalent to 11,100 full-time jobs (CNFU, 2017). In addition, the average incidence of unpaid overtime by regulated nurses was 12.2%. The result has been that nurses are overworked and practising in understaffed and unsafe work environments (Gormanns et al., 2011; Oglivie, 2014; Winston, 2011). Consequently, nurses, particularly new graduates, are leaving the profession due to these workforce and work environment issues (Casey, Fink, Krugman, & Propst, 2004; Lavoie-Tremblay, O'Brien-Pallas, G linas, Desforges, & Marchionni, 2008; VanWyngereen, & Stuart, 2010).

aging with increasing longevity⁹ (CFNU, 2012; CIHI 2012b). In effect, continually more Canadians with complex health needs will require increasingly sophisticated health services for which there is limited funding and an inadequate supply of RNs to provide safe and competent care.

A diminished and slow-growing RN supply coupled with increased demands on the healthcare system places significant strain on the nursing profession (CNA, 2013; CFNU, 2012). The vital role RNs play in defending the health of the Canadian population is being eroded by ever-rising professional demands and excessive workloads due in part to inadequate staffing. This is “exacerbated by increasing patient acuity, higher patient volumes and the growing complexity of treatment modalities” (CNA, & RNAO, 2010, p. 1). RNs are faced with ever-increasing cognitive, psychosocial, and physical work demands, and in some cases must also contend with unsafe and unhealthy work environments and conditions (e.g., workplace violence) (CNA & RNAO, 2010; CFNU, 2012, 2013a). Consequently, levels of nurse fatigue¹⁰ are rising (CNA & RNAO, 2010; RNAO, 2011). Other outcomes for RNs include illness, injury, disability, and absenteeism (CFNU, 2013a, 2013b). These effects and other outcomes have been positively linked to

⁹ The population of Canadians age 65 and older is growing faster; seniors now outnumber children in Canada (Statistics Canada, 2017). Seniors are frequent users of the healthcare system. In 2014, the latest available year for data broken down by age, more was spent on seniors’ healthcare than the health of any other age group (CIHI, 2016). Although population aging is a modest driver of healthcare costs (CIHI, 2016), this trend poses challenges to the current healthcare system that necessitate coordinated and targeted responses involving re-evaluating and reorienting services, and addressing health human resources issues (Canadian Health Services Research Foundation, 2011).

¹⁰ A CNA and RNAO joint report defines nurse fatigue as “a subjective feeling of tiredness (experienced by nurses) that is physically and mentally penetrative. It ranges from tiredness to exhaustion, creating an unrelenting overall condition that interferes with individuals’ physical and cognitive ability to function to their normal capacity. It is multidimensional in both its causes and manifestations; it is influenced by many factors: physiological (e.g., circadian rhythms), psychological (e.g., stress, alertness, sleepiness), behavioural (e.g., pattern of work, sleep habits), and environmental (e.g., work demand). Its experience involves some combination of features: physical (e.g., sleepiness) and psychological (e.g., compassion fatigue, emotional exhaustion). It may significantly interfere with functioning and may persist despite periods of rest” (p. 1).

the overall measure of the quality of nursing work life (McGillis-Hall et al., 2006) and patient safety (CNA & RNAO, 2010; Flin, Winter, & Cakil Sarac, 2009; RNAO, 2011; Scott, Hwang, & Rogers, 2006).

To address the nursing shortage and related challenges, recruitment and retention of nurses has become a major focus of healthcare organizations, unions, professional associations and colleges, and governments across Canada. However, at the same time, research findings show that retention of disabled nurses is poor with little to no effort being made to recruit and retain these nurses (Ferguson et al., 2009; Neal-Boylan, Fennie, & Baldauf-Wagner, 2011). In several studies, disabled nurses described having trouble attaining interviews and being hired, practising in unsupportive and disabling work environments, and leaving working environments because they are prevented from carrying out their nursing duties (Korzon, 2011; Matt, 2008; Neal-Boylan, 2014; Neal-Boylan et al., 2011; Neal-Boylan, Hopkins, Skeete, Hartmann, Iezzoni, & Nunez-Smith, 2012). Adding to this, nursing practice expectations continue to emphasize able-bodiedness and give preferential deference to non-disabled nurses (Aaberg, 2012). The findings of a number of recent studies (Joyce, Higgins, Magin, Goode, Pond, Stone, Elsom, & O'Neill, 2012; Joyce, McMillan, & Hazelton, 2009; Neal-Boylan & Guillet, 2008a, 2008b, 2008c; Matt, 2008, 2011; Wood, & Marshall, 2010) demonstrate that nurses (both disabled and non-disabled) and healthcare administrators harbor concerns about disabled nurses' competence and ability to practise safely, despite a lack of evidence.

Disability and Nursing Regulation

Despite greater movement towards including disabled people into labour markets (Collin, Pang, & Lafontaine-Émond, 2013; Conference Board of Canada, 2015; Williams,

2006), nursing education, regulation, and practice in Canada remains largely focused on an assumed able body. Except for psychiatric nursing in Canada's four Western provinces, nursing education and regulation in Canada is based on a generalist model. In a generalist model, nursing students are prepared as generalists with the fundamental knowledge and skills to practise at an entry level in a variety of settings and situations of health and illness across the lifespan and gender with clients (e.g., individuals, families, groups, communities, and populations). The generalist model assumes that the normative nurse is an able-bodied adult. In recent years, this assumption has been affirmed by nursing regulators across Canada (e.g., CNO, 2012, College of Registered Nurses of British Columbia, 2007) through articulation of requisite skills and abilities' regulations that detail fitness parameters deemed necessary for practising nursing. A key rationale for the use of regulatory fitness standards has been that they help to safeguard the public by ensuring safe and competent care (CNO, 2012). However, these standards and fitness to practise processes raise questions and concerns about the systemic discrimination of disabled people (Disability Rights Commission, 2007; Haycock-Stuart, James, McLachlan, & MacLaren, 2014; Matts, Maheady, & Fleming, 2015; Sin & Fong, 2008; Walker, Dearnley, Hargreaves, & Walker, 2013). Sin and Fong (2008) note that "the potential for systemic discrimination against disabled nursing professionals lies in the existence and nature of regulatory fitness standards, as well as in how these are interpreted and implemented in practice" (p. 642). Sin and Fong's investigation of fitness standards in the UK concluded that there is serious doubt about the usefulness of fitness standards in managing risk. Matt et al. (2015) comment that when essential functions for employment are used in nursing education, they may be a barrier to accessing nursing education.

Disabled Nurses in Canada

Disabled nurses are largely a hidden population. It is unknown exactly how many members of the nursing population in Canada are disabled. However, the data available (e.g., absentee rates, hours lost, and costs due to injury, illness, or disability) (e.g., CFNU, 2017; Gormanns et al., 2011; Lasota, 2009; O'Brien-Pallas, Shamian, Thomson, Alksnis, Koehoorn, Kerr, & Bruce, 2004; Shields and Wilkins, 2006) provides some indication of the prevalence of disability within this population.¹¹ Although helpful, this data does not provide a comprehensive picture of the spectrum of disability or the impact of working with a disability. Obtaining accurate representation of this population requires disclosure, which is problematic under many circumstances. For example, the disclosure of a disability by a candidate at the point of professional registration can initiate a case-by-case review, resulting in the candidate being made ineligible for registration despite fulfilling all other requirements. Additionally, as discussed in the previous section, disabling employment practices and work environments can discourage nurses from disclosing their disability.

Disability Research and Disabled Nurses

There is a scarcity of reported research literature focusing on disabled nurses and their practice experiences in the workplace. Much of the literature available about

¹¹ A 2017 study by the Canadian Federation of Nursing Unions (CFNU) reported that an average of 124,000 publicly employed nurses were absent from work each week in 2016 as a result of their own illness or disability (CFNU, 2017). This represents an increase in the absentee rate from 7.9% in 2014 to 8.7% in 2016. The report also found that the rate of absence due to their own illness or disability among nurses was higher than the average of all other occupations in 2016 (9.0% vs. 5.7). O'Brien-Pallis et al. (2004) found that Canadian nurses had increased rates of musculoskeletal (MSK) injuries compared to other occupations. Shields and Wilkins' (2006) survey study of Canadian nurses found that in 2005 37% of nurses had experienced serious pain in the previous 12 months that prevented them from carrying out nursing activities. The same study found that back problems were more common among female nurses than employed women in the general population and rates of depression were higher than the general population of employed people (9% of males and females vs. 4% and 7% of employed men and women, respectively).

disabled nurses' experiences focuses on nursing students. Most writing about disabled nurses is anecdotal and informational. Although these writings provide much insight, systematic inquiry is needed to increase and deepen our understanding of disabled nurses' experiences and inform practice and policy in this area. Whilst it is not possible or appropriate to form generalizations based on the data presented in a single study, important research such as this study set future research directions and foster insights into the experiences of disabled nurses, potentially enhancing the quality of disabled nurses' work life by informing policy practices in nursing workplaces and nursing education.

Understandably, policy is not a panacea for the issues and problems disabled people experience in the workplace. Policy can, however, provide an opportunity for disabled people to be included and their experiences acknowledged and responded to. Informed policy decision- makers in healthcare and nursing education can develop and enact policies that recognize and reflect the experiences of disabled nurses, fostering emancipatory rather than oppressive practices (McColl, & Jongbloed, 2006).

Purpose and Aims

The purpose of this qualitative descriptive study was to explore the practice and work-life experiences and perceptions of disabled RNs. The primary aim was to produce a rich descriptive account of the practice and work-life experiences and perceptions of disabled nurses from their perspective. This allowed the secondary aims to be met. These were to provide future direction for further research related to disabled nurses and begin to make recommendations to inform individuals working at the nursing practice, policy, and education levels.

Research Question

This research study attempted to answer the central research question: What are the practice and work-life experiences and perceptions of disabled RNs? Through in-depth face-to-face interviews, the study sought to describe the following:

- the impact of having a disability on the work of a nurse
- disabled nurses' perceptions of their workplace environment and their practice
- barriers disabled nurses experience in their work as nurses
- facilitators of disabled nurses' ability to practice nursing

Significance of the Research

Qualitative research examining the work-life experiences of disabled nurses within a Canadian context is important and needed for several reasons. First, gaps in the literature exist where the experiences and perspectives of disabled nurses have been relatively unstudied. Work that is available on this topic is largely undertaken within the discipline of nursing and framed within traditional paradigms of disability that discount social dimensions of disability. Influenced by the ideals of the emancipatory research paradigm, this qualitative study adds new knowledge and dimension to existing data and research findings in the field of disability studies and the discipline of nursing. Second, research of this nature is needed to help build a more complex understanding of the emerging climate related to disability within the profession and discipline of nursing in Canada. Such a climate encompasses the intersections of disability discourses, disability legislation and policy, movement in nursing education to define suitability for the profession through requisite skills and behaviour lists, and concerns related to the nursing labour force shortage. Lastly, research of this kind provides information to

inform practice, curricula, policy decision-making, and further research. This important study can help nurse administrators and educators inculcate nurses and nursing students with knowledge and an understanding of disability from the perspectives of disabled people themselves and beyond traditional paradigms. Further, the study has the potential to help nurses and nursing students develop an appreciation for their colleagues with disabilities and build supportive collegial relationships.

Terminology and Definitions

Although language has been an important issue in the emancipatory struggles of disabled people, there remains no clear consensus about terminology (Beresford, 2004, 2005; Linton, 1998). The terms used to name and identify disabled people have been problematic and contentiously debated. Terminology used to identify and describe disabled people tends to construct disabled people entirely in terms of their disabilities (Dajani, 2001). Longmore (1985) described three categories of disability terms: 1) language that renders disabled people as objects of medical treatment and socially incapacitated (e.g., *person afflicted with, suffering from, stricken with a condition*) (Dajani, 2001); 2) euphemistic terms intended to lessen the prejudice and harm of the offending terms they have replaced (e.g., substitution of terms such as *imbecile, idiot, moron* with *mild, moderate, or severe mental retardation*) and; 3) politicized terminology intended to create alternative, self-defined identities and narrative that counter predominant medicalized roles expressed through terms such as *handicapped*. Dajani (2001) additionally highlights the use of adjectives as nouns when describing disabled people. Terms such as *the blind, the disabled, and the developmentally disabled* serve to Other and stigmatize disabled people by reinforcing the notion that they are no more than their disabilities.

Despite arguing names matter because of the effects they produce in hearers, disabled people themselves are uncertain about terminology. There is an abundance of self-descriptions in use by disabled people. The literature suggests that this uncertainty may result from different understandings due to the diversity of perspectives and priorities among disabled people (Beresford, 2004; Oaks, 2007), as well as changes in approaches to activism over time (e.g., McLean, 2000).

Within the literature on disability, different terminology are used by scholars and commentators based on their theoretical perspectives, politics, and priorities (Oaks, 2007). Peers, Spencer-Cavaliere, and Eales (2014) comment that person-first language, such as *people with disabilities*, has become widely accepted terminology within disability literature. Person-first language is resultant of the rights-based disability activism, of which the American Disability movement is emblematic, that occurred during the period of the 1970s to 1990s. Person-first terminology is underpinned by an understanding of disability as an individual trait, akin to race or gender that requires protection from discrimination and exclusion through legislation and policy. Person-first language has been an important strategy to change the ways in which disabled people are perceived; however, it connotes an understanding of disability that is not shared by all researchers and scholars. Other alternative terminologies have been articulated that are underpinned by different theoretical perspectives.

The debate over disability terminology is not without criticism. Scholars, and disability activists and organizations have characterized the debate as a diversion from more important matters (e.g., Shakespeare 2013). Shakespeare (2013) points out that people-first language is the dominant terminology used in the internal disability rights field and the political terminology of choice in many English-speaking countries. He

argues that “quibbling over [terms] is a diversion from making common cause to promote the inclusion and rights of disabled people” (p. 19). Others have argued that the debate is English-centric and gives little consideration of how disability terminologies translate in other languages and are understood (Handicap International, 2014).

The linguistic pluralism within disability literature suggests that a single, most correct, or appropriate term is unattainable. In this context, it is important that the meanings of and theoretical approach underpinning key terms being used are clearly delineated. Pragmatically, it would make sense in this study that I use the term *person who experiences disability* (and derivatives) when referring to the population of interest in this study and study participants. This term “acknowledge[s] the wide variety of embodied sensations, social structures, cultural understandings and identities that may be related to someone’s experience” (Peers et al., 2014, p. 275). Additionally, use of the term would be in keeping with how participants in this study tended to view their experiences.¹² While I am accepting of and comfortable with this term, as well as people-first language, I recognize, as others have (e.g., Beresford, 2004; Beresford & Campbell, 2004), that due to the lack of consensus, any term I choose to use will likely rouse some objection. As such, in this document I have chosen to use the term *disabled people* and its derivatives over other terms because of its broad acceptance in the field of disability studies.

¹² Most participants did not describe themselves as *disabled persons* or as *persons who identify as disabled*. Participants’ tendency to talk about having a disability best aligns with people-first language, e.g., as *persons with disabilities*.

Definition of Disability

Equally as complex is the definition of disability. Up until the 1970s, disability has been predominantly defined as a problem residing within the individual because of some form of impairment. Whilst it continues to be a prevailing societal notion, this individual perspective of disability has been successfully countered by social approaches that locate disability beyond the person, and are concerned with social and cultural forces and the values of society that shape the lived experiences of disabled people. The radical influence of these social approaches is evident in the definitions and conceptualization of disability presently in use by government agencies and organizations at various levels.

In this study, I utilize the understanding of disability put forth by the United Nation's (UN) Convention of the Rights of Persons with Disabilities (2006) as a definition of disability. The convention recognizes that disability is "an evolving concept and ... results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders full and effective participation in society on an equal basis with others" (Preamble). Defining disability as an interaction affirms that disability is not an individual attribute. The definition also reflects the emphasis social approaches place on social factors as significant and important contributions to the problems experienced by disabled people. Taking from the study's definition of disability, disability was operationalized for recruitment purposes in two ways: 1) having a physical/medical, psychological, psychosocial and/or cognitive condition, impairment, or experience that manifests as either transient or permanent; and 2) self-identifying as disabled.

Although the operational definitions used were helpful in recruiting eligible participants, their descriptions of themselves and their experiences most often reflected a medically oriented understanding of disability. None of the participants in the study identified as disabled. They were most comfortable with and used the terms *condition*, *illness* or *experience*. While the terms *disability* or *impairment* were used, these instances tended to reflect participants mirroring of my use of the term when posing questions. Additionally, participants did not use language in keeping with social approaches, despite discussing practices that would be understood as disabling from a social perspective of disability.

Summary

In this introductory chapter, I have set out the broad context within which this dissertation is situated by highlighting the gray literature about disability and work in Canada and published literature about disability in the context of nursing in Canada. Additionally, I have set out the aims, research question, significance, and terminology that structured the systematic inquiry into the work-life experiences and perceptions of disabled nurses discussed in the chapters that follow.

Chapter 2: Literature Review

Introduction

As a population, disabled nurses have not been well studied. While a sizable number of studies have explored attitudes towards and the experiences of disabled nursing students, much less is known about the experiences of these individuals when they enter professional practice as RNs. By the same token, there is a dearth of literature about how impairments acquired by registered nurses during professional life impact their nursing practice and perceptions of their practice and work environments. As a starting point for this research, it was important to review the available literature pertaining to how disability was constructed at a broad societal level and how it is understood and depicted within the context of nursing. It was also important to examine what published research about disabled nurses there is.

This chapter is divided into three sections. The first section considers how disability has been constructed and prevailing perspectives within the literature. The second section of the literature review examines disability in the context of nursing by exploring perspectives of disability within nursing. Included in this discussion is the examination of the contribution of theorizing within the field of disability studies to nursing scholarship. The section also reviews the literature about portrayals of disability within nursing. Thirdly, the literature review explores research focusing on the lived experience of disabled nursing, providing an outline of the gaps and limitations of this small corpus. The conclusion from this review is that no published Canadian literature could be identified that describes the work experiences and perceptions of disabled RNs.

Constructions of Disablement

Until recently and despite the presence of disabled people throughout much of history, disability was largely the province of all but disabled people themselves (Mitchell & Snyder, 1997; Pfeiffer, 1993; Terzi, 2004). In medieval times disabled people experienced discrimination, and poor and inequitable treatment based on religious and superstitious beliefs and fears. Religious perspectives conceptualize disability as punishment for wrongdoing, virtuous suffering, and cases for charitable activity (Otieno, 2009). Disabled people were also associated with witchcraft, evil, and the devil. These beliefs and inhumane treatments notwithstanding, disabled people still contributed in some way to the communities they lived in during this period.

With the arrival of industrialization, discrimination against disabled people became systematized and institutionalized (Metzler, 2011; Wheatley, 2010). Industrialization in Western societies brought about increasingly detrimental changes for disabled people culminating in their incarceration in asylums, hospitals, and prisons (Barnes, 1991; Burleigh, 1994; Largent, 2008; Porter, 2002). The rise of waged labour, and mechanized, scheduled work changed attitudes towards people with impairments. Disabled people who were unable to do this new type of work were labelled deviants and excluded from participating in the emerging labour market (Malhotra, 2001). Disabled people were segregated into institutions and asylums as attitudes hardened and families unable to care for members with impairments abandoned or sent them off. The emergence and proliferation of social Darwinism and the eugenics movement in the late 1800s and early 1900s led to further oppression and tragic consequences such as forced sterilization, euthanasia, and, in the most extreme example, extermination (Pfeiffer, 1993, 1994).

The rise of the medical profession in the 19th and 20th centuries brought about a shift in the way society conceptualized disability (Sullivan, 2011). Underpinned by the Enlightenment pursuit of scientific reasoning, medicine cast a scientific light onto disability, arguing that impairments could be explained scientifically and, therefore, could be addressed by the same means through cure, treatment, or rehabilitation. However, conceptualizing disability as a medical problem has done very little to change social attitudes about disabled people or improve their lives. To the contrary, by many accounts, the medical approach to disability has solidified the belief that disability is an individual problem or defect that required fixing to bring the person closer to being normal. This approach has also reinforced long-standing perceptions of disabled people as weak, dependent, and incapable of fully participating in social life.

Although advocacy on behalf of disabled people existed, it was not until the late 1960s that disabled people themselves began to establish their own organizations to seek human rights and the right to define their identities and futures. The development of this movement has varied according to society; however, similarities cutting across these efforts have fostered a global cross-conscious disability movement. The two primary foci of this global movement have been to garner human rights primarily through legislative and policy changes, and establish an alternative social narrative of disability and disability identity. This latter advocacy effort has involved challenging the dominance of medical approaches to disability and other related, often negative, conceptualizations and replacing it with alternative narratives of disability.

The disability movement has seeded critical constructions of disability that directly counter the medical model of disability and/or support disabled people's quest of a disability identity of their own. The result of this early work is an interdisciplinary

field of disability studies that has brought greater epistemological dimension to disability. The pioneering work of Hunt (1966), Finkelstein (1980, 2001), and the Union of the Physically Impaired Against Segregation (UPIAS) has evolved, with the help of contemporaries Oliver (1990, 1996) and Barnes (1991, 1996ab), into a social model of disability (SMoD). The SMoD refutes the medical model by locating disability outside of the individual and in the social sphere. Other disability theorists and scholars have gone on to problematize this model, arguing for ontological pluralism and a more nuanced understanding of disability that accounts for and reconciles embodied experiences, identity, and impairment with this social-political approach (e.g., Corker & Shakespeare, 2002).

Contemporary theories and approaches to the understanding of disability have been framed and furthered by several key debates. These debates focus on the relationship between the disabled individual and society, the location of disability, the importance of embodiment, and the role of identity and experiences in theorizing disability.

Individual vs. Social Approaches to Disability

This debate centres on the relationship between the individual and the social environment and is drawn along two distinct lines of understanding disability: 1) disability as a phenomenon located within the individual, and 2) disability as a phenomenon that is outside of the individual and located within the social sphere. According to individual approaches, disability results from either a material condition of the individual (individual-materialist) or is the creation of an individual as they autonomously interact with others and their environment (individual-idealist) (Priestley, 1998). Among these approaches, the medical model of disability is the most dominant.

The fundamental tenant of the medical model of disability is that disability results from a bio-physiological impairment located within the individual that is associated with genetics, disease, pathology, or trauma (Swain, French, & Cameron, 2003). Therefore, disabled people are themselves the root cause of their social isolation and other problems. The medical model purports that through cure, correction, or rehabilitation disabled people can rid themselves of their deviance and achieve the level of normalcy necessary to be accepted by and function within society (Oliver, 1990, 2010).

Detractors of the medical model contend that although medicine established the model as scientific and objective, it is in fact a subjective perspective that is underpinned by longstanding fears and angst about the non-conformity of disabled peoples' bodies and minds. To the contrary, socio-politically oriented scholars and activists advocate a materialistic understanding of disability, arguing that disability resides outside of the individual within the social environment. They campaign for social perspectives that view disability as being caused by social and cultural forces that shape the experiences of disabled people (Oliver, 1990).

Gabel (2006) has noted that the resistance to individual interpretations of disability that typified disability theorizing (e.g., social perspectives) has given way to what Davis (2010) characterizes as a new wave of theorizing that takes aim at the interpretations that have dominated disability studies. Within the disability studies literature, there are many examples of works that are emblematic of this direction in theorizing. Scholars such as Garland Thompson (2002, 2005) and Meekosha (2006) have taken disability theorizing in new directions by framing and underpinning their work in critical perspective from feminist theory, queer theory, and race studies, to name a few.

The Social Model of Disability

Building on the UPIAS's materialist ideas about disability as his foundations, Oliver (1983) introduced the SMoD. At the core of the SMoD is the assertion that disability is "the disadvantage of restriction of activity caused by a contemporary social organization which takes little or no account of people with physical [and other] impairments and thus excludes them from participation in the mainstream of social activities" (UPIAS, 1976). A fundamental tenant of the SMoD is the belief that disability and impairment are recognizably different phenomena with no causal relationship to each other. From the SMoD perspective, disability is a social response to an individual's impairment or medical condition, and oppression and institutionalized discrimination are the root cause of the issues affecting people with impairments.

Since the SMoD introduction, it has been taken up and furthered by several scholars. Today there are many versions of the SmoD (e.g., Gleeson, 1999). Despite some differences between these models, they all retain the belief that disability is largely socially constructed (Lang, 2001). The SmoD has been critiqued by several disability scholars within disability studies and elsewhere in the academy. Some scholars have commented that the model is narrow and crude in its interpretation of disability and requires a stronger theoretical basis (Crocker & Shakespeare, 2002; Shakespeare, 2010; Terzi, 2004). Others have taken issue with how the model interprets the relationship between impairment and disability, noting that impairment is inextricable from the political dimensions of disability given that it is often a major aspect in the lives of disabled people (Crocker & Shakespeare, 2002; Crow, 1996; Hughes & Patterson, 1997; Meekosha, 2004; Shakespeare & Watson, 2001).

Notwithstanding these formidable critiques, few would argue that the SmoD has not had an impact as a political tool. The SmoD has been successfully applied in many jurisdictions globally to build the disability movement, politicize a social change agenda, and help gain civil rights in the form of legislation for disabled people (Shakespeare, 2010). To ardent supporters, such as Sheldon (2007) and Oliver (2007; 2010), such successes are reason to further develop rather than dismiss or diminish the model.

Embodiment and Impairment

Impairment and embodiment are important themes in disability discourse and the theorizing of disability. The materiality of disability is at the core of both medical and social model approaches to disability. To medical or individual approaches, disability is a wholly embodied experience, a property of the individual's body. Conversely, those who support a social model approach to disability adamantly reject this understanding and locate disability outside of the body and elsewhere in the material world (Oliver, 1996). Many worry that acknowledging the role disabled peoples' bodies play in the experience of disablement runs the risk of re-establishing the dominance of the medical model, which, subsequently, could dispel the socio-political disability movement and its gains (Shakespeare & Watson, 2001). However, in doing so, they almost entirely write out the body in their theorizing of disability.

Other disability theorists support theorizing a social approach to disability that incorporates impairment thereby accounting for the differences in disabled people's experiences (Hughes & Paterson; Mulvany, 2000; Siebers, 2008; Terzi, 2004). Terzi commented that by severing any links between disability and impairment, the social model loses potency as a theory because we cannot discount the possibility that an individual's impairment is the very reason why they cannot fully participate in social life.

Further, Siebers (2008) has called for a theory of complex embodiment that “raises awareness of the effects of disabling environments on people’s lived experiences of the body but [also] emphasizes as well that some factors affecting disability, such as chronic pain, secondary health effects, and aging, derive from the body” (p. 25).

Feminist disability studies have contributed considerably to theorizing embodiment. Feminist disability theorizing counteracts essential notions of the body, conceptualizing disability as encompassing all bodies that are culturally identified as non-normative and uncovering the societal processes involved in identifying and oppressing these bodies (Garland-Thomson, 2005). Casper and Talley (2006) comment that while this theorizing of disability as a universal category may be political and theoretically useful, it has the potential to dilute the details of impairment or embodiment that may be crucial to understanding lived experiences.

Although theorizing embodiment remains contentious in disability studies, it is extensively engaged within the study of disability and illness within medical sociology. According to Thomas (2004), disability is studied in medical sociology through a social deviance framework in which disability is embodied, “caused by illness and impairment and entails suffering and some social disadvantage” (p. 570). Themes in this area of study include the social experience of living with chronic illness and societal responses to people with disabilities and enduring illness. Disability scholars have critiqued medical sociologists’ treatment of disability (e.g., Oliver, 1990; Mulvany, 2000), arguing that all impairments cannot be studied through an illness framework. Others are cautious about the contributions of medical sociologists’ work, noting that there is the potential for this research to overemphasize the negative aspects of illness at the expense of more complex meaning-making that incorporates social-materialist elements (Shakespeare, 1996;

Thomas, 2010). Furthermore, some theorists have expressed concern that by focusing on illness the SmoD efforts to advance a socio-political ideology and understanding of disability will be hampered (Mulvany, 2000; Oliver, 2010).

Thomas (2004) has argued the divide between medical sociology and disability studies over the embodied nature of disability is the result of a misinterpretation of the conceptual work that underpins the SmoD. Thomas explains that:

the social relational model understanding of disability developed by Vic Finkelstein and Paul Hunt in the 1970s has been lost over time, overshadowed by the rise to prominence of its offspring: the social model of disability. . . . It is important to recognize that, for Finkelstein, [the separation between impairment and disability] did not mean that living with the effects of impairment posed no difficulties for disabled people. What it meant was that these difficulties did not make up the substance of disability. Rather, such difficulties were, and should remain, private and personal matters (p. 572).

Mulvany (2000) added that while disability theorists have recognized the relationship between impairment and chronic illness, they have also “acceded too much to medicine...[ignoring] the possibility of exploring the complex relationship existing between embodied impairment and disability [and retreating] from a critical analysis of all aspects of medical involvement in the lives of people with disabilities” (p. 50). In doing so, disability theorists fail to recognize that there is legitimate medical care that is sought out by disabled people. Mulvany recommends that disability scholars should seek out and undertake critical examination of this work as part of the broader project of mapping the terrain of social barriers experienced by disabled people.

Identity and Identity Politics

The concept of identity has been deliberately invoked by disability activists and scholars as part of political and academic practices referred to as identity politics (Sandahl, 2003). At the core of this practice is the examination of how identities are

broadly constructed for social groups and, more specifically, the construction of disabled peoples' identities. Identity politics also aims to expose how constructed disability identities are linked with vulnerabilities to exploitation, marginalization, and powerlessness. According to Heyes (2009), identity politics:

starts from analyses of oppression to recommend, variously, the reclaiming, redescription, or transformation of previously stigmatized accounts of group membership. Rather than accepting the negative scripts offered by a dominant culture ... [a group transforms their] own sense of self and community, often through consciousness-raising (para 2).

Largely through the disability movement, disabled people have been engaging with the notion of disability identity, providing a counter-narrative of what it means to be a person with a disability that opposes those established by traditional approaches such as the medical model. The result of this disability identity politics is an increased awareness of the social dimension of disability and the minority group status of disabled people (Alcoff & Mohanty, 2006; Mollow, 2004). Disability scholars and theorists such as Linton (1998), Garland Thomson (1997), and Siebers (2001, 2002, 2008) have taken on in their work the agenda to have disability recognized as an identity category.

Disability identity politics forms the basis for Swain and French's (2000) affirmative model of disability. They describe the model as a counter narrative, "a non-tragic view of disability and impairment which encompasses positive social identities, both individual and collective, for disabled people grounded in the benefits of lifestyle of being impaired and disabled" (Swain & French, p. 569). Like the SMoD critique of the medical model, the affirmative model aims to dislodge the narrative that disability is a personal tragedy and replace it with several possible positive narratives. Smith and Sparkes (2008) have noted that the counter narrative of the affirmative model may be liberating for some disabled people as it allows them to reconstruct their identities by

resisting and discarding old gloom-and-doom storylines (e.g., life with a disability is no life or not worth living) and:

expand the cultural repertoire of stories on which to draw when re-plotting a life...therefore as a counter-narrative affirmative model [the model] can have revelatory, liberatory, therapeutic, and transformative possibilities for some individuals and communities by making available and legitimising different ways of living as a disabled person (p. 233).

Disability identity politics is not without criticism (e.g., Davis, 2010; Mollow, 2004). Mollow (2004) has suggested that identity politics “sometimes has the effect of discouraging class analysis, reifying identity categories that might better be contested, creating hierarchies of disability, and fostering antagonism with other minority groups” (292). Supporters of identity politics have responded that such critiques are mostly misguided or mistaken. For example, Houston (1994) has challenged claims that identities are interchangeable, noting that the practice of substituting identity categories is not a characteristic of identities themselves and is a practice that is externally imposed. Additionally, Alcoff and Mohanty (2006) remind that identities are complex, theory laden, and can be accurately and plausibly formulated.

Disability in the Context of Nursing

Despite the inroads the disability movement has made, traditional perspectives of disabled people such as medical models have largely influenced how disability is understood and, subsequently, how disabled people are treated in healthcare and other areas of social life (e.g., education, employment, social policy, housing). Specific to nursing, the influence of traditional conceptualizations of disability is evident within the domains of nursing practice, scholarship, and education.

Portrayals of Disability in Nursing Practice and Scholarship

A number of researchers (e.g., Scullion 1999a, 2000; Boyles, Bailey, & Mosseys, 2008; Smeltzer, Dolen, Robinson-Smith & Zimmerman, 2005) have commented that the depictions and representations of disability in nursing are problematic because they tend to reinforce the systems of oppression that disables people living with impairments. Northway (1997, 2000) contends that nursing's portrayal of disability is situated within medical models of disability, constructing disability as an individual tragedy and thereby constituting a form of oppression. Northway (2000) has cogently argued that so long as medical models of disability form the theoretical foundations for understanding disability within nursing, traditional approaches to disability research in nursing will remain unchallenged and nurse-led research is likely to be viewed as oppressive (p. 394–395). Richardson (2000) and others (e.g., Boyles et al., 2008; Northway, 1997, 2000) have suggested that nurses must develop an awareness of disability beyond medical approaches by adopting social and critical perspectives of disability and considering emancipatory methodologies as part of the research process.

Because of their positionality within the systems often regarded by disabled people as contributing to their oppression (e.g., healthcare), nurses may represent or be perceived as representative of these systems of disablement. Research findings indicate that nurses and nursing students tend not to perceive disabled people in a positive light (e.g., Brillhart, Jay, & Wyers, 1990; Cushman & Dijkers, 1990; Gerhart, Koziol-McLain, Lowenstein, & Whiteneck, 1994; Pfeiffer, Sam, Guinan, Ratliffe, Robinson, & Stodden, 2003; Roscigno, 2013; Seccombe, 2007) and conceptualize disability as an individual, medicalized problem, or chronic illness that can be rehabilitated (Goodall, 1995; Northway, 1997; Scullion, 1999a; Seccombe, 2007). Although nurses are highly regarded

and trusted by the public, findings identify that they tend to lack knowledge about disability, overlook the expertise of disabled people regarding their disabilities (Brown & Kalaitzidis, 2013; Morgan, Blount, & Buzio, 2002; Smeltzer, Avery, & Haynor, 2012; Sowney & Barr, 2008; Velonaki, Kampouroglou, Velonaki, Dimakopoulou, Sourtzi, & Kalokerinou, 2015), and fail to meet the healthcare needs of disabled people (Gibbs, Brown, & Muir, 2008; Iacono & Davis, 2003; Morgan et al., 2002; Phua, Reid, Walstab, & Reddihough, 2005; Smeltzer et al., 2012). Further, George (1992) found that nurses working within a medical model of care were overtly negative and hostile towards disabled people, in some instances disempowering and dehumanizing their patients.

Portrayals of Disability in Nursing Education

Within the literature nursing education is identified as both an influencing factor and a means of changing nurses and nursing students' attitudes towards disability and disabled people. According to several studies there is inadequate attention paid to disability and related issues in pre-registration and post-graduate nursing curricula (Boyles et al., 2008; Smeltzer, Blunt, Marozsan, & Wetzel-Effinger, 2015; Scullion, 1999b; Smeltzer et al., 2005).¹³ Smeltzer and colleagues (2005) surveyed 234 accredited schools of nursing in the United States and reported that disability content in nursing curricula is more likely to be taught in medical/surgical and pediatric courses using mostly textbooks as teaching strategies. Books and videos about disability, disabled people, and disability experiences were rarely used as teaching strategies (Smeltzer et al., 2005). In another study, Smeltzer, Robinson-Smith, Dolen, Duffin, and Al-Maqbali

¹³ Although the clear majority of this published research is American, similarities in nursing education curricula and, particularly, in the textbook used allows for some degree of generalization to a Canadian context.

(2010) found that disability-related content was largely absent from nursing textbooks and categories of textbooks used in American nursing programs. Where disability-related content is available, it is primarily conceptualized from medicalized and rehabilitative perspectives of disability, and focused predominantly on acquired disability (Scullion, 1999a; Smeltzer et al., 2005; Smeltzer et al., 2010). And while disability-related content may be available in the context of medicine and rehabilitation, Smeltzer et al. (2005) contend that these perspectives are not representative of the diversity of viewpoints about disability and disabled people in society. Disabled people are not necessarily ill or diseased and in need of treatment and rehabilitation, as they are often portrayed by these perspectives (Uysal, Albayrak, Koçulu, Kan, & Aydın, 2014). Thus, this content alone cannot wholly constitute what is taught about disability in nursing education (Smeltzer et al., 2005).

The importance and influence of nursing educators' support and student exposure to disability content and disabled people is readily discussed within the literature (e.g., Neal-Boylan, & Guillet, 2008b; McConkey, & Truesdale, 2000; Slevin & Sines, 1996; White, Kouzekanani, Olson, & Amos, 2000). However, several authors have expressed concern that nursing students are not given adequate opportunities to engage in dialogue and questioning about disability, and interact and learn from disabled people themselves during their educational experiences (Ilkhani, Glasper, & Jarrett, 2016; Nolan & Nolan, 1999; Oermann & Gignac, 1991; Scullion, 1999ab, 2000). The effectiveness of various interventions, such as increasing disability content in curricula, on nurses and nursing students' attitudes has been the focus of research and discussions within nursing literature (e.g., Boxtel, Napholz, & Gnewikow, 1995; Biordi, & Oermann, 1993; Chan & Cheng, 2001; Chenoweth, Pryor, Jeon, & Hall-Pullin, 2004; Goddard &

Jordan, 1998; Goddard, Mackey, & Davidson, 2010; Honey, Waterworth, Baker, & Lenzie-Smith, 2006; Oermann & Lindgren, 1995; Lindgren & Oermann, 1993; Peterson & Quartstein, 2001; Slevin, 1995; Thompson, Emrich, & Moore, 2003). The findings of these studies suggest that interventions may have some positive impact on attitudes; however, the literature is unclear about which forms of interventions are most effective and whether single or combined strategies are best. In addition, some authors have suggested interventions involving simulation activities (e.g., simulating a physical disability by using a wheelchair) may encourage negative attitudes by focusing on problems associated with disability, thereby reinforcing medical model constructions of disability. Further, it has been pointed out that there is little research demonstrating that improving attitudes about disability results in positive changes in nursing practice or improves the perceptions of disabled people about how they are treated by nurses.

Nurses' Attitudes Towards Disability and Disabled People

Nurses and nursing students' attitudes towards disabled people, the extent these attitudes impact nursing practice, and what can be done to change attitudes have been the focus of considerable discussion and, to a lesser degree, research. Studies focusing on the attitudes and perceptions of nurses and nursing students report contradictory findings. Some studies report that nurses, nursing students, and nurse educators, with varying degrees between each group, do not perceive disabled people positively and are less positive in comparison to other groups (e.g., Kim, Park, Lee, & Kim, 2010; Lewis, & Stenfert-Kroese, 2010; Matziou, Galanis, Tsoumakas, Gymnopoulou, Perdikaris, & Brokalaki, 2009; Temple, & Mordoch, 2012; Tervo & Palmer, 2004; White, & Olson, 1998; Uysal, Albayrak, Koçulu, Kan, & Aydın, 2014). Temple and Mordoch's (2012) study found that the nursing students they surveyed viewed disability from a medical

perspective as physical impairment and represented by a wheelchair. Matziou and colleagues (2009) surveyed the attitudes of first-year nursing students, post diploma nurses completing graduate-level courses, and nursing professionals and found that attitudes toward disabled children were generally poor. The graduate students surveyed were more positive than both the nursing students and professional nurses. The professional nurses in the study held the least positive attitudes. Contrarily, a subset of studies indicates that nurses and nursing students' attitudes toward disability and disabled people are positive and accepting (e.g., Chenoweth, Pryor, Jeon, & Hall-Pullin, 2004; Gething, 1991; Slevin, 1994). Particularly, several studies suggest that nursing students tend to have more positive attitudes towards disabled people (Au & Man, 2006; Brillhart, Jay, & Wyers, 1990; Ten Klooster, Dannenber, Taal, Burge, & Rasker, 2009).

International studies focusing on nursing faculty and educators characterize this group as harbouring negative attitudes and prejudices about learners with disabilities (Aaberg, 2012; Ashcroft & Lutfiyya, 2013; Dahl, 2010; Ryan, 2011; Ryan & Struhs, 2004; Sower & Smith, 2004). Ryan and Struhs (2004) report that among lecturers, nursing students, and nursing directors, lecturers were the least supportive of admitting disabled people into nursing programs, primarily because they believed that the impairments of these applicants would affect their ability to undertake the program and, subsequently, nursing work. Aaberg (2012) reported that nurse educators exhibit bias toward disabled people. Ashcroft and Lutfiyya's (2013) grounded theory study of Canadian nurse educators found that this group has positive attitudes towards students with disabilities and their ability to become competent practitioners, and expected them as part of the student population. However, the nurse educators felt that, at times, disabled students presented challenges.

Work Experiences of Disabled Nurses

The world over, paid work is an important aspect of modern social life that is crucial to personal and sociocultural identity. Employment assists individuals to locate themselves within a community (Gottlieb, Myhill, & Blanck, 2010). The employment of disabled people has been a much-debated and contentious topic over the last century. In many countries, until more recently, it was expected and mandated that disabled people did not work. For example, in Canada, prior to the enactment of the Canadian Human Rights Act in 1985, there were no clear laws or policies preventing employers from denying disabled people employment. Through advocacy and awareness raising by disabled people and their allies, amended and new disability-specific legislation has been introduced, reducing employment discrimination against disabled people and garnering greater access to the labour market in Canada and other countries. Notwithstanding these important strides forward, employment and related outcomes for disabled people remain poor and significantly lag those of non-disabled people worldwide. Globally, 80 to 90% of working-age disabled people are unemployed. In 2004, according to the International Disability Rights Monitor (IDRM) Regional Report of the Americas, the unemployment rate of disabled peoples in Canada was estimated at 26%, five times higher than non-disabled persons (Center for International Rehabilitation, 2004). While the unemployment rate for disabled people has improved, a significant gap remains compared to the unemployment rate of non-disabled people.¹⁴ Disabled people continue to face numerous disadvantages and experience difficulties that are exogenous to their

¹⁴ Statistics Canada reports that in 2011, the unemployment rate of disabled people aged 25–64 was 11%, compared to 6% for people on reporting a disability. The employment rate of these groups was 49% and 79%, respectively.

impairments such as stigma and being denied accommodations (Collins, Lafontaine-Emond, & Pang, 2013; Conference Board of Canada, 2015).

There is much in the literature about the experiences and perceptions of disabled people in relation to work and employment. Studies generally highlight that disabled people value and desire employment; however, they continue to face many challenges and barriers despite protective legislation and policy. Much of the research examining work-life experiences offers recommendations for further research, attitudinal change, improving support systems, educational interventions for both people with and without disabilities, and strategies addressing specific barriers.

Although literature examining the work-life experiences of disabled people is established, not all populations, disability types, and circumstances have been given the same, if any, attention. Very little has been published about the practice and work-life experiences of disabled nurses. In comparison, there is far more literature about the experiences of disabled students. In recent years, new and amended legislation in several countries¹⁵ explicitly require providers of higher education to ensure that students with disabilities are not discriminated against. Correspondently, disability among nursing students is a growing area of interest within nursing literature. Discussion and research has focused on the experiences of students with varying types of impairments (Kolanko,

¹⁵ For example, in the United Kingdom, The Equality Act of 2010 has made it illegal for education providers to treat disabled students unfavourably and requires providers to make reasonable adjustments to ensure disabled students are not discriminated against (UK Government, 2014). In the United States, the 2009 amendments to the Americans with Disabilities Act requires higher education providers to proactively prevent discrimination against disabled students. In Ontario, the Ontarians with Disabilities Act requires the government ministries responsible for education to develop annual plans for identifying, removing, and preventing barriers for people with disabilities. The ODA also requires post-secondary education providers to ensure that their facilities and services are assessable, that there are appropriate and dignified accommodation processes and disabled students are accommodated to the point of undue hardship. Under the act, post-secondary educational institutions must also complete accessibility plans. Educators of these institutions have a duty to be knowledgeable about and sensitive to disability issues and are responsible for participating in the accommodation process (Ontario Human Rights Commission, nd).

2003; Maheady, 1999; Mark, 2007; Morris & Turnbull, 2006, 2007; Ridley, 2010; Stanley, Ridley, Harris, & Manthrope, 2011), the perceptions of nursing educators about disabled students (e.g., Aaberg, 2010; Ashcroft & Lutfiyya, 2013; Dahl, 2010), and interventions and challenges to supporting these students (e.g., Andre, & Manson, 2004; Azzopardi et al., 2014; Griffiths, Worth, Scullard, & Gilbert, 2010; Magilvy & Mitchell, 1995; Owens & Standen, 2007; Sanderson-Mann & McCandless, 2006; Smith-Stoner, Halquist, & Glaeser, 2011; Watkins & Kurz, 1997).

There is a dearth of research literature about the work-life and practice experiences of disabled nurses. The available literature about this population consists mostly of personal accounts of experiences, opinion and commentary letters, brief articles, and legal and other case examples. A search of scholarly databases as well as a review of the reference lists of key documents for research studies focused on disabled nurses and their experiences in the workplace yielded 21 relevant citations reporting on 15 studies about the practice and work-life experiences of disabled nurses (see Table 1). Most studies identified were conducted in the United States, situated within traditional paradigms of disability and focused on the perceptions and experiences of the disabled nurses themselves or nurses and other colleagues who have had experiences working with disabled nurses. The disabilities reported by participants in these studies varied, however, most were physical or sensory disabilities. Two studies focused on nurses with mental health problems (Joyce & Hazelton McMillan, 2007; Joyce, Higgins, Magin, Goode, Pond, Stone, Elsom, & O'Neill, 2012; Joyce, McMillan, & Hazelton, 2009).

Studies of Others' Experiences with Disabled Nurses

Several studies were identified that explored nurses, supervisors and/or hiring personnel's attitudes, perceptions, and experiences working with disabled nurses

(Kontosha, Fletcherb, Frainb, & Winland-Brown, 2007; Matt, 2011; Neal-Boylan & Guillet, 2008a, 2008b, 2008c; Joyce et al., 2012; Wood & Marshall 2010; Winland & Pohl, 1990). Collectively, these studies affirm the findings of other works (e.g., Berry & Mayers, 1995; Hernandez et al., 2008; Hernandez, Key, & Balcazar, 2000; Kaye, Jans, & Jones, 2011; Unger, 2002) indicating that attitudes and perceptions play a key role in the employment experiences of disabled people. The findings of these studies indicate that attitudes and perceptions of non-disabled nurses, supervisors and those hiring disabled nurses are significantly influenced by the quality of previous experiences with disabled nurses and/or patients. Four of the six studies (Kontosha et al., 2007; Joyce et al., 2007; Winland-Brown & Pohl, 1990; Wood & Marshall, 2010) found that previous experience with disabled nurses in which these nurses performed well positively correlated with participants' willingness to hire a nurse with a disability. Additionally, having positive past experiences with disabled nurses seems to contribute to a positive attitude towards working with a disabled nurse in the future (Kontosha et al., 2007; Joyce et al., 2012; Wood & Marshall, 2010). Further, two studies found that acceptance of a disabled nurse and willingness to work with or hire them varied by disability type (Kontosha et al., 2007; Winland-Brown & Pohl, 1990). Nurses were less willing to work with nurses with a history of back pain and neck injury.

Studies of the Practice and Work-Life Experiences of Disabled Nurses

A sub-grouping of the studies identified explored the perceptions and experiences of disabled nurses (see Table 1) (Guillet, Neal-Boylan, & Lathrop, 2007; Joyce et al., 2007; Joyce et al, 2009; Koenes, 2001; Korzon, 2012; Matt, 2008; Morris-Turnball, 2007; Neal-Boylan, 2012, 2014; Neal-Boylan, Fennie, & Baldauf-Wagner, 2011; Neal-Boylan et al., 2012; Neal-Boylan & Guillet, 2008a, 2008b, 2008c; Neal-Boylan & Miller,

2017; Pohl & Winland-Brown, 1992; Schick-Makaroff, 2005). The findings of these studies indicate that disabled nurses face numerous barriers but have limited resources to help them practice and integrate into the work environment successfully. As a result, disabled nurses perceive they must work harder than those in the physical and social workplace environment to compensate for their embodied limitations. The themes emerging from these studies include changing self-conceptualizations, adapting and knowing limitations, being emotional, dealing with the workplace environment, accommodations, attitudes of and interactions with others, and acceptance by and support from others.

Most of these studies similarly found that disabled nurses often perceive that they must and do work beyond their limits or compensate to allay their own and others' concerns about their disability jeopardizing patient safety and professionalism (Joyce et al., 2009; Matt, 2008; Morris-Turnball, 2007; Neal Boylan, 2012, 2014; Neal-Boylan, & Guillet, 2008a, 2008b, 2008c; Neal-Boylan, Fennie, & Baldauf-Wagner 2011; Neal-Boylan & Miller, 2017). Additionally, the results of these studies indicate that the workplace climate and culture experienced by disabled nurses is significantly impacted by the attitudes of and interactions with others. Recent studies (Joyce et al., 2007; Joyce et al., 2009; Matt, 2008; Neal-Boylan, 2012; Neal-Boylan et al., 2011; Schick Makaroff, 2005) validate Pohl and Winland-Brown's (1992) earlier findings that non-collegial and unsupportive interactions with others, as well as the physical environment, often leads to negative feelings and diminished self-confidence and self-worth in disabled nurses.

Accommodation was a theme in several of the studies reviewed. Neal-Boylan (2014) reported that disabled nurses believed it was easier to receive accommodations if you have a visible disability, but overall, they felt supported. Other studies reported

nurses have difficulty obtaining accommodations (Matt, 2008) or avoided requesting them (Neal-Boylan, 2012). Lack of accommodation was a significant reason why nurses experienced difficulties remaining in a job (Matt, 2008; Neal-Boylan, 2012, 2014; Neal-Boylan & Guillet, 2008a, 2008b, 2008c; Neal-Boylan et al., 2011). Neal-Boylan and Miller (2017) found that during their nursing education disabled nurses' accommodations were not granted by their programs despite being approved by the institution's disabilities office.

Although discrimination due to disability is identified in the literature as a barrier for disabled people, this experience is not directly validated by the studies identified. Participants in these studies tended to describe practices often associated with discrimination rather than naming them as discrimination. In a study of nurses with mental health problems, participants perceived colleagues' actions towards them as ill-treatment and discriminatory actions (Joyce et al., 2007). In other studies participants identified stigma and lack of understanding and compassion from colleagues as deterrents to disclosing their disability and the reason for their work-related emotional difficulties (Neal-Boylan, 2012; Neal-Boylan & Guillet, 2008a, 2008b, 2008c). In one study, disabled nurses reported that during their nursing education they were frequently told they could not be nurses and experienced fear and anger from faculty (Neal-Boylan & Miller, 2017). In contrast, Kontosha and colleagues (2007) found that participants did not feel discriminated against in their workplace despite the majority also reporting that their job opportunities were severely limited because of their disability. Despite not naming discrimination, nurses with invisible disabilities discussed their hesitancy or avoidance of disclosing their impairments to colleagues and their employer (Korzon, 2012; Morris-Turnball, 2007; Neal-Boylan, 2012; Neal-Boylan et al., 2012).

Identity emerged as an explicit theme in some of the studies reviewed. These studies reported similar findings indicating that nurses struggled with their identities in the context of having an impairment (Koenes, 2001; Korzon, 2012; Pohl & Winland-Brown, 1992; Shick Makaroff, 2005) and had to renegotiate their conception of themselves as nurses (Shick Makaroff, 2005; Koenes, 2001). Korzen (2012) reported that when negotiating a disabled identity, the individual or medical model of disability largely influenced the nurses studied. These nurses framed their experience of impairment as problematic and their responsibility to address.

Other studies reviewed addressed aspects impacting nurses' identities. Several studies highlighted the emotionality of the experience of working with a disability (e.g., Neal-Boylan, 2012). Nurses reported feeling anger and uncertainty (Koenes, 2001; Pohl & Winland-Brown, 1992), feeling hurt and fearful (Shick Makaroff, 2005), but also hopeful (Shick Makaroff, 2005; Pohl & Winland-Brown, 1992). Nurses also reported that their embodied experiences due to their impairment had an impact on their practice and work experiences. Nurses described experiencing physical, reduced stamina, and fatigue (Koenes, 2001; Neil-Boylan & Guillet, 2008abc). Other nurses reported that their impairment prevented them from practice at times (Joyce & Hazelton, 2007).

Author(s)	Purpose & Design	Key Findings & Study Limitations
Koenes (2001)	Investigate the experiences of injured nurses after they were injured and forced to leave their previous bedside nursing positions Qualitative; Phenomenology	Loss of professional identity Pain during transition Anger and unknowns during the transition Survival, new beginnings and new identity
Matt (2008)	Explore the lived experiences of nursing with physical and sensory disabilities practising in hospital workplaces and identifying factors within a hospital organization that contributes to disability climate Qualitative; Grounded Theory	Nurses struggled with work environment issues such as difficulty obtaining accommodations; Peer acceptance is critical for disabled nurses Managers supervisors <i>Limitations:</i> unclear study design; Data collection over the telephone may have limited richness of data; transferability limited to hospital environments
Matt (2011)	RN attitudes towards RN with disabilities in the hospital nursing workforce Quantitative; Survey of non-disabled and disabled nurses	Type of nursing and acuity of practice influenced disabled nurses' experience of the work environment; Positive link between exposure and previous experiences with disabled people and attitudes towards nurses and others with disabilities. <i>Limitations:</i> Provides limited insight into experiences of disabled nurses due to sample and design; validity and reliability of instrument unknown; response bias
Neil-Boylan, Fennie, & Baldauf-Wagner (2011)	Explore perceptions and characteristics of registered nurses with sensory disabilities and their risk for leaving their jobs Quantitative; Survey	Hospital nurses with sensory disability at risk (3 times) for retention problems with many leaving the profession; Nurses with hearing difficulties experience frustration at work <i>Limitations:</i> Generalizability; insights limited by study design

Table 2-1 Summary of Literature Review

Author(s)	Purpose & Design	Key Findings & Study Limitations
Winland & Pohl (1990)	Identify and analyze the prevailing attitudes and practice of nurse administrators and hospital personnel directors towards hiring disabled RNs Quantitative; Survey	Nurse leaders willing to hire nurses with a disability, however, personnel directors were unwilling to hire nurses in wheelchairs for bedside positions; Nurse administrators felt accommodations would be needed when hiring disabled nurses <i>Limitations:</i> insight into experiences and depth of analysis (e.g., employment setting) limited by design; low response rate yielding small sample size
Wood & Marshall (2010)	Explore attitudes, concerns and work experiences of nurse managers regarding staff disabled nurses Quantitative; Exploratory descriptive (attitudinal instrument)	Most nurse managers rated the work performance of disabled nurses as exceptional or above average; Nurse managers concerns: patient safety due to risk posed by nurse's impairment; abilities to carry out nursing duties; interpersonal interactions and issues; Positive link between previous exposure to disabled nurses and a willingness to hire disabled nurses <i>Limitations:</i> does not directly study disabled nurses; design limits insight into experiences of disabled nurses; validity and reliability of modified instrument
Schick Makaroff (2005)	Explore disabled nurses' experiences of feeling understood Qualitative; descriptive exploratory	3 themes: acceptance-non-acceptance of changing abilities and expectations engenders joyful relief and aching hurt (p. 166) Being believed-not being believed by others resides along with honesty-dishonesty manifesting wavering support (p. 166) Self-confidence fluctuates with the enthusiasm and fear of wanting to make plans <i>Limitations:</i> does not directly focus on nurses' workplace experiences

Table 2-1 Summary of Literature Review (cont'd)

Author(s)	Purpose & Design	Key Findings & Study limitations
Joyce & Hazelton McMillan (2007); Joyce, McMillan, & Hazelton (2009)	Explore the workplace experience of disabled nurses who have a mental health problem Qualitative; Discourse analysis and Ethnography	3 Themes: Crossing the boundary from nurse to patient: a) developing a mental illness b) hospital admission and c) being managed Being a nurse with a mental illness/health problem largely a negative experience in which nurses subjected to discriminatory actions (ill-treatment, inequities in workload; target of gossip) Non-disabled nurses use discriminatory practices to enforce perceived appropriate conduct of a professional nurse <i>Limitations:</i> Unclear methodology; minimal details provided about data analysis process; limited transferability of findings
Joyce, Higgins, Magin, Goode, Pond, Stone, Elsom, & O'Neill (2012)	Explore nurses' knowledge and understanding about mental health and their experiences working with nursing with mental health problems Qualitative; Data analyzed using framework analysis	Peer attitudes and responses towards nurses with mental health problems influenced participants' workplace experiences; Textbook knowledge about mental illness did not guarantee ability to recognize issues and support colleagues with mental health problems; Despite desire to and sympathy towards these nurses, supporting nurses with mental health problems can be stressful resulting in coping mechanism such as gossiping; Work practices and environments make it difficult to detect informal issues <i>Limitations:</i> Does not directly study disabled nurses' experiences; limited transferability of findings

Table 2-1 Summary of Literature Review (cont'd)

Author(s)	Purpose & Design	Key Findings & Study Limitations
Neal-Boylan, L. J., & Guillett, S. E. (2008a, 2008b, 2008c); Guillett, S. E., Neal-Boylan, L. J., & Lathrop, R. (2007)	Explore the work experiences of physically disabled RN and understand the perspectives of RNs with disabilities and RNs who interview other nurses for hire Qualitative	Nurses with physical disabilities' experiences are characterized by concealment of their disability in the workplace out of fear of being rejected for employment and stigmatized by colleagues; Nurses with physical disabilities engage in heroics and use creativity to compensate for limitations and meet requirements of their practice; Support from colleagues is facilitator of their ability to practise nursing with a disability Modifications that would enhance ability to participate in nursing profession: education to promote awareness; organizational flexibility; accommodations in the workplace Limitation: poorly described methodology; transferability limited by sample characteristics (e.g., disabled nurses only); data collection (telephone interviews) may limit depth and richness of data
Pohl, & Winland-Brown (1992)	To examine the perceptions of disabled nurses about their disabilities Qualitative	2 Themes: Self-image- Disabled nurses perceived having fewer options in their future; angry about their limitation and interactions with others, however, some had hope Support- Disabled nurses had both positive and negative perceptions of the support they received from others Limitation: study design and method of analysis not identified; limited transferability due to age of publication (21 years), lack of details about sample and sample characteristics (e.g., participants were all unemployed)

Table 2-1 Summary of Literature Review (cont'd)

Author(s)	Purpose & Design	Key Findings & Study Limitations
Kontosha, Fletcherb, Frainb, & Winland-Brow (2007)	Understand how social and physical barriers affect disabled nurses' employment opportunities through analysis of the perceptions and experiences of employers and other nurses (with and without disabilities) Quantitative; Survey	Disabled nurses did not feel discriminated against despite many reporting being limited in their employment options Significant correlation between past experiences with nurses with specific disabilities and willingness of nurses without disabilities to work with disabled nurses in the future; Significant correlation between past experiences hiring disabled nurses and the likelihood of administrators/personnel directors hiring disabled nurses in the future <i>Limitations:</i> design limits insight into experiences of disabled nurses; design limits depth of analysis of influencing factors identified; small sample size
Neal Boylan, (2012); Neal-Boylan, Hopkins, Skeete, Hartmann, Iezzoni, & Nunez-Smith (2012)	Examine work-life experiences of physicians with disabilities; explore the work-life experience of disabled nurses; discover how the two professions compare with each other with regards to these experiences Qualitative	Disabled nurses and physicians have very similar work-life experiences: Disability narrows and alters career choices trajectories; Struggled with disclosing/discussion of their disability in workplace; Rarely request accommodations but view patient safety as their own responsibility; Link between interactions with others and organizational climate and culture Experience a broad range of emotions about their disability related to their workplace and practice <i>Limitations:</i> Limited/unclear information about study design; purposive sampling may have excluded potential participants

Table 2-1 Summary of Literature Review (cont'd)

Author(s)	Purpose & Design	Key Findings & Study Limitations
Neal-Boylan & Miller (2017)	Explore the experiences of RNs who had disabilities while in their nursing programs Qualitative; constant comparative analysis	Participants reported hiding their disabilities, experiencing fear and anger from faculty, and were told they could never be nurses; Having a disability as a nursing student made participants more empathetic as nurses; Participants perceived themselves as strong advocates for patients, and for better instructors and preceptors; They were more conscious of patient safety and of providing quality of care. <i>Limitations:</i> Study excludes nurses with diagnosed mental illness; does not directly focus on nurses' workplace experiences; discussion and implication limited in scope
Korzon (2012)	Explore the experience of nurses who have acquired impairments and the impact on their identity and their nursing practice. Qualitative; Narrative Methodology	Participants had trouble negotiating identity formation in the context of their impairment due to disabling work environments that upheld an oppressive and discriminating perspective of disability; Despite this, nurses could find their way and negotiate continuity in their nursing identity and maintain participation in the profession after they acquired their impairment. <i>Limitations:</i> Limited transferability as study focuses only on nurses with acquired impairments during practice

Table 1: Summary of Literature Review (cont'd)

Gaps and Limitations of the Literature

Although the studies identified provide useful information about disabled nurses' experiences in the workplace, none specifically focus on the practice and work experiences of disabled nurses within a Canadian context. Of the literature reviewed only

one study was conducted in Canada. The differences between Canada and the United States in how employment and workplace disability issues are approached warrant study of the practice and work-life experiences of disabled nurses practising within a Canadian context.

Additionally, within the available literature there are very few rich portrayals of the practice and work experiences of disabled nurses in their own language. In many of the studies reviewed the work-life experiences and perceptions of disabled nurses had been represented in other terms by the researcher(s), often based on unclear methodological practices and/or theoretical and philosophical orientations. As very little is known and understood about disabled nurses as a population, it is important that research focuses on fully explicating the perceptions of disabled nurses and their experience of practising nursing before moving towards generating hypotheses, developing concepts, or formulating theory about the experiences of this population.

Lastly, there is a general absence of discussion and integration of critical perspectives on disability in the studies reviewed. The studies tended to rely on medical or rehabilitation paradigms to inform their discussion of findings and draw conclusions and recommendations. Except for a few, the studies reviewed linked the experiences of disabled nurses with individualist interpretations of disability. Consequently, implications of findings, recommendations, and directions for future research are restricted to the individually contextualized level, ignoring socio-political aspects.

To address the issues associated with research situated within traditional disability paradigms, it is suggested that those conducting disability-related research adopt an emancipatory paradigm and participatory research approaches that recognize issues of ideology and ethics such as the “production and situatedness of knowledge,

representativeness, reflexivity, empowerment, emancipation, critical praxis and positionality and [determining] how these might be best addressed” (Kitchen & Wilton, 2000. p. 61).

Summary

This chapter has examined traditional and contemporary constructions of disability and how dominant discourses of disability have been taken up (or not) in and influenced nursing practice, education, and knowledge development. I also discussed the literature on the work experiences of disabled nurses. Taken together the review highlights that, inasmuch as nursing has been characterized as an autonomous knowledge profession, with respect to disability this has come by virtue of its close association with medicine and the conceptualization of disability through a medical, individualist lens.

Chapter 3: Methodology

Introduction

Having established the need for research on disabled nurses' experiences and perceptions of work within a Canadian context, this chapter provides an overview of the research design and process undertaken in this study. First, I discuss my assumptions and other factors that shaped how this research was conducted. In section two, I discuss the research methodology of the study and explicate the research methods used. Lastly, I conclude by examining how trustworthiness was established and relevant ethical issues and reflexivity were addressed during the research process.

Approach to the Research

Research is a complex undertaking layered with matters of expression, representation, and interpretation. It involves careful consideration of many aspects, including the decision to study a topic, formulating a question, and choosing an appropriate approach to conduct the inquiry. Caelli, Ray, and Mill (2003) note that:

in its many different forms, the central aim of research is knowledge development. The processes of knowledge development are framed by the types of knowledge that are sought and are, of necessity, rigorous, demanding, and meticulous. These processes must be scrupulously applied throughout the entirety of a study, to ensure that the knowledge that is developed is not flawed, and therefore of use to the discipline it purports to inform (p. 3).

Thus, it follows that explicating one's theoretical positioning¹⁶ is an important first step to undertaking any kind of inquiry. Without this step, a researcher is more likely to choose a methodology and methods that are incongruent with each other and

¹⁶The term *theoretical positioning* refers to the researcher's "motives, presuppositions and personal history that leads him or her towards and subsequently shapes, a particular inquiry" (Caelli et al., 2003, p.5).

the research question. In turn, this may result in misinterpretations of data (Kahlke, 2014). Furthermore, according to Caelli et al. (2003), it is incumbent on the researcher to discuss how their position influenced design choices so that readers can judge the quality of the research for themselves.

Suffice it to say then that the theoretical positioning underlying this research is important to its outcomes and trustworthiness. The following section outlines these presuppositions and beliefs, and discusses their influence on the research process.

Philosophical Assumptions

This research is underpinned by a constructivist inquiry approach — or naturalistic inquiry, as it is less commonly labelled (Lincoln & Guba, 1985). Constructivism supports a relativist ontology that espouses a reality that is neither singular nor tangible (Appleton & King, 1997). Through my practice as a registered nurse, I have come to believe, as Lincoln and Guba suggest, that realities are multiple, intangible constructions. “What people know and believe to be true about the world is constructed or created, and reinforced and supported as people interact with one another over time in specific social settings” (LeCompte & Schensul, 2010, p. 67). My nursing practice in psychiatry helped me to develop a rational understanding that, in a sense, reality is a “state of mind.” Therefore, knowledge is “a function of our interpretation of events and the meaning we create to explain those events to others” (LeCompte & Schensul, p. 67).

Appleton and King (1997) contend that, epistemologically, a constructivist researcher “takes a subjective and transactional approach to examine the phenomena under investigation” (para 5). As a researcher who adopts a constructivist stance, I recognize that research data are generated through a co-constructive process, to which

both myself and participants bring constructed realities. The data itself represent realities created through relationships and interactions between participants, myself as the researcher, and the context. In these instances, there are possibilities for congruence or divergence of beliefs and assumptions about the world. Methodologically, such contradictions are important in constructivist inquiry. Appleton and King identify that constructivist inquiry adopts a dialectic approach whereby contradictions are viewed as useful in gaining more in-depth understandings. Dialectic logic “involves seeking out convergent and divergent thinking about the phenomena under study, which may bring to light conflicting ideas and viewpoints” (para 6). Constructivist researchers also adopt an interpretive approach (hermeneutic), seeking to know and understand constructions in-depth. Accordingly, in undertaking this research, I was cognizant that it might not be possible to attain a single understanding of the experiences and perceptions of disabled nurses (Appleton & King).

Approach to Inquiry

I take a pragmatic, pluralist approach to inquiry. Weaver and Olson (2006) comment that a pragmatic approach “stresses critical analysis of the facts, applications, and outcomes rather than abstractions and verbal solutions” (p. 466). By taking a pragmatic approach, I wish to extricate myself and my research work from being embroiled in the debates about different research paradigms (Cohen & Crabtree, 2006a; Morgan 2007). My aim is to move beyond the boundaries and restrictions of any one single paradigm towards generating knowledge that fits circumstances.

Weaver and Olsen (2006) describe the strategies of a pragmatic approach to inquiry as beginning with a critical review and appraisal of existing knowledge to uncover “gaps in available knowledge, areas where existing knowledge is untrustworthy,

and areas requiring further information before conclusions can be drawn” (p. 466). This is followed by decision-making about whether knowledge needs to be developed in the under-studied or underdeveloped areas. It is at this stage where the researcher determines which research paradigm to use. The decision of which paradigm to use is guided by “the purpose of inquiry, in conjunction with the state of knowledge development in the substantive area” (p. 466).

Positionality and Research Topic

Approaching this research from a constructivist perspective required that I explore my positionality to the subject of this research. The subject of this research is significantly linked to my lived experience and professional practice as a registered nurse. I chose to study disabled nurses’ experiences in the workplace after a series of events changed the direction I intended for my dissertation.

I entered the Critical Disability Studies PhD program at York University with the intent to address the relative neglect of disability within nursing literature. I was concerned about the absence of disabled peoples’ voices among the disability narratives that informed nursing practice. Specifically, I wanted to uncover the experiences of persons with mental disabilities in relation to nursing care. However, a short time after entering the PhD program, I was diagnosed with a chronic illness followed a few years later by a cancer diagnosis. My illness experiences had a profound impact on my self-concept, identity, and my ability to continue my studies and nursing practice. Prior to these experiences and despite having a history of learning difficulties, I had not contemplated my identity as a disabled person. Through reflexivity brought on by these experiences, I could unmask and challenge hidden assumptions and beliefs about

disability and came to understand how dominant disability narratives influenced my own identity development.

Because of this self-exploration, I shifted my research focus onto disabled nurses' experiences. Although I remained strongly committed to addressing the gaps within nursing knowledge about disability, I now wanted to understand disabled nurses as a population and uncover their practice experiences and perceptions. Following the pragmatic approach to inquiry described above, I began by conducting a critical review and appraisal of the literature relating to disabled nurses. From this review, it became apparent that disabled nurses were a hidden population. There is a dearth of academic research about this population. Arriving at the conclusion that knowledge development in this understudied area was needed, I chose to conduct this research to uncover disabled nurses' practice experiences.

Research Methodology and Methods

Weaver and Olsen (2006) assert that in choosing a methodology for an inquiry, the researcher must consider the purpose of the research and the research question. The chosen methodology should be congruent with the research question (Caelli et al., 2003). Further to this point, Kahlke (2014) argues there must be congruence at all levels of the research framework.¹⁷ The following section discusses the accordance between the constructivist underpinning of this research, the chosen methodology and methods, and the decisions made during the research process.

¹⁷ According to Kahlke (2014), there should be congruence in the philosophical stance of the researcher and methodology (or design) of the study, in methodology and methods, and in methods and techniques.

Research Methodology

Research projects can be classified into three categories: descriptive, exploratory, and explanatory.¹⁸ This study is exploratory because it seeks to explore an experience (i.e., work experiences of disabled RNs) that is not well known and studied (Brotherton, 2008). According to Brotherton, the goal of exploratory research is to develop a well-grounded mental picture of what is happening in a situation or with an experience and become familiar with the basic facts. The primary aim of this research was to provide insight into the work experiences and perceptions of disabled nurses by producing a coherent, meaningful, and straight descriptive summary. To arrive at this aim, qualitative description (QD) was chosen as the research methodology.

Qualitative description is suited to this research because it is “a stand-alone method that affords a comprehensive summary of human experience without an in-depth level of interpretation” (Milne & Oberle, 2005, p. 413). The goal of QD is a “rich description of [an] experience/event/process depicted in easily understood language” (Sullivan-Boylai, Bova, & Harper, 2005, p. 128). This goal differs from other qualitative methodologies such as ethnography, grounded theory, and narrative inquiry, which aim for a thick description, theory development, and narrative explanations, respectively. It also differs from phenomenology, which seeks to develop a nuanced understanding of a lived experience through interpretive meaning-making (Hsieh & Shannon, 2005; Sullivan-Boylai et al.).

¹⁸ In exploratory research the researcher seeks to find out about a phenomenon or see it in a new light while in a descriptive study the researcher attempts to explore and explain a phenomenon in detail based on already established knowledge of the situation or phenomenon. Usually, a descriptive study is building on an exploratory study. If a study is explanatory it seeks to uncover any explanation (e.g., cause-and-effect relationship) to a situation or problem.

Qualitative description is intentionally less theoretically driven than other qualitative methodologies (Sandelowski, 2010; Neergaard, Olesen, Andersen, & Sondergaard, 2009). While QD does not articulate an enduring set of theoretical assumptions and a priori theory or pre-packaged theoretical perspective (Caelli et al., 2003; Kahlke, 2014; Sandelowski, 2000, 2010), it draws upon the tenets of constructivist inquiry (Sandelowski, 2010). QD aligns with the constructivist “commitment to studying a phenomenon in a manner as free of artifice as possible in the artifice-laden enterprise known as conducting research” (Sandelowski, 2010, p. 79). QD is consistent with the basic beliefs of constructivist inquiry (see Table 3.1). It assumes that knowing an experience requires knowing the “facts” about that experience. It supposes that the facts of an experience are constructed intersubjectively and do not exist outside of the specific context that gives them meaning. The representation generated by the researcher is inextricably linked to who the researcher is and dependent upon their inclinations, sensibilities, and sensitivities (Sandelowski, 2000). As Sandelowski (2000) notes, “researchers seeking to describe an experience or event select what they will describe and, in the process of featuring certain aspects of it, begin to transform that experience or event” (p. 365).

As a constructivist endeavor, qualitative descriptive studies involve interpretation. However, Sandelowski (2000, 2010) points out that relative to other qualitative methodologies, such as phenomenology and grounded theory, QD is less interpretive. In QD, the researcher aims to stay close to the surface of data. The researcher abstains from describing “an event in terms of a conceptual, philosophical, or other highly abstract framework or system” (Sandelowski, 2000, p. 336). It is possible to accomplish this goal because interpretation remains at the superficial level and refrains

from transforming participant descriptions into interpretations dictated by a specific methodological approach or framework (Sandelowski, 2000). Sandelowski (2010) characterizes the findings produced at this level of interpretation as thematic surveys, noting that, rather than being transformed away from the raw data, the information participants provide — such as their concerns and perceptions — remain concerns or perceptions. In their representations, the researcher is obliged to consider all data they observe within the field (Sandelowski, 2000). This level of representation is fitting with research that aspires to give or make central the voice of a population, as in the case of this study.

Item	Constructivist Inquiry	Qualitative Description
Basic beliefs	<i>Relativist ontology</i> - local and specific constructed realities	Knowledge of an experience exists only within the context that gives it meaning.
	<i>Transactional/subjectivist epistemology</i> - findings are created; The researcher is not an objective discoverer and/or receiver of knowledge; knowledge is co-construction there can be no separation of the knower and the known	The description of an experience is a reconstruction of information generated through dialogue between the researcher and participants. It is imbued with who the researcher is.
	<i>Hermeneutical/dialectical methodology</i> - interpretation of information that is constructed captures various perspectives and makes the context evident through a process that involves comparison and contrast of different views (Lincoln & Guba, 2005).	Interpretation is low-inference; the researcher avoids high-level abstraction and chooses to present the information generated in everyday language. The researcher represents the facts of an experience and the meanings participants give to them, and is obligated to consider all the data in the representation of findings (Sandelowski, 2000).

Table 3-1 Basic Beliefs of Constructivist Inquiry Approach

Positions		
Inquiry Aim	Reconstruction; understanding	A comprehensive summary of an event.
Nature of knowledge	“Individual reconstructions coalescing around consensus” (Lincoln & Guba, 2005, p. 166)	Descriptions of the facts, an event, or experience are representations or reconstructions that aim to convey information gathered in a coherent and useful way.
Goodness or quality criteria	Trustworthiness and authenticity	Researcher seeks descriptive validity and interpretive validity.
Voice of researcher	“passionate participant” as facilitator of multi-voice reconstructions (Lincoln & Guba, 2005, p. 166)	Researcher stays close to the data, reconstructs information generated as close to what was reported as possible (Sandelowski, 2000).

Table 3-1 Basic Beliefs of Constructivist Inquiry Approach (cont'd)

Methods

The qualitative descriptive design adopted in this research represents what Sandelowski (2000) refers to as a “reasonable and well-considered combination of sampling, and data collection and analysis, and representational techniques” (p. 337). Consistent with the characteristics of operational constructivist inquiry,¹⁹ the typical design features of QD include use of a purposive sampling technique, one or more of a set of data-collecting strategies enabling the researcher to discover details of an

¹⁹ Lincoln and Guba (1985) identify 14 characteristics of operational constructivist inquiry based on the basic underpinning of this paradigm (axioms): 1) conducting research in the natural setting or context of the experience; 2) humans as the primary data-gathering instrument; 3) use of tacit knowledge; 4) using qualitative methods; 5) purposive sampling to increase scope of data exposed; 6) inductive data analysis; 7) emerging theory grounded in the data; 8) design of study is emergent and flexible; 9) negotiated meaning and interpretation with human sources that data is primarily drawn; 10) case study reporting mode; 11) idiographic data interpretation; 12) tentative application of findings; 13) focus-determined boundaries that are emergent; and 14) special criteria for trustworthiness that differs from the conventional (e.g., internal and external validity, reliability, objectivity).

experience (e.g., in-depth interviews, focus groups, observations), and emergent analytical strategies that are common to many qualitative methodologies (e.g., coding).

To address the questions posed in this research, I used snowball sampling to identify participants, collected data through in-depth semi-structured interviews, and analyzed data using conventional content analysis. The data generated was represented with no other mandate than to provide a descriptive summary of the experiences of disabled nurses (Sandelowski, 2000). Below, these methods are discussed in greater detail.

Sampling and Sample Size

English-speaking disabled RNs with current or recent (within the last 12 months') work experience in the province of Ontario were invited to participate in this study using the snowball sampling technique. The snowball sampling technique utilizes referrals from an initial set of recruited participants to generate additional eligible participants (Patton, 1990; Sadler, Lee, Lim, & Fullerton, 2010). This technique was used to recruit participants because of the unknown and difficult-to-access nature of the population to which they belong. Snowball sampling was also chosen because it is the most appropriate approach for locating participants likely to provide in-depth, information-rich descriptions of an experience (Patton). The usefulness of snowball sampling is offset by the risk to privacy it imposes (Patton). To mitigate this risk, participants were recruited through self-referral or contacted after they had expressed consent for their contact information to be disclosed. Using these strategies, I could avoid accessing any personal information about others without their consent.

A total of 12 participants were recruited for this research over an eight-month period. Recruitment ended when sufficient depth of information and redundancy of data

was obtained to satisfy the purpose of the study (Mason, 2010; Patton, 1990; Sandelowski, 1995). Most of these participants were recruited by word of mouth resulting from an email invitation I sent to individuals within my professional and personal networks. The email outlined the study's inclusion criteria and encouraged recipients to forward the email or pass on an informational document attached to the email to others who might qualify or know potential participants. A similar verbal script, as well as follow-up email and verbal scripts responding to requests for information, were also used.

Data Generation

Consistent with the constructivist inquiry stance taken in this research, data was generated using face-to-face, semi-structured interviews with open-ended questions. Rodwell (1998) notes “the constructivist [interview] is a context–embedded conversation with a purpose ... Both the purpose and the context shape ‘what’ is said” (p. 122). Using an open-ended interview format allowed participants to share their experiences and discuss their perceptions in full detail. Additionally, conducting the interviews face-to-face provided the opportunity for reciprocity, clarification, and meaning to be enhanced by nonverbal data (Rodwell). To ensure an accurate account of the data was generated, each interview was recorded using a digital recorder and transcribed. Lastly, as suggested by Rodwell, interview conversations were conducted in a safe, comfortable, and respectful environment that provided participants with privacy and anonymity.

From a constructivist stance, the conversation that occurs in an interview is closely tied to the ethical dimensions of research. Before a conversation can occur, fully negotiated and informed consent must be obtained. Prior to meeting each participant, I provided them with a research consent form, clarified questions and concerns, and

confirmed their verbal consent. At the start of each interview I reaffirmed consent by reviewing the details of the study and determining that each participant was fully aware of the potential risks, voluntary nature of their participation, and their willingness and ability to engage in the inquiry process (Rodwell, 1998). At this point, formal written consent was obtained.

To direct the conversations I had with participants, I developed a semi-structured interview guide based on the aims of the study, research question, and available literature on the topic (Appendix A). The questions developed addressed the four areas this research sought to describe: 1) the impact of having a disability on a nurse's work; 2) disabled nurses' perceptions of their workplace environment and their practice; 3) barriers disabled nurses experience in their work as nurses; and 4) facilitators of disabled nurses' ability to practise nursing. The following components were also included in the interview guide: 1) demographic indicators (i.e., age, gender, ethnicity/race, country of birth, years living in Canada, years of nursing practice, and languages spoken and written); 2) questions about the participant's disability (i.e., how they considered themselves disabled, nature of their disability, and how long they have lived with their disability); and 3) an open-ended question inviting the participant to share additional information.

Prior to using the interview guide I sought feedback from my dissertation supervisory committee and a nurse researcher familiar with qualitative research methods. Further, I tested the guide by conducting a mock interview with a nursing colleague who had no previous interview experience. The feedback received was used to modify the guide before it was first used. However, Rodwell (1998) reminds that a constructivist's interview guide is always in flux. The researcher may need to update the

guide as data is collected and connections grow or ideas come into focus. In this research, although the essential aspects of the questions guiding the conversations with participants did not change, the guide was refined and became more focused after the first several interviews, all the while being flexibly applied.

Positionality and Data Generation

Richards (2015) argues that qualitative research is an intensely personal endeavour. In this research, my personal connection to the subject matter created several tensions for me as a researcher. During the research process, I was acutely aware of the importance of my positionality and how it might influence the research process and the data generated. I was also aware of the possibility of tension because of my relationships with some of the participants (i.e., as past or present work colleagues). Maier and Monahan (2009) suggest that qualitative researchers commonly experience tensions related to closeness and detachment during the research process. The researcher may struggle to establish a balance between closeness and detachment that maintains the focus on the participants and builds enough trust so that they feel safe to share their narratives (Dickson-Swift, James, Kippen, & Liamputtong, 2007). Appleton and King (1997) contend trust and rapport are critical to constructivist inquiry and note that “the genuine and respectful relationship that can develop during encounters between [the researcher and participants] culminates in depth and richness of data” (p. 19) Additionally, having clarity about one’s motivations and situatedness helps to cultivate an environment that encouraged participants to reveal their stories.

Understanding that the meaning of both the questions posed and the answers provided during conversations were being jointly constructed and grounded in the context of each interview, it was important that I encourage an openness that fostered

balanced and authentic conversations. To foster closeness with participants I openly 1) discussed the rationale and significance of the study; 2) shared my situatedness in relation to the study, identifying my professional background and practice experience; and 3) acknowledged any relationships and connections that existed between them and myself. Yet, as the intent of the research was to enter the lives of others and facilitate disclosure, I also attempted to establish a certain level of detachment by strategically self-disclosing and refrained from sharing personal information that could potentially shift the focus of the interview onto myself (Poindexter, 2003). Additionally, using open-ended questions during the interview helped to maintain focus on the participants, allowing for access to their thoughts and perceptions. In instances where it was evident that participants were concerned about what I was expecting, I encouraged them to share what they thought was relevant information. Lastly, I was careful not to make assumptions about the backgrounds and experiences of participants and sought clarification when they made assumptions about what I understood or knew.

Data Analysis

Milne and Oberle noted that “the goal [of QD] is to stay close to the surface of data while capturing all the elements of that experience, and the inherent scientific rigor is a reflection of a researcher’s ability to achieve that goal” (p. 413). To achieve a rich, thick description of disabled nurses’ workplace experiences, conventional content analysis (Hsieh & Shannon, 2005) was used. Conventional content analysis is the data analysis strategy of choice in qualitative descriptive studies (Neergaard et al., 2009; Sandelowski, 2000; Sullivan-Bolyai et al., 2005) because it allows the researcher to gain “direct information from study participants without imposing preconceived categories or theoretical perspectives . . . [It generates knowledge that] is based on participants’

unique perspectives and grounded in the actual data” (Hsieh & Shannon, 2005, p. 1280). Additionally, in conventional content analysis “there is no mandate to re-represent the data in any other terms than their own” (Sandelowski, 2000, p. 338).

Conventional content analysis is an inductive process involving the development of a modifiable coding system that is directly derived from the data. It begins with identifying relevant text from the transcribed conversations with participants (e.g., phrases, thoughts, expressions of emotion) and labelling them (coding). As the analysis progresses, the researcher continuously adjusts the coding system as new data and insights about the data emerge from each transcribed conversation (Hsieh & Shannon, 2005). If necessary, the coding system “may even be wholly discarded in favor of a new system, to ensure the best fit to the data” (Sandelowski, 2000, p. 338). The knowledge generated from conventional content analysis is a “straight descriptive summary of the informational data [accompanied by supportive exemplars from the data and] organized in a way that best fits the data” (Sandelowski, 2000, p. 338–339).

In this research, I analyzed the textual representations of the conversations with participants (transcripts) following the conventional approach to qualitative content analysis outlined by Hsieh and Shannon (2005) (Table 3.2). I began the data analysis by reading all the data to first verify the accuracy of the transcript and then read each again to immerse myself in the data. Next, I read each transcript carefully, manually highlighting text that appeared to be relevant and labelling them using participant words in the margins (coding). While coding, I attempted to stay close to the surface of data, paying attention to how often words or comments were repeated, which thoughts or ideas participants explicitly stated were important, and convergent and divergent thinking. I also used observational notes I made during or after the interviews to assist in

identifying relevant text. From this step, an initial coding system was developed. Prior to completing the additional steps of the analysis, the text used to derive the initial coding system was recoded later and then compared to ensure the consistency of coding decisions across text (i.e., stability) (Schreier, 2012).

The results of the data analysis presented in chapters 4, 5, and 6 represent a textual summarizing of the conversations I had with disabled RNs about their workplace experiences and perceptions. The summaries are organized under categories in a way that enables the reader to appreciate these experiences, thereby potentiating the possibility for developing insights and understanding. Although, as Sandelowski (2000) notes, the summaries “might easily lend themselves to more penetrating re-presentations of the data” (p. 339), the value of this qualitative descriptive study is in the comprehensive and detailed accounting reproduced to provide insight into disabled nurses’ work experience in their own words. Additionally, Hsieh and Shannon (2005) warn it would be inappropriate to move to a greater level of inference (e.g., develop a nuanced understanding or theory of a lived experience) given the sampling and analytical procedures used in this study.

Ethical Considerations

In conducting qualitative research, the researcher must anticipate any ethical issue that may arise (Creswell, 1998). Further, when research involves human subjects, the researcher has an obligation to respect the rights, needs, values, and desires of the participants. The researcher must also protect participants by promoting the integrity of the research, being trustworthy, and guarding against any potential direct or indirect harm that may come to them. In this research, several measures were taken to safeguard participants and their sensitive information. These are discussed below.

Phases and Step of Conventional Content Analysis	Description of activity
1. Preparation	Read data transcriptions while listening to digital recordings to verify accuracy of the transcriptions Repeatedly read the data to achieve immersion and a sense of the whole and make notes about first impressions
2. Organization	
a. Open Coding and Creating Initial Coding System	Read transcript to derive codes by labelling words, phrases, or sections of the text that appeared relevant while remaining close to the surface of the data. Limited codes developed by deciding which codes were important to form the initial coding scheme (e.g., codes reflective of more than one key thought)
b. Generating and Label Categories	Sorted codes into categories based on how different codes related and linked to each other to create meaningful clusters. Large clusters were organized in subcategories. Labelled categories and subcategories using participants own words
c. Generating Definitions	Developed definitions with exemplars from the data for each category, sub-category and code.
d. Testing Coding System Applying and modifying coding scheme	Coded remaining transcripts and recoded original transcripts used to develop coding system, making modifications and adding new codes when relevant data did not fit any of the existing codes.
e. Reviewing data within codes and organizing codes into a structure	Reviewed data within each code and made additional modifications to coding scheme. If appropriate, clusters of codes were organized together.
3. Reporting	Represented thick descriptive summary of the data supported by examples and organized based on the categories and sub-categories generated.

Table 3-2 Data Analysis Process

Ethical approval for this research was obtained from York University's Research Ethics Board prior to the start of this research. In accordance with the requirements for research involving human participants, each potential participant of this research received written information about the study including the role of participants and their rights. Before scheduling interview conversations, verbal or informal consent to

participate in the study was obtained and potential participants were given the opportunity to ask questions about the study. Prior to the start of each interview, the details of the study were again reviewed and participants were given the opportunity to reaffirm their consent by signing the study consent form (Appendix B).

In research ethics, however, more is required than obtaining formal consent. Research ethics also involves ongoing reflection, anticipation of issues that may cause ethical problems, and problem-solving and negotiation when ethical issues arise. In this study, two main ethical concerns arose. The first related to the ethical concept of beneficence — the duty of the researcher to have the welfare of the participant as a goal. Although the potential for harm to participants in this study was very low, the possibility that participants may become emotionally upset existed. This potential risk was openly discussed with participants and identified in the written information they received. During interview conversations, participants were also provided with a contact list of counselling and crisis intervention services and resources they could access if desired.

As anticipated, a few participants experienced emotional upset while recounting their experiences. In these instances, it was important to balance research objectives with the emotional safety of the participants (McCosker, Barnard, & Gerber, 2001). Using my mental health nursing skills, I could assess for cues signalling emotional upset, acknowledge and indicate acceptance of these emotional responses, and negotiate options with the participants (e.g., stopping the interview briefly to take a break, ending the interview, or withdrawing from the study). In each situation involving some degree of emotional upset, the participant chose to continue the interview conversation.

The second ethical issue I experience related to self-representation and self-disclosure. As discussed previously, my positionality has an influence on this research.

Pomerantz and Zemel (2004) argue that in interview conversations “the possibility of the interactants’ making inferences about each other’s perspectives presents certain problems for both the interviewer and interviewee in terms of how to formulate and interpret queries and responses” (p. 215). Therefore, the researcher is obligated to “see the interview as an interactional occasion in which respondents’ expressed views are partially shaped by the respondent’s perception of: the reasons for the interview, the sympathies of the interviewer, previous interview talk, anticipated upcoming topics, etc.” (p. 219).

Abell and colleagues (2006) argue that while self-disclosure on the part of the researcher may provoke elaborated sharing on the part of the participant, the outcome is dependent on how this information is being received by the respondents. These authors suggest “both interviewee and interviewer negotiate appropriate identities for themselves within an interview interaction, sharing concerns about how to present one’s self, one’s knowledge and one’s similarity or difference from the other” (p. 241).

Prior to and during each interview I conducted, I had to consider the ways in which the relationships I had with participants structured the interview conversations. I aimed to facilitate a coetaneous frame of detachment and closeness. The fact that most of the participants and I shared some connection (e.g., belonging to the same professional, past and current working relationships, and/or having mutual acquaintances) facilitated a level of closeness that established a fertile context of sharing. However, to avoid ambiguity about roles during interviews, I refrained shifting from the question-and-answer format to disclosing information about myself (e.g., discussing my personal life or disability-related experiences) (Abell et al., 2006). This strategy helped to ensure that

the interviews remained purposeful conversations intended to generate data about the participants' experiences.

Trustworthiness

In qualitative research, there are multiple sets of standards for evaluating the trustworthiness or quality of a study (Cohen & Crabtree, 2006; Morrow, 2005). This plurality is owing in most part to the variety of disciplines, understandings of knowledge, and paradigms that exist within qualitative research. Although there is no consensus about what set of standards should be used to judge the soundness of qualitative research,²⁰ the debate over criteria highlights the importance of maintaining rigour in qualitative research. Cohen and Crabtree (2006) strongly advise that it is inappropriate to use a single set of criteria to evaluate qualitative research. They suggest that the criteria used should match the research approach or tradition used by the researcher.

Within the constructivist paradigm, differing criteria have been identified by scholars; for example, Lincoln and Guba's (1985) proposed four criteria to enhance trustworthiness of naturalistic/constructivist research (credibility, transferability, dependability, and confirmability). Morrow (2005) argues that while these criteria can be used to assess the goodness of work undertaken from a constructivist stance, authenticity or intrinsic criteria appear to be more relevant. However, it is important to note that there is overlap between sets of criteria within and between paradigms.

²⁰ For example, Creswell (1998, 2003) identifies that internal validity, rather than generalizability or reliability, play a major role in qualitative research. Alternatively, Lincoln and Guba (1985) propose four criteria (credibility, transferability, dependability, and conformability) as parallel alternatives to positivist criteria. Others have chosen to completely reject positivist evaluation criteria. As an example, Angen (2000) has developed categories of validation (ethical and substantive) rather than validity.

Morrow forwards that there are qualities that cut across paradigms and are of general concern to qualitative research endeavours.

To address concerns of trustworthiness in this study, I 1) applied Lincoln and Guba's (1985) four criteria; 2) addressed subjectivity through making my assumptions and biases explicit, approaching the research reflexively, and attending to concerns about representation; and 3) used strategies to ensure the adequacy of the data and interpretation. In the preceding sections, I attended to aspects of subjectivity through discussing the influence of my assumptions, biases, and positionality on the research. I also addressed issues related to the adequacy of the data collected and its interpretation such as the sufficiency and immersion of the data. In this section I focus on discussing the strategies employed to meet credibility, transferability, dependability, and confirmability. Table 3.3 summarizes the activities and strategies employed in this research for each criterion. Additionally, I discuss how I engaged reflexively and concerns regarding representation within the study.

Trustworthiness Criteria

Credibility

Credibility refers to the extent to which a researcher has “accurately recorded the phenomena under scrutiny” (Shenton, 2004, p. 64). Lincoln and Guba (1985) characterize credibility as important to making a case for trustworthiness. In this research, credibility depends on the adequacy of the representations of the informational content of data generated. Table 3.3 outlines the strategies I used to establish credibility in this research. Most noteworthy, this research adopted well-established methods that were appropriate to the chosen methodology, congruent with a constructivist stance, and used in comparable studies (e.g., O'Shaughnessy & Laws, 2009/2010).

Member checking was also used to establish credibility in this research. Member checking refers to testing and confirming data with the participants from whom the data were initially attained (Cohen & Crabtree, 2006b). Using member checking to validate qualitative research has been problematized within the literature (Angen, 2000; Chapman, 2005; Emerson & Pollner, 1988; Sandelowski, 1993). Member checking is criticized as relying on the supposition that certain realities are fixed and can be accounted for and confirmed (Sandelowski, 1993). Such reliance is incongruent with the beliefs underlying constructivist inquiry, espousing that data is contextually bound and co-constructed, and there is no objective reality to which it can be compared. Thus, using member checking to validate interpretations or what was contextually co-constructed assumes that participants will not have changed their opinions about the subject matter, experienced interceding events, and/or been influenced by participating in the research. It follows from this and other arguments²¹ that researchers need to be cognizant of what they intend to validate through member checking.

In keeping with the constructivist standpoint, member checking was used as a means of confirming the information emerging from dialogue during interview conversations. Participants were asked to confirm, elaborate upon, and/or clarify the information they shared. I also made summary statements that invited participants to confirm through their agreement or provide correction.

²¹ Other problems with using formal member checking include poor recall on the part of participants, participant agreement to please the researcher with whom they have a close relationship, and disagreement and conflict over the researcher interpretation of the data. In the latter example, because the participant and researcher co-construct the data, questions arise as to whose interpretation should endure.

Transferability

Transferability concerns whether findings can be related to a reader's (e.g., researcher or practitioner) own position. To do so the reader must believe that their situation is like that of those described in the research. From a constructivist stance, it could be argued that because all observations are bound to a specific context, generalizability is never possible nor can the researcher make transferability inferences. However, as Lincoln and Guba (1985) and others (e.g., Firestone, 1993; Shenton, 2004) have suggested, it is possible for a reader to make a transfer to their situation if given sufficient contextual information by the researcher. In this research, transferability was facilitated through providing a thick description of the findings and methods and the following detailed contextual information: 1) location of the study and interviews; 2) participant demographics; 3) restrictions in the type of people who could contribute to the study; 4) data collection methods and the duration of data collection period; and 5) the number and length of interviews conducted (Shenton, 2004).

Dependability

In qualitative inquiry, dependability corresponds to some extent with issues of reliability discussed within the positivist paradigm. However, the two evaluative criteria are not analogous. To address reliability, a positivist researcher would use techniques to demonstrate similar results can be achieved if their work was repeated using the same methods, participants, and under the same conditions. In constructivist inquiry, the intentionally emergent nature of designs precludes an exact replication. According to Lincoln and Guba (1985), dependability and credibility are closely linked; that is, demonstrating the credibility of a study significantly ensures its stability. Shenton (2004) proposes that to address issues of dependability more directly, the qualitative

Criteria	Activities/Strategies
Credibility: Do the data sources (most often humans) find the inquirer's analysis, formulation, and interpretations to be credible (believable)?"	<ul style="list-style-type: none"> • Peer debriefing/scrutiny with experienced qualitative nurse researcher familiar with qualitative search and conventional content analysis (Shenton, 2004) • Study adopted well-established methods appropriate to the methodology that have been used in comparable projects (e.g., Shaughnessy, 2009) (Shenton, 2004) • Familiarity with the profession of nursing helped establish relationship with participants (Shenton, 2004; Guba & Lincoln, 1982) • Provide thick description of disabled nurses of their workplace experiences and perceptions helped reader determine if the study findings “ring true” • Ongoing reflection about positionality and influence on the research processes • Checking with participants regarding the accuracy of the data during interviews (e.g., reviewing what was said; asking for clarification; revisiting what was said and seeking additional information) • Examination of the results of other similar or related work for points of congruence
Transferability: can the findings be related to the reader's own position?	<ul style="list-style-type: none"> • Provided sufficient thick, rich descriptions and detailed information about the research methods so that others (e.g., researchers, practitioners) are able to make judgments about the transferability of the findings to different contexts or settings • Provide contextual information (Lincoln & Guba, 1985)
Dependability	<ul style="list-style-type: none"> • Described the research design and how it was implemented • Described the details of what was done during data collection • Reflected on the effectiveness of the inquiry process
Confirmability	<ul style="list-style-type: none"> • Ongoing reflexive commentary • Documented decision-making and other activities and thoughts during the study to completion of the analysis

Table 3-3 Trustworthiness Criteria and Strategies

researcher should report study processes in detail such that another researcher can repeat the work, albeit not to gain the same outcomes. The dependability of this research is demonstrated through the detailed research design and its implementation described herein and in Chapter 7.

Confirmability

Confirmability is concerned with the quality of the results of a study; that is, how well they reflect the experiences and ideas of the participants rather than the perspectives and preferences of the researcher. Confirmability criteria used to determine the acceptability of the results include the extent of detail about the research methodology and the researcher's positionality (Carcary, 2009; Lincoln & Guba, 1985; Shenton, 2004). The researcher's positionality is conveyed through reflexive commentary. Guba and Lincoln (1982) define reflexivity as the process of "attempting to uncover one's underlying epistemological assumptions, reasons for formulating the study in a particular way, and implicit assumptions, biases, or prejudices about the context or problem" (p. 248). The intent of reflexivity is to shed light on the research as much as possible such that the reader can appropriately evaluate it and determine its quality and utility.

In qualitative research, the details about the research methodology and researcher's positionality are included in the reporting of the research. Researchers may also include this information in an audit trail, which documents the course of the research to completion of the analysis. The intent of the audit trail is to provide a record such that it may be possible for another researcher, given their positionality and situation, to follow the process and come to comparable results (Carcary, 2009; Sandelowski, 1993).

The confirmability of this research is established through ongoing reflexive commentary in this chapter and hereinafter with the aim to make explicit how assumption, beliefs, and other factors shaped the research. Additionally, the research methodology and methods are detailed herein and an audit trail consisting of reflexive journaling and other documentation was maintained during the research.

Reflexive Approach to Research

Morrow (2005) notes that, by their very nature, qualitative research projects are grounded in subjectivity. According to Northway (2000), the significance positivism places on objectivity and neutrality belies the inextricability of the researcher from the research. From beginning to end, the researcher influences the research and, in turn, is influenced by the research process (Hand, 2003). This is particularly evident in research involving narrative interviews where meaning is co-constructed by the participant and researcher (Enosh & Buchbinder, 2005; Mauthner & Doucet, 2003). In qualitative approaches, this mutuality is readily acknowledged through researcher reflexivity.

Wasserfall (1993) describes the concept of reflexivity as:

A continued self-awareness about the ongoing relationship between a researcher and [participant], which is certainly epistemologically useful; the researcher becomes more aware of constructing knowledge and of the influences of [his/her] beliefs, backgrounds and feeling in the process of researching. Reflexivity is a position of a certain kind of praxis where there is a continuous checking on the accomplishment of understanding (p. 24–25).

Reflexivity is increasingly recognized as being crucial to qualitative research²² (Berger, 2015). Engaging in reflexivity serves several purposes, the least of which is that

²² In the last several decades, researcher reflexivity has increasingly been integrated into qualitative scholarship and research (Cumming-Potvin, 2013; Dowling, 2006) (e.g., Houghton, Casey, Shaw, & Murphy, 2013; Koch & Harrington, 1998; Northway, 2000; Pellatt, 2003). Indeed, reflexivity has become a relatively uncontested and important aspect of qualitative research and reporting (Cumming-Potvin, 2013). The literature in both nursing and disability studies is replete with commentary and examples of reflexive

it affords the researcher insights that can be integrated into the research to build a more careful, albeit not to be interpreted as an objective truth, representation of data²³ (Hand, 2003). Reflexivity invites the researcher to examine their positionality, values, beliefs, and account for their decision-making during the process of conducting research and after the research is completed. From a constructivist stance, taking account of the researcher's "voice" is important because of the co-constructive nature of the data generated in research. Such an account involves "examining the personal position, identity and self of the researcher ... [as well as their] values, assumptions, prejudices and influence" (Hand, 2003, p. 18). Berger (2015) adds that:

reflexivity helps maintain the ethics of the relationship between the researcher and the research by 'decolonizing' the discourse of the 'other' and securing that while interpretation of the findings is always done through the eyes and cultural standards of the researcher, the effects of the latter in the research process is monitored (p. 222).

Thus, rather than obscuring the data, a reflexive account is an important source of information to be integrated into the research. Therefore, it was important that I approach this research reflexively to explore my role within the research process, reflect on how my biases affected the quality and representation of the data collected, and address how my position as an insider and outsider may have influenced the process and ethics of the research.

accounts by researchers (e.g., Clarke, 2006; Hand, 2003; Mogendorff, 2013; McCabe & Holmes, 2009; Rinaldi, 2013; Shah, 2006).

²³ Additionally, reflexivity makes the research process transparent, thus establishing an audit trail and, consequently, contributing to the rigour of the study (Creswell & Miller, 2000; Finlay, 2002; Koch & Harrington, 1998; Lather, 2004). Second, as Rinaldi (2013) contends, reflecting on the influence of the researcher's position and perspectives, and researcher-participant relationships contributes to emancipatory principles. Third, as suggested by Walker, Read, and Priest (2013), reflecting helps the researcher to gain confidence, and develop and refine research skills throughout the research process and dissertation writing. Lastly, through being reflexive, the researcher can develop insights themselves, as well as an understanding about the complexities of research.

Reflexivity as Introspection

In this study, I engaged reflexively through personal introspection.²⁴ During data collection, reflecting on my interactions with participants helped me to identify my tendencies towards focusing on aspects of narratives that resonated with my interests or experiences at the expense of other content. When analyzing and reporting the data, reflecting on the influence of my beliefs and understanding of the research topic helped me to be aware of unconscious editing (Valentine, 2007).

In my role as a researcher, I acknowledge that my preconceptions and presumptions about nursing and nurses may have influenced how I initially perceived participants and conducted interviews. One presumption I had was that participants would resist being labelled “disabled.” My practice in direct patient care and academia informed me that the disability discourse in these domains differed greatly. The literature I reviewed prior to the start of the study further served to confirm my thinking. As a result, early in the study, I thought a lot about the implications of the language being used to talk about disability and was concerned that I might offend or put participants off by labelling them disabled. In the first few interviews conducted I was awkward and uncomfortable with asking participants to describe how they believed they were disabled. I also shied away from using the term *disabled* when referring to participants. This behaviour may have negatively impacted these interactions with participants. It is possible that my behaviour may have made participants ill at ease.

²⁴ In engaging in personal introspection, the researcher may use their reflecting, intuiting, and thinking about themselves and their experiences to not only generate personal knowledge and meaning, but to also gain insights that inform the research process. Finlay (2002) notes that personal introspection can “form the basis of a more generalized understanding and interpretation” (p. 214) that can influence how we make sense of participants’ experience and the directions we take our discussion of findings.

Engaging introspectively during these early interviews helped me to come to terms with the bedeviling nature of disability terminology and work through the tension I experienced.

In terms of my perceptions of the participants, I anticipated that participants would share stories about the challenges they experienced working, including difficulties interacting with their nursing colleagues. I derived this presumption from my practice experiences and the literature I reviewed about the research topic. During data collection, I was surprised by the number of experiences participants shared that disconfirmed my presumption. Hearing unexpected experiences during initial interview conversations queued me to work to sustain a stance of unknowing and listen more carefully for disconfirming data. Notwithstanding this, in a few instances, I believe that data collection was hindered by this presumption about participants. For example, I was caught off guard and struggled with my responses to Sophia's disconfirming experiences and perceptions. In our interview conversation, Sophia mostly discussed her educational experiences and expressed the belief that the way she learned, which others had labelled a disability, did not impact her ability to practise nursing. Reflecting on this experience, I realized that engaging reflexively and strategizing about how I would address unexpected situations during data collection would have helped to establish a stance of openness early in the interview process and promoted depth of engagement with participants.

Introspective reflection also enabled me to consider the representativeness of my reporting of the interview conversations. Initially, I planned to report the sample demographic data followed by a description of the findings using the categories and sub-categories generated in the analysis phase. However, I realized that this way of representing the findings was void of context and depersonalized participants'

narratives. I also questioned whether I was unconsciously editing out my role in constructing the findings while at the same time presenting them in a way that reflected my understandings and sensitivities. To redress these concerns, I elected to include a chapter that described the context of participants' practice and presented vignettes about the participants and our interactions and conversations during data collection. Although, as the constructivist stance espouses, this knowledge is unmistakably filtered through my own lens, I made a strong effort to generate vignettes that represented interview interactions.

Reflexivity as Intersubjective Reflection

Finlay (2002) notes that researchers engaged in reflexivity as intersubjective reflection “explore mutual meanings emerging within the research relationship . . . [focusing] on the situated and negotiated nature of the research encounter” (p. 215). This form of reflexivity involves examining the complex dynamics that can exist in the researcher-participant relationship and consideration of self in relation to participants. During the research process, I reflected upon the possible influences of the identities within myself and in the situated interactions with participants. My identities as a nurse, peer, and colleague positioned me as an intimate insider.²⁵ In this study, I was a nurse conducting research on nurses, some of whom I shared varying degrees of personal

²⁵ Broadly, the term *insider* is used to describe a researcher who shares a characteristic with the object of the research. More specifically, Griffith (1998) defines an insider as “someone whose biography (gender, race, class, sexual orientation, and so on) gives [them] a lived familiarity with the group being researched while the outsider is a researcher who does not have any intimate knowledge of the group being researched, prior to entry into the group” (p. 361). While these identities are often framed as dichotomous, McGinn (2008) notes that the relationship between the researcher and participant may fall along a continuum from distant to close and friendly. Taylor (2011) notes that a researcher is an intimate insider if they have pre-existing personal relationships, or ongoing contact with participants, or both.

connection. To some participants, I was a distant former colleague. To a few others, I was collegial peer in their work environment.

While conceptualizing this study, I perceived my position as an intimate insider to be a valuable advantage by comparison to being an outsider. The merits of being an insider or outsider to the group being studied have been extensively discussed within the literature. Several authors have commented that the common ground shared between an insider-researcher and participants can help facilitate the research process, thus contributing to the quality of the study (McEvoy (2001; Edwards, 2002; Kim, 2012; Shah, 2006). In this study, I believe that my being a nurse helped in the recruitment of disabled RNs. My position as a nurse with a disability and having pre-existing connections with participants also provided for familiarity and rapport (McDermin, Peters, Jackson, & Daly, 2014), helping to garner the trust necessary to generate a rich, thick account of participant experiences (Appleton & King, 1997). Additionally, as Kim (2012) contends, as an insider I could pick up the nuances in the stories of participants and move beyond the surface to attain the rich details I sought.

As previously discussed in this chapter, while interviewing participants I considered how my relationships with some participants might influence the data generated and the analysis and representation of the data. In these instances, reflecting on the subject/object relationships I had with participants supported my efforts to balance closeness and distancing. Bondi (2003) characterizes such a balancing act as endeavouring to be reactive and present while also having an awareness of one's emotions to avoid blurring the line between the interviewee and interviewer. Having knowledge about nursing practice and, in some cases, the work environments of the participants provided direction about what topics to explore during interviews. I believe

it also enhanced participants' willingness to share certain aspects of their experiences that were deeply felt and emotional (e.g., Sandra's sharing her experience of being humiliated in the presence of her peers and patients because of her weight). At the same time, I had to make a concerted effort to avoid developing "over-rapport" with participants that I had past or current relationships with (Shah, 2006).

Several authors have problematized the insider-researcher position (e.g., Alvesson, 2003; Drake, 2010; Kim, 2012; Reay, 1996). Edward (2002) comments that knowing a population's characteristics and being familiar with cultural practices, behaviours and/or norms may result in the insider-researcher overlooking certain practices that a participant may be noting. Additionally, an insider-researcher may fail to ask certain questions because of the established nature of the knowledge, behaviour, or traditions (McEvoy, 2001). Lastly, Taylor (2011) has noted that "as an insider one does not automatically escape the problem of knowledge distortion, as insider views will always be multiple and contestable, generating their own epistemological problems due to subject/object relationality" (p. 7).

During the research process, I tried to be conscious of and minimize the potentially problematic influences of my identities on the study. For example, when participants made assumptions about my insider knowledge, I tried to respond in ways that invited them to explain in their own words so that the meaning was not left to my interpretation. Likewise, I was cognizant of my own presumptive understandings (e.g., avoiding responses such as "I understand" or "I know what you mean") and tried to focus on asking for clarification and using open-ended follow-up statements such as "can you tell me more about that?"

Reflexivity as Critique of Social Position and Power

The concept of power is embedded in the qualitative research. Orb, Eisenhauser, and Wynaden (2001) note that “the desire to participate in a research study depends upon a participant’s willingness to share his or her experience” (p. 93). This sets up a circumstance where the researcher, as the knowledge keeper, has power over the participant and decides how to analyze, write about, and publish participants’ stories (Das, 2010; Karnieli-Miller, Strier, & Pessach, 2009). This relational power dynamic may be furthered by structural power (e.g., gender power relations) and institutional macrosettings of dominance and authority (e.g., healthcare settings) (Karnieli-Miller et al., 2009). Thus, a reflexive approach should include critique of the researcher’s positionalities in relation to power within the research process and participant-researcher relationships.

According to Finlay (2002), researchers using reflexivity as social critique are also concerned with addressing the power imbalance that exists between the researcher and participants. Left unaddressed, power inequities can shape the nature of participant-researcher relationships and, in turn, affect the information participants are willing to share, introduce unnecessary risks for participants, or result in the acceptance of the apparent linearity of findings and conclusions filtered through the researcher’s lens (Russell & Kelly, 2002). In engaging in reflexivity as social critique, the researcher openly acknowledges tensions that arise because of the different social positions and attempts to deconstruct their authority and reduce the power differences that exist. Several scholars note that this practice has become widely accepted as a responsibility of the qualitative researcher (Das, 2010; Karneili-Miller et al., 2009; Orb et al., 2001). In addition to cultivating an awareness of power relations and addressing the inequities, the

researcher must also engage reflexively on the ethical issues that arise from efforts to equalize power in their relationships with participants. Karneieli-Miller and colleagues (2009) highlight the possibility of incongruence between efforts to minimize power and authority, and the context within which the research takes place (e.g., research in the healthcare system or in the context of incarceration). More practically, actions to create parity in researcher-participant relationships may generate methodological dilemmas such as how to deal with conflicts that arise involving participants in the research process beyond data collection.

With a view to imbue the research with emancipatory ideals, I attempted to engage reflexively in relation to the question of power in the researcher-participant relationship. As an example, at the start of the research I used my insider status as a nurse and colleague to identify potential participants and encourage involvement in the study. I was also aware that my outsider position as an academic might lead participants to perceive me as an expert. In response, I was careful not to exhibit behaviours that reinforced expert researcher-lay participant relational dynamics in which the role of the participant was to simply provide information that I needed. I also tried to reduce vulnerability and power imbalances through acts such as self-disclosure of my personal experience with disability, and meeting participants where they felt most comfortable conducting the interview.

However, as the research process unfolded, engaging reflexively about positionality and power became increasingly complex and was fraught with tension for me. Trying to untangle, understand the influence of, and address the always present personal identities (e.g., participant, nurse, researcher, academic) that were bound with broad, structural power roles based on gender, class, social status, and culture proved to

be confusing and difficult. It was also difficult to get a sense of participants' perspectives of the researcher-participant relationship or gauge their responses to my attempts to manage the power dynamics in our interactions. It may be that participants who knew me felt more comfortable and experienced a power dynamic that was closer to being equalized. However, as there is the risk for coercion in narrative interview situations, particularly those involving sensitive topics (Corbin & Morse, 2003), individuals that I had previous connections with may have felt obligated to participate in the study and share their experiences. Additionally, some participants may have unintentionally shared information they would not have shared with a stranger-researcher because of the familiarity we shared.

Dywer and Buckle (2009) comment that it is not often that a researcher can be characterized as a complete outsider and complete insider. Upon reflection, I realize that I was never just an insider or outsider and, instead, occupied both positions. Dywer and Buckle (2009) suggest that researchers position themselves in the space between the two positions by recognizing that they are not absolute and antagonistic of each other. I believe that cultivating a sense of dwelling in the "space between" would have helped to reduce the tension I experienced, enabling me to develop comfort with the ambiguities and complexities of the researcher-participant relationship and issues of power.

Gender and Power

The influence of gender identity and gender roles on the research process has been discussed within the literature (e.g., Broom, Hand, & Tovey, 2009; Herod, 1996; Pini, 2005; Sallee & Harris, 2011). Although this research was not designed to study disabled female nurses' experiences of working, it came to be that I was a male researcher conducting research with female participants and interpreting their accounts

of their lived experiences. Prior to beginning this study, I had an awareness that gendered power dynamics may have influenced the interview conversations I had with female participants and, in turn, on the finding of a study. I could acknowledge the possibility that some participants may feel inhibited or uncomfortable to share personal information about their disability experiences because of the gender difference between myself and them.²⁶ In this regard, being an insider and using strategies to build rapport may have helped to counteract these effects. However, Bellamy, Gott, and Hinchliff's (2011) work casts some doubt on whether it is possible to extricate any one influencer among the multitude of factors involved in face-to-face interviewing. Further, while a comparable study involving the same participants with a researcher of the same gender may yield different data, the revisionist nature of narratives, among other factors, make

²⁶ Although I have identified gender as an important social location of power, it should be understood as one of many possible intersecting markers of social location that are involved in the relationship between a researcher and participant. Most notably is how my racialized identity and gender may have interacted between myself and participants in relation to issues of power and representation. In this study, I was a black man interviewing mostly white women. It is difficult to conclude one way or the other how the racial differences between myself and participants influenced the authenticity and "truthfulness" of responses. While it is recognized that "race" does influence interviews and what respondents say, some researchers (e.g., Rhodes, 1994, Twine, 2000) have highlighted there is no unitary or clear effect of race.

Archer (2002) argues that "race' and gender interact between researchers and participants in highly complex and unpredictable ways to produce particular [interactional] accounts" (p. 108). For example, it is possible that, despite the influences of gender, racialized participants perceived less power imbalance during our interactions because they thought of me as a racial or minority insider. However, some researchers (e.g., Gunaratnam, 2003; Hill, 2002; Tinker & Armstrong, 2008) have argued that matching of identities does not guarantee that existing power imbalances will be reduced. Matching race or ethnicity could introduce biases and reproduce simplistic beliefs about commonalities and differences among members of racial groups.

Notwithstanding these arguments, Törngren and Ngeh's (2017) work highlights the need for methodological discussions about non-white researchers studying white-majority populations. In retrospect, I realized that I assumed that racialized power relations would exert very little influence in comparison to my intimate insider position and social location as a male. Reflecting on the notion of the "reverse gaze" forwarded by Törngren and Ngeh, I now recognize the importance of engaging reflexively about the hierarchical nature of social location power, how and where racialized dynamics are (re)produced in the research process, and negotiating this and other influence in research work.

it difficult to attribute any differences in findings to the gender of the researcher.

Sandelowski (1993) highlights this problem noting that:

stories are remembrances about the past in a fleeting present moment soon to be that past. Research participants often change their stories from one telling to the next as new experiences and the very act of telling itself causing them to see the nature and connection of the event in their lives differently (p. 4).

Although I was attuned to the influence of gendered power relations during data collection, I initially did not consider the influence of social maleness performance beyond this phase of the research. It was not until I started analyzing the data that I began to evaluate the impact of my social gender position on all aspects of the research. A key question raised in my mind that I had not previously considered was, can or should a male conduct research with female participants? Bellamy et al. (2011) highlight that this question is contentious and highly debated within feminist literature. Analogous discourses can be found within the literature in other fields and disciplines (e.g., Agyeman, 2008; Allen, 2010). Reflection on this question through engagement with the literature on this topic, I concluded, as did Bellamy et al. (2011), that “focusing solely upon gender [or any other identity category] similarity as a pre-requisite for conducting . . . research with female participants fails to acknowledge the role of other factors that enable 'good' research to be done” (699).

While examining the discourse in the literature on this topic provided the desired insight, I was still left with the challenge of how to better handle and present the data collected considering, among others, the potentially negative effects of gender power relations. I also contemplated how best to democratize the data analysis and reporting. Such consideration led to an iterative process of planning, writing, rewriting, consultation, and redirection during the data analysis phase and when representing the

findings. As previously discussed, I considered using post-interview member checking; however, I chose not to use this strategy due to methodological and practice concerns and issues. Other activities I engaged in included 1) seeking feedback from my supervisor, committee members, and an experienced qualitative researcher; 2) paying careful attention to how I used language; 3) going back to transcripts, audio recording, and notes to ensure how I was remembering and describing interview experiences was as accurate as possible; 4) using participants' own words to derive codes and categories; and 5) interpreting the data by reading the lines rather than into, between, over or beyond lines (Sandelowski, 2010).

Thoughts on Doing Reflexivity

Using reflexivity in qualitative research can be challenging, particularly if the researcher is new to engaging reflexively (Adam, 2013; Finlay 2002). As a novice qualitative researcher, at the start of this research, I sought to understand what reflexivity entailed through a review of literature on the topic. With this knowledge, I begin the research process with some confidence that I could engage reflexively to support the quality of the research. At the broad level, I understood from the literature that reflexivity was important to qualitative research primarily as a tool for ensuring the rigour of a study. The reflexive activities I engaged in during the study included tuning into my emotions and responses during data collection, reflecting after interviews and making notes, reading, writing, and rewriting during the analysis phases, and sharing and discussing my work as it progressed.

As I began my reflexive journey, what seemed like a straightforward endeavour became increasingly complex. At times, I experienced tension and frustration trying to self-monitor and address the many aspects involved in being reflexive. Characterizing

the endeavour as “full of muddy ambiguity and multiple trials” (p. 209), Finlay (2002) invokes the imagery of navigating a swamp to reflect the complex interplay of deconstructions, self-analysis, and self-disclosure that are involved in reflexive practice. Through engaging in intersubjective reflection at different points of the research process, it became apparent to me that the insider and outsider positions are multifaceted, flexible (Pels, 2000), and, as suggested by Mercer (2007), can be double-edged swords. Both Hand (2003) and McEvoy (2001) describe the process of interviewing participants from the practitioner/nurse perspective as muddied, concluding that constructing knowledge is difficult regardless of the researchers’ status as an outsider or insider, and yet both command attention to specific issues that should not be underestimated or left unaddressed. Conferring with the first-person accounts of these nurse-researchers, Wilkes and Beale’s (2005) research found that nurse-researchers moved between the role of nurse and researcher when conducting research and do so using a mixture of frameworks such as their own personal-moral values and professional ethics.

In reflecting on my research journey, I have come to understand that clearly demarcating which researcher perspective (insider or outsider) is better or most appropriately suited to one type of research over another is not possible. I also realize that, intuiting this, I negotiated and navigated my multiple identities in much the same way as described by Wilkes and Beale (2005). I moved between my different insider and outsider-selves as I interacted with participants and then analyzed and made decisions about how I would represent the experiences of participants. Most often, I moved between my role as a researcher, trying to maintain a balance between closeness and distance, and a “caring other” who tuned into and acted depending on how participants reacted to the interactional dynamics and sharing their experiences. Hammersley and

Atkinson (as cited by McEvoy, 2001) comment that the merits of being in such a position needs to be judged considering research purposes and the context in which the research is being conducted.

The use of reflexivity in qualitative inquiry has been problematized by Pillow (2003, 2010) and other scholars (e.g., Finlay, 2002; Lynch, 2000; Macbeth, 2001; Probst & Berenson, 2013). Pillow (2003) has expressed concern about the use of reflexivity as a methodological tool for ensuring quality, identifying four problematic ways reflexivity is used: reflexivity as recognition of self, reflexivity as recognition of other, reflexivity as truth, and reflexivity as transcendence. Pillow (2003, 2010) argues that, while reflexivity is needed in qualitative research, researchers must look beyond using reflexivity simply as a validity method towards uncomfortable reflexivity wherein the researcher confronts the unfamiliar. Reflecting on my journey of reflexivity in this study, I believe that entering the research process with a greater depth and breadth of understanding of reflexivity would have helped me to better navigate some of the situations I encountered and move, as suggested by Pillow (2003, 2010), towards seeing and using reflexivity critically as well as a means of supporting quality of the research. Hand (2003) suggests that while reflexivity is important, it requires great skill that itself is developed through continued engagement in research and being reflexive. From this, my aim is to continue to develop as a reflexive researcher by taking what I have learned through engaging reflexively in this study and applying to future research endeavours.

Summary

In this chapter, I have demonstrated that this research is situated within a constructivist inquiry approach. I have shown that there is coherence and congruence between the research questions, the philosophical stance taken, and the methodology

and methods used to develop a representation of participants' experiences of working with disabilities. In this chapter, I also discussed the measures that were planned and executed to establish the overall trustworthiness of the research based on a widely accepted framework of criteria. Lastly, I identified some of the issues and challenges of the research in relation to positionality and ethical consideration that may have influenced the results. Through ongoing reflexivity and self-awareness during the research process and because of the strong design, I was able to aptly address these challenges.

Chapter 4: Participant Interviews

Introduction

The purpose of this qualitative descriptive research was to explore the practice and work-life experiences and perceptions of disabled registered nurses (RNs). A rich, thick description of disabled RNs' experiences in and perceptions of their workplaces was sought using semi-structured conversational interviews as the main source of data collection. The findings of the study are reported in the next chapter. In this chapter, I provide a summary of participant demographics, followed by vignettes that briefly describe each participant and provides a reflexive account of their interview conversation. The intent of these vignettes is to make more evident the uniqueness of the participants (Chapman, 2005) and remind the reader and myself, as the researcher, of the individual identities and voices that comprise the thematically organized descriptive summaries presented in Chapter 5.

Study Participants

Participant Demographics

To be included in this study participants had to meet the following criteria: 1) English speaking; 2) registered to practise in Ontario as a RN in the General Class²⁷; 3) currently practising or have practised nursing in the previous 12 months in Ontario; and 4) identify as disabled or have a physical, medical, psychological/mental, and/or cognitive impairment, condition, or experience that either manifests as transient or

²⁷ In Ontario, there are three categories of nurses that are distinguished by their educational preparation and legislated scope of practice: RPNs, General Class Registered Nurses, and Extended Class Registered Nurses or NPs extended class. Since 2013, nurses in Ontario are further categorized into either a Practicing or Non-Practicing Class.

permanent. In total, 12 General Class RNs meeting these criteria were interviewed over a nine-month period from May to December of 2014. Table 4.1 provides an overview of the demographic characteristics of the study sample. The participants in this study were all female, ranged in age from 24 to 65 years, and resided and practised in Ontario. Participants were either currently employed as staff nurses in acute care hospitals (n = 6) or as nursing professors in a college or university (n= 6). All participants practising in nursing education had previous work histories as staff nurses in a number of different areas within acute care hospital and long-term care facilities. The direct care practice areas participants currently or previously worked in varied greatly from in-patient psychiatry to pediatric intensive care to the emergency department. The participants of the study were employed by a total of four employers (two hospital-sector employers, two post-secondary institution employers). Several of the participants were direct colleagues, either working in the same department/unit or within the same organization. With the one exception, all participants were employed within the Local Health Integration Networks (LHIN) of Toronto Central LHIN.²⁸

None of the participants in the study labeled themselves as “disabled”. When asked in what way participants considered themselves to be disabled, most either identified a category of the operational definition of disability (e.g., physical or emotional) and/or provided a label ascribed by a professional such as a medical

²⁸ LHINs are not-for-profit corporations established by the Ontario government. LHINs do not provide services directly; however, they have the legislated authority to plan, fund, and manage health services within their geographical boundaries. LHINs must ensure the health services within their regions are integrated. There is a total of 14 LHINs in Ontario. The Toronto Central LHIN meets the needs of approximately 1.2 million residents. Due to the large number of service providers (e.g., hospitals) and program, the Toronto Central LHIN also provides healthcare and services to thousands of Ontarians from four bordering LHINs and beyond (Toronto Central LHI, 2014). One participant, an nursing educator, worked in the Central East LHIN, which borders Toronto Central.

Variable	n
Gender	
Female	12
Male	0
Race/Ethnicity	
Caucasian/Anglo-Saxon	8
Black	1
Pilipino	1
Metis	1
Portuguese	1
Age	
Mean	46
Median	45
Range	41
Years as a Registered Nurse	
1–10	3
11–20	3
>20	6
Area of nursing practice	
Inpatient Acute Care Area	2
Education	6
College	5
University	1
Inpatient Psychiatry	3
Outpatient Care	1
Disability Category	
Physical/medical/functional	5
Physical impairment	3
Medical condition	2
Learning	1
Psychological/Emotional	6
Anxiety	2
Depression	4

Table 4-1 Participant Demographics

diagnosis. In their narratives, only a few participants used the term *disabled* or other derivatives in direct reference to themselves. Instead, most tended to use the term in a

depersonalized or hypothetical manner. Two participants openly expressed that they did not consider themselves disabled.

Participant Vignettes

The purpose of the vignettes presented in this section is to make more visible the individual identities and voices of participants. The vignettes were crafted using data extracted from interviews and notes, and are presented in the order in which interviews were conducted. Each vignette consists of a brief biographical sketch and a reflexive account of the interview situation of each participant. Participants' own words are integrated into the vignettes to maintain the integrity of participant voices. Although some information is presented in the present tense, these vignettes reflect the status of participants at the time their interviews were conducted. To preserve the anonymity of the participants, pseudonyms have been used and all identifying information including place of employment, and specific geographic and other personhood-related data, have been omitted.

Participant 1: "Dorothy"

Dorothy is 45 years old and has been an RN for 24 years. She has lived and worked in Ontario since immigrating to Canada as a young child. Dorothy began her nursing practice as a staff nurse in an acute care paediatric hospital. She says working in this environment was fast-paced and stressful. Her work consisted of "a lot of the technical skills [such as] obtaining vital signs, . . . inserting NG tubes; all the things that the nurses would do engaging in the nursing process [including] implementing different interventions for patient care throughout the day." Dorothy also held higher-level positions within the same organization before moving on to her current position as a nursing professor six years ago. She summarizes this work as "basically facilitating

student learning in the nursing program.” Dorothy’s responsibilities and activities as a nursing professor include lecturing, conducting and debriefing simulations, and participating in curriculum development.

Dorothy was the first participant I interviewed. She volunteered to participate in the study during a casual conversation about my dissertation. We conducted the interview for an hour and 45 minutes in a private meeting room at her workplace. The interview was the first time Dorothy had shared her experiences with someone outside her circle of family and friends. After the interview, she commented that she experienced an emotional release from sharing her story.

In the interview, Dorothy disclosed that she has general anxiety disorder on the high end of the disorder spectrum. She describes living with the disorder as being "difficult," adding:

I basically feel that something always is going to happen that is negative so I'm always worried . . . when I was [working as a nurse] at the bedside with patients I wouldn't, for instance, take breaks . . . I was always functioning at a very fast-paced rate, checking in even before the shift really technically started, because it would start at 7:15 and I would be there around 6:15.

Dorothy says her disorder also impacts her relationships with others:

I always appear flustered to others. . . . I'm also aware that I carry this load, this bag of anxiety on my back, whatever that is, like this worrying, shortness of breath and I feel like the others are aware of it and don't understand it.

Dorothy also discussed feeling not understood and marginalized by others in her previous work environment. Although her experiences in her current workplace are much more positive, she believes being labelled and marginalized by her nursing colleagues and administrators in her former workplace has had a lasting impact. Dorothy sees herself as a “survivor of something,” but cannot name the experience. Nonetheless,

she is adamant that change is needed in nursing workplaces to create healthy work cultures free of labelling, name calling, and other forms of horizontal violence.

Participant 2: “Sophia”

Sophia is a 24-year-old and has been an RN for three years. Like Dorothy, she immigrated to Canada as a young child. She volunteered to participate in the study after she received an email invitation forwarded by a mutual colleague to multiple recipients. Sophia hopes sharing her story will help others with experiences like her own. We met in a public library to conduct the interview. The library was busier than I had anticipated; however, we were able to find a private area to complete the interview.

Sophia has worked within and outside of Ontario as an RN. Presently, she works in three different acute care nursing environments: an emergency room (ER), a cardiac care unit, and a coronary care unit. She describes the ER as a fast-paced and demanding environment with high turnover. Sophia’s practice in the ER involves all manner of nursing activities and requires that she be “able to critically think on her feet” and be “flexible to changes” in the environment. Her practice in the adult acute care areas is “a lot different” and “slower.” In these areas “patients have a plan” and unlike the ER, nursing care is “more focused on patient and the family, . . . [and involves] getting to know the patient, interacting with them more, one-on-one educating, [and] doing health promotion and prevention.”

The interview with Sophia was short in comparison to the others I conducted, lasting less than 29 minutes. Our discussion focused on Sophia's experiences as a nursing student. She spoke only briefly of her nursing practice. Sophia shared that although she was diagnosed with a learning disability when she began high school, she does not identify as disabled. Sophia says she is a "more hands-on thinker" and rejects

being labelled “disabled” because she experiences learning differently from others. In terms of her nursing practice, Sophia believes these differences have no bearing on her abilities as a nurse, nor do they have an impact on her professional relationships and how others perceived her practice. She has not disclosed her diagnosis in her current workplaces.

Sophia became tearful as she recounted her experiences as a nursing student. I suggested we take a break; however, she declined and indicated she was fine to carry on. Sophia explained that she was emotional because she was remembering things she had forgotten and not thought about for some time. She says being labelled “disabled” has been unhelpful and had detrimental effects in her life. When Sophia entered university and disclosed her diagnosis, she was told by a couple of her faculty that she “shouldn't be in nursing school” if she had a learning disability. She recalls them saying, “well, if you're not able to answer a question someone raised ... and if a patient is critically ill then if you're not able to make a decision then you're not able to make a decision in that time and a half.” For Sophia, this was upsetting: “if you think about [it], someone tells you you're stupid and can't do anything, how would you feel?” She now challenges the validity of these attitudes and beliefs but says, “back then you don't know because you're in first-year nursing, you don't know what to expect.”

Following her graduation from nursing school, Sophia says she put the learning-disabled label and her experiences in her first year behind her: “I forgot about it and I moved on because it doesn't have that bad of an impact on my life. I just moved on.” When Sophia was qualifying for registration as a nurse she did not disclose her diagnosis because of her concern that it might be used as a reason to not grant her a license.

Participant 3: “Rose”

Rose is 52 years old and has been an RN for 27 years. She works in the ambulatory clinic of an acute care hospital in a “fairly autonomous position” from Monday to Friday. Rose volunteered to participate in the study after she received an email invitation forwarded by a mutual colleague to multiple recipients. Initially, Rose was unsure if she met the study's eligibility criteria. I corresponded with her through email and clarified the criteria and operational definition of disability. We agreed to meet after her workday in a meeting room of a post-secondary institution library located near her workplace. The length of our interview conversation was approximately 43 minutes.

Rose identified that she has “an anxiety condition,” which she further qualified as “interpersonal anxiety.” She manages her condition without using medications, preferring to “just go for counselling and try to do things off work that will help minimize anxiety like meditation and exercise.” During the interview conversation, Rose spoke at length about the interpersonal difficulties she experiences in situations involving her colleagues and, to a lesser extent, patients. To Rose's knowledge, her colleagues are not aware that she experiences interpersonal anxiety. However, after a recent issue arose in the workplace, she disclosed to her supervisor that she “had [an] anxiety problem” and was receiving counselling.

Rose feels isolated and stressed because of her anxiety:

I see a lot of people don't really have anything like [interpersonal anxiety]. They are able to interact really easily with people and it comes naturally to them. They may work at it, but generally the people I work with are team-focused people so being the only one of the few people that has difficulty with interpersonal relationships makes it-it's isolating and um, it's just stressful when there's conflict at work, which is every day.

Rose also believes that her condition “is not like a physical disability where you can see it,” adding, “it’s kind of a hidden thing.” She says the invisibility of her condition can be good in some ways but can also be problematic.

Participant 4: “Blanche”

Blanche is 64 years old and born in Canada of English descent. She has been an RN for 42 years, practising in the areas of mental health nursing and inpatient psychiatry. Presently, Blanche works part time as a staff nurse in an acute care psychiatric unit. She commutes to work from another city. Blanche’s practice involves “helping patients learn different coping mechanisms, . . . working with a team to deal with psychosis, [and getting] people re-stabilized on medication.” She primarily works evening shifts and tends to arrive early to her shift to “scope out the scene [in the unit] and get the lay of the land and sense the tension among the staff.” Blanche says her work has become increasingly medically focused: “if I have a medical patient, I must count on my colleagues to help me with IVs [and other tasks. For example,] we help each other out with patients that require assistance getting out of bed and dressing.”

Blanche volunteered to participate in the study after she received an email invitation forwarded by a mutual colleague to multiple recipients. I interviewed Blanche in the apartment where she was staying during a stretch of shifts. The interview unfolded with ease and lasted an hour and 32 minutes. Blanche is a storyteller; she was forthright and candid, addressing several of the questions I had planned to ask as she recounted her experiences practising nursing with chronic depression.

Blanche was diagnosed with chronic depression in her mid-30s. Although her experiences of depression have tended to coincide with major life events (e.g., the death

of a parent), she says she was not depressed when she was diagnosed and undergoing treatment for cancer:

I had a melanoma that had spread . . . I had all this anger, I had this rage and this wasn't fair. . . . And you know, I felt like ending my life but I [was] also afraid of dying so that was quite an oxymoron but I wasn't depressed. . . . I sort of grabbed onto this meaning of life and how important it was and let go of the things that weren't so important.

In the interview, Blanche described the effect depression has had on her nursing career. She spoke at length about her past and recent struggles with managers and administration in relation to her chronic depression. Reflecting on these experiences, Blanche expressed an earnest concern for the rights of nurses, particularly novice nurses. She emphasized the importance of nurses finding supportive mentors in the workplace and knowing their rights and entitlements as employees within healthcare organizations:

I mean, if you can feel badly about yourself real easily, you know, one of the areas that you want to feel some sort of security in is your work environment. That there is fairness and there are rules and that you follow those rules. I'm expected to show up on time. [As] my manager, I expect [you] to know what my rights are . . . don't take me aside and talk to me about explaining [my] charting when you're conning me into basically working for free.

Participant 5: "Helen"

Helen is 65 years old and identifies as a black female. She has been a nurse for 47 years. Helen began her nursing career as a midwife. She immigrated to Canada 22 years ago and has been practising in the areas of mental health nursing and in-patient psychiatry. Presently, Helen works on an acute psychiatric in-patient unit and in a mental health day clinic. Her practice in both environments involves engaging in one-to-one, goal-oriented psychotherapeutic conversations that support patient wellbeing. In the acute care unit Helen's work focuses on acute symptom management, whereas in the day clinic she is involved in supporting patients to maintain their mental health while living in the community. Within the acute care unit, she also works in a specialized area

called the psychiatric intensive care unit (PICU) where care is provided for patients requiring close monitoring, and behaviour and other symptom management.

Helen and I are acquaintances; however, it had been several years since we last spoke with each other. She learned of the study through an email invitation forwarded by a mutual colleague to multiple recipients. Helen contacted me to volunteer to participate and we arranged to meet in her home to conduct the interview. The interview with Helen finished in just under an hour. Prior to the start of the interview, we updated each other on our histories; however, I refrained from disclosing the details of my experiences with disability so as not to detract from the focus of the interview.

When asked to describe the way she considered herself disabled, Helen responded that she had developed hyperthyroidism four years ago and up until a few months ago, had been taking medication to regulate her thyroid gland. As a result of her medical condition, Helen experienced many life-altering changes including losing 20 pounds, being consistently “very tired,” and “eating very frequently.” Her condition had a significant impact on her nursing practice. It limited her ability to meet her basic duties and responsibilities as a staff nurse. Helen says she was consistently tired and unable to do anything extra:

[When I would] go to the patient to give the patient medication I had to sit down while the patient was taking medication. . . . I couldn't stand up and I was so tired and listless all the time. . . . My writing was very shaky.

In the interview, Helen spoke impassioned about how nurses with illness and disability are treated. She was critical of nursing employers in terms of their concern for the welfare of nurses and their quality of work life. Helen believes her workplace contributed very little to her recovery and return to work. She says her manager didn't even acknowledge or recognize that she was ill: “[you're] there as a number to do the

work and that's all. It's mostly your colleagues you got your support, not the people in charge." She added, "I do not think that occupational health and HR [Human Resources] is for the nurses. They try to get the nurses back [to work and] the health of the nurses are not considered at all, scarcely considered!" Helen appealed for more activism for recognition and compensation of front-line nurses:

[Front-line nurses] are the ones who are carrying the weight of nursing and the employers are like, they're on their backs trying to extract more, for as little as possible, whether it's an RPN or RN, it's-those are the ones that are really carrying the brunt of nursing in this country and they're not recognized.

Participant 6: "Louise"

Louise is 45 years old and had been practising as an RN for 24 years. She is employed in post-secondary education as a nursing professor. Louise experiences chronic pain as a result of a medical treatment complication. I was aware Louise had a chronic pain condition and contacted her through email to invite her to participate in the study. She agreed to participate and we arrange to meet in her workplace to conduct the interview. The interview took 50 minutes to complete.

Louise says her experience of chronic pain has affected her work as an educator. She notes that, for the foreseeable future, her practice is limited to teaching in the classroom:

I don't do clinical anymore. I'll never be able to do clinical anymore simply because the [complication]. When it is [addressed I] will never . . . want to risk me doing lifting, anything like that, because nobody knows a lot about this [complication] and these after-effects even when it gets [addressed] because there are so few people that have it.

In the classroom, Louise says her pain impacts her work to varying degrees from day to day. She is often in a lot of pain and discomfort by the end of the days that she lectures. Louise is also not able to sit for prolonged periods of time. This limits her participation in activities such as meetings. Additionally, Louise has had to make adjustments to other

aspects of her work. For example, she cannot sit for lengthy periods to mark assignments or tests. Instead, she lies down on the floor in short periods.

In the interview, Louise reported that disclosing her condition has resulted in camaraderie with some of her colleagues and has been helpful in teaching students about chronic pain. In general, she feels understood and supported by her colleagues. However, Louise has had some difficulties relating to and obtaining accommodations from the chair of her program. She commented that the biggest barrier to practising has been the lack of understanding on the part of her chair, which has resulted in being denied accommodations in the workplace. Yet, in spite of this, Louise says her desire for her work keeps her moving forward and facilitates her ability to practise with a disability.

Participant 7: “Jenny”

Jenny is 37 years old and has been an RN for seven years. Nursing is Jenny’s second career. She began her practice working in an emergency department of a large hospital. She then moved into oncology nursing. Presently, Jenny works part time in a surgical oncology unit while also attending graduate school. She describes her practice in the surgical oncology as physically heavy with very ill and dependent patients.

Jenny was referred to the study by her academic mentor, Dorothy (participant 1). With Jenny’s permission, I contacted her through email. I also met with her in person to provide details about the study. Jenny agreed to participate in the study and we arranged to conduct the interview in a meeting room of a post-secondary education institution. The interview took one hour and 22 minutes to complete.

Jenny has been diagnosed with degenerative disk disease (DDD). She describes this as a condition in which the disks in her spine are “squished down, compressed, which [allows] the nerve to sort of spill out a little bit.” Jenny noted that she experiences

chronic lower back pain. Coincidentally, about partway through the interview, she interrupted the interview and brought to my attention that I was shifting in my chair. I responded that I was shifting because my back hurt. She replied, “my back hurts too,” adding “I think these [chairs] are terrible for backs.”

Jenny does not identify with the “disabled” label and says she would never declare herself disabled. When I probed further, Jenny responded that she did not identify with being disabled because of the associations she makes with the label:

. . . [It's] probably because of the stigma attached [to disability]. I've never really thought about it but I guess when I think of the term disability it's more of a . . . formally recognized status, where it affects the type of job you might have or the benefits you might have or parking in different parking places.

The severe pain Jenny experiences in her lower back and body has had significant consequences for her nursing career. She was emotional as she described her first episode of severe back pain during her undergraduate nursing education. Jenny says:

I missed a few months . . . I was actually made to write all the papers [I missed] . . . I was working my butt off even though I was still in a lot of pain, so I was exhausted. I was on medications, so I had to get through all of that. . . . When I came back they were accommodating to me in the sense that . . . [I was allowed] to lie down on the ground in the classes so that was kind of humiliating too. . . . Regarding the placement, that's where I had the struggle because the Head [of the program] felt that I wasn't safe . . . back then I felt really disappointed because I sort of felt like it was an attack. . . . I was really down. I was close to probably suicidal at one point.

Jenny experienced a second major episode of severe back pain a few years after she began her nursing career. She recalled that, although she had to inform her employer, she initially withheld her history and diagnosis because she thought “it might limit job opportunities” within the organization. However, as her pain worsened, Jenny realized she must disclose her history to her employer if she was to be granted more time away from work. It took a total of nine months for Jenny to recover. Getting

compensated time off work and returning to work posed many challenges and became political. Jenny recounted that she initially was denied disability benefits and has to fight and make her case before it was approved. The process of negotiating a return-to-work plan and accommodations was also difficult and left Jenny feeling very uncomfortable and conflicted. She found herself caught between her manager and her union representative. Speaking of a particularly adversarial exchange between her manager and herself, Jenny stated,

I realized after that I have to play a game now. . . . Everything I say and do is going to be political and I have to somehow appeal to management and my union rep. . . . I really had to suck a lot of things up and absorb a lot.

This experience, in addition to her chronic pain, led Jenny to question the longevity of her career as a direct care provider. Subsequently, she has taken steps to move her career into the domain of education by undertaking graduate studies and teaching students in the clinical setting.

Participant 8: “Mary”

Mary is 29 years old and a Canadian of Filipino descent. She has been a nurse for seven years and has been practising in the area of mental health since becoming a nurse. Presently, Mary works on an acute psychiatric inpatient unit. She notes that, “essentially the nature of the work [she does] has been medically focused and not as much mental health as it use to be.”

Mary contacted me and agreed to participate in the study after she received an email invitation forwarded by a mutual colleague to multiple recipients. I met Mary after her workday to conduct the interview in a library meeting room of a post-secondary institution located near her workplace. The interview took an hour and 24 minutes to complete.

In the interview, Mary discussed her experience with depression, and the effect it had on her nursing practice. Although she describes herself as “generally an anxious person,” her anxiety did not affect her ability to do her work. However, circumstances changed a year ago when family members close to Mary passed away. Mary’s anxiety increased and she went into a depression. After trying to manage her anxiety and depression for some time while continuing to work, she decided to take a leave from work for respite and treatment.

Although no one overtly questioned her competence and ability to nurse, Mary says she was eager to prove herself when she returned to work:

Initially I went for the tough ones because I felt I needed to prove myself to not just my nursing colleagues but my medical colleagues and administration that, ‘you know what, I’m ok and I am able to do this.’ So it took a while to get used to [being on a return-to-work plan], but overall I have to say that my nursing colleagues have been extremely supportive.

Similar to the experiences recounted by other study participants, Mary felt supported by her work colleagues. In contrast, she stated that “overall the administration hasn’t been as supportive throughout this entire process.” Early in the process, Mary’s attempt to modify her work schedule to create additional time off was denied by her nursing administrator. She attributes this and other responses to her nursing administrator’s communication style and her “very business model approach, which means it comes down to the money all the time”:

[I have to] remind myself that it’s not anything personal even though it’s hard sometimes but I have to take that extra step and remind myself that it’s not a personal thing. It has nothing to do with how I practise or my competency. That just how she communicates.

Participant 9: “Sondra”

Sondra is 51 years old and Canadian born. She has been an RN for 25 years. Sondra has practised nursing in Ontario for most of her career; however, she briefly

worked in the United States while attending graduate school. For the first half of her career, Sondra practised emergency nursing. She describes working in the emergency department as busy and “highly physical.” In the last 13 years, Sondra has practised as a nurse educator at the post-secondary level. She currently holds a tenured professor position. Sondra says being a tenured professor involves:

teaching in the classroom, which is somewhat physical, [in] three-hour blocks typically, preparation for that, meeting with students and evaluating [them], development of curriculum, [and] development of new courses. There’s a research component that can/has a lot of opportunities to do different kinds of investigations depending on my area of interest. And there’s [a] service component of serving the community and other kinds of things. But the biggest area of my job is . . . direct teaching.

Sondra regards teaching as a performance art:

you are on your feet all the time, . . . directing your performance of that class, . . . you are moving around, you are engaging, you are leading the class for that period of time. It takes a fair bit of psychological energy . . . and it takes some physical energy.

Sondra volunteered to participate in the study after receiving an email invitation that I sent directly to her and others in my professional network. Sondra and I conducted the interview over the phone because we were unable to coordinate our schedules to meet face-to-face. The interview took 49 minutes to complete.

In the interview, Sondra candidly discussed her life-long struggle with obesity:

I was experiencing such high degrees of obesity that it significantly impaired my ability to carry out some of my daily life functions so that I was not comfortable walking for long distances or even standing on my feet for long periods of time.

In recent years Sondra has also developed severe arthritis in both knees. Depending on the status of her arthritis, Sondra’s mobility and the level of pain she experiences with standing and walking can significantly impact her ability to walk or stand with ease. The effect of Sondra’s obesity on her nursing career has been profound. Sondra described

having horrible and humiliating experiences as a nursing student in her clinical field placements. As a staff nurse, she often felt challenged by the physicality of her work, such as maneuvering her body in often limited spaces. Now in her current role as a nursing professor, Sondra is finding it harder to reach students in the classroom due to her mobility limitations and pain.

Additionally, Sondra discussed the high visibility of her obesity and the challenge of managing her perceptions of how others view her and her self-concept:

I think that for me the challenge was always finding a balance to it in my own mind as opposed to what other people might think. . . . Did I feel that I was less than? . . . There may have been times but I would now, at this vantage point, say those were about me and not about someone else trying to convey that or think that or believe that . . . it is easy to not feel good enough if you don't feel like you fit and having any kind of disability I think raises that specter. Raises that possibility that you don't fit.

Participant 10: “Florence”

Florence is 59 years old and has been an RN for 39 years. She began her nursing career in psychiatric nursing, but has worked primarily as a nurse educator. In the past, Florence taught nursing and unregulated health worker students in both the clinical environment and classroom. In recent years, she has been teaching only in the classroom because of activity and functional limitations. Florence says teaching in the classroom involves a lot of time spent “on the computer, both developing courses and developing classes, standing in the classroom lecturing . . . [and also] a lot of marking.”

The interview with Florence was impromptu. I met Florence by chance during the data-collection phase and recalled that she had previously disclosed a history with Fibromyalgia and arthritis. I told her about my dissertation study and invited her to participate. Florence agreed to participate and offered to be interviewed on the spot. We

conducted the interview in a private meeting room at her workplace. The interview took just under an hour to complete.

Florence experiences chronic pain because of the additive effects of living with fibromyalgia, arthritis, depression, and migraines. She tries to control her pain with various medications and routine treatments such as cortisone injections in her knees.

Florence reports that her chronic pain has significantly impacted her career choices:

I couldn't do shift work anymore and that was one of my biggest impotencies going into education . . . I could not sleep during the day and the irregular sleep hours made my migraines really bad, made my FM really bad and I just couldn't take it anymore and that's why it dictated what I would do and what my job would be [as a nurse].

In the interview, Florence also described continued frustrations about not being taken seriously by others such as family and work managers. She commented that she has learned to “really push herself” to carry her load to manage how others perceive her as a nurse:

I think because I work so hard at carrying my load that as long as I'm doing that I think [other people] don't care. . . . They don't care that I have a disability. They don't see me as having a disability . . . unless I'm limping when my knees are really bad, I try and make it so that they don't see it . . . I don't want them to think I'm not carrying my load. That I'm [a] hypochondriac and there's nothing really wrong with me and I'm just faking.

Florence became emotional as she spoke about her struggles to have her disability acknowledged and accommodated by her program Chair:

I don't feel that I get support from my chair. In fact I feel like she's somewhat vindictive about my [disability]. . . . I think between the issues with the chair and that I'm not able to carry my load I think that's pushing me to retire early.

Despite her challenges, Florence says her disability experience has had some positive influences:

My empathy for my patients went up significantly . . . and that I think really improved my practice as a nurse. . . . I have brought [my experiences] into my

own practice as a teacher. . . . And I tell my students, ‘I have chronic pain. Would you know that I have pain? You wouldn’t know that. I still smile, I still joke, I still manage, but I still know when I have to take my medication and that’s the only way I can get through the days’. So, I pass that on and I’m hoping I use my disabilities to instruct my students.

Participant 11: “Heather”

Heather is 39 years old and has been a nurse for 16 years. She identifies as “part Métis.” Heather is a nursing professor. She describes her roles as focusing primarily on classroom teaching. In the past Heather has “done clinical out in the clinical setting as well as in a lab setting, which would be simulating, and taking care of patients.” Prior to teaching, Heather practised nursing in the area of neuro-surgery trauma. She also has worked as a clinical nurse educator and nurse practitioner within the hospital sector.

Heather responded to an email I sent inviting her to participate in the study and volunteered to participate. We conducted the interview in a private meeting room in Heather’s workplace. The interview took 44 minutes to complete.

Heather developed a neurological syndrome following a musculoskeletal injury that affected her ability to walk. She took a leave of absence from work for a year and a half after the injury and returned only when she could walk well enough. Heather described the effects of her condition as follows:

I have constant pain all the time. It’s [a] kind of burning pain I get. Temperature changes, colour changes, I have muscle weakness in the leg so that fact that I’m walking is significant progress compared to how I started.

In the interview, Heather discussed the adaptive changes she has had to make in her work to meet her responsibilities. She described facing numerous challenges returning to work. This was made more difficult by the inaccessibility of her physical work environment and lack of support and accommodation from her program chair. Heather described that she has had to self-advocate strongly to her chair for accommodations

that had already been negotiated and approved through her union and Human Resources: “The biggest challenge has been really to make sure accommodations have been respected in terms of the [modifications to] working hours and when things are starting to go beyond that or what is realistic for where my abilities are.” Despite these challenges, Heather acknowledges there are qualities of her job and work environment that have supported her to continue practising nursing with her impairments:

Actually, if I was working in a hospital setting I wouldn't actually be working now. I would probably be in a situation where I would have had to be/make a choice about whether I would be able to work or not work at all so I think the fact that I do have a job that has some flexibility and some different settings I can work in has actually been a good thing for me that way.

Participant 12: “Natalie”

Natalie is 42 years old and has been a nurse for 22 years. She is employed as a nursing professor in a post-secondary education institution. Natalie’s responsibilities as a professor include preparing and providing lectures, marking, meeting with students, and developing and revising courses. On a typical workday, Natalie arrives early to prepare for her lecture. She says she mostly stands to deliver her lecture but also engages in other activities with students. After class Natalie will often meet with students who want to connect with her. Prior to working as a professor, Natalie worked in palliative care as a staff nurse providing direct care. She describes this work as “pretty intense [and] busy because it was one RN, one RPN, and one personal support worker (PSW) for ten clients who were at different stages [of the palliative process].”

Natalie was referred to the study by Florence (participant 10). Natalie gave permission for her information to be shared with me and I contacted her through email. After reviewing the information about the study, Natalie volunteered to participate and

we decided to meet in her workplace to conduct the interview. The interview conversation took an hour and four minutes to complete.

In the interview, Natalie discussed practising as a nurse educator while experiencing depression. She was diagnosed with depression two years ago. Speaking of her experiences of depression, Natalie commented:

I had a strong sense that I needed help. That I didn't know what this was and I didn't know why I was feeling this way . . . what was unique this time around is because I actually had a title for it. Depression. And a plan to deal with it.

In hindsight, Natalie believes she has had other episodes of depression in the past that were moderate. She describes working while experiencing depression as “kind of like holding on, . . . like being in a river. Like you're just flowing, like you're just going with it.”

The nature of Natalie's work is such that most of her colleagues did not know that she was experiencing depression. Natalie herself was confused by how she was able to get her work done during this period:

There were things to be done . . . but not being able to focus and finding myself just getting up and going home to bed. Somehow I still managed to get the work done so nobody would question me on anything but at the same time I was falling apart. I guess that's probably something that confused me as well . . . I found myself going to therapy for the longest time just questioning, 'is this really depression? Am I just lazy? [or] Just not good at what I do... it didn't make sense to me that a person that's depressed could function. . . . The idea of a [depression] continuum wasn't there until I was actually going through the therapy and treatment.

For Natalie, getting through it also meant foregoing the process of obtaining accommodations and modifications to her work schedule. After the accommodations she first received did not work as they were intended to, Natalie “started to see it as more of a stress to go through that process then to just go through, and do what [her workload

assignment] says to do.” Notwithstanding this and other obstacles, Natalie believes the flexibility afforded by her job and workplace were helpful to her recovery.

Summary

The purpose of this qualitative descriptive research was to explore the practice and work-life experiences and perceptions of registered nurses with disabilities. Twelve nurses with disabilities were recruited and interviewed using a semi-structured interview guide. The findings of these interviews are presented in the next chapter. In this chapter, the demographic characteristics of the participants and vignettes that described each participant and summarized their interview conversations were presented. Each participant vignette was crafted using data extracted from interviews and participant’s own words were integrated using verbatim quotes to maintain the integrity of their voices. The intent of presenting the demographic characteristics and vignette was threefold: 1) to provide a means for the reader to situate the findings presented in the next chapter and assess the context in which the study was conducted, thereby contributing to the trustworthiness of the study; 2) to allow for greater retention of the identity and individuality of the participants that are often obscured when narratives are represented as categorically organized descriptive summaries; and 3) to “give voice” to an unrecognized group within nursing that is seldom heard from or included in the discourses of the profession.

Chapter 5: Findings – Participant Experiences and Perceptions

Introduction

In this study, participants were asked to recall their experiences and perceptions related to practising nursing with a disability. In Chapter 4, vignettes describing each of the study participants and their interview conversations were presented. Collectively, these vignettes provide a broader context to consider the categorically organized descriptive summaries presented in this chapter. Although each participant described experiences and perceptions that were unique, participants' narratives shared certain commonalities. Using conventional content analysis (Heish & Shannon, 2005), data collected were analyzed and categories were identified within four content areas corresponding to the study's research questions (Graneheim & Lundman, 2003). The findings of the study are organized accordingly into four sections: 1) experiences practising nursing with a disability; 2) perceptions related to practising with a disability; 3) facilitators of practising with a disability; and 4) barriers to practising nursing with a disability. This chapter presents the first and second sections. The remaining sections are presented in Chapter 6.

Practising Nursing with a Disability

In this study, three major categories were identified when participants were asked to share their narratives about practising nursing with a disability: experiences, interactions, and exposures (Table 5.1).

Experiences

The experiences described by participants were related to changes they experienced, the practice conditions they worked in, and their reactions and embodied responses. Participants also recounted both negative and positive interactions, as well as the outcomes of their interactions. Finally, participants' described exposures involving disclosing their disability and being visible in the work environment (Table 5.2).

	Practising nursing with a disability			
Content Areas	Practising with a disability	Perceptions of others	Facilitators of practice	Barriers to Practice
Categories	Experiences Interactions Exposures	Uncertainty Perceptions of abilities Perception of person	Facilitating factors Factors that would facilitate	Nature of disability Nature of nursing Work Work environment factors

Table 5-1 Major Categories from Analysis of Participant Narratives

Changes

In this study, most of the participants described changes to their nursing practice because of disability. Changes were organized into two categories: changes in amount of time spent practising and changes in ability to practise.

Changes in the Amount of Time Spent Practising

Most of the participants in the study reported changes in the time they spent practising or in their ability to practise or both. In most instances, these changes coincided with the onset of a new or recurring condition or illness. However, for nurses who experienced disability on a consistent basis, change was an enduring characteristic of their practice experiences.

Taking Time Off, Had to Work. Several participants identified that they took time off from working because of their disability. In each instance, taking time off was prompted by the onset or reoccurrence of disability. Blanche and Mary, both mental health nurses, described experiencing mental health problems and struggling to work for a period of time before making the decision to take time off from working:

Things were really piling up on me . . . and I got depressed enough that I needed time off, so I went on short-term disability. I couldn't cope at work. . . . I was a mess. —Blanche

I started to take some time off on my own and I was able to find my own replacements . . . [but] I decided to take the official leave of absence because I couldn't focus on anything else other than [ill family member]. —Mary

Conversely, two participants reported taking time off working almost immediately after the onset of physical impairment. Jenny stated:

When [my back pain] first happened, I stepped away from all my physical activities. . . . [I] had another episode of back pain while I was in nursing school], but my back was fine, I was running, I was spinning, I was doing weights. Occasionally it would hurt but not too bad and uh, the pain started to come back one day a little bit but I kept going and I did a kettle bell class and the same thing happened. It was excruciating pain. I couldn't walk. I couldn't do anything. I was working as a nurse at the time. . . . I think I was off work for about nine months.

Similarly, Heather remarked that she took a year and half off from working to recover from a physical injury. She added that as a result of the chronic condition she developed following her injury, she continues to routinely take time off for treatment: “I have to have some of this time off to be able to go do my rehab therapy so that I can get better to be able to come back and be able to do more work and be able to meet the hours.” One participant who had a medical condition affecting her physical and cognitive abilities reported she had to work and could not take time off to care for herself and recover.

Content Area	Practising nursing with a disability						
Category	Experiences						
Sub-category	Poor Practice Conditions	Changes		Reactions		Embodied Responses	
Sub-sub category		Amount of time spent practising	Changes in ability to practise		Physical Responses	Cognitions	Negative emotional responses
Codes	Discriminated against Not accommodated Unsupportive climate	Doing nothing extra Had to work Taking time off	Changed practice Improved my practice Limited opportunities No change Unable to do part of work Work modifications	Became depressed Fighting back Getting used to Great effort Plow through Struggle to work Self-care Unable to hold together	Exhausting Makes it worse	Conscientious Hard to deal with Questioning Prove self Pulling weight Re-evaluate working	Angry Disappointed Frustrated Guilt Tired Less than Sad Stressful Upset

Table 5-2 Sub-categories, Sub-sub categories, and Codes under the Category of Experiences

I had to work because that was my income and because I have travelled and lived in different countries I haven't worked here long enough to have a substantial income and so I had to work so in a way it was a good thing that I didn't stay at home all the time being lonely and thinking about it but at the same time it took great effort just to walk . . . to park the car and walk from the car park to where I had to take my-I could not hurry. —Helen

Doing Nothing Extra. Three participants revealed that, because of their disabilities, they were unable to perform any duties that extended beyond their usual work. Nor could they participate in extra activities. Helen explained:

Usually at work, with colleagues, you might exchange a joke or talk [but] I found I had to save my energy to concentrate on what I was doing so there wasn't this bubbly and chatting and carry. . . . I could not do anything extra. . . . Just to get through the shift.

Two participants, both educators in post-secondary education, echoed Helen's sentiment.

I have classroom responsibilities and the reason why is for predictability. . . . I don't want any new assignments, other assignments, so we've just been going that route where I strictly go to the classroom, I teach, I prep, I mark. . . . I know what I need to do and how long it takes. —Louise

[Working] became very limited. There was no kind of extra. I would go to class and I would teach my class. . . . If I didn't have a class I probably wouldn't be around on the campus at all. —Natalie

Changes in Ability to Practice

The majority of the participants in this study reported changes in their ability to practise nursing as a direct or indirect consequence of their disability. However, a couple of participants reported that their ability to practise had not changed because of their disability. Among participants who reported changes, most identified a loss(es) in ability; although, a few also reported improvements in their practice abilities.

Unable to do Part of Work. Half of the participants in the study revealed that they were unable to do part of their job as a result of having a disability. Most of these

participants described difficulty completing or not being able to do the physical aspects of their work. Speaking about the period of time she worked in the direct practice,

Sondra stated:

Getting my body, that imperfect body around in that [practice] setting, was a significant impediment to my practice.

It became harder and harder to continue to do my job and more and more likely that I would prefer to be assigned to certain roles . . . Even though [they were] much more emotionally gruelling, there was a difference in the physicality of it.

Natalie, a nursing professor, described how being depressed changed the way she engaged with her students: “I still even interacted with students but I would say [it was] limited compared to where I am now.”

Several other participants reported changes in their role function. For example, Helen, a mental health nurse, commented that she could no longer work in the acute care area of the psychiatric unit where she was a staff nurse. Similarly, two nurse educators discussed only being able to teach in the classroom.

I don't do clinical [practice] anymore. —Louise

[The arthritis] was impacting what I could do as a teacher. . . . I cannot stand on my feet for long periods of time and as a Clinical Instructor you're on your feet all the day. You, I rarely get a lunch break even because half my students would be on the unit and half the students would be at lunch so I would have to be there and I just couldn't do it anymore. —Florence

Work Modifications. Modifications to work duties were discussed by many of the participants in this study. Half of the study participants reported that their work duties and responsibilities were formally or informally modified because of their disability. Several of the participants described negotiating modified work plans that slowly increased their workload and activity level towards full duties. Jenny's description of how her work was modified typified this experience.

I graduated on from clerical to modified duties. . . . I had the day-long assessment. Then I also had an assessment on the unit where they would see what I would be doing and what's painful and that type of thing. So they decided that I had to do no lifting, no bending, no twisting, that type of thing. . . . It was quite a slow graduation of duties.

Two participants described making informal modifications to their work. After the formal accommodations she negotiated with her employer were not realized, Natalie made modifications of her own. Florence, a nursing professor, also reported making her own modifications to the way she delivered courses to accommodate her disability.

I have tried just marking papers online but it took way too long and I just couldn't do it. . . . [So] one course that I developed, I developed [it] with no papers so that I didn't have to mark. It just worked out well for the students as well. They didn't need to have another course that they wrote papers in that semester. But I really had to alter the delivery of the course because of my disability. I had to reduce the other course and reduced the number of papers that they wrote because I couldn't mark them.

Changed Practice. Of the participants reporting they were unable to do parts of the jobs, several also described changing the area of nursing in which they practised because of circumstances relating to their disability. Florence discussed moving from direct-care practice to education: "I could not do shift work anymore and that was one of my biggest impotencies going into education. . . . [My disability] dictated what I would do and what my job would be." Likewise, both Jenny and Sondra commented on transitioning their practice into education after realizing that they could not sustain working in direct-care practice.

I worked [in clinical practice] almost full-time hours casually but I noticed that it's starting, the pain started to get pretty bad so I tapered it off. . . . When I work now, I can't work a lot of shifts. . . . But I'm teaching in the hospital too, at a different hospital which is ten times better on my back . . . I'm still doing quite a bit with the students physically but nothing compared to . . . having a patient assignment. —Jenny

Later in time it became much more attractive to move to a different kind of nursing practice and I would not have been able to maintain that practice so my

move to education was much a requirement because of my changing physical needs as it was a desire to change my practice. —Sondra

Another participant, a mental health nurse, spoke about leaving her long-term employer and taking a position in the same area of practice but within a different organization:

[After the discrimination grievance] I started to work casually [in another organization]. . . . I did not like the out-patient job. . . . I finally just thought 'I can't take this anymore.' I just couldn't stand the unprofessionalism . . . [For example] there were two of the eight staff in the clinic that after every client took a cigarette break, and just on principle that really annoyed me. —Blanche

Limited Opportunities. Two participants discussed having limited opportunities in their work environment as a result of their disability. Both participants discussed the self-imposing nature of this experience.

[My anxiety] did prevent me from acquiring different roles in the organization. —Rose

I might have tried have taken more chances and tried for promotions or other things had I not experienced that disability but who knows, right? —Sondra

No change. Although most of the participants reported changes in their ability, a couple of them reported that their disability had no impact on their ability to practise nursing. Sofia was adamant in expressing her belief that her ability to practise in the acute care areas she worked was unaffected by her learning disability. She explained:

I think it depends [on where you work]. . . . I'm more of a hands-on person and I'm able to think fast on my feet, critically think. . . . I don't have any time constraints [in the areas where I work]. When I see [patients] presenting symptoms I know what to do. . . . I've never done other parts of nursing like, maybe writing and like research . . . I think that might be where it would take me longer. Everybody has different categories, right?

Another participant, Louise, stated that while she was unable to teach clinically, she believes there have been no changes in her teaching abilities. She described her relationship with her students and her efforts to use her experience of disability as a teaching and learning example.

No, there's no difference at all [in my teaching], at least and I try and build my experiences into my teaching as well. I talk about chronic pain. . . . That's when I give my examples. . . . I try and build off of [my experience] and I encourage them to ask me anything they want about it.

Improved My Practice. Three participants reported that their disability-related experiences have improved their practice. These nurses described developing “compassion,” “understanding,” “appreciation,” and “tolerance” for others and their circumstances.

I think [my experience of disability] really improved my practice as a nurse. . . I do think I'm a little more tolerant because of my own experiences. —Florence

What it did was made me more compassionate towards people because you understood the suffering, [it] increased your awareness of people's suffering. . . . So I became more compassionate when I looked at people and the illnesses and um, the understanding of how they felt and when someone said they didn't feel well and they wanted to stay in bed, you know, it might be from depression, but I could understand this feeling because it also had its mental health things with me you know, with hope and fear and all that sort of thing. . . . It made me more compassionate. It made me feel a sense of gratitude of being alive and getting better so it invoked all of those feelings within me but I would say the deepest one is compassion. —Helen

I think [it] really makes you pause and makes you appreciate life and struggles and what people are going through a little bit more when you're having a difficult time . . . I think [my experiences] made me more patient. —Heather

Poor Practice Conditions

Participants in the study described experiences practising nursing with a disability in which the practice conditions of their work environments factored prominently. Specifically, they discussed practising within unsupportive work climates, not being accommodated for their disabilities, and being discriminated against.

Unsupportive Environment. Half of the participants described practising nursing within an unsupportive environment. One participant with a physical disability spoke about the challenges she experiences relating to the built work environment.

Just day-to-day obstacles can be a challenge. For example our office area has no accessibility button to open the door so being able to physically open the door has been a challenge. . . . Even sometimes things like the elevator. Waiting for a long time just to get an elevator and it's crowded and trying to find balance and just get there. Things like when there's like you know in the classroom dealing with the stairs to help the students. —Heather

Other participants identified negative experiences in dealing with the administrative policies and structures or employees or both within their work environments. The following comment made by Mary, a mental health nurse working in a large hospital, typifies the experiences described by these nurses: “overall the administration hasn't been as supportive throughout this entire process.”

Not Accommodated, Discriminated Against. Several participants identified that they were denied or prevented from receiving accommodations. One of these participants characterized her experience as discrimination. Three participants working as professors in the same department of a post-secondary education institution described difficulties obtaining the accommodations that had been officially approved through negotiations between their union and employer. Louise's characterization and example typified the experiences of these nurses.

When I would say that I had certain accommodations they were never met. Or they were ignored. . . . So, I was only supposed to be doing three-hour rotations . . . [but] I'm doing double my time that I was supposed to been doing because that was all that was available so it was almost wrong. They can't fit [my accommodation] in.

Blanche, a mental health nurse, described being denied a new position that would have accommodate her disability.

In terms of accommodation, they were going to get me a Monday-to-Friday day job. . . . [The union said] the manager was not prepared to accommodate me. The [union] executive did say to me, "You know, the employer has a duty to accommodate." Specifically, that unit had a duty to accommodate me.

She characterized this incident as discrimination and filed a grievance against the managers involved. She stated:

They interviewed me, I didn't get the position and I really felt discriminated against and I felt that [my former manager] had talked to . . . the Manager of the [area I applied to] and I was poisoned. And the years that I contributed to the department didn't amount to anything.

Reactions

In discussing their experiences, participants described their reactions to their situations. Participants described eight physical and mental response to practising nursing while experiencing disability: struggling to work, great effort, plowing through, getting used to, fighting back, unable to hold it together, became depressed, and taking care of self.

Struggling to Work. Most of the participants in this study described struggling to work while experiencing disability. They discussed difficulties and challenges with performing duties that were important to the roles they occupied. Participants described struggling with their mental faculties such as concentration and memory because of their disabilities. For example, Mary commented that she “had difficulty concentrating” and was “distracted” while working. Helen commented that she “started to forget things.” Both participants described having to develop strategies to counter these responses.

Participants with physical disabilities described experiencing impairments that limited what they could do in the workplace or their effectiveness when carrying out the duties of the job. Sondra and Heather, both professors, described struggling to perform the physical aspect of their work such as standing to lecture or grading assignments. Heather stated, “the physical piece [of teaching] has been a challenge. . . . I have trouble climbing the stairs to be able to answer [students’] questions.”

Two participants who lived with anxiety revealed that their disability affected all aspects of their nursing practice. Rose commented that her anxiety was with her “all the time,” influencing “anything” she did. Similarly, Dorothy described struggling with anxiety-related symptoms such as “overanalyzing . . . and making everything a bigger deal than it was.”

Great Effort. A few participants described putting forth a great deal of effort to do their work. Participants experiencing mental/emotional disabilities discussed the mental and emotional effort they put forth to manage their emotional state of mind and focus on the work they had to do for their jobs. Dorothy, for example, stated: “[I’d say to myself,] ‘OK, I’m going to try very hard tomorrow to not show my anxiety to people’ . . . but that was hard. It was difficult to do.” Florence and Heather, both nursing professors, described the physical effort that was required of them to reach a point where they were functional to work. They also discussed the ongoing effort it took to continue to do aspects of their jobs while living with chronic conditions affecting their physical functional ability.

It's been really challenging to come back to work. I found just getting back to a point of having any stamina at all has been difficult. [I've been] trying to increase hours gradually over time. —Heather

It's hard because I can't stand for long periods of time um, so I have to sit at a desk. That impedes my ability to interact with my students. It's hard for me to walk up and down the aisles. . . . I can't teach like I want to. —Florence

Plowing Through. Half of the study participants described plowing through the situations and difficulties they experienced while practising nursing with a disability. Several participants commented on pushing through pain, suffering, and other difficulties in order to get their work done. For example, Jenny discussed continuing to work despite the significant pain she was experiencing in her back.

My pain would get bad. I would hide my pain . . . so I would start doing work and then I would have to go lie down in the break room.

I would still work through the pain and my colleagues would say, “What are you doing? Why are you pushing?”

Depending on that person . . . I would say “hmm, yeah it's getting bad” but I could never always be really truthful, you know? And I couldn't tell them that I'm totally depressed inside, you know? I've cried a lot over it. —Jenny

A few of the nurses revealed that they continued to work knowing or having some sense that there would be negative consequences. Mary described how she put pressure on herself to continue working, resisting the sense that she needed help, in the hope that she could overcome her depression on her own. Florence commented that she continues to put pressure on herself to do more despite knowing the consequences. She stated:

I mean I really push myself and try and um, carry my load . . . I wanted to carry my load. . . . So I will push myself and I will do more than I probably should and I end up in pain for a couple of days.

Similarly, Natalie revealed that she had an awareness that she was “falling apart” while somehow managing to get work done. To convey this sense of incongruity, Natalie provided this example about her emotional state:

Going into class at the beginning where they're all sitting there and getting ready to put up the slides and stuff and I would have my moments where I would be on the verge [of crying] and was wondering if I would get through the class but then I just did it because I had to do it.

Getting Used To. Two participants, Mary and Heather, discussed getting used to the changes in their work life brought on by disability. Mary described having to get used to the modified work schedule she was placed on when she returned to work after time off for treatment of depression. Heather described having to get used to the changes in bodily functions after she developed a chronic condition. Heather provided examples of the adaptation to her workflow and activities:

I was not able to walk for a period of time so have to use a cane now to get around for stability and also just because of the weakness in the leg and this makes some physical stuff challenging. . . . Even just having to physically change how I'm teaching . . . I've had to adapt my style that way to make it work for me. Even having tools like a cordless mouse or using a microphone has been a little different too.

Fighting Back. Several participants described instances where they reacted to circumstances related to their disability by fighting back. These participants described fighting back when they were denied accommodations or support. Dorothy, who at the time was working in direct patient practice, recounted that as a matter of patient safety she got to a point where she had to find the strength to fight back against the ridicule of her colleagues. The sense that these participants all reached a tipping point where they felt compelled to make their voice heard or advocate for their needs is exemplified by Louise's comment:

I had to put my foot down this time [when they denied the accommodation], which I really haven't done in the past. I just basically said, 'I'm not feeling good.'

Unable to hold it Together. One participant, Natalie, described reaching the point in her experience of working with depression where she was unable to hold it together. She explained:

What bothered me most about the episode of depression is I am a person who can hold things in. I can hold it together and with an episode of depression I wasn't holding it together.

Became Depressed. Two participants identified that they became depressed as a result of circumstances relating to working with a disability. Jenny indicated she developed depression while on a disability leave from a back inquiry. She attributed the cause of the depression to the "rough" situation she found herself in during this period of time. She stated:

I was so depressed. So depressed . . . and even when I was getting money I was not getting much money from disability.

Florence identified that she developed depression while working with a chronic condition. However, unlike Jenny, Florence largely attributes the cause of her depression to the pain associated with her medical illness. She explained this relationship in these terms:

The depression . . . only seemed to get worse as the years went on when I worked in psychiatry. I had passive thoughts of suicide . . . I think that the depression was so very tied in with not just the low serotonin levels with the [fibromyalgia] because the anti-depressants really helped with that but also with the pain and the constant pain and not being able to do the things that I would want to do.

Self-care. The notion of taking care of oneself was common among several of the narratives of participants. Although in different contexts, these participants all identified coming to a point of realizing they needed to engage in some form of self-care. Self-care involved taking actions or changes in behaviour. Florence and Heather described making changes to the way they approached their work to support their physical wellbeing. Similarly, Blanche changed how she interacted with others in efforts to support her mental/emotional wellbeing. The following statement by Blanche exemplifies the notion of self-care:

I had to learn to say 'No,' because not saying 'No' and being trampled on didn't make me feel good about myself. . . . the only person that I have to be accountable for is me and that's a good feeling because all my life I have been accountable for so many people.

Embodied Responses

In their narratives, participants described three categories of embodied responses to practising with a disability: emotional, cognitive, and physical.

Negative Emotional Responses

Participants reported a range of negative emotional responses, most of which occurred during times of tension and conflict with others in current or past work environments. However, two nurses described experiences that occurred while attending nursing school.

Upset One participant, Sophia, recalled how upsetting it was to be told by her professor in nursing school that they did not think she belonged in nursing because she had a learning disability. She stated:

It was just upsetting. . . . If you think about, like, someone tells you you're stupid and can't do anything, how would you feel? . . . It was kind of upsetting because the first year of nursing I took it horrible.

Disappointed. Two participants reported a sense of disappointment related to their circumstance. Jenny recounted being disappointed in the administration of her nursing program, particularly the dean, who expressed concerns and questioned Jenny's fitness to practise and ability to provide safe patient care in the clinical environment. Jenny stated that from her perspective the response from the dean "felt like it was an attack." Sondra also reported that she experienced disappointment; however, unlike Jenny, Sondra stated she was disappointed with herself. She explained:

I think I have experienced feelings of disappointment in myself and recognizing because I can experience a variation in my capacities, recognizing the difference that decreased mobility has on my teaching so that's an experience and that's probably work for me to do-to find ways to overcome that, my own evaluation of that or my own experience of that.

Less Than. The most frequently identified emotional response by participants was a sense of being less than. Half of the participants described a sense of being less than. All but one of them alluded to or directly identified their self-esteem as a factor that influences this emotion.

I knew that [the work modifications] would just tested me in my . . . insecurities that I always felt even before [my depression] about how competent I am and how I am as a nurse because I had somebody else telling me I couldn't be with a patient. —Mary

[Seeing a psychiatrist] was so demoralizing for me because here I was a Psych Nurse and um, surely I could cure myself. You know, I helped my patients, why can't I help myself? So there was this feeling of incompetence as a nurse. —Florence

One participant shared her reflection on why she may have she experienced a sense of being less than.

Did I feel that I was less than? . . . There may have been times but . . . at this vantage point, [I] would say those were about me and not about someone else trying to convey that or think that or believe that . . . it is very easy in the world to, you know, whether you're fourteen years old and not in the right clique in high school or fifty-one years old, it is easy to not feel good enough if you don't feel like you fit and having any kind of disability I think raises that specter. Raises that possibility that you don't fit.

Contrary to the other participants who experienced a sense of being less than, Dorothy identified the willful actions of her colleagues that included name calling as the primary causal factor of her feelings of being less than. She described:

I thought it was just a name . . . and I'm gonna learn to just forget about that . . . But then when they brought it up again it would bring up all these emotions again, like we're not obviously normal.

Frustration. Three participants described being frustrated by situations relating to practising with a disability. Louise discussed the frustration she experiences related to obtaining accommodations and dealing with the responses of others in the work environment to the modifications she requires to do her work.

I'll have some people [who] will say to me "Well it must be nice to be leaving." Well I'm leaving to go home to continue my work but I don't feel like I have to explain it every single time. It gets, I don't want to say upsetting. It's just frustrating. By this point it's been four years. Everybody should know that's why I'm leaving.

Similarly, Florence expressed her frustration with being in conflict with her supervisor about accommodations. In addition, she also voiced frustration with experiencing pain and trying to meet the duties of her position as a professor.

I can't mark more than five to seven papers a day because the amount of pain it causes me, which means that I am marking every single day of the week including weekends. There's never a time when I never do work at home and that becomes frustrating.

Stressed. Two participants discussed feeling stressed as result of their circumstances within their workplace. Rose described difficulty managing her anxiety and finding the conflicts that arise within her work team stressful. Rose's description of conflict as an "everyday" occurrence provides a sense of the extent of the stress she experiences.

Sad, Angry, Tired. One participant, Dorothy, spoke about being sad and angry about her situation while working as a nurse with a disability in direct care practice. She described being both saddened by and "very angry" because of the teasing and name calling she experienced at the hands of her colleagues. Dorothy provided the following example of how her colleague would speak to her about her anxiety-related behaviours:

[Being called that name] really made me feel really, really sad. . . . I thought, 'Well, what does she mean by that?' It was almost like I was a spark, always trying to, you know, always create or look for problems and I was always on-the-go to the point that they said well, "You know what? You're just always on-the-go. Maybe you should . . . be the fire captain.

Dorothy also summated that having generalized anxiety in the context of practising nursing was tiring:

I just think ultimately it's very tiring living like this because you're always thinking that, you know, something is going to happen and you're going to miss something.

Guilt. Two participants reported experiencing guilt. Louise's sense of guilt stemmed from being accommodated. She stated:

The amount of time that I can actually stay [at work] sometimes makes me feel guilty. I see others who will stay the full 8:00–5:00 workday [whereas] I will do 8:00–10:00 and I'm walking out the door at 11:00.

Jenny recalled feeling guilty about not disclosing her disability to her employer when she began practising nursing. Jenny stated that she believed disclosing that she had back problems would possibly limit her opportunities in the organization that hired her.

Cognitive Responses

In discussing their experiences of practising with a disability, participants commented about and described their state of mind during their experiences. They also provided some indication of their thinking during this time.

Conscientious. More than half of the participants described experiencing a heightened awareness of self in practice and being careful and in their work. Helen described her conscientiousness in this manner:

I started to forget things as well so I had to be very careful with my medications and giving things [to patients] and so that of course I wrote down things. I had to be so careful that I didn't make a mistake because [the condition] affected your memory as well . . . Your work was impacted from the sense that you couldn't buzz around and rush like how you would do and you have to take your time and do everything very precisely.

Helen's comments were reflective of the statements of several other participants.

Participants discussed being cognizant of the changes and challenges presented by their disabilities and worried about it negatively affecting aspects of their work, particularly, patient care. This is evident in the comments made by Jenny and Blanche:

I was on Percocet then so I was hyper-vigilant knowing I might not be so clear on things.

The pressure I was feeling from Occ. Health contributed to my self-consciousness on the unit because I knew now that I was a liability. —Jenny

I have to really watch out for [missing things] —Blanche

Two participants reported using particular strategies to ensure they did not make mistakes and maintained the expected level of performance. For instance, Mary created a “cheat sheet” to help her remember details, particular about her patients. Another two participants discussed the extent of their conscientiousness. Sondra explained that she spent considerable time being concerned about herself in the space and places she occupied: “So much of my focus becomes that . . . how am I going to manage this? . . . Am I drawing negative attention to myself?”

Likewise, Dorothy characterized herself as being highly conscientious: “[Because of anxiety disorder] I was always super conscientious to a degree that . . . it was just all-encompassing even physiologically.”

Questioning Self. Two participants identified that they questioned themselves and had doubts about their experiences and abilities. Natalie discussed questioning herself and trying to determine what it was she was experiencing: “[it was] a self-blame game in terms of why I’m feeling this way and then you know trying to figure out what . . . this is that I was experiencing.” Once she was diagnosed with depression, Natalie says she continued to question the authenticity of her experience:

I was getting stuff done and I was still functioning and I was still interacting with people, still smiling, . . . [It] didn't make sense to me that a person that's depressed could function. . . . The idea of a continuum [of depression] wasn't there until I was actually going through the therapy and the treatment.

I found myself even going to therapy for the longest time just questioning you know, 'Is this really depression? Am I just lazy?' Just not good at what I do because the idea that I could actually function.

Jenny discussed questioning her ability to provide care for her patients in a safe manner but decided to keep her concerns to herself. She explained:

I think I'm safe to [patients] but I might not be safe to them because . . . if they fall let's say, and I can't help them up because I hurt my back, then I could be unsafe as well but I've never, ever talked about that because I think that Occ. Health would come back in and they would restrict me or... So I've just... You know, I've never actually consciously thought about it and said, "Don't tell them, don't tell them" but it's just to me it's just out of the question to re-visit all of that with [them].

Re-evaluating Working. Two participants reported that they re-evaluated working as they experienced more challenges practising with a disability. Florence expressed that not being able to “pull her weight” was pushing her to end her career early and retire. Sondra discussed how her weight and arthritis related-mobility issues caused her to consider and eventually withdraw from providing direct patient care. She stated, “it’s a heartache because I saw myself receding from my practice, from my potential as a practising nurse.”

Hard Time. Several participants described having trouble dealing with the circumstances related to return to working after time off. Both Mary and Jenny described how hard it was for them to be on modified duties. Mary stated, “for the first two weeks . . . I was not allowed to work with patients so I didn’t have a patient load and that was hard. It was extremely hard.” Another participant, Heather, described the hard time she experienced managing the pressure to return to the full duties of her position as a nursing professor: “It's been challenging sometimes to have my restrictions on working hours and workload, accepted or recognized. I've been pressured to be back a hundred percent full-time [workload] and it can be very difficult getting pressures.”

Pull Weight. Several participants discussed the notion of pulling their weight, expressing concern about not doing their fair share of the work and contributing equally in the work environment. Jenny described thinking that she was not doing enough because she was on modified duties. She stated, “I’m used to pulling my weight all the time . . . I felt like I was slacking.” Florence expressed a similar sentiment, noting, “I don’t want to be seen as someone who is not carrying their load.”

Not only were participants concerned about doing their fair share, they also discussed thinking they had to prove themselves to others in the work environment. These participants discussed working or driving themselves harder and doing more than was expected or required to prove they were still capable of doing the work of a nurse. Sondra related that she did more than what was required to try and make up for her deficits: “There was probably part of me driven to be more than, more than what was required, more than what would be reasonable to make sure that I was making up for any deficits I had.” Mary discussed pushing herself and taking on challenges in the workplace to demonstrate to herself and others that she was capable of doing the work she had always done. She explained:

[Since returning to work] I think I have put a lot of pressure on myself to kind of get back to where I was. . . .Initially I went for the tough [patient assignments] because I felt like I needed to prove myself to not just my nursing colleagues but my medical colleagues and administration that you know what, I’m ok and I am able to do this [work]. . . . I would say insecurities have always been there and I think that with the time off with this particular and with my mental issues I think I’ve put even more pressure on myself to prove to myself and to prove to others that I am capable.

Prove Self. Concerned about how they were being perceived by others in their work environments, several participants indicated that they tried to prove themselves such that they are above reproach or scrutiny.

I think I overworked myself because I never, never want to be viewed as somebody who's kind of a slacker who's taking advantage. —Jenny

[I managed to get the work done] so nobody would question me. —Natalie

[My workplace] sent me off to see a disability specialist. Well he's hired by the hospital so, you know, I saw a copy of the report that he sent to my own psychiatrist and it really wasn't very favourable. So I felt this need to get back to work and prove myself and not get into the long-term disability stuff. —Blanche

Physical Responses

In additional emotional and cognitive response, participants also discussed their physical responses to their circumstance related to working with a disability. Participants described being exhausted and discussed how working makes their embodied experiences worse.

Exhausting. Three participants with physical impairments described feeling physically exhausted. In all three participants' descriptions, feeling exhausted resulted from a combination of factors relating to the nature of their work and the nature their disability. The interconnected nature of the experience of exhaustion is illustrated in the following statement by Jenny:

I think it's [working with a disability] a little bit taxing mentally. I think that the pain . . . when it gets strong enough I don't concentrate as well I find and I try to hide it. . . to nurse it's not so much, it's when I come home that I feel exhausted and I have to put on the heating pad.

Makes it Worse. Several participants described how working while experiencing disability negatively impacted their impairment. Participants described increased bodily pain and discomfort because of the nature of their work. For example, Louise commented that on her busiest day at work, she is in “a lot of discomfort” by the time she finishes working. Helen, who had a medically related disability, described in detail the physiological impact of working a night shift on a psychiatric unit:

I cannot do nights because it interferes with my heart, my heart rhythm and I find that when I do nights I am wiped out for about a week. I'm so tired and my heart then it feels as if it's stressed so I have to be very careful so that I don't put any stress on my heart. . . . After a certain hour in the night, say around 12:00–1:00 when it comes to 3:00 I feel a tension in me. My heart gets very stressed then and it continues because even when I come home and sleep during the day you wake up and you still have that fogginess about you and that went on . . . say a full week until you start feeling yourself again.

Natalie, who experienced depression while working, recalled the impact work-related stressors had on her symptoms: “I knew [the depression] was worse because of certain stressors, . . . what I was actually involved in at that times, . . . [and] certain personalities.”

Interactions

Participants’ experiences practising nursing with disabilities also entailed their interactions with others — patients, students, colleagues, and other employees of the institutions and organizations they worked in. Participants described positive and negative aspects of their interactions, perceptions of interactions, and outcomes. (Table 5.3)

Content Area	Practising with a disability					
Category	Interactions					
Sub-sub category	Negative Perceptions	Positive Perceptions	Positive Interactions	Negative Interactions	Positive Outcomes	Negative Outcomes
Codes	Not understood Unsupported	Supportive colleagues Understood	Asked for help Stayed the same	Unkind Political Disrespect by other Tension Treated unfairly	Benefited relationships Reframed understanding No impact	Feeling Isolated Stereotyped Negative affect on others Stigmatized

Table 5-3 Sub-categories, Sub-sub Categories, and Codes under the Category of Interactions

Negative Interactions

Among the participants of the study a sub-set reported having negative interactions with others in the work environment that they associated with working with a disability. Participant who reported negative interactions did not describe positive interactions as well. A slightly greater number of types of negative interactions were reported than positive.

Unkind. Several participants identified that others in their work environment were unkind in the behaviours towards them. Of these participants, Dorothy spoke the most about experiencing unkindness. She described several instances like the following:

I found that my colleagues would then highlight [my behaviour] to a patient or a family member and then they would say things to me like "Oh, super cracky nurse is on tonight" . . . I thought 'Oh how dare someone say that,' but . . . whoever would say this would chuckle and say "It wasn't said in a negative tone," but the words that they would use to describe you . . . were horrible.

Other nurses described similar direct and veiled unkind verbal behaviours from colleagues:

[There was] on conversation where one of the nurses said to me . . . "how are you going to nurse? Look at you . . . you can't even sit" —Jenny

I told [someone about my depression] who I thought was a friend. And um down the road she just turned her back on me and in a really nasty way. —Blanche

In the case of Sophia, who has been practising nursing for only a few years, the unkindness she experienced was through her interactions with certain professors in her nursing program. She recounted: "A couple of [professor] said, ' . . . if you're not able to make a decision then you're not able to make a decision in that time and a half.'"

Disrespected by Others, Treated Unfairly. Dorothy also recounted instances in which she was disrespected and treated unfairly by her nursing colleagues. She explained

that she was not alone in her experiences; her nursing colleagues tended to treat other nurses whom they labelled different unfairly and with disrespect:

I felt [there was] a lack of respect for people that weren't so-called . . . 'Normal.'

You felt a lot of disrespect from people, constantly. When you knew you were doing so well and trying so hard to do your best and you have team members who are demeaning just because perhaps you're a little bit overly anxious.

I thought it was very unfair. . . . If you [were perceived to have] had a problem, you were always the ones that would be [volunteered to do the hard work]. . . . How dare they not look at seniority. . . . I had had no experience [in these areas they sent me to work].

Tense, Political. Two nurses described in detail the tense interactions between themselves and their managers during the process of negotiating workplace accommodations. Blanche described the tension she experienced after filing a harassment and discrimination grievance against a manager in her organization:

I brought [the hiring policy violation] up at the grievance . . . And he sat there and said, ". . . I never did anything like that. I would never do anything so unethical." So I was stuck between a rock and a hard place.

Although Blanche won her grievance, she relayed that the outcome was less than satisfactory: "The letters [of apology the managers had to write] were "I'm sorry if you felt hurt by. . ." You know, not taking responsibility for themselves." In the same way, Jenny described how the tension involved in negotiating her return to work accommodations led to circumstances becoming political:

There was a lot of talk with my Union Rep and my manager and Occupational Health because I wanted to get back to work somehow . . . some tension developed with my manager . . . then the politics came in because the union rep and the manager don't get along. . . . It became very political and the manager became very angry with me and that became a whole other dynamic of the process. . . . all I knew was that I wanted to get better and I wanted to go back to work and it was becoming heated so um, my Union Rep said, "Whatever you talk to [the manager] about, you record it and you send an email back to re-iterate exactly what you talked about because I don't trust her," and I actually wasn't feeling like I could trust her either.

Jenny recalled that her actions only served to ignite further tension between her and her manager. This tension continued to persist despite time passing.

And so I did that [tape recordings with manager] and it wasn't received well so we had a meeting soon. I had a response from my manager and she said, "First of all: A, second of all: B" so she was angry and at the next meeting-and I didn't know what to do because my Union Rep was saying, "Things are going to change now, because if [the manager] doesn't like what you say it's going to, it could ignite a little bit." So the first meeting I had . . . I was uncomfortable already, and she just stared at me just like this and she was very angry. I could tell. . . . I think she thought that I was trying to throw her into some sort of web and get her in trouble and meanwhile I wasn't.

I used to joke with her all the time. Now when I see her, I am not myself. . . . She is still currently my manager . . . [but]I feel that our relationship completely changed and . . . [I] feel like somehow she sees me as sort of a pain, sort of a hindrance, an inconvenience . . . I've tried to not get in her way at all and so I was even surprised when I did run into her she was quite chummy with me so maybe she's over [it], she's forgotten . . . but I have a definite discomfort now when I see her.

Positive Interactions

Several participants' interactions that occurred in the context of working with a disability were categorized as positive interactions. Positive interactions consisted of interactions in which participants asked for help from others and those that participants indicated had stayed the same during the period of time they were experiencing disability.

Ask For help. Participants discussed asking for and receiving help from their nursing colleagues and other healthcare professionals. Two participants recounted asking their colleagues for help with work. Other participants revealed they came to realize they needed professional help and sought the services of a mental health professional. Natalie described this sense of needing help in the following statement:

I actually ended going to the doctor and saying 'I think I'm depressed' and breaking down. And then from that point um, we put a lot of things in place in terms of initially medication then, and I just said I want everything because I didn't like the way I was feeling so I said I want to try everything so uh, you

know, psychiatrists, psychologists, I just brought everything on board. . . . I had this very strong sense that I needed help. That I didn't know what this was and I didn't know why I was feeling this way but I didn't want to so for me, whereas other people may not go that route, I felt I had a strong sense of 'I need to get help for this.'

Stayed the Same. Two participants commented that their interactions with certain people in their work environment did not change after the onset of their disability. Louise reported that, based on her experiences, her disability has not had a significant impact on her availability to her students. Natalie reported that the nature of her interactions with people in her work environment depended upon whether they were aware she had a mental disability. She stated, “with other people who I didn’t say anything to [about my depression], I don’t think anything changed.”

Negative Perceptions

Participants reported their perceptions about the interactions they had with others in their work environment within a context of practising with a disability. Some of these perceptions were of a negative nature, with several participants describing that they were not understood or supported or both.

Not understood. A few participants discussed a sense of not being understood by others. In Dorothy’s narrative about practising with a disability in a direct care setting, she expressed the sense that others did not understand her disability experience or how she felt when they were unkind or disrespectful:

I feel like the others are aware [that I carry this load of anxiety] and don't understand it.

They had these little names, [for myself and others], so I don't think they realized how we felt as nurses.

Likewise, Louise and Heather expressed the sense the others did not understand their circumstances.

I walk away going 'What part do you not get?' Especially when you're dealing with managers that are nurses... I probably would get more sympathy from somebody that's a non-nurse. ... I think sometimes we [nurses] are too close to the situations, um, and the other thing with. —Louise

You get questions like 'How come you're not better yet?' . . . not necessarily understanding what day-to-day is like . . . kind of almost feeling like you're being trivialized in a way. —Heather

Unsupported. Half of the participants in this study described experiences in which they felt unsupported by others in the work environment in relation to practice with a disability. A few participants expressed that they felt unsupported by their supervisors and other administrative employees. Louise characterized her supervisor as “almost not approachable.” She explained that:

When you're given accommodations and they are not met or they are ignored or they are seen as insignificant, . . . why would I wanna go ask for that? [I had] an assessment done . . . about a chair that would help me get better. Maybe a raised keyboard so that instead of me sitting, bending on my knees that I could stand and work with it. Um, that was ignored. Um, again, my next accommodation was ignored. . . . Why am I having all these assessments done by Occupational Health and for what? So I just felt like everything that I had done to try and make me want to be here was ignored so why would I even approach with something else I found that might help me get through my day?

Florence, who works in the same department as Louise, also perceived this supervisor as unsupportive:

I don't feel that I get support from my chair. In fact, I feel that she's somewhat vindictive about my [schedule]. [W]hen I explain to her that the eight o'clock classes are very difficult and I don't live in the city so it's a long commute for me um, and what do I find but this semester now I have all eight o'clock classes.

Likewise, Heather discussed a lack of support from her colleagues. She described receiving unsupportive comments from her colleagues:

Occasionally I've had the odd comment where 'You better yet?' um, 'Well you should be able to do more because you're walking better' but those are few and far between. . . . I had the one person said you know, 'It's been long enough, why aren't you better yet?' and it was actually quite unexpected. It was someone I don't actually work very often either so I wouldn't say that I have a strong relationship with that person to begin with and um, it was you know, kind of taken aback and surprised.

Another participant, Blanche, noted that she lost friends during her experience fighting cancers and recalled an exchange with a colleague whom she considered a friend:

I went through that year of chemo having lost some friends along the way. I mean, one friend [a nurse colleague] said to me, "I can take you shopping and buy groceries for you, do your housework, whatever, but I can't do the emotional support side." This is a mental health nurse. So, ok, she couldn't do that.

Positive Perceptions

More than half of the participants positively perceived the relational interactions they had with others in their work environments. Participants revealed that their colleagues were supportive and that they felt understood by certain people in their workplaces.

Supportive Colleagues. Half of participants in this study recalled experiences of support for others, namely their colleagues. Two participants indicated that most but not all of their colleagues in their workplace were supportive. Blanche commented that after she returned to work from a long-term disability leave, she had "a fairly decent support system." Likewise, Sondra stated, "mostly I have been fortunate with feeling accepted and validated by my colleagues."

Other participants indicated that they had colleagues that demonstrated their support through the help they provided or the caring behaviour they exhibited. The following comment by Mary exemplified this perception: "my colleagues were wonderful and really supportive and helping me out when they can." Lastly, Sofia, who mostly

discussed her experience while in nursing school, also identified that some of her faculty were supportive during her studies.

Understood. Participants also discussed being understood by others or understanding others or both. Heather discussed her sense that the students she teaches understand her circumstance: “the students are quite understanding, which has been good. I find most of the students are pretty understanding. I can't say I have had any negative interactions with students.” Two other participants described the mutual understanding perceived between themselves and other people with whom they had circumstances in common. Dorothy indicated she formed friendships in her work environment with people struggling with issues like her own. She explained her sense of being understood within this context:

My good friends usually were other nurses that were struggling with issues. . . . It was almost as I stayed with the people who had other issues as well. Other issues, I don't know if I want to call them disabilities, but they had other medical issues so we kind of worked together because we understood. . . . It was almost like we became this exclusive little team.

Comparably, Jenny stated:

There's a certain understanding that people feel when they're back on modified there's a certain understanding I think that people have with others when they're on modified because you go through a huge identity crisis I think because you're suddenly something else. You're not yourself anymore. You're not-yeah.

Negative Outcomes

Participants discussed the outcomes of their interactions with other people in the work environment within the context of practising with a disability. These interactional outcomes fell in two categories: negative outcomes and positive outcomes.

Negative effect on others. Several participants in this study either expressed worry that working with a disability would in some way have a negative effect on others. For example, both Blanche and Rose expressed worry that working with a mental

disability will somehow negatively effect on their patient care. Blanche remarked, “if I’m having a hard time, I lose focus and I miss [something] and I mean it’s not good at all. It’s [about] accountability. . . . There were times when patients picked up on it.” Rose commented that she worried about the indirect affect her difficulty communicating with members of the healthcare team might have on patient outcomes. She explained:

If I can’t clearly be able to communicate what I found [in my assessment of the patient] . . . because of my anxiety, . . . then the decision for the patient . . . isn’t going to be a good decision.

Rose also detailed how her anxiety affects others’ ability and desire to be in relationship with her. She described the dynamic as self-fulfilling, stating:

I might be behaving in a way that seems anxious but I don't know that's what I'm doing and it makes it hard for people to approach me and if they do and I'm anxious I might get even more anxious cuz they've come to talk to me. . . . You're hoping they'll come and talk to you but if they do it's not going to go well, and so I think it makes more stress on other people as well and they just avoid talking to me to make it easier on them, right?

Participants whose work did not involve direct patient care also expressed worry about negatively impacting other people. For instance, Louise, a professor, stated that she worries that the modifications she has made in the way she does her work may bother her colleagues. She provided the following example:

On Tuesday I would only teach [from] 8:00–10:00 and then I was done and then I had the option of I can either stay a bit longer or I can go home. . . . I can work better when I'm at home because I have the ability to lay on the floor. I can't do that [at work]. . . . If I wanna sit for five minutes and get up and move around I'm not bothering people at home versus [in the office] somebody might find that annoying if I stand up every five or ten minutes.

Natalie, who is also a professor, recalled having been worried about how her mood affected her relationships with other people, including her students. She described “having low tolerance” and being concerned that she would cry in front of her students.

She explained: “At that point it was a point where when that kind of overflow of emotion came on me I couldn't control.”

Whereas other participants wondered or worried about the negative effect working with a disability might have on others, Sondra shared her belief that her physical and mobility-related impairment had a negative effect in that they acted as barriers, keeping her from reaching her students. She explained:

Thinking of my career now in education . . . there would be ups and downs depending on the status of my arthritis but there are times when I feel that I'm . . . able to engage in a way that I feel vibrant and there are times when I feel that I am, you know, sitting like a slug on a log and as much as the rest of me is there it is a difficult experience for me personally and it feels to me, and again this is my own interpretation but it feels to me as though it is a much, much harder process to reach students. There is a barrier between us and I think that barrier is me removed from them and it is much harder to overcome that.

Feeling Isolated. Several participants discussed feeling isolated from others as an indirect consequence of working with a disability. Dorothy and Rose discussed the isolation they experienced because their anxiety set them apart from others. Dorothy described being on the outside of “cliques the clique that was supposedly not the depressed one, not the sparky nervous one or the quiet one, overly quiet,” and relayed her sense that she was being purposefully isolated because she did not present as “part of the normal group.” She stated:

So they wouldn't put me and the depressed person in the room. It was almost like I felt at one stage there was some pre-planning going on to ensure that you wouldn't be putting certain people [they had] labelled [to work together].

Similarly, Rose identified feeling isolated because of her difficulty with interpersonal relationships. Rose also described her tendency to withdraw from others in small group settings. She explained:

It's a bit isolating because . . . I see a lot of people don't really have anything like that. They are able to interact really easily with people and it comes naturally to

them. They may work at it, but generally the people I work with are team-focused people so being the only one of the few people that has difficulty with interpersonal relationships makes it-it's isolating.

If [an activity is] something that's just for everybody, that I can do [that] . . . but if it's a small meeting, I can't do it. . . . I mean I could but I wouldn't be-I just withdraw. I'll just withdraw from that. It's part of my anxiety-just staying away [from] authority-type situations.

Two other participants discussed being isolated from others as an aspect of their experience of practising with a disability. Jenny attributed her feelings of isolation to being on modified duties and not being able to do the same work as her colleagues. She relayed an interaction she had with a colleague, which made her feel an acute sense of isolation:

I felt like I didn't belong in that way because someone who's very direct was saying, "Well what are you going to do? Why are you here because you can't really do very much?" and she's sort of a motherly type, but you know, I felt further alienated and I think people don't realize how alienated people feel when they're back, when they're on modified.

Natalie attributed the isolation she experienced in part to the nature of her job as a professor. She explained, "even though we are in arm's length of each other you are still kind of isolated . . . I think a lot of people didn't know I was going through [a depression]."

Stereotyped. One participant, Dorothy, discussed being stereotyped by her immediate colleagues and other people in her work environment. She commented being stereotyped and the impact it has on her.

"[There was a] stereotype about who I was. [I] became this person who is spunky-like, overly conscientious, doesn't take breaks . . . as much as she's conscientious she's not coping or she needs to learn to delegate and trust others . . . I developed this persona that I wasn't aware that I was projecting, which was really hard to live with for years.

Stigmatized. Florence described feeling stigmatized because of the amount of medication she took to alleviate her pain and help her to function. She stated, “there's a lot of stigma around that. A lot of stigma around taking medication and the amount that I take.

Positive Outcomes

Benefited relationships. Three participants commented that their experience of practising nursing with a disability benefited their relationships with colleagues. Both Louise and Blanche described developing a sense of camaraderie with other colleagues with disabilities.

There's a couple of other faculty here who also have disabilities and I think um, it makes us feel that we can share with one another. —Louise

We have one nurse who is going through a depression right now. . . . I have sort of mothered her in making decisions in her interest. . . . And the best way of telling her/showing her was telling her my experience. —Blanche

Sondra described how her disability has facilitated authentic relationships with others in her work environment. She explained:

I have been blessed with good, solid friends . . . I don't feel inadequate in life. I don't feel unable to engage in relationships . . . I relationally experience I think really honest, authentic relationships because you have to take me as I am and I have a greater opportunity to take other people as they are.

Reframed Understanding. The experience of practising nursing with a disability resulted in several participants' reframing their perspective and understanding of their work environment. Mary and Natalie described a change in their perception of the organizational context in which they work. Both identified having a greater awareness of the business aspect of their respective workplaces.

I have to remember that that's our focus [managing costs] and work is work and it's not a place where you know you develop relationships. —Mary

It was a business and had to do with numbers and even though I don't doubt the support . . . think what I realized was that the only person who is out for me was me. . . . It just gave me the, a, sense of "Ok this isn't going to be a kind of a partnership-type thing. —Natalie

No impact. One participant, Natalie, explained that her depression did not have a negative impact in terms of relating to others to the extent that she was able to observe. She attributed this to the hidden nature of her depression and to the fact that she had not disclosed it with many people. She stated:

[My depression is] not [a] on-the-table discussion but I don't get a sense of that in terms of discussions and stuff like that. . . . With other people who I didn't say anything to [about my depression], I don't think anything changed . . . sometimes you don't see certain people until the end of the semester at the staff meeting so they never had a sense that anything was happening.

Exposures

All of the participants in the study described experiences of exposure in relation to practising nursing with a disability. Participants described experiences about the visibility of their disability and disclosing their disability in the work environment (Table 5.4).

Content Area	Practice nursing with a disability			
Category	Exposures			
Sub-category	Disclosing		Being visible	
Sub-sub category	Consequences of disclosing	Decision to disclose	Degree of visibility	Consequences of being seen
Codes	Positive response Negative response	Comfortable No disclosure Reluctant Unsure	Hidden Public	Vulnerable Humiliated

Table 5-4 Sub-categories, Sub-sub Categories, and Codes under the Category of Exposures

Being Visible

Several of the study participants described experiences while practising nursing in which the visibility of their disability was a major factor. Specifically, participants discussed the degree to which their disability was visible and the consequences of it being seen.

Degree of Visibility

Participants discussed the degree to which their disability is visible in terms of being either hidden or public.

Hidden. Three participants discussed that their disability was hidden and could not be easily observed by others in the work environment. Rose described the anxiety she experiences as “a kind of hidden thing” in comparison to a physical disability. She acknowledged that there are advantages and disadvantages to the hiddenness of her disability. Rose explained:

It's not like a physical disability where you can see it and, which is good in a way . . . but I think because it's so subjective . . . unless something's critical it's not going to come up or be a part of um, an employee relation or whatever. It's kind of a hidden thing, right?

I think it adds more stress because [others in the work environment are] not really always sure what's going on with me because a lot of it is inside my head.

Similarly, Florence identified that her disability was hidden and not visible to other people. Florence described the challenges and personal consequences of having a hidden disability:

They believe that I had [the fibromyalgia] from a neck injury when I was four. . . . [It] was not diagnosed until I was in my thirties, which created a lot of difficulty for me because as you know, there's nothing that they can, there's no tests that say yes, you have FM although you can tell now by the tender points. Um, I was diagnosed with it as soon as it went into the diagnostic manual. . . . I had been on and off to doctors over the years and of course they told me there was nothing wrong with me, it was all in my head. My family, my dad thought I was a hypochondriac. Um, it influences me to this day that I will not go to the doctor

unless I know absolutely that I have to see the doctor. . . . So it impacts you know, there's been nothing wrong with me, and I shouldn't be complaining about this pain and I have so much pain all the time.

Dorothy, who has generalized anxiety, described the effort she made to ensure that her disability was hidden from other people while practising as a direct patient care nurse. Dorothy recalled her attempts to hide and suppress any indication in her behaviour that she had a condition that set her apart from other nurses whom she described as “in control and respected.” She stated:

I just always felt that I had to hide from everybody. That I was this so-called high-strung nurse that people just, you know, wanted to avoid me. . . . I just felt that I couldn't be the true person that I was even though I have this condition and tried to manage it medically in the way that I could.

I felt that I had to hide behind a veil of secrecy.

I tried to mask what I had as a diagnosis and lived with it.

Dorothy revealed that her efforts to hide her disability served only to reinforce that she was different from her colleagues:

[When] I tried to behave in ways that the nurses that were so-called in control, respected and were very calm and didn't worry did . . . people thought I was off, so clearly they noticed something was different about me.

Public. Only one participant, Sondra, directly addressed the visibility of her disability. Sondra used the term “absolute publicness” to express the degree to which she perceived her disability as visible. She discussed that although her obesity was visible to everyone she encountered, it was never mentioned. Sondra referred to this circumstance as “an elaborate charade” that was only revealed in very rare situations. She provided this example:

It was inevitable, you know, if I was working in an area with patients with mental health challenges that I was waiting for the moment that they would start talking about how fat I was and you know and it is that publicness of it. The absolute publicness of that and even though you would feel supported in lots of

ways by your colleagues there's no way to get rid of it. . . . I think we all have our Achilles heel and maybe you know, I wasn't the only one but certainly for me it's like pulling off a scab, and the publicness of it. So it is the validation that you are right, that what you think people are thinking really is what they're thinking because here this person is, they're just saying it out loud.

So people-something would make a statement, they would make gestures, they would do something to call attention to your deficit in front of other patients, in front of your colleagues and stuff, in front of the physicians. . . . And it's not that they wouldn't have normally seen . . . so maybe at other times we're all part of an elaborate charade where we don't mention it but in those situations the patient did not follow suit.

Consequences of Being Seen

A few participants discussed the consequences of their disabilities being visible to others while practising nursing. Participants described experiences of humiliation and a sense of vulnerability as a result of this visibility.

Humiliation. Two participants discussed feeling humiliated as a result of their disability being visible or exposed to others in the context of working as a nurse. Mary, a mental health nurse, expressed that she was “mortified” at having asked a colleague for assistance to access professional help for her depression. Jenny recalled the humiliation she experienced as a nursing student, in both the classroom setting and the practice setting, because her private struggle with her back problems was visible to teachers and student colleagues. She stated:

When I came back they were accommodating to me in the sense that I couldn't sit so I could come back but I had to lie down on the ground in the classes so that was kind of humiliating too.

I also had back pain when I was [in placement] and I mean everybody knew too that I had that back pain so socially it was, it was sort of embarrassing because I was seen as sort of a special student.

Sondra shared that on numerous occasions in her career as a nurse her obesity was a source of humiliation. She recalled the following incident that occurred as a nurse working in an Emergency Room:

I think um, [the humiliation] often came at the hands of people who were disinhibited. . . . I remember one time being at the triage desk . . . one paramedic who I had never met before . . . looked at me and said "What are you wearing, pajamas?" referring to my scrubs and they were nursing scrubs but clearly . . . made for a very large woman. I don't know why he thought that was funny but it was humiliating.

Sondra surmised the effect of these humiliations in this way: "For me all I could feel was the sting of that humiliation of having that disability or deficit [obesity] pointed out. Pointed out for everyone to see."

Vulnerable. One participant, Jenny, also discussed feeling vulnerable because of the visibility of her disability. Jenny recalled feeling vulnerable during negotiations for accommodations when she returned to work after injuring her back. She stated:

I was starting to feel a bit vulnerable too, um, because I felt sort of like [my manager] had coerced me around what I should and shouldn't be doing at work. I was so uncomfortable with [negotiating my return to work] and I felt really threatened and intimidated.

Jenny also identified that she felt vulnerable knowing that other people were aware of her circumstances:

I think there's a vulnerability now that they see in me that they didn't exist before, um, and it makes me feel more vulnerable too. It's sort of like I feel like people have been privy to a very private space, um, that was very strange for a big group of people to sort of know about you because people always talk.

Disclosing

All but one participant recounted experiences related to or contextualized by their decision to disclose their disability at work. These participants discussed their decision-making about disclosing and the consequences of disclosing their disability.

Decision to disclose

Participants described being comfortable, unsure, and reluctant to disclose their disability.

Comfortable. Two participants identified that they were comfortable disclosing their disability and related circumstances at work. Blanche stated that she is comfortable disclosing that she has depression but limits the information she provides to others: “Yeah, [I’ve disclosed that I have depression. It was received] fine. But I don’t go on about it. You know, I don’t need to have allies and I don’t tell everybody.” Louise conveyed a high level of comfort with disclosing information about her condition in her work environment. She discussed disclosing to colleagues as well as the students she teaches:

I'm not uncomfortable about it anymore. I just simply tell [students] what it is. I might be having a bad day. I'll be upfront in the classroom and say, "I'm having a lot of pain today so I might be sitting more, I might be standing more.

I'm ok with [colleagues focusing on my disability]. I am, because I disclosed it to them, right. If I didn't want them to know I didn't, but I would rather them know it's a good day or bad day.

No disclosure, Reluctant to Disclose. Many participants stated they chose not to disclose their disabilities to all or some of their colleagues at work. Several participants also discussed their reluctance to disclose due mostly to concerns or fears about the consequences of disclosing.

Several participants reported being careful not to reveal that they had a disability to anyone within their work environment. Dorothy revealed that while practising direct patient care she never told anyone about her disability. She indicated that she took great effort to veil any signs that would give indication to others that she was living with an anxiety disorder. She shared the following cautionary example of what happened when a friend at work disclosed she was depressed:

I would never disclose it to anybody. I felt that I couldn't tell my Manager that I had this condition and that it was medical. . . . I had a friend that was depressed and she decided to disclose that to the team and I think that was the biggest

mistake for her because forever that was it. This nurse was labelled as 'We don't know what she's going to do, she's odd,' 'she won't be able to keep up with the stresses of the shift.' It was almost like if you were depressed you couldn't keep up with [working].

Dorothy discussed her belief that there would have been negative consequences to disclosing such as being made to look incompetent:

I think . . . there would have been consequences because it was a non-unionized organization and I feel that if I had come out and been honest with my Manager [about my anxiety disorder], I think that would have been piece for her to work, to build a case even though I was safe with patient care and super conscientious but take it in a direction where I would have been labelled as incompetent from many other ways.

Rose indicated that despite the isolation and stress she experiences, she has never disclosed to others in her workplace that she has interpersonal anxiety. Rose stated that the only person she has told is her manager. She explained:

It's only in the last six months that an issue came up and I did talk to my boss about it and mentioned that I had an anxiety problem and that I was getting counselling so that was the only person I've ever told that I work with.

Two participants indicated that since they began practising nursing, whenever possible, they have refrained from disclosing their disability. Sophia revealed that she has not disclosed to any of her managers or colleagues that she has a disability. She was adamant her disability did not have an impact on her practice and questioned why others at work would need to know this information. She stated, "I didn't say anything. I just worked and no one knows anything. . . . No one has issues. [I] just forgot about it and moved on. . . . No [nobody knows], why would they know?" Sofia also indicated that her experiences as a nursing student have influenced her decision to not disclose her disability. Providing an example, she stated:

I wrote [the RN exam] and I passed it without even identifying that I needed extra time because the reason why I didn't want to see anyone to think that um,

“We don't want to give her a license because she needs extra time.” . . . cuz of what I was told in first year.

Similarly, Jenny shared that she did not disclose the problems with her back when she began working as a nurse: “I just said I don't have a back problem and I never declared anything. . . . I never declared anything when I started working as a nurse.” Jenny recalled that after she injured her back during an exercising class she did not immediately disclose her history of back problems when reporting the injury to her employer. And after moving to a different unit where she was not known to others, Jenny stated she did not reveal any details about her history of back problems:

I had never really talked ... about what had happened a long time ago [with my back] because I didn't want people to know about it.

I did say I hurt my back but I didn't elude to any history. I just said, "Oh I hurt my back but so I can't make the..." but I didn't um... I haven't shared that.

Jenny's reasons for not disclosing information about her back problems have been different at different times in her career. As a new graduate nurse, Jenny stated she “withheld” information about her back problem because it “might limit job opportunities.” She explained her reluctance to disclose her disability in recent times in this manner:

[I] never said anything to anyone [in the new work environment]. I think I had had enough of the problems with my back in the workplace before and I just thought I don't want to go there again.

Both Helen and Louise discussed their reluctance to disclose about their disability and how they only did so under certain circumstances. Helen indicated that while she did not volunteer information, she told people when they asked her about what she was experiencing. Similarly, Louise stated, “I have to expose myself out there so

something I don't want to have to share with people [but] I sometimes have to because it's so unique.”

Other participants described being very selective in their choice of whom they disclosed to at work. Blanche, Mary, and Natalie identified that they did not discuss their disability with certain colleagues or their supervisors. Natalie expressed that she was reluctant to disclose to her supervisor because she was uncertain about how it would be received: “I just didn’t know how it would be received. . . . I just didn't know how [my supervisor] would react or just the idea of having the conversation and it was just too much.”

Unsure. Natalie also described being unsure about whether she should disclose to others. She recounted the thoughts and ideas that she grappled with as she tried to decide whether to disclose to others including her manager.

That was different in terms of, where I pretty much see myself as . . . talking to everybody about everything, I started to kind of [question myself], 'Well do I really want to put this out there with my Chair? What would that mean and how would that impact my work?' . . . I usually don't go there in my thinking but that was a time where I did kind of wondering . . . ‘do I say anything? How will people see me? How will it impact my job, my job security?’ You know, ‘what will that mean moving forward?’

Consequences of Disclosing

Several participants who recounted experiences about disclosing their disability also discussed the consequences of disclosing. These participants identified both positive and negative responses to disclosing.

Positive response. Three participants described that colleagues and others at work responded positively when they disclosed their disabilities. Blanche and Natalie reported a few of their colleagues responded by disclosing to them that they had a similar disability.

I disclosed to some of my peers, couple that I was closest to. And I mean, two of them said 'Oh, I'm on anti-depressants too, I'm on anti-depressants now.'
—Blanche

I did end up telling some colleagues and it's really interesting because even probably the couple of colleagues that I talked to actually you find out that other people have suffered with depression. —Natalie

Natalie commented that this mutual disclosure provides a sense of support in the workplace:

[It] was good because then it meant that there were people to connect with. Not that we talk about it or anything but it just becomes almost like a-people having other peoples' back and you know, just keeping an eye out for when moods start to change that maybe somebody needs a little support.

Louise remarked that disclosing to some of her colleagues was easy because they are nurses. She added that the response of her students has also been positive: “Some of my colleagues, it was easy enough. I mean, we're nurses. We should have some kind of understanding about pain and chronic pain.”

Negative response. Two participants described instances where others at work responded negatively when they disclosed they had a disability. Blanche, a mental health nurse, described the unanticipated negative response she received from some of her colleagues:

I felt that there was such a push on the destigmatization on mental illness. Ok, I'm a mental health nurse, I have this chronic depression, I can function, I can tell people. Wrong. Because it came back to bite me.

I think that working in the mental health profession and feeling that I was alienated because I was open about having chronic depression was just deplorable.

Sofia's experiences of negative responses to disclosing her disability occurred while she was a nursing student. Sofia provided this example of the type of response she received

from some of her nursing professors: “They [said], ‘you shouldn't be in nursing school if you have that.’”

Perceptions of Others

This study asked participants about their perceptions of others’ views relating to their practice as nurses with disabilities. In this section, descriptions of participants’ perceptions of how others view them and their ability to practise are presented under the following three categories: uncertainty about perceptions, perceptions about competence, and perceptions towards person (Table 5.5).

Content Area	Perceptions of Others				
Category	Perceptions about Competence	Perceptions towards Person			Uncertainty about Perceptions
Sub-Category		Attributed Characteristics	Feelings and Attitudes	Behaviour Towards	
Codes	Good Do more Positively No problem No change Not good enough Different	Thorough Reliable Tense Unpredictable Knowledgeable Good communication Controlling On the go	Valued Respected Understanding Nuisance Not coping Judged	Tread lightly Hard to approach Protective Concerned Wondered	Hard to say Uncertain

Table 5-5 Categories, Sub-categories, and Codes of Content Area: Perception of Others

Uncertainty about Perceptions

Uncertainty about perceptions comprised of participants’ difficulties perceiving the views of others or their uncertainty about how others perceive them or both.

Hard to Say. Although all of the participants in the study provided comments and opinions about how others perceive them and their nursing abilities, a few initially

responded that it was “hard to say,” they “can’t really say,” or “did not know.” Sophia, an emergency and critical care nurse, made the following remark about the subjectivity of the question posed: “Un I donno . . . It's very hard to say about how someone else views [my ability to work as a nurse] cuz . . . it's my opinion basically.”

Uncertain. Two participants stated that they were uncertain about how others, particularly their administrators, perceived them and their ability to practise as nurses. Mary discussed her uncertain about the veracity of her belief that her medical colleagues and the manager thought she was incapable of doing the work of a nurse:

I'm more, I guess, aware of how the administration or medical colleagues . . . interact with me and I could just be hyper vigilant about it. . . . I don't know if it's that I perceive them to believe that I'm not capable. . . . I don't know if someone is checking up on me. . . . I think if that were to happen now I think I would interpret that as negatively in terms of again, are they checking up on me? Do they not think I'm able to do this or able to get back to work fully?

In a similar way, Natalie expressed that while her sense was that others perceived her positively as a person living with depression, she was still uncertain to a degree that she would not openly engage others to directly discuss her depression. Natalie identified her supervisor as someone whom this uncertainty applied to. Natalie explained:

I would still not entertain a conversation with my chair because I still don't know, even though there's no evidence of it, . . . there's just always something in the back [of your mind] . . . because you just see in society how . . . people with mental health issues or diagnosis are treated or are perceived and there's always just at the back of your mind, you know, there's nothing in evidence in front of your face, . . . [but] you just don't know.

Perceptions about Competence

Perceptions about competence consisted of participants’ beliefs about how others viewed their ability to practise and the practice-related characteristic they attributed to them.

Good, Do More. Several participants reported the perception that others viewed them as good nurses with strong nursing abilities: I think people know that the quality of my work is usually good. This comment by Heather is representative of the perceptions held by other participants. Heather also commented that she perceived that her supervisor thought she should do more. As Heather put it, “I think she knows that I do good work but . . . I think it's more [to do] with the quantity . . . rather than the quality piece.” Dorothy asserted that some certainty that her colleagues knew she “was a good practitioner.” This is despite the many interpersonal problems and issues between Dorothy and her co-workers.

Positively. Participants also stated that they perceived that others thought positively of them as nurses. In addition to her overall appraisal that others view her as an “exceptional nurse” or a “good nurse,” Sondra indicated her belief that in the context of her past practice in direct patient care, and her current practice in education, others such as her students would positively assess her abilities as a nurse. Based on her interactions with others in the work environment, Natalie expressed her sense that others’ perceptions of her were positive: “My sense is a positive one. Well at least that's what I'm getting from people because I'm still, you know, there's still accessing me, they're still asking my opinion.”

Don't See. Some participants believed that the perceptions others in the workplace held about their abilities as nurses had not changed because these individuals don't see or are unaware of their disability. Natalie and Jenny based their perception on their observation that colleagues appeared not to have an awareness of their disability or knowledge about their past. Natalie stated:

I don't think it impacted a lot of people's perception of me . . . because they didn't see me going through the changes. . . . Even if I was emotional talking

about the stresses at work and that, it was more of a commiseration . . . I don't think they picked up on the impact.

Similarly, Florence and Louise identified the invisible nature of their disabilities as the reason for their belief that the perceptions of others about them had not changed.

Florence stated: "They don't see me as having a disability. I think that's probably more unless I'm limping." Florence also revealed that she makes an effort to manage this perception that her abilities as a nurse remain unchanged:

When my knees are really bad um, I try and make it so that they don't see it . . . because I don't want them to think I'm not carrying my load. That I'm hypochondriac and there's nothing really wrong with me and I'm just faking.

Louise expressed her sense that her supervisor chooses not to see her disability and, therefore, perceives that her ability to the work is the same:

I think [my circumstance is] just completely put in the back of the mind. . . . I'm a functioning person of this team. . . . That's all that matters at the end of the day and too bad if you suffer.

No Problem, No Change. Among participants working in environments where others were aware of their disability, several reported the belief that others had no problems or issues with their abilities as nurses.

I think [my nursing colleagues] think I'm ok when I'm working with them.
—Jenny

I understand what it means to be a nurse and I can convey the content in a way that makes them understand nursing so my credibility piece with [students] has not been an issue. —Heather

Heather also maintains a belief that in terms of the quality of her work, the perceptions of her colleagues and students have not changed since she has been practising with a disability.

Lastly, Mary explained how she arrived at the perception that her nursing colleagues had no problem with her abilities as a nurse:

I've actually asked [my colleagues] flat out and I don't know if they would tell me to my face, but I asked if they were concerned about my ability to practise and whether they felt the need to be concerned I guess in that way and the individuals that I asked they said 'No,' and if there was anything they were concerned about to let me know, which is great.

Different. A few participants discussed their perception that others, such as their colleagues and patients, viewed them as being different from themselves and other nurses. Rose revealed her perception that her patients view her as different from the other nurses in the clinic where she works and might, therefore, prefer her colleagues to her. She explained:

“My personality is much quieter and I'm not as outgoing and [other nurses] might be more approachable and outgoing and maybe more fun but the care would be the same but [patients] might have more fun or something.”

Dorothy and Jenny discussed the identities that have been ascribed to them because of their experiences practising with a disability. Dorothy believed that her nursing colleagues unfairly viewed her as different because of her inconsequential behaviour in the work environment. This was a source of significant frustration for Dorothy who remarked, “I should not be perceived as sparky overly compensating for her inabilities to relax.” Jenny spoke in length about her identity on the hospital units where she was working when she had a back injury.

“My identity is very strong as far as back problems goes on that particular unit. . . [The nurses] still ask me [about my back problems] if I haven't seen them for a while.”

I think I'll always be known as somebody that has a chronic physical problem so people will often-sometimes I'll just forget about it but then people always ask, "Oh how's your back?" I think now they remember me as having a back problem.

Not Good Enough. Two of the participants described a sense that others perceive their nursing abilities as not good enough. Jenny stated that she worries that her professional colleagues may think she is “not a complete package” as a team member

because of her back problems. Sondra explained her belief that others may perceive her as not good enough in this way:

The world doesn't like fat people and there is some sense of not being the right person to be on show. . . . I remember an event where I was receiving an award. . . . My biggest concern being . . . [was] how was I going to be able to make up the stairs without a hand rail. . . . at this moment that should have been a wonderful moment where I felt pride and satisfaction I just felt sick thinking 'Let me get through this. How am I going to get through it?' and 'let me get through it.'

I remember one time being overlooked for a promotion and someone much less capable being offered that job and who knows if that had anything to do with [my weight and] . . . me being seen as unsuitable or not the best candidate for something that I was clearly the most suited for.

[In my old work environment there was] that feeling of knowing that you weren't good enough . . . [that] there is something wrong with you.

Perception Towards Person

Perceptions towards person comprised participants' thoughts about others' attitudes and feelings as well as their treatment and behaviour towards them. These perceptions fell into three categories: attributed characteristics, feelings and attributes, and behaviour towards.

Attributed Characteristics

Four participants identified one or more characteristics that they thought others would ascribe to them. In all instances, the characteristic(s) identified by a participant was consistent with their belief about how others perceive their nursing abilities.

Reliable, Thorough, Tense, Unpredictable. Consistent with her perception that others viewed her as competent yet different from themselves, Rose expressed her belief that her colleagues and supervisor would describe her as reliable and thorough, but at times tense and unpredictable. When asked to share her thoughts about how they would describe her as a nurse, Rose responded:

Conscientious . . . and meticulous and detailed but um, a little unpredictable and maybe just a little bit on the tense side. . . . The care that I provide when [patients are] with me is complete. I guess . . . that's reassuring to them probably that they know that I will go and do what I am supposed to be doing, so reliable in that way. . . . [*what about your boss or immediate supervisor?*] The same as others. Uh, just reliable probably and um, but a little bit unpredictable and tense in situations as well. Like, not knowing if I'm going to create more tension and conflict. . . . Depending on how much anxiety it is, it could change the amount of tension that I add to a situation or not. . . . They probably say 'Oh well, mostly it's going to be more tension but on occasion it may not be so it's unpredictable in that way.

Rose also expressed the belief that her patients may perceive her as tense: “[Patients] might not be able to relax as much as with the other nurses. A little more tense so maybe harder for them.”

Knowledgeable, Good Communication, On the Go, Controlling. Similar to Rose, the characteristics that Heather, Sophia, and Dorothy stated were ascribed to them by others were in keeping with their own beliefs about how others perceived their ability to practise nursing. Heather stated that her students would perceive her to be “knowledgeable.” Sophia shared her perception that patients she provided care to would say that she was a “strong, good communicator” who worked to inform them of the care they were receiving. Finally, Dorothy stated that her former colleagues and manager would likely perceive her as different because of her behaviour, describing her as “on the go” and “controlling.” She explained:

Maybe I was perceived to be a little-I don't want to use the word bossy-but a little controlling with the care.

I think they would put me in assignments that required a lot of tasks . . . because supposedly I'm always on-the-go.

Feelings and Attitudes

In their response to questions about how others viewed them and their abilities as nurses, participants also shared their perceptions about others' feelings and attitudes towards them.

Valued. Participants expressed their sense that their colleagues valued them. Four participants spoke about being valued in the context of being a part of a team or group of professionals. The following comment by Sondra exemplifies what participants stated about this perception: "In my current practice again, I would probably say the same, um, validate-I feel validated, I feel value."

Respected. A couple of participants perceived that others respect or have a respectful attitude toward them. Each participant provided examples to support their belief.

I think I feel respected . . . Twice I have done [a] presentation on my experience . . . as a young grad. . . . The first time I did it, [our Nurse educator] said 'Oh my God, you should have seen Judy's [a nurse] eyes! They were so big and her mouth was open," because I saw insulin coma and unmodified ECT and um, that kind of stuff. — Blanche

I think [my students] would see me very positively and I think they would be respectful and appreciative. I think for me part of that is about choice—that I make choices to be honest and to be fully present and to be as authentic as I can be in my engagement with them. . . . I think I do my very best to create opportunities in being different myself, creating opportunities for them to express who they are without having to make excuses or apologize. — Sondra

Understanding. One participant, Heather, perceived that her colleagues and students have an understanding attitude towards her and the changes in her ability to do her job. She stated:

I think it's only from the physical point of view, that you know, that I can't necessarily do the lab piece and the clinical piece. I find that my colleagues understand why I can't necessarily do that piece and the students usually understand that piece as well.

Nuisance, Not Coping. Two participants expressed that others in their work environment held negative attitudes towards them. Jenny revealed her belief that her manager felt she was a nuisance because of past circumstances. Jenny explained:

I think [my manager] thought I'm just a big pain in the butt. I'm just-I felt like an annoying little pipsqueak. That's what I felt she thought I was. . . . When I wasn't getting better or when she wanted me in the hospital doing filing then, and then it didn't work so well, I was a huge inconvenience.

Dorothy provided an example that highlighted her belief that her former colleagues thought, albeit wrongly, that she was not able to cope with her workload: "If they want structure and efficiency on the unit, but if I choose not to go [on my breaks] I should not be perceived as not coping. That is completely wrong."

Behaviour Towards

The responses of several participants about their perceptions of others' views of them and their practice also included interpretations of others' treatment and behaviours towards them.

Wondered. Two participants expressed the sense that others such as their colleagues and patients wondered about them and their abilities as nurses. Helen expressed her sense that because of the changes in her physical appearance and her behaviour in the workplace, both her colleagues and patients must have wondered about her and her ability to do her work. Similarly, Mary discussed her perception that patients probably wondered about her because of the modifications to her workload assignment.

I've only had two patients in compared to you know, everybody else who has a fuller load, but I haven't been asked about why that's the case and I actually haven't thought about what I would say but . . . if I were a patient I would wonder why does that particular nurse only have two patients.

Concerned, Protective. Participants perceived that the way their colleagues treated them indicated they were concerned about and protective of them. Louise

commented that her colleagues who were aware of her situation showed interest in her wellbeing that was beyond the everyday pleasantries she was accustomed to. She explained:

I would have to say that [my colleagues] have concern for me, not that they didn't before, but because they are aware of the situation. [Concern] takes over sometimes. . . . previously [my colleagues] would [be] like, "Hey, how are things? How's it going?" in general, but they're more specific. Like, they really put an influence on their wording to me.

Helen recalled that her colleagues were forthright in making their concerns known. She provided this example: "One day my colleague came and she was concerned because [she said,] 'You don't look well and you're still coming to work,' so they were concerned."

Lastly, Mary shared that, although she initially questioned whether her nursing colleagues' behaviour towards her signalled they did not think she was competent, she has come to the conclusion that they were demonstrating their concern and desire to protect her. She explained:

[My colleagues are] checking in, . . . asking me several times whether 'Are you sure you want this complex patient?' or 'Are you sure?' or 'Do you need help with A, B, C and D?' and I have to remind myself that . . . it's coming from a place of concern. That it's not about them questioning my ability or questioning my competency.

I don't know exactly how to word it but there are times when I feel like I'm being babied. So I feel like they are trying to protect me from becoming overwhelmed.

Treads Lightly. One participant, Blanche, expressed the belief that her manager "treads lightly" with her. She proved the following explanation.

[I] let her know that I was the unit rep for [the union] and that the nursing staff are really becoming conversant with the Collective Agreement. . . . She had been denying overtimes to people so I just let her know [I would grieve it] and I did encourage others you know, if you're denied, grieve it.

Hard to Approach. One participant shared her belief that patients in the clinic where she worked might perceive her as hard to approach because of her personality and anxious demeanour.

[Patients] might find it hard to approach me on certain things . . . - maybe some of their emotional issues. They maybe find it hard to open up to me. — Rose

Judged. Another participant shared her belief that certain individuals within her workplace would judge her if she discussed her mental illness with them.

There's probably some other people . . . [who] would see [my diagnosis] as an excuse . . . So I think there's a couple of people I wouldn't have the conversation with. — Natalie

Summary

This chapter presented the findings of an in-depth, semi-structured interviews of nurses with disabilities regarding their experiences and perceptions related to practising nursing. The raw narrative data of descriptions of experiences, feelings, statements, and opinions were organized into a categorical system structured at the broadest level by the research question and the areas explored in the semi-structured interviews conducted with 12 participants.

Although the specific details of the experiences reported by participants were unique to their circumstances, many commonalities exist. Participants described experiencing changes in aspects related to their work life, their reactions, and their emotional, cognitive, and physical embodied responses to practising nursing with a disability. Many participants also described and discussed relating to others in the workplace within the context of working while experiencing disability. Participants described positive and negative interactions, perceptions, and outcomes. Lastly,

participants' narratives included descriptions and discussion about being visible and disclosing in the workplace.

The findings of this study also included participants' thoughts about how others perceived them and their abilities to practise nursing with a disability. Participants shared their thoughts about how others perceived their ability to practise, and their characteristics and quality as nurses. Participants also discussed their perceptions of others' feelings, attitudes, and behaviours towards them.

The next chapter continues the presentation of study findings with a description of participants' perceptions of factors influencing their ability to practise.

Chapter 6: Findings – Barriers and Facilitators of Practice

Introduction

This chapter presents the remaining content areas of the findings of in-depth, semi-structured interviews of nurses with disabilities about their practice. The first section of the chapter presents the barriers to practising nursing described by participants. This is followed by a section presenting the facilitators of practice that were identified and discussed by nurses. Lastly the chapter concludes by presenting the final thoughts shared by participants at the end of their interview conversations.

Barriers to Practice

In this study participants were asked to describe any barriers they perceived to have had an impact on practising nursing with a disability. This section presents descriptions of the barriers participants identified and discussed. Participant descriptions of barriers to practising nursing with a disability are organized into three categories: the nature of their disability, the nature of nursing work, and workplace factors (Table 6.1).

Nature of Disability

Barriers related to the nature of participants' disabilities were further grouped under the categories of mental embodiment, physical embodiment, and person-environment interactions.

Content Area	Barriers to Practice					
Category	Workplace Factors		Nature of Disability			Nature of Nursing Work
Sub-category	Workplace Culture	Interpersonal Interactions	Person-Environment Interactions	Physical Embodiment	Mental Embodiment	
Codes	Stigma Physical environment Lack of accommodation/interventions	Poor treatment Lack of knowledge Negative attitudes	Hiddenness Fatigue Limited in work	Pain Physical impairments	Anxiety Symptoms of Depression	Physicality of work Variability Isolating Always at their ready

Table 6-1 Categories, Sub-categories, and Codes of Content Area: Barriers to Practice

Mental Embodiment

Several participants with mental disabilities identified their experiences of anxiety and depression as barriers to practising nursing.

Anxiety. Two participants commented that the anxiety they live with acts as a barrier to practising nursing. Both Dorothy and Rose described the ways in which their anxiety impacts their ability to work and carry out their duties and responsibilities. For example, Rose stated that her anxiety “makes it hard to get decisions made [and] to get the right care” for her patients. She added that her anxiety was a barrier to being able to communicate effectively. Dorothy spoke extensively throughout her interview about the difficulties she experienced working because of her anxiety. For example, she stated:

I always feel like maybe with anxiety disorder, no matter how much I watch, it gets in the way of me seeing something that might be coming and dealing with it effectively. . . . So I've learned that I have to be very-To be supervigilant and super worried all the time is not a good thing. I shouldn't say super worried but worried frequently because then sometimes you can't cope with bigger problems and that is something that I have learned to say 'Ok, refocus today,' and I think that is where the focus comes in.

Symptoms of Depression. Two other participants identified the symptoms of depression they experienced as barriers to practising as nurses. Blanche, who has been

living with depression throughout her nursing career, described the intersections between her disability, personal life, and her practice as a nurse.

When [my husband] and I were going through some adjustment difficulties and I was down [in the city] working and I was feeling very overwhelmed I was just like 'I can't go in and do my shift, I can't,' and so I was taking shifts off... yeah so sometimes I get scared when I get overwhelmed, um, and so the first thing that the depressed/disability does is make me want to run. You know, fear-fuck everything and run.

Blanche also spoke about how living with her disability over time has changed her in the context of relating to others within the work environment.

I'm not as outgoing as I used to be, and whether it's through the process of struggling with depression off and on for such a long time and you know, not wanting people to see when I'm depressed.

Similarly, Natalie identified the symptoms of her depression as a barrier to practising nursing. She explained:

It was the actual symptoms of the depression that were the biggest barrier to practice just in terms of, again, not concentrating, not focusing, not being able to um, control my emotions or how I was feeling so I think that became a focus so that took away from any energy or focus that could go into teaching so I think students at that time got a very basic. — Natalie

Physical Embodiment

Pain and physical limitations were identified as barriers by participants with physical disabilities.

Pain. Two participants discussed the impact of pain on practising nursing. They stated:

For me it's the unpredictability of chronic pain. There's days where I feel really good and then there's days where I get up in the morning and go 'I'm not even out of bed' and I know I have to be there from the time I get ready, commute an hour and a half and I would stand here for six hours and then do another hour-and-a-half commute home. It's-I'm almost a write-off for the next two days so then that impacts the next couple of days so I kinda like grin and bear it. — Louise

A lot of that standing can really hurt and just fatigue-wise... I do think I'm way more exhausted since I hurt my back...at the end of a shift I'm now in a fair bit of pain. — Jenny

Physical Impairment. One participant described the impact her physical limitations have on her ability to meet the physical requirements and demand of her nursing practice as a professor.

The physical is the biggest barrier that I have. So for me it's the standing, the walking, the lifting, pushing, pulling. So a lot of the physical acts that would be essential to taking care of a patient or doing work in an environment that simulates a patient setting so the physical is a big barrier. But even in terms of physically getting to my classrooms. Sometimes when I first started it was a bit of a physical challenge to get from one side of the building to the other. — Heather

Person-environment Interactions

Participants identified the interactions between their embodied experiences and the environment as barriers to practising nursing. Participants identified three person-environment interactions: the hiddenness of disability, fatigue, and linked in working.

Hiddenness. One participant identified the hiddenness of her disability as a barrier to practising nursing because it limited the amount of support and resources available to help facilitate her ability to work. Drawing comparison with visible disability, the participant explained this person-environment interaction in this way:

If you had to be a nurse and you had to work on crutches or something, the workplace would make some accommodation for you coming to work with adjustments...it may not be the perfect situation but there would be some supports in place but with something like anxiety there isn't really anything even though it's just as present in my mind . . . So, I guess I could take medication but there's nothing really in place ... I'm not suggesting in any way that . . . a physical disability is better than mental disability. It's just that there's nothing really in place to [support those with mental disability]. — Rose

Fatigue. One participant identified that the fatigue she experiences acts as a barrier to practising nursing. Heather explained that her fatigue resulted from working

with a physical impairment, which, in turn, made it difficult to continue her duties and responsibilities at work:

“fatigue can be a barrier as well because it can really [have an] impact on focus and concentration and just needing more breaks than usual sometimes can be a problem.”

Limited in Work. Two participants identified that the nature of their disability together with the nature of their work impeded working, which, in turn, was a barrier to practising nursing. Heather commented about the limitations in her nursing practice and the impact on her identity as a nurse. She explained:

I can't do patient care and that's a big part of the identity piece for me as a nurse. I can't go and take care of somebody who's sick in a hospital but I could still probably do nursing in a certain context where there's not as much of a physical demand but as a nurse you identify yourself as being able to be the caregiver and I don't want to be in a situation where the patient feels like they have to take care of me.

Similarly, Jenny discussed the emotional effect of not being able to do all that is required of her as a nurse because of her back problems. She stated:

Nurses are naturally taught to work as a team, to help out any patient that needs help and . . . all the sudden so you can't help out like you would like to. You can't be doing the same thing, you can't help another nurse. . . . So you can't work as a team very well when you're on modified duties or when you, when it's acknowledged that you have an impairment. It's tough. It's very tough. . . . I mean if I cannot have a heavy patient I think it's a definite barrier.

Nature of Nursing Work

When discussing perceived barriers to practising nursing with a disability, participants also identified aspects of the nature of the nursing work they were doing.

Physicality of Work. Several participants described the physicality of nursing work as a barrier to practising with a disability. Although the physicality of nursing work varies depending on the domain of practice, it was identified as a barrier by participants with practice experience in both direct care practice and education. Sondra described

how physically dependent her direct-care practice was and the challenges it posed because of her disability.

I think the challenge is the physicality of direct nursing practice and ...[the] many challenges that are related to that. I'm not sure how you overcome them in the kind of practice are that I worked in. . . . It means being on your feet for twelve hours. That you end up inevitably being the one pushing the stretcher over to X-Ray because there's not somebody who can come-it means that having to do the physical things as much as everything else. Many of which are typically defined within your job but fall within the "and/other activities as required."

Participants employed as educators in post-secondary institutions discussed the challenges they experienced due to the physical aspect of their jobs. For example, Heather stated:

The physical is the biggest barrier that I have. So for me it's the standing, the walking, the lifting, pushing, pulling. So a lot of the physical acts that would be essential to taking care of a patient or doing work in an environment that simulates a patient setting so the physical is a big barrier. But even in terms of physically getting to my classrooms. Sometimes when I first started it was a bit of a physical challenge to get from one side of the building to the other.

Variability. Blanche, a mental health nurse who lives with depression, identified that the day-to-day variability associated with her job as a mental health nurse was a barrier to practising with a disability. Blanche described the impact shift work and a frenetic work environment has on her state of mind:

I do need more of a routine and I think age is part of this too. I couldn't be bouncing between two different shifts. The only time I make myself available for days is on the weekend. I think to work days Monday to Friday anytime, even one of those days, the chaos would just overwhelm me so that's where I avoid as opposed to rise to the occasion. That's how I protect myself.

Isolating, Always at their Ready. One participant identified that the isolating nature of her work as a professor was a barrier to working with a disability. Natalie described the independence afforded by her job as a hindrance because if she met basic requirements of her job, her depression could go unnoticed. She explained:

Nursing role is independent and isolated so even though . . . I'm in an office interacting, you know everyone's doing their own thing so nobody really has a sense that-there's nobody checking in whether it's from-not necessarily how are you doing emotionally but nobody checking in to see you know, where's the work up to this point . . . and that's a good thing for a lot of people, [but] that's not what I want. I guess it's a sense of 'Does anyone really care?' like, hello, what am I doing this for? I think because there is nobody checking in and could a long period and be in the depression but not have it really be seen because nobody's even looking at the work I'm doing and as long as I could hold it together enough that at least I didn't have any impact for students. — Natalie

Natalie also identified that, as a nurse and regardless of whether you were involved in working with patients or students, “you always have to be kind of at their ready . . . and do that in a way that is kind of compassionate and understanding and together and on your feet.” To Natalie, these performative aspects of nursing practice were barriers because they “meant there was no real down-time.”

Work Environment Factors

Several participants unequivocally stated that factors related to their work environment in some way negatively impacted their nursing work. They discussed barriers related to the culture of their work environments and interpersonal interactions within those spaces.

Interpersonal Interaction

Poor Treatment. Two participants identified the poor treatment they received from others in their work environment as a barrier to practising nursing. Both individuals became emotional as they recalled their experiences. Helen expressed disappointment with how her manager treated her during the period she was ill and continued to work: “[He] never said 'how are you doing? You don't look so well. What's going on? And perhaps we can have a talk about it, you know, as a support.’” For

Dorothy, talking about the poor treatment by her nursing colleagues brought back strong emotions she had compartmentalized. She stated:

I just wanted to say that I've learned to bracket this world so if I wasn't making eye contact with you it's because I was living this world again. ...I just wanted to tell you that I was reliving it all again and just to show you how powerful that is, those images in my mind and the name calling.

Negative Attitudes. One participant identified the negative attitudes of others in the work environment as a barrier to her practice, noting that she hides her pain and pushing herself beyond what she should be doing for fear of being perceived as not contributing enough:

You know, [the] attitude of your colleagues, [the] attitude of your bosses. If you have physical disability and [then it's] are you using that to get special attention or are you using that as a way to get out of doing certain jobs and I can guarantee that's what my chair thought when I had told her that I don't like doing clinical. ...I think that she saw that me using my arthritis as a way to get out of it and that bothers me.

Lack of Knowledge. Another participant identified lack of knowledge as a barrier. Speaking of her experience as a nursing student, Sofia expressed her belief that her professors' lack of knowledge about disability contributed to the challenges she experienced during her education. She explained:

I think it's the lack of knowledge people have and if they don't have enough knowledge to know that people can still be successful with this then they can still do it, you just need to support them.

Workplace Culture

Stigma. Stigma was the most commonly identified workplace culture-related barrier. Although only a few of the participants specifically named stigma when asked about barriers to practising, all participants directly or indirectly brought up the topic of stigma in the course of their interview conversations. Stigma was mostly identified by participants with non-visible disabilities. Rose, who lives with anxiety, stated:

There's some stigma around admitting that there's an anxiety problem and having some sort of way to work that into the type of care that you provide or the type of assignments you get or the type of projects you can do.

Mary, a mental health nurse, discussed the role self-stigmatization played in her experiences practising with a disability. She also pondered the role mental health stigma played in her interactions with her manager.

Some of the barriers or at least is the stigma surrounding mental illness. I know for myself that was a barrier for me. I mean, I'm a mental health nurse, not that I shouldn't have mental health issues but that I should be able to overcome them and so that took me a while and that was a barrier for myself and I think I'm not sure if that's um, I don't know, what is going on with my manager. I don't know if she thinks is going on with me, but I wonder if there's you know, a stigma around individuals around mental illness and them working in this particular environment and so I think that that's one of the main barriers that I can see.

Jenny echoed a similar sentiment in stating, "I think there's a very broadly generalized stigma, you could even say, around people who are on disability [leave]." She also discussed the impact of being labelled as someone with a disability. Jenny explained why she is often reluctant to disclose that she has a back problem during the course of her work as a nursing instructor in a clinical setting:

I don't publicly identify with that [disabled] label. . . . Actually delving down into that [it's] probably because of the stigma attached . . . I guess when I think of the term disability it's more of a, sort of a formally recognized status, you know, where it affects the type of job you might have or the benefits you might have or parking in different parking places. That type of thing so that's probably why I guess it's my association with the label.

I make sure to not feel too free to talk about it [back problems] in the first while [with students]. I think I have let my guard down a little bit um, maybe the last week or second last week I felt ok to [share] . . . because I think 'Well, it's the end' (laugh)

Physical Environment. Two of the participants with physical disabilities discussed the challenges they face due to the physical environment they work in. Both participants worked within the same physical space and described problems with the

design of these spaces. For example, Heather commented that, “barriers for me can be for me things like an ... auditorium room [in which] ... there's no railings to go up the stairs.”

Lack of Accommodations/Intervention. Other participants identified the lack of accommodations or interventions related to disability as a barrier to practising nursing. Participants commented on the lack of supportive resources and accommodations in their work environments such as being able to work shifts that facilitated optimal physical functioning.

[What comes] to mind is the lack of accommodations. Why would I be forced to work days and nights when evenings is really the best time for me? Physically that's the best that I can function at my best. —Florence

One participant, who identified her work environment as a learning organization, reported that learning opportunities for staff failed to address disability:

More needs to be done at leadership levels besides team-building exercises. . . . No one is really addressing that you could be the leader with general anxiety disorder. . . . I think that being aware of others with disabilities needs to be a little bit more present in organizational talks. . . . Something's missing because I think we're just dealing with, you know, the normal leader. —Dorothy

Facilitators of Practice

When participants in this study were asked about the factors that facilitated or acted as barriers to practising nursing with a disability they identified a far greater number of facilitating factors than barriers. In addition to identifying the factors that they believed to facilitate their ability to practise nursing, participants also identified factors that, were they to exist or be implemented, would have a positive influence on their ability to practise with a disability (Table 5.7).

Facilitating Factors

The facilitators’ participants identified as helpful to their practice were further organized into five sub-categories: support, resources, relational factors, intrapersonal factors, and work environment factors.

Support

Participants described receiving support from a variety of sources, which helped them in their nursing practice. Participants identified support from colleagues and the HR departments of their workplaces. They also reported receiving support beyond the work environment from friends and family, and professionals such as a counsellor.

Content Area	Facilitators of Practice				
Category	Facilitating factors				
Sub-category	Support	Resources	Relational Factors	Intrapersonal Factors	Work Environment Factors
Codes	Helpful colleagues Support from similar others Support from human resources Professional support Support from friends/family	Workplace resources Public transit Medication	Relating to others	Desire Personal strategies	Flexible Job structure Supportive atmosphere Physical environment

Table 6-2 Categories, Sub-categories, and Codes of Content Area: Facilitators of Practice

Helpful Colleagues. One participant commented on the support she received from her colleagues. Heather noted that she could ask for and receive help from her

colleagues. She explained that it was important for her to try to reciprocate whenever possible:

I want to feel like it's a two-way street as well so I don't want to feel like I'm always the one asking for help all the time so if I can assist with something so whether it's a little marking or review something for them.

Support from Similar Others. Another participant, Dorothy, discussed the camaraderie and support she received from others in her work environment dealing with issues similar to her own. Dorothy discussed that she received support from other nurses who were also treated poorly and labelled as “different” by their nursing colleagues.

Dorothy commented on how this support helped reinforce self-conception as a nurse:

Knowing that there are others for social support, so my colleagues that I knew that we were very close and we knew that we were not different but I think it's just we came together because people would call us by name, you know, jokingly and it appeared friendly but there was almost a negative connotation to it so support from them saying 'You know, we know we're very good nurses.'

Support from Human Resources. Two participants described the support they received from the human resources department of the teaching institution they worked in. Both participants commented on the receptiveness of the HR staff to accommodating their needs. Natalie stated: “The fact that I could go to human resources and go for that modification was good even though it didn't turn out to be what I needed.”

Professional Support. A few participants spoke about the support they received from healthcare professionals such as a physician. Two participants with mental health-related disabilities commented that attending regular therapy facilitated their ability to continue practising nursing.

It's mainly the therapy . . . that's made the big difference in terms of dealing with things—Natalie

I use the counselling. . . . With the cognitive behaviour therapy has been the main support. —Rose

Support from Family/Friends. In addition to her intrapersonal development, one participant discussed the positive impact of the support she receives through her close relationships with family and friends.

It's a combination of getting older [and] being in a very happy, healthy relationship, um, not perfect . . . I have had a handful of very close friends that I've had for years . . . those are the kind of friends I really treasure. —Blanche

Resources

Several participants identified resources both from within and outside of their work environment, which facilitated their ability to continue working while experiencing disability.

Workplace Resources. One participant, Rose, identified the wellbeing programs in her workplace as a facilitator. Rose explained how these programs and activities helped her to deal with her anxiety. She stated, “taking part in wellbeing programs... .. helps reduce the stress level and anxiety... a chance right at work to be able to go and work out some of the stress.”

Medication, Public Transit. Another participant, Louise, identified the resources she used to help her to continue working as a nursing professor. Louise commented that she sometimes used medication to help manage her pain in order to function in her work environment. She also identified public transit as a helpful resource to mitigate the pain and discomfort she may often experience after driving to work. She explained:

[the train] works out in every sense of my lifestyle. . . . I would say the disability outweighs everything because of the ability on the Train to be able to either stand or if I want I can walk through the train so it works out for me that way better.

Relational Factors

Relating to Others. Participants commented on how relating to others in the work environment facilitated their ability to work with a disability. These connections

occurred with colleagues, as well as patients and students. One participant discussed the connection she felt with her patients:

I can relate to patients and engage in therapeutic use of self. . . I think it makes a nice connection—Blanche

Another participant discussed relating to the students she teaches:

I feel like I am contributing and when I am making my contributions they are valued, in particular from the students I get a lot of positive feedback from the students and um, a lot of thanks from them as the term goes along and I find that's quite rewarding. —Heather

Intrapersonal factors

Several participants identified factors within themselves that supported their ability to practise nursing while experiencing disability. Participants identified their desire to work and the personal strategies they have developed as facilitators.

Desire. Desire was identified by several participants as a motivating factor to continue or return to practising nursing with a disability. Helen identified her desire to help other people as one of the reasons she continued to work while experiencing disability. The following comment made by Louise illustrates the depth of her desire to work: “I grin and bear [the pain] and do what I have to do [to] be here because it does make me happy.”

Personal Strategies. Participants commented they relied on personal strategies to help them address their challenges and continue working with a disability. Participants indicated that these strategies either developed over time or were devised in response to their experience of disability. Several participants identified behavioural strategies that they used within and outside of the work environment. These participants discussed physical behaviours such as taking a break when it was needed or participating in activities that supported their physical or mental wellbeing. For example, Jenny stated

she began swimming regularly because it helped to strengthen the muscles that help to support her back.

Other participants identified cognitive strategies such as having a positive attitude. Helen, a mental health nurse, discussed at length how she used her belief system to maintain her nursing practice during her experience of disability. She explained:

Now my belief system I have a more holistic aspect and a spiritual aspect to it so I searched for the holistic remedies so I didn't just depend on the homeopathic way of dealing with an illness. I looked at what was the spiritual aspect of the illness, the emotional aspect of it, the mental aspect and then it comes down to the physical. I see things-the illness has a spiritual, mental, emotional and physical-when it comes now into the physical body that's the last stage of it manifesting for you. So I sought healing on those levels and I think that is what helped me to recover and what helped me to deal with everyday stuff, and helped me to deal with work so um, when a challenge arose then I asked for healing on all the levels so I could deal with it and move on.

Work Environment Factors

Participants identified several factors relating to their work environment that facilitated their ability to practise with a disability. Participants spoke about the flexibility of their jobs, having a supportive work atmosphere, and a physical environment that was conducive to working.

Flexible Job Structure. Three participants spoke about the flexibility their jobs as professors afforded them. The following comment by Natalie about the nature of her job as a professor was representative of what the other participants reported: “The work environment is good in terms of getting better and being able to put into play some strategies because of the way the job is structured.”

Supportive Atmosphere. Two participants commented about the supportive atmosphere in their work environment. Sondra described the atmosphere of the educational institution she works in as accepting. She contrasted this current work

environment with the Emergency Room she worked in for more than half of her nursing career: “In the emergency room you were accepted as long as you can do the job...but it meant there was no room, for me not to be perfect, or at least in my mind.” Similarly, Dorothy described what it felt like in her former work environment to be working on a shift where she was supported by colleagues rather than harassed:

It was a relief to see the board and see that 'X' isn't here today, oh thank goodness. I'm not going to hear that name that they are calling me something. I think that's the top relief was that. Not being around these individuals.

Physical environment. Heather spoke about the positive impact the physical environment in which she worked had on her ability to carry out her duties and responsibilities. She explained:

Being all in one building is very helpful because I don't have to worry about going outside and slipping on the snow and the ice. . . . Where some of the classrooms are flat has been quite helpful because I can physically get around to the students.

Factors that Would Facilitate

In addition to identifying factors that facilitated working with a disability, participants also spoke about what they perceived would help their ability to practise. These factors organized into the similar subcategories as those that facilitated their practice: support, resources and strategies, and work environment factors. Some participants identified facilitators that would address challenges such as a lack of accommodation. Others shared that they wanted more of the same type of facilitators presently helping them to continue to work.

Support

More Supportive People. Participants identified that having more supportive people within their work environment would facilitate their ability to practise with a

disability. The people participants identified consisted of colleagues and administrative staff such as managers and occupational health staff.

I would like to see people in occupational health being more open to disabilities including emotional disabilities—Blanche

[Knowing] that if I choose for my boss to know and that [the response would be] it's Ok to have anxiety . . . we will try to help you from an institutional point with that. —Rose

Sophia, who recently became a registered nurse, commented on what a nursing professor could do to support students with disabilities. She stated: “supporting those students [would help]. Giving them whatever, if they need extra time. Giving them.”

Resources and Strategies

More Workplace Resources. Two participants commented that having more workplace resources would better facilitate theirs or others' abilities to work with a disability. One participant made general reference to workplace wellness programs and provided an example such as massage therapy. The other participant was more specific and suggested that counselling be made available in the workplace for nurses with disabilities.

Counselling would be nice so that nurses with disabilities are able to identify jobs in nursing that they can do and not being told, 'No you can't do it' and 'You should know better.' —Heather

More Workplace Strategies. Two other participants discussed the lack of options in the workplace for nurses with mental disabilities. Natalie, a professor, explained her experience in this regard:

I kind of felt boxed in. I didn't feel I had that option and as things were getting harder to deal with the only option for me would be to cancel a class. ... so that would be something I would say would be a facilitator that might have taken off some stress.

Both participants highlighted the need for a workplace strategy or plan that would facilitate nurses with mental disabilities to continue to work while addressing their circumstances. Rose stated, “if the institution had some kind of plan for people that do have mental disabilities . . . that I could know, I could use those strategies in my workplace.”

Better Workplace Initiatives. One participant made the case for better workplace initiatives that take into consideration the systems-related and other issues that prevent nurses from engaging in activities that promote wellbeing in the workplace:

[There are] all of these different activities to do in order to promote mental health. . . . there's like a yoga program, that is offered during lunch. . . . On a day-to-day it's very challenging to be able to go for your lunch to be able to attend this particular activity. or there's again, this is a push . . . to be more mindful of your mental health and you know to take time off when you need to kind of rejuvenate but in order to do so you need to call in sick. We don't have mental health days, we don't have specific days allocated for us to be able to take care of ourselves in that way. It's either you have pre-approved vacation time or you know, you have to try to find yourself a replacement for yourself if the schedule is already out or you call in sick. . . . If you call in sick a certain amount of times, you get placed in this what-you-call attendance support program . . . even though it's not a punitive program, it certainly feels that way.—Mary

Assistive Tools and Devices. Another participant discussed her desire for her employer to provide tools and devices that would help her to do her work. Louise, a professor within a post-secondary institution, identified a number of assistive tool and devices that would help her ease the discomfort she experiences while engaging in tasks such as typing or marking assignments. She stated:

Maybe if I had different equipment or better chair that I could, you know, put up/down easier. . . I had things like the keyboard. If I had a chair that was more comfortable it might [help].

Work Environment Factors

Factors in the work environment that participants identified would help facilitate their practice fell into two categories: work characteristic and culture/climate.

Work Characteristics

Accommodating Needs, More Autonomy. Several participants commented on the need to facilitate the ability of nurses with disabilities to practise by providing accommodations and more flexibility in working arrangements. One participant spoke broadly about the importance of providing nurses with disabilities with whatever accommodation they need to support their ability to work. Helen and Jenny, who both worked in hospitals, identify specific accommodations that would facilitate their ability to work. Helen, in particular, spoke passionately about “being forced” to work certain shifts despite knowing “you don’t like it” and “you are not full time.” Lastly, Dorothy shared that having the autonomy to organize her work the way she wanted would have helped her to practise in direct-patient care: “Having autonomy on my breaks was an important issue for me. I didn’t want to go on a break. I wanted to have autonomy to do that and I didn’t want to feel guilty.”

Culture and Climate

Greater Understanding of Disability. Speaking more broadly about practising with a disability, Sondra, a nursing professor, commented that it was important that nursing as a profession develop a greater understanding of difference. She explained:

It would be important to have greater insight within our profession to difference, to understanding disability and understanding difference so that in a collegial way nurses can work together without judging each other so that it doesn't feel that trial by fire, so it doesn't feel like you're not ever going to be equal or good enough.

More Opportunities. Helen also spoke more broadly, stating that experienced nurses would be better facilitated if nursing employers provided them with more opportunities:

Anyway to create [opportunities] where you could do more of what you like doing and contributing that to the patient rather than the hospital say, "Oh

you're sixty now you go through this practice or that practice," to do something practical where the person is asked: What do you really like doing? What is being something that gives you passion in your nursing career and how can you contribute that to the patient for the wellbeing of the patient?"

More Supportive Atmosphere, Afraid to Ask. Participants discussed their desire for a more supportive atmosphere in the workplace. Sondra provided an explanation of why the workplace atmosphere or culture mattered so much to her:

How is the culture supporting you to do your very best but also to feel safe, to feel comfortable, to feel validated in other things... that's probably the most critical thing. . . . culture's going to filter down into relationships people have with each other, the stance people take towards each other and what kinds of behaviors are accepted and not accepted.

Two participants identified their desire for a work environment that was open and felt safe to express themselves and their needs. Rose spoke at length about being afraid to ask for supports related to her disability. She stated:

[Knowing] that if I choose for my boss to know and that [the response would be] it's Ok to have anxiety . . . we will try to help you from an institutional point with that. . . . I don't know what kind of accommodations that could be made in the area I work in. . . . I'd be afraid to ask. . . . I would be embarrassed to ask for something [like] that. I'm not there to have the employer to provide a service for me. I would feel like I was taking something away from the system to help me rather than helping the system... I have to be there to help people that don't have anything and are trying to get better so it feels wrong to ask for that. It feels like I should do that myself.

Likewise, Mary, a mental health nurse, spoke about her desire to work in an environment where she could openly address issues arising from working with a disability and not be fearful that there would be reprisal for speaking out.

Additional Thoughts

At the end of each interview conversation, participants were invited to share any additional thoughts about what they had discussed or anything else relating to the topic of nurses with disabilities. Most of the participants concluded by summing key

thoughts shared during their interview. However, many shared additional thoughts that fell into two broad categories: forethoughts and insights.

Insights

Several participants shared insights into issues they perceived nurses with disabilities face while working in various settings. These insights were organized into two categories: insights about self and insights about nursing.

Insights about Self

Stronger, Survivor. The closing comments made by two participants suggests that the process of being interviewed led to some insights about themselves. When asked if she had any final thoughts to share, Sofia spoke about her sense that she is “stronger” for having gone through the challenges she faced in nursing school. She stated:

Basically in my experience I would say that I think it made me stronger as a person. . . . Maybe it kind of enhanced me to become more stronger and speak on behalf of myself and know what kind of resources I need to succeed.

Reflecting upon her interview conversation, Dorothy remarked that she was “reliving it all again.” In this context she expressed that she saw herself as a “survivor of something,” but at the same time, she believes this to be a lie that she was telling herself: “When I think about it, I feel like I'm a survivor of something. ... I think I am a survivor but I'm lying. But it's tough. It's tough.”

Self-awareness. One participant discussed becoming self-aware because of her experiences of depression and working with depression. Natalie described coming to understand that she held un-checked perceptions about people with depression. Natalie commented on how learning more about depression has helped her to understand her own experience of the illness.

We all [need] to check in with what our perception of somebody with depression is because even I was going with an old concept of what depression is. . . . I think there's a continuum and I think more people are going to suffer with it as long as we have pigeon-holed what a depressed person looks like, including the stereotype.

Insights about Nursing

Not Talked About. Several participants expressed their perception that the topic of disability is not talked about in nursing. Dorothy stated that to her recollection, disability was never directly addressed in any of the environments she has worked in. Sondra commented on the failure of nurses to talk about issues related to disability and the lack of any “meaningful discussion of disability and difference” in nursing education:

We're educated and we try to be broad-minded but we don't challenge disability issues head on. We don't talk about it head on and our curriculums are absolutely barren of really meaningful discussion of disability and difference. Then we go into the practice world where we can't tease out oppression that is about difference and what that means for us as individuals, professionals, and a profession.

Uncomfortable with Disability. In her final remarks, Sondra also postulated the reason why she believes nursing is “uncomfortable” with disability.

I think nursing is uncomfortable. There is a mirror effect in nursing where, externally, nursing experiences challenges with our own sense of value in the world, fighting to be recognized, fighting to be a player at the table but feeling unwelcomed and not good enough. Out of that springs this internal struggle with anyone who looks in any way might reflect what society sees as less-than and I think that's where you see any kind of disability or impairment become/feel threatening to nurses in practice. I think it is a socialization process that is really challenging and deep-seeded and not even well-recognized. . . . We're educated and we try to be broad-minded but there's the subtleties of it because we don't challenge this head on. We don't talk about it head on and our curriculums are absolutely barren of really meaningful discussion of disability and difference and then we go into practice world where we can't tease out oppression that is about being different in lots of different ways and disability and what that means to us as individuals and as professionals and as a collective.

These sentiments offered by Sondra at the end of her interview were echoed at various junctures in the interview conversations of other participants. For example, Louise and

Florence shared the following insights about nursing that are in keeping with the comments made by Sondra:

You know how the nurses eat their young and each other. Very judgmental. . . . I hide sometimes the pain and what I should be doing because I don't want anybody to say that I'm not carrying my load and that's because nurses will say that about each other. . . . [nurses think], 'If you have a disability, are you using that to get special attention or are you using that as a way to get out of doing certain jobs. — Florence

I would probably get more sympathy from somebody that's a non-nurse. . . . I think sometimes [nurses] are too close to the situations. . . . I think that sometimes as nurses that's all we see, right, is somebody that has a limitation and it just becomes part of your day-to-day, [disability is] just not as evident [to nurses] as somebody . . . who is not in healthcare . . . it's part of your routine. — Louise

Fallible. In her concluding comments, Florence spoke about fallibility and the need for nurses to recognize that they are not infallible but rather like everyone else. In her comments, Florence highlights that there is a common misperception among nurses that they should be able to cure themselves.

As nurses we need to understand that we are fallible. . . . That just because we are a nurse, doesn't mean we can't have a disability. We can't cure ourselves which has always been this stigma. . . . We need to have support and understand that it's ok, that it's ok to say that you're not perfect.

Forethoughts

The forethoughts shared by participants at the end of their interviews conveyed the concerns they had and their perspectives on what needs to happen to address some of the issues they raised in their interviews. One participant, Dorothy, spoke at length about what concerned her and what she believed needs to happen within nursing work environments.

Concerns

Plight of Nurses with Disabilities. Two participants expressed concern for the plight of nursing students and new graduate nurses with disabilities. Both Dorothy and Blanche's comments conveyed worry about the work environment that nursing students and new graduates with disabilities are learning and working in, respectively. Blanche spoke about new graduates practising with a mental disability such as depression and the challenges she perceives they face today compared with when she entered the profession:

I think new nurses' struggles and experiences is going to be very different from mine. Nurses coming out today have a huge debt load, have difficulty finding full-time jobs and then getting a full-time job and not really liking it. . . . I think it would be very traumatic. . . . I think it would be demoralizing. If you can feel badly about yourself real easily, one of the areas that you want to feel some sort of security in is your work environment. That there is fairness and there are rules that everyone follows. You know, like I'm expected to show up on time. My manager I expect to know what my rights are and not take advantage of me.

Speaking more broadly, Dorothy echoed a similar sentiment, stating:

It worries me because now with so many of our [nursing] students with disabilities, what would a healthy work environment or an increasing awareness about disabilities in the workplace look like?

Questioning. In addition to commenting on the plight of nursing with disabilities, Dorothy also questioned how workplaces could be made better for nurses with disabilities:

“How do you fix work environments to allow people with disabilities, with depression, with different types, to feel not only respected but feel that the work you know-they can have more autonomy and I really don't know.”

Addressing Issues

In the final remarks, some participants commented on how the issues they raised during their interviews could be addressed. Participants suggested interventions or spoke about the need for something to happen or both.

Interventions. Several participants identified specific interventions they perceived would benefit nurses with disabilities in the workplace. Two participants suggested that educational interventions might be helpful to nurses with disabilities. One of these participants, Jenny, also shared her perception that more dialogue is needed in the workplace about disability and the issues facing nurses with disabilities. Relating her comments to the experience of back pain, she stated:

There are a lot of in-patient nurses who have back pain and who have been denied disability or time off so I think we need to face as nurses-this is a reality. We are using our bodies a lot so I hope that there's more discourse on the topic.

Dorothy pondered several related interventions, such as increasing disability awareness, that could potentially facilitate a healthier work environment for nurses with mental disabilities. Dorothy emphasized that such interventions should target staff and those higher in an organization hierarchy such as management.

So I think there should be a lot more education. . . . Maybe a tool, maybe just an intervention that includes a tool that assesses your level of discrimination. A discriminatory tool because I think unless you can identify you discriminate, you can didactically present, you can engage-maybe it's some exercises face-to-face with people, looking in their eyes to say 'Do you know if I have a disability or not? Let's be respectful.'

I wish there had been something to increase awareness in management and my colleagues because like I said, I saw a lot of suffering happening and till this day these nurses are still labeled as the 'Nurse with the bad back,' she was too skinny, that's why. She was an anorexic and you know, her back went. Or she fell purposely or you know, tried to move the bed so she could get a job in the clinic.

In her final comments, Helen called for recognition of the impact of night shifts on the wellbeing of nurses. She stated:

People like me, I could not go to my doctor and say um, "Please write a letter." I tried to do it but it's not acknowledged I think nurses need to be able to call on those things more and for it to be recognized. It's not recognized. ...To say, "I still want to work but can my work be modified to acknowledge my disability" because I think people want to work.

Speaking more broadly, Helen also appealed for greater consideration and action at higher and more political levels:

Not enough credence is given to the grassroots of nursing. Whether RPN or RN, those are the ones who are really carrying the brunt of nursing in this country.

It has to be a body like [professional nursing organization] . . . comes up and starts talking about that [recognition]... These things need to be negotiated. It has to be on the papers for/on the table to be negotiated so that nurses have more recognition. . . . It has to be from these people who represent nurses. . . I do not think enough credence is given to the grassroots nursing. Those are the ones who are carrying the weight of nursing and the employers are like, they're on their backs trying to extract more, for as little as possible, whether it's an RPN or RN, it's-those are the ones that are really carrying the brunt of nursing in this country and they're not recognized.

Need to Address, Unsure How to Address. Notwithstanding the ideas she provided and her assertion that issues such as “horizontal violence” needed to be addressed, Dorothy expressed uncertainty about what could be done to address the issues she perceived to be having a direct or indirect impact on nurses with disabilities.

I don't understand how this can be increased at the front line and at leadership and how you can create healthier work environments for people that a lot of people, even students now I know, have disabilities. How do you help people to be-I mean healthy work environments, there are so many variables to that right now, but I don't even know if dealing with disability and conditions is one of them.

You could have units with horizontal violence . . . but if you don't address, you know, aspects like this . . . At the end of the day, you're still labelling people and people start to think they fit into that . . . personality, right? —Dorothy

Another participant, Rose, also conveyed her uncertainty about how the challenges and issues nurses with disabilities faced should be addressed. However, she expressed hope for solutions in the future:

I hope that maybe the future generation will be able to provide things to help those people be able to work in an environment with that disability and still, um, not be judged for having it, be able to talk about it and have things in place to help so that they can do that job.

Summary

In addition to the experiences and perceptions presented in Chapter 5, this chapter provided an account of study participants' responses when asked to describe barriers and facilitators to practising nursing with a disability. These findings were organized into categories and sub-categories under two broad content areas: barrier to practice and facilitators of practice.

Participants identified barriers that organized into three main categories: nature of disability, nature of nursing work, and work environment factors. Barriers relating to the nature of participants' disabilities tended to correspond with the type of disability that participants reported. For example, participants with mental disabilities identified embodied experiences, such as anxiety and symptoms of depression, as barriers to practising nursing. Participants also identified barriers resulting from interactions between personal and environmental factors such as fatigue.

The findings of this study revealed that participants identified a greater number of facilitators of practice than barriers. In addition to commenting on the facilitators that have helped them to sustain their practice, some participants shared facilitators they perceived would help themselves or nurses in general or both to practise nursing to their fullest ability possible.

Lastly, when participants were invited to share additional thoughts at the end of their interview conversations, many provided one or more insights and forethoughts. Participants shared both personal and general insights about nursing and disability. Others expressed their concern for new nurses with disabilities entering the profession and offered ideas about how workplace issues related to disability could be addressed.

This chapter and the previous chapter presented the findings of interviews with nurses with disabilities about their experiences and perceptions. In the next chapter, these findings will be discussed considering what is known about nurses with disabilities from a critical disability studies perspective.

Chapter 7: Discussion

Introduction

The previous two chapters presented the findings of this study. This chapter provides a discussion of these findings. Section one provides a summary of the research that was undertaken to pursue the research question, what are the practice and work-life experiences and perceptions of disabled RNs? Section two is divided into two sub-sections. First, a discussion of how the findings have developed understanding of the research question is presented. This is followed by an exploration of the relationship of the findings to previous work on the topic and critical literature on disability and nursing. Section three discusses the strengths and limitations of the study with the aim to further enhance the transparency of this research and provide information for the reader to determine the utility of the findings. In section four, the study's contributions to existing knowledge and its implications for practice and education are outlined. In section five the recommendations for future research that were drawn from the study are discussed. The chapter concludes with a summary and final insights about my experience conducting this study.

Summary of Findings

The purpose of this study was to explore the practice and work-life experiences and perceptions of disabled RNs. The primary aim was to produce a descriptive account of the practice and work-life experiences and perceptions of disabled nurses from their perspective and within a Canadian context. In doing so, secondary aims to provide future direction for research and make recommendations to inform practice and education could be achieved. To arrive at these aims, qualitative description (QD) was used. QD

was an appropriate methodology for this research because it allowed for the development of a comprehensive description of disabled nurses' experiences without in-depth interpretations and abstractions that transform data away from how participants depict their experiences and perceptions. Data was collected through semi-structured face-to-face interviews with 12 Registered Nurses (RNs). The interviews were recorded, transcribed, and analyzed using conventional content analysis.

This research study sought to answer the central research question, what are the practices and work-life experiences and perceptions of disabled RNs? This was accomplished by describing: 1) the impact of having a disability on the work of a nurse, 2) disabled nurses' perceptions of their workplace environment and their practice, 3) barriers disabled nurses experienced in their nursing practice, and 4) facilitators of disabled nurses' ability to practise nursing. The descriptive accounts of disabled nurses' experiences and perceptions that emerged were organized into categories and sub-categories under five content areas: 1) practising with a disability, 2) perceptions of others, 3) barriers to practise, 4) facilitators of practice, and 5) additional thoughts.

Although the perceptions and workplace experiences of the study participants were nuanced and complex, there were many common features and elements. The current study found that nurses' experiences of working with a disability entailed a mix of negative and positive aspects. Participants' practice experiences were characterized by changes in the way they performed their roles or the type of nursing work they did. Participants reported mostly negative reactions and embodied responses — physical, emotional, and cognitive — to their circumstances in the workplace. It was clear from the findings that participants' practice experiences and perceptions were strongly influenced by aspects of the milieu of their work environments, including their

interactions with others. Although there were many more negative interactions, leading to negative perception and outcomes, participants also identified positive interactions, perceptions, and outcomes.

Disclosure and the consequences of this disclosure also had a significant influence on participants' experiences and perceptions of working with a disability. Although a few participants were comfortable with disclosing in the workplace, most were hesitant or chose not to for a variety of reasons. Participants described both positive and negative consequences to disclosing. For some participants, disclosure helped form or strengthen collegial relationships, but other participants reported negative responses from those they disclosed in the workplace.

The findings revealed facilitators and barriers to successfully practising with a disability. Participants identified a far greater number of facilitators (actual and desired) than barriers. Participants identified the embodied nature of their disabilities and intersections with their environments as significant barriers. Additionally, workplace factors such as the climate of the workplace and the nature of the nursing work were also barriers to being able to successfully practise. The facilitators identified by participants, both real and desired, corresponded to the barriers identified. These included supports from various others, resources provided in the work environment, and improvements in aspects of the workplace milieu.

Discussion of Findings

Understanding Findings in Relation to the Research Question

Overall, it is clear from the findings of the current study that the experience of practising nursing with a disability is complex, multi-faceted, and, in some respects, individual. The milieu of the workplaces where participants practised acted as the

backdrop within which experiences occurred, while in some instances directly shaped these experiences. For participants practising nursing with a disability, this involved a mix of positive and negative experiences and interactional encounters with others in the work environment that produces positive and negative reactions, embodied responses, perceptions, consequences, and outcomes. The ability of participants to successfully practise with a disability is influenced by a range of factors, more of which are facilitators than barriers. For some participants, the experience of practising nursing with a disability provided insights into themselves and the profession of nursing. It also spurred reflection on issues and concerns related to practising with a disability and how these can be addressed. In this section, these findings are examined more closely to understand the practice experiences and related perceptions of disabled nurses.

Practice Experiences and Perceptions

From the findings, it is evident that undesired change is a characteristic of practising with a disability. For most participants in the current study, practising with a disability involved experiences of undesired changes in their work or the time they spent doing their work, or both. Participants reported not being able to do parts of their work and needing modification to their work. Some also indicated that they changed the type of nursing work they were doing or were limited in their professional opportunities or both because of disability. Participants' most commonly reported reaction was that they struggled to work. Some participants identified that the experience of working with a disability was exhausting and sometimes made their symptoms worse. Others described having to put great effort into completing their work and plowing through the work despite actual or potential detrimental effects to their wellbeing and health. Moreover,

several participants expressed concern that their working with a disability might in some way negatively affect others.

The findings demonstrate that there is an emotionality associated with practising with a disability and, more specifically, with the changes in working and other challenges in the work environment. Participants described experiencing mostly negative emotions in response to their circumstances. Some recalled being disappointed in themselves while others expressed they felt stress and guilt about their perceived shortcomings in their work. Most participants described a sense of being less than what they perceived they ought to be as nurses. Additionally, some described having a sense that they needed to prove themselves and pull their weight in the work environment because of their limitations.

The above findings suggest that presenteeism — “on the job productivity losses or costs attributed to the work limitations of employees with a disability” (Prince, 2015, p. 19) — is an important concept in participants’ experiences practising with a disability. In support, Lack (2011) notes that presenteeism is widespread among workers and is impactful. Citing emerging research, Pilette (2005) identifies nursing as an occupational group with high presenteeism. Yamashita and Arakida’s (2006) concept analysis of presenteeism reported that the consequences of presenteeism included aggravation of quality of life and health status, deterioration of the quality of products and services, and adverse effects on colleagues.

From participant narratives in which the work environment factored prominently, it is obvious that workplace milieu has a significant influence on disabled nurses’ practice experiences and perceptions. The milieu of a workplace encompasses both the physical and social setting in which an employee works. It includes the culture

and climate of the environment in which the employee works and the people with whom they interact. The findings of the current study suggest that aspects of workplace milieu posed significant challenges to disabled nurses' ability to work. For example, half of the participants reported being unsupported in the work environment while working with a disability. Several participants described situations where their requests for accommodations were not granted or granted but not fulfilled by a manager. Additionally, a few participants described being discriminated against and stigmatized by others in the workplace.

Participants' narratives about their interactions with others — patients, students, colleagues, and administrative personnel — while practising also illustrate the important influence of workplace milieu. Participants recounted more negative than positive interactions, perceptions of interactions, and outcomes. They reported experiencing unkindness, unfair treatment, tension, and disrespect from others, particularly managers, administrators, and human resources staff. One participant described her interactions with her manager and union representative about returning to work as political. Because of interactions of this nature, participants perceived they were not understood or supported by others. Consequently, participants believed they had been stereotyped and stigmatized.

Not all interactional experiences, perceptions of those experiences, and outcomes were negative. In contrast, several participants described positive interactions such as being able to ask for and receiving help from professional colleagues. Other participants indicated that the nature of their interactions with others remained the same. These kinds of relational interactions contributed to the positive perceptions of interactions reported by participants. These participants reported that they felt understood and

supported by their colleagues and developed a better understanding of others. In addition, a few participants identified that their interactional experiences resulted in a change in their perspective and new insights into the functioning of the organization they worked in. Furthermore, few other participants reported that the experience of practising with a disability benefited their relationships with others in the workplace in some way.

The (in)visibility of disability was another factor that played a role in the practice experiences of participants. Disabilities are often broadly categorized as visible or invisible. Many hold the view that individuals with disabilities not easily identified use strategies, such as passing or covering,²⁹ to take advantage of abled-bodied privilege (Samuels, 2003). The perception also exists that “nonvisibly disabled people prefer to pass and that passing is a sign [of selling out] and product of assimilationist longing” (Samuels, 2003 p. 240). The findings of the current study complicate such notions about the visibility of disability. To the contrary, they illustrate, as Prince (2005) comments, that:

the (in) visibility of impairment is socially constructed as well as medically diagnosed and physically founded. An invisible disability has a material reality that is personally experienced in the social world; as a result, there is not always a sharp distinction between visible and invisible disabilities. Invisible disability is not the opposite of visible disability; they are interconnected and dynamic: a condition can have characteristics of visibility and invisibility depending on the symptoms and the circumstances (p. 2)

²⁹ Prince (2005) defines passing as “when a person with a significant disability succeeds in appearing to others to be non-disabled, by keeping undisclosed information about their impairment. Covering involves efforts by a person with a less than obvious disability to keep the impairment from looming large in everyday interactions” (p. 2)

In the current study, participants discussed the degree to which their disability was visible and the consequences of this visibility. Three participants whose disabilities were by their accounts hidden described the challenges this status posed. One participant commented that having a hidden disability was good in a way but also added stress because others were unaware of the rationale for what was happening with her. Two participants discussed challenges with the invisibility of their disability; both described being frustrated and struggling but for divergent reasons. One participant reported that, despite never revealing or having any knowledge that others were aware she experienced generalized anxiety, the participant worked tirelessly to keep her disability hidden from others. She described being hypervigilant about her behaviour, making sure she did not exhibit signs that would alert others of her condition. The other participant described that her efforts to gain others' acknowledgement of her hidden disability and experiences were often ineffective. This led her to avoid seeking help and managing her symptoms on her own. The dynamical and complex nature of disability identity is also exemplified in the narrative of one participant who is impaired by her obesity. This participant pointed out that despite her obesity being very visible, it was never mentioned as if it was not visible. To the participant, this circumstance was an elaborate charade that when unveiled became "absolute publicness."

Another factor emerging from the finding of the current study as relevant to nurses' experiences of working with a disability was disclosure. All but one of the participants recounted an experience related to or contextualized by disclosure. That disclosure is a complex and difficult issue and is demonstrated by the stories of disclosure and predicaments of disclosure shared by participants. The predicament of disclosure is summarized by Prince (2005) as the situation that results where on the one

hand “ disclosure is the route to a workplace accommodation process and can be in the best interest of the employee with a disability, [but on the other] it is a highly risky decision . . . with numerous potential disadvantages along with advantages” (p.24).

A clear and unsurprising finding was that the decision to disclose or whether a participant had disclosed was contextually individual; i.e., individual’s personality, nature of their disability, their understanding of disability, their beliefs and attitudes about disability, their precipitating circumstances, and the milieu of their workplace. Participants’ decisions about disclosing fell into several categories: comfortable with disclosing, unsure about disclosing, reluctant to disclose, and no disclosure. Participants reported they did not disclose or were reluctant to disclose because of past negative experiences with disclosure and fear of negative repercussions. In terms of the predicament of disclosure, several participants discussed weighing the necessity for and benefits of disclosing with perceived risks. For example, one participant shared that she weighed her fear that disclosing her mental health problem would diminish others’ perceptions of her abilities with her need for workplace accommodations and professional support.

Perception of How Others Perceive Participants

The findings regarding participants’ perceptions of what others think suggests they perceive that others generally think of them and their ability to practise nursing favourably. Of note, participants’ general positive appraisal of how others perceive them and their abilities did not match their own thoughts and feelings about themselves and their abilities. Participants believed that others thought of them as thorough, reliable, knowledgeable, and demonstrating good communication. They perceived others valued and respected them, and showed an understanding attitude towards them. However, not

all perceptions were positive. A few participants shared the perception that others would characterize them as tense, unpredictable, controlling, and not coping. Some participants also expressed the sense that others questioned their ability to practise or were concerned about them and wanted to protect their wellbeing in the work environment. One participant indicated that she felt judged by certain individuals in the workplace. Another indicated her belief that others “treaded lightly” around her. Finally, one other participant remarked that her colleagues might perceive her as hard to approach because of her personality and presentation of self.

Barriers and Facilitators of Practising with a Disability

In the current study, the barriers identified by participants represent an interplay between embodiment, the nature of nursing work, and the milieu in which work occurs. For analysis and discussion purposes, these barriers were extracted and presented as distinct from one another; however, it is clear from participants’ narratives that these barriers are an enmeshment of influencing factors that are not so easily disentangled. Participants identified physical and mental embodied experiences, as well as person-environment interactions (e.g., fatigue) that impeded their ability to practise. They also identified aspects of nursing work as barriers, including its physicality, variability, and unpredictability. In terms of milieu, a couple of participants discussed being treated poorly and another discussed how the negative attitudes of others negatively impacted her work, forcing her to hide her pain and push beyond her limits to mitigate these negative attitudes. Stigma was the most common workplace culture-related barrier identified by participants. Stigma negatively impacted the work of both nurses with physical limitations and those experiencing mental health problems. In addition to

stigma, nurses identified the physical environment of their workplace and the lack of accommodations and interventions to support nurses with disabilities as barriers.

A key finding of this study is that participants identified a far greater number of facilitators of practising nursing with a disability than barriers. Once more, aspects of the workplace milieu factored prominently in participants' descriptions of what has and would facilitate practice. Support was the most commonly identified facilitator of practice. Nurses discussed receiving support from a variety of sources within the context of work and their personal lives. These included family and friends, colleagues, and similar others in their work environments. They also indicated that their work was facilitated by having a flexible structure, a support atmosphere, an enabling physical environment, and interpersonal factors. Lastly, participants identified that intrapersonal factors such as their desire to work and personal strategies facilitated their ability to practise nursing with a disability.

In addition to identifying factors that have facilitated their ability to practise, participants identified would-be facilitators that were focused in the same areas as the facilitators they identified as having been helpful. Participants expressed the belief that more supportive people and resources within their workplaces would help them to practise effectively. They also identified that their work would be facilitated if their employer were to accommodate their needs, provide greater autonomy and opportunities, and, in general, provide a more supportive environment.

Relationship of Findings to Previous Research and Literature on Disability

It is evident from the current study's findings that disabled nurses desire employment and value working as well as being productive. However, disabled nurses experience challenges and barriers that make it difficult to feel that they are fully

participating in work. In response to their circumstances they described experiencing negative reactions and embodied responses, including thoughts of inadequacy and feelings of guilt, among others. Despite their barriers, the disabled nurses interviewed used factors in their work environments and personal lives to facilitate their ability to practise. These findings confirm many of the findings reported in previous research about the experiences of disabled nurses. The current study's findings also support findings reported in other studies about disabled peoples' work experiences. The discussion in this section focuses on explicating these relationships as well as positioning the current study's findings within the context of discourses in the field of disability studies and nursing.

Experience of Change and Emotionality

In the current study, participant narratives were characterized by the challenges they faced while practising nursing. Although everyone's challenges were unique to them, several commonalities emerged. For nurses who had been practising nursing prior to the onset of their disability, the experience of change was about transitioning, sometimes quickly, to unfamiliar circumstances and learning to navigate this new terrain. For example, one participant who developed a medical condition described her experience in terms of what was and what now is. She stated:

Usually at work, with colleagues, you might exchange a joke or talk [but] I found I had to save my energy to concentrate on what I was doing so there wasn't this bubbly and chatting . . . I could not do anything extra. . . . Just to get through the shift.

The change narratives of participants whose disabilities were life-long or preceded their nursing career focused on the enduring nature of the challenges they faced while

working. These participants spoke about these experiences with familiarity and contrasted them with those of their colleagues whom they presumed were not disabled.

Within the literature about disabled nurses, a few studies address the theme of change in work. In a study by Neal-Boylan (2012) most of the disabled nurses discussed their career choices since acquiring a disability or after their disability worsened to the point of impacting their ability to practise. The current study confirms these findings. Several participants discussed career changes or major shifts in the focus of their practice because they were no longer able to negotiate their disability amidst work demands. The current study also confirmed Neal-Boylan and Guillet's (2008a) findings that nurses experienced fatigue, loss in stamina, and pain while working with a disability.

Based on their findings, Neal-Boylan et al. (2011) and other scholars (Neal-Boylan, 2012; Neal-Boylan & Guillet, 2008a; Matt, 2008) have speculated that disabled nurses may be leaving the profession because of the difficulties they experience or they do not feel able to participate in work. In the current study one nurse discussed leaving the profession because she could no longer manage her disability and the demands of her position as a postsecondary nursing educator. While other research findings have suggested that disability may play a role in nursing workforce attrition (e.g., Koenes 2001), more inquiry is needed on this topic to confirm this hypothesis.

It is clear from the findings of the current study that the experience of practising with a disability elicits emotional responses. Previous work has highlighted the emotionality of practising nursing with a disability. Neal-Boylan (2012) found that disabled nurses experience a broad range of emotions regarding the disability-related challenges they face in the workplace. For example, nurses grieved over job losses, and

felt anger and resentment because their colleagues undervalued their abilities. In an earlier study, Pohl and Winland-Brown (1992) found that nurses practising with a disability experienced anger at their limitation, and while interacting with other and workplace systems.

Recently within nursing literature, attention has been given to the concepts of emotional labour and emotional intelligence (EI). Emotional labour refers to the process of managing feelings and expressions to fulfill the emotional expectations of a position or work environment. EI can be understood as a group of competencies, skills, and personality traits that influence our ability to respond to others and manage personal feelings. Smith, Profetto-McGrath, and Cummings' (2009) integrative review of EI found that despite the need for additional research, there is consensus that EI is integral to nursing and has influence on nurse and patient outcomes in the practice setting. Additionally, the concept of burnout is readily discussed in relation to nursing practice. Maslach, Jackson, and Leither (1987) theorized that burnout entails feeling emotionally exhausted, depersonalizing behaviour, and diminished sense of personal accomplishment. Brothridge and Grandey (2002) discuss that emotional labour is often conceptualized from two perspectives that may be predictive of burnout: "job-focused emotional labor (work demands regarding emotion expression) and employee-focused emotional labor (regulation of feelings and emotional expression)" (p. 17). Insofar as they would be for any nurse, these forms of emotional labour seem to be relevant to disabled nurses' experiences practising nursing. However, the emotionality described by nurses in the current and previous studies suggest that, unlike their non-disabled colleagues, disabled nurses may also experience a disability-focused emotional labour

that is characterized by regulating feelings and emotional expression relating specifically to working with a disability.

Disclosure and Visibility

Disclosure of disability in the workplace is paradoxically a very private decision with very public implications and consequences. Disclosing disability in the workplace can confer benefits, namely accommodations and support in the workplace.

Accommodation is often the primary driver of employee disclosure of disability to their employer (Stanley, Ridley, Harris, Manthorpe, & Hurst, 2007). For employers, disclosure can carry benefits such as the ability to make accommodations and comply with other legislated requirements. It is also suggested that when an employee self-identifies as disabled in a work environment, this action contributes to a disability-friendly climate for all disabled employees. Given these benefits, it stands to reason that employers would encourage disclosure and employees would be more likely to disclose their disabilities. However, the findings of the current study and previous work indicate the disability disclosure is a complex process involving many factors that are, in some instances, conflicting.

In the current study, participants discussed a range of choices relating to disclosing their disability in the workplace. They reported being comfortable, unsure, or reluctant. Some participants identified that they were afraid of the potential negative repercussions of disclosing their disability. Many other studies of disabled employees have reported similar findings (e.g., Joyce, McMillan, & Hazelton, 2009; Neal-Boylan, 2012; Neal-Boylan & Guillet, 2008a, 2008b, 2008c; Stanley, Ridley, Harris, & Manthorpe, 2011). Stanley et al. (2011) found that practising nurses were more likely than other professional (e.g., social workers) to report negative stories about disclosing

in the workplace. Neal-Boylan (2012) interviewed nurses and doctors and found that both cohorts struggled with the decision to disclose in the workplace. A study by Joyce et al. (2009) of nurses with mental health problems found that some nurses felt comfortable disclosing their mental illness in certain contexts while others inferred some hesitance.

Legally, employees are not mandated to disclose a disability in the workplace. However, for nurses and other professionals in healthcare, the decision to disclose disability carries with it moral and ethical elements. In Ontario and other Canadian jurisdictions, anyone seeking registration as a nurse must meet a list of requirements, including declaring “whether you suffer from any physical or mental condition or disorder that could affect your ability to practice nursing in a safe manner [and] practise with decency, honesty, and integrity” (CNO, 2014, “Health and Conduct”). Although this requirement includes the qualifier ‘could,’ it is ultimately for the registrar and not the potential registrant to determine whether an impairment may impact practice. Nevertheless, the ambiguity of this language may create a moral/ethical dilemma and possibly legal implications, for a potential registrant with a disability. In the current study, only one participant discussed disclosure in the context of professional registration. The participant remarked that she chose not to disclose her disability at the point of registration primarily because of her belief that her learning disability did not affect her ability to practise. However, the participant also commented that she feared the potential procedural difficulties of disclosure and worried that if she disclosed she may be denied registration. A study by Stanley et al. (2007) exploring the processes and consequences of disclosing disability, reported that disabled professionals (including nurses) experienced a loss of control over information disclosed to regulatory bodies

because “they received little in the way of individualised responses or information concerning the process and consequences of disclosure” (p. 5).

Perception management is an important aspect of disclosing disability. As previously highlighted, the border between visible and non-visible disabilities is not clear-cut. The visibility of a disability is in part socially constructed, defined by stereotyped characteristics of the disabled body and signifiers of disability such as assistive devices (Prince, 2005). This discourse notwithstanding, the degree of disability visibility is an important factor in the choices made and strategies used by an individual to manage others’ perceptions of them. It also has an impact on the decision to disclose. Within the literature, the concept of passing and concealing/hiding have been discussed as perception management strategies used by disabled people in various contexts including work (e.g., Joyce et al., 2009; Olney & Brockelman, 2010; Samuels, 2003;).

The relationship between visibility, perception management, and disclosure is illustrated in the current study and previous research. Joyce et al. (2009) found that some disabled nurses spent a considerable amount of time trying to avoid detection as persons with a mental illness. They guarded their disability status closely and were concerned about the post-disclosure reactions of their colleagues. Neal-Boylan (2012) reported that the nurses and physicians she studied chose to hide their disabilities so that they could get hired or remain in their positions. Similarly, Neal-Boylan and Guillet (2008 a,2008b,2008c) reported that disabled nurses believe that nurses should hide their disability because they would be more likely to receive support. In the current study, some participant narratives confirmed these previous findings. One participant briefly discussed her belief that having hidden disability has an advantage. Another participant explicitly discussed her efforts to hide her disability, fearing that she would

be stigmatized and bullied as others who disclosed their disability had been. A participant with back problems shared that she did not disclose her disability when applying for a job because she did not want it to limit her opportunities. This same participant also reported that when she moved to a different organization she did not reveal her back issues because she wanted a fresh start and to avoid the kinds of post-disclosure outcomes she previously experienced. Lastly, a recently registered nurse working in a couple of organizations stated that she does not believe her disability has any bearing on her ability to practise nursing and, therefore, there is no reason for her to disclose her learning disability in any work-related context.

According to Olney and Brockelman (2003), passing and other perception management strategies have been distilled through deviance theory and characterized as forms of self-denial, internalized ableism, and behaviours adopted in response to fear and shame. Samuels (2003) agrees, writing that these actions, even when acknowledged as viable strategies to dealing with situations, continue to be viewed as undesirable responses. Olney and Brockelman's (2003) study of students with disabilities found that students held positive self-concepts and viewed the perception management strategies they used to project images of themselves as complex individuals as interpersonal skills. From this perspective, Olney and Brockelman challenge us to understand choices and behaviours such as the disclosure-related decisions made by disabled nurses in the current study, as part of the complex ways in which individuals negotiate and maintain their sense of self-relation to others rather than simple reactions to internalized negative messages about what it means to be disabled.

Disability climate in the workplace

From participants' narratives in the current study, an overall sense emerges that the physical and social environments in which they worked were not friendly to disabled individuals nor conducive to effective practice. This is evidenced in participants' numerous accounts of negative experiences and challenges dealing with various aspects of what is generally referred to as the workplace milieu or climate. Matt and Butterfield (2006) use the term *disability climate* to describe organizational climate in the context of disability. Disability climate is evidenced "by the workers' perceptions [with respect to disability] of policies, procedures, practices, and behaviours at all levels of the organization" (Matt & Butterfield, p. 130). Matt (2008) expands this explanation noting that disability climate encompasses several levels within an organization (e.g., work unit level, organizational) and is shaped by factors the socio-political and economic context the organization is situated within. Matt (2008) also notes that within the workplace, unit-level interactions with others and organizational policies, procedures, and communications also affect employees' perceptions of the disability climate. In chapters 2 and 4, I discussed the context within which the participants in the current study practise nursing. This context includes legislation and a legal framework that is intended to ensure disabled employees are afforded the same opportunities and benefits in the workplace as non-disabled employees. Additionally, this outside context includes the nursing organizations, associations, regulatory bodies, and educational institutions that influence the disability climate through the way they conceive and address disability among nurses.

The outside context and the findings of the current study infer that participants perceive the disability climate in their workplace as more negative than positive. The

findings reveal that disabled nurses experienced negative interactions with co-workers, supervisors, and other administrative personnel, and faced challenges in dealing with policies, procedures, and programs intended to support their ability to practise. For example, participants described working in an atmosphere in which there was a lack of knowledge about disability. They also experienced challenges dealing with administrative structures and policies, as well as with employees administering disability-related programs. Several participants described the difficulties they encountered engaging in their workplace return-to-work and attendance monitoring programs. Additionally, participants reported experiencing discrimination and identified stigma and poor treatment from others as barriers to their ability to work. With respect to their interactions with others, participants recounted both positive and negative experiences. They discussed being supported by colleagues, but some also expressed relational difficulties.

These findings confirm previous research findings relating to elements of disability climate such as interactions with others and dealing with the system. Pohl and Winland-Brown (1992) found that disabled nurses experienced anger in their interactions with others and with the system. More recent studies have identified a similar theme. In a study exploring the lived experiences of 11 nurses with physical and sensory disabilities, Matt (2008) identified several factors that comprise disability climate such as acceptance from co-workers. In other studies, nurses' perceptions of the disability climate in the workplace have been linked to the type of workplace setting. Matt (2011) and Guillett et al. (2007) similarly found that among nurses working in the hospital, less acuity units seemed to be more accommodating to disabled nurses while physically demanding units were the least welcoming to disabled nurses. Although not a

key finding in the current study, the experiences shared by several participants seem to support this relationship. For example, one participant discussed leaving her practice in an ER department for a less physical job and finding her new work environment more accepting of disability and other diversities. Another participant with back problems also discussed moving her career from direct practice into a teaching role in post-secondary education because she perceived this environment to be more disability-friendly.

The influence of workplace culture and climate on the work experiences of disabled people is discussed in the broader literature about disability and work (e.g., Harpur, 2014; Kulkarni & Lengnick-Hall, 2011; Houtenville & Kalargyrou, 2012; Schur, Kruse, & Blanc, 2005; Schur, Kruse, Blasi, & Blanck, 2009; Wehman, 2003). Research by Kulkarni and Lengnick-Hall (2011) identified that coworkers and supervisors significantly influence disabled employees' integration into a work environment. Lengnick-Hall, Guant, and Kulkarni (2008) found that employers were not proactive in hiring disabled people and held unfounded stereotypical beliefs about this population. Schur et al. (2005) concur, arguing that change must occur at the corporate level if gains are to be made in the employment of disabled people. Harpur (2014) makes a case based on contact theory for integrating more disabled individuals in the workplace as a means of helping to foster a positive disability culture by "normalizing" disability. However, Kulkarni and Lengnick-Hall (2011) found that employee proactive behaviours were less important. Additionally, the proactive employee behaviours require the employee to disclose their disability, which may be difficult as it places a burden of this disclosure on the individual. Harris (2014) states that the tension between the individual versus the collective good is emblematic of social movements. Harris remarks that "in fact, disability studies scholars have identified open discussions about disability by and with

people with disabilities as a central requirement of collective action” (Harris, 2015, p. 529). Thus, living the notion of the “personal being political” can be difficult in the workplace when one is faced with challenges that threaten your ability to retain your employment.

Barrier and Facilitators of Practice

In the current study, it is not surprising that the facilitators and elements participants desired to enable them to practise correspond with the aspects of their experiences they found challenging or identified as barriers. Support was strongly endorsed as having a significant influence on disabled nurses’ experiences. Overwhelmingly, nurses in the current study identified that support at the person-to-person and organization level was integral to their ability to practise. Participants also voiced that more support was needed to help them practise successfully. This key finding is consistent with findings reported in previous studies. Matt (2008) reported that disabled nurses identified peer assistance as being critical to their ability to practise. However, Neal-Boylan (2012) found that collegial and administrative support for disabled nurses was evident but rare in comparison to negativity from these others. Similarly, a study by Joyce et al. (2007, 2009) of nurses with mental health problems found that the experiences of these nurses were largely negative due to discriminatory actions of others in the workplace, such as ill-treatment and gossip. In another study of the same sub-population, Joyce et al. (2012) reported nurses’ experiences in the workplace were strongly influenced by peer attitudes and responses towards them. This work and finding of the current study echo those reported over two decades ago by Pohl and Winland-Brown (1992). That study found that psychosocial support was important to disabled nurses. The current study also mirrors Pohl and Winland’s (1992) finding

that disabled nurses held both positive and negative perceptions about support from others.

That participants identified numerous facilitators relating to different levels of support suggests there may be a positive relationship between the perceived responsiveness of the work environment to the needs of disabled nurses and their ability to practise and sense of wellbeing in the workplace. Whereas this hypothesis is speculative at present, recent research conducted by Schur et al. (2009) examining workplace outcomes for disabled employees supports the plausibility of such a relationship. The authors' analysis of a dataset of 30,000 surveys enabled them to examine the relationship between disability to variables that included employee perceived treatment by their employer and their responses such as willingness to work hard and job satisfaction. The study found that in work environments where all employees rated the employer high for fairness and responsiveness to their needs, there were no gaps between the attitudes of disabled and non-disabled employees towards the job and the company. The authors summarize that their findings "indicate that corporate cultures that are responsive to the needs of all employees are especially beneficial to employees with disabilities" (p. 381).

Research about non-disabled nurses, administrators, and supervisors' perceptions and attitudes provides some insight into disabled nurses reports of unsupportive workplaces. A study of the experiences of nurses with mental health problems (Joyce, 2007; Joyce et al., 2009) reported that participants perceived that their non-disabled colleagues' lack of support and use discriminatory practices (e.g., giving them heavier workloads and gossiping about them) were attempts to enforce more appropriate behaviour in them. In the current study, one participant with an anxiety

disorder reported similar behaviours of her nursing colleagues. Joyce et al. (2012) studied non-disabled nurses' perspectives about their nursing colleagues with mental health problems and found that they resorted to actions such as gossiping to cope with perceived stressors of having to support their disabled colleagues. This study also found that non-disabled nurses' textbook knowledge about mental illness did not guarantee they would be able to recognize issues and support colleagues with mental health problems. Wood and Marshall's (2010) study of nurse leaders' experiences with disabled nurses reported that while managers rated the work performance of disabled nurses high, they expressed concerns about disabled nurses' ability to carry out their duties, their interpersonal interactions and issues, and the risk they might pose to patient safety.

Contact between disabled individuals and non-disabled nurses and nurse administrators has been reported by several studies as beneficial to disabled nurses' practice experience (Kontosha et al., 2007; Matt, 2011; Neal-Boylan, 2012; Neal-Boylan et al., 2011; Wood and Marshall, 2010). These studies found that non-disabled nurses' perceptions and attitudes towards disabled nurses (e.g., believing they are as capable as those without a disability) and their willingness to hire or work with them were positively associated with previous experiences caring for patients with disability or having positive experiences with disabled nurses in the past. These findings and others in the broader literature about disability (e.g., Au & Man, 2006; Diska & Rogers, 1996; Gosse and Shepard, 1979; Harpur, 2014; Knudson, 1990; Vezzali, 2007) support contact theory. Contact theory posits that prejudices can be reduced when members of different groups interact with each other under ideal circumstances (Pettigrew, Tropp, Wagner, & Christ, 2011). Research examining the correlation between attitudes towards disabled people and contact with disabled individuals suggests that the strength of this positive

relationship is conditional upon variables such as the personal characteristics of the non-disabled person and the type, duration, and context of the contact experience. Other studies have found that only certain types of contact, such as contact with disabled individuals at equal social status or higher, have positive effects on attitudes (e.g., Shannon, Tansey, & Schoen, 2009; Smart, 2001). These results conflict with Matt's (2012) findings relating to contact with disabled patients.

Work Productivity

The findings of the current study confirm previous work reporting that disabled nurses perceive that they must and do work harder beyond their limits or compensating to assuage others and their own concerns about their abilities to do the work of a nurse. Although concern for patient safety is a theme in several previous studies (e.g., Neal-Boylan, 2012; Neal-Boylan & Guillett, 2008; Wood & Marshall, 2010), the participants in the current study working in direct patient care settings rarely discussed patient safety or did not overly express concerns about jeopardizing patient safety. Their thoughts about having to prove themselves, plow through, pull their weight, and put a great deal of effort into completing tasks seemed to be related more to concerns about meeting productivity, expectations of their roles, self-conception, and managing the image of competence they perceived is called for by others in the workplace than to worries about jeopardizing patient safety. Participants reported being conscientious in their work so they did not make errors. Here again it seems that these efforts also relate more to productivity and maintain role expectations than an acute concern about not being safe to care for patients.

The concept of productivity is often invoked in relation to disabled peoples' participation in the workplace. At a technical level the term *productivity* refers to the

amount of value produced given the amount of time or cost required to do so (Fuller, 2016). Building from this idea, employee productivity represents an assessment of the efficiency with which a worker or group of workers complete the task and functions that yields a desired outcome. Measuring employee productivity in the nursing workforce is challenging due to complexity of factors affecting productivity. However, owing to an increasing scarcity of resources and the demand to meet the needs of patients with complex health needs, issues of productivity are critical to the healthcare administrators who employ nurses. In areas of direct patient care nurses are the largest workforce and account for a large proportion of the budgets of organizations such as hospitals. Within the literature there is a significant body of work focusing on the productivity of nurses and factors that influence nurses' productivity. The factors that have been identified as impactful include leadership style, work-related stress, amount of support in the work environment, and workload (e.g., Laschinger & Wong, 1999; McNeese-Smith, 1996). Research focusing on disability and work indicates that disabled people often face stereotypes and misconceptions about their abilities to do their work (e.g., Shier et al., 2009). These perceptions can impact disabled peoples' ability to attain and maintain work (Colella & Varma, 1999; Shier et al., 2009). Specific to disabled nurses, Neal-Boylan's (2012) study of disabled nurses and physicians reported nurses were frustrated that their coworkers lowered their expectations of their abilities after they acquired a disability. In the current study one participant expressed that they were concerned about lowered expectations.

It is possible that the combined effect of working in an environment that has certain expectation of productivity (e.g., direct patient care facilities such as hospitals) and where there is a biased expectation of disabled people may have resulted in

participants experiencing a heightened expectation of productivity. This pressure to embody the ideal employee who is efficient, always on the go, and consistently producing may be a contributor to the negative emotionality and cognitions reported by disabled nurses in the current study. The findings of the current study and previous studies of disabled nurses provide some indication of this perceived pressure. Several participants in the current study shared concerns that others in the work environment would perceive that they were not competent or were making the workloads of others harder by being accommodated. Neal-Boylan (2012) also reported that disabled nurses worked to compensate for their limitation so they could meet their own and others' expectation.

Self-concept and Managing Identity

Beyond productivity, the thoughts participants in the current study shared about themselves also conveyed a sense that their self-concept as nurses was effected by their circumstances. The most commonly identified cognitive response by participants to working with a disability was the sense that they were less than others or what they once were, or both. It is also evident from participant narratives that they were concerned about how others perceived them as nurses and in some cases, they worked to manage the image being perceived. Participants also discussed concerns about their contributions as members of a team.

Previous studies have identified that disabled nurses struggle with self-image and their identity as nurses in relation to having an impairment (e.g., Pohl & Winland-Brown, 1992; Shick Makaroff, 2005; Koenes, 2001; Korzon, 2012). Neal Boylan (2012) reported that disabled nurses grieved the loss of others' respect that they were accustomed to. Additionally, Shick Makaroff (2005) and Koenes (2012, 2001) reported

that disabled nurses had to renegotiate their conception of themselves as nurses after the onset of disability.

Disabled nurses' concerns about identity management and their self-concept may be a function of their professionalization and the ideological beliefs inculcated in nursing through the process of professional identity formation. Professional nursing identity formation, and hence self-image, is a complex and dynamic process that begins with nursing education and carries on into practice as an individual develops their nursing career. Kaiser (2002) posits that professional identity formation is a process that involves breaking down a person's individuality and replacing the undisciplined, nonconforming individual's identity with a professional ideology. Kaiser (2002) notes that this process involves a denial of an individual's uniqueness. In nursing, current literature indicates that professional identity in nursing is developed through two types of curricula: a formal curriculum that primarily occurs within an academic setting and a hidden curriculum that is understood and caught most often in the clinical environments where learners are supported to put into practice what they learned (Karimi, Ashktorab, Mohammadi, & Abedi, 2014). This hidden curriculum often continues after learners complete their formal education, register as professionals, and begin practice. Within healthcare literature considerable attention has been given to the contradictions between what is explicitly taught in the classroom and what students learn through the hidden curriculum (Monrouxe, & Rees, 2017). However, much of this discussion focuses of the discordance between the two types of curricula and fails to interrogate assumptions underpinning both curricula as well as consider that they may be working in tandem to reinforce harmful ideologies and reproduce oppressive systems of privilege.

Some scholars have problematized the professionalization of nurses in important ways that may help in understanding the disabled nurses' experience of identity (e.g., McGibbon, Mulaudzi, Didham, Barton, & Sochan, 2014). Hickson and Holmes (1994) and Lawler's (1991) discussions of nurses' relationship and engagement with their own bodies and those they care for offers a lens through which to consider participants' thoughts about who they are as nurses and how they manage their image. Hickson and Holmes describe the antithesis of the undisciplined body (e.g., the disabled body) as the disciplined body (e.g., the non-disabled body). Hickson and Holmes propose that nursing's problems with the body are rooted in nursing developmental history. Lawler (1991) adds that nursing's problems with the body are linked to our society's problematic relationship with the body. In part, this relationship suggests that an understanding of the ways in which the bodies of nurses have been viewed and conceptualized is key to gaining an understanding of contemporary issues relating to identity within nursing.

Hickson and Holmes (1994) note that the body of the nurse was and continues to be expected to yield itself "up to the bureaucracy in unquestioning obedience" (p. 4). These authors posit that the nurse's body, predominantly a female body, is an idealized body that mirrors hegemonic culturally constructed ideals. However, the female body, like anybody, is imperfect. It, therefore, disrupts the cultural aesthetic that has been constructed. According to Hickson and Holmes, professionally, the nursing body has been desexualized and dehumanized but not sanitized to the point of being degendered. This professionalization process is often linked to the Nightingalian ideals that encourage denial of self in complete servitude to the other (e.g., the patient). However, the desexualized, dehumanized, docile, disciplined, and, thus, professionalized nurse's body is still an object-lived body that is imperfect. While maintaining its own mirroring

image, the nurse is also charged with the task of maintaining the mirroring image of the patient body constructed by society. As indicated by Hickson and Holmes, nurses take over the responsibility for managing this surface image to undermine the imperfect corporeal body's inherent corruption.

The problems of the body that nursing faces are most evident when we examine the relationship between nurses and the undisciplinable body — the disfigured, disabled, corporeal body. Following from Hickson and Holmes (1994), nurses often characterized these bodies as unpopular or the bad patient. The disabled body challenges and disrupts the mirroring body image that society upholds for both the nurse and the patient. This image is strongly connected to notions of normalcy within our culture. Hickson and Holmes contend that disabled bodies are constructions of imperfection that are then stigmatized and subsequently excluded from the discourse of normalcy. Lawler (1991) builds on this notion by suggesting that because nursing involves dirty work, nurses try to distance themselves from the undisciplined body while concomitantly espousing a philosophy of caring and universal acceptance.

Viewed from the perspective presented by Hickson and Holmes (1994) and Lawler (1991), the self-concept and image concerns of participants in the current study and previous work are understood as cognitive dissonance responses that elicit questioning of identity or concern that others may also question. With the onset of a disability, the nurse transgresses the boundary between nurse and patient, disrupting the mirrored image that has been carefully and tenuously held together. To avert these tensions, a disabled nurse may expend considerable energy trying to manage the mirrored image they once projected. Managing their mirroring image serves to convince the disabled nurse of the intactness of this identity while also garnering external

validation for intactness. This dynamic is evidenced by Joyce and colleagues' (2007, 2012) research investigating the perceptions and experiences of nurses with mental health problems and their colleagues' perceptions of these experiences. These studies reported that disabled nurses were made to "toe the line"; that is, a nurse's "failure to live up to the expectations of nursing colleagues may result in a nurse with a mental illness being exposed to various actions designed to ensure appropriate conduct" (p. 376). Colleagues used several tactics such as bullying or assigning unfair workloads. Nurses with mental problems themselves reported that when unwell, their sense of self shifted from nurse to patient. They discussed having to constantly negotiate boundaries for fear of crossing over into patienthood. These nurses reported being constantly pushed to demonstrate their mettle. In the current study, participants discussed the notion of crossing the line between nurse and patient. As an example, one participant discussed her struggles with the idea of slipping into patienthood is this way: "I'm a mental health nurse, not that I shouldn't have mental health issues but that I should be able to overcome them."

McGibbon and colleagues' (2014) work focusing on postcolonial theory suggests that nurses learn to understand the profession's body politic through professionalization, involving colonizing processes and practices that exalt a body politic based on compulsory able-bodiedness (idea of an able-bodied norm) (McRuer, 2010). These processes include erasures of histories and imbuing beliefs of equality and universalist assumptions of the dominant culture. McGibbon et al. note that nursing's participation in colonizing processes and practices has yet to reach nursing consciousness or politics.

The implications of the colonization of nursing in terms of professional identity formation vis-à-vis nursing education provides insights into how disabled nurses are

treated by their non-disabled colleagues. Through colonized nursing curricula, nurses learn denial strategies (e.g., denial of racial diversity, denial of individual prejudice and ableism) that they can use as defenses and shields when faced with the realities of their own and others' bodies. The mirroring of an idealized nursing identity enables the colonized professional nurse to hold onto the prejudices and erroneous ideas initially inculcated through societal forces and later reinforced through professionalization processes. The colonized nursing identity also gives nurses moral/ethical authority to leave negative attitudes and beliefs about disabled people unquestioned. It also provides justification for attitudes and behaviours that negatively impact the ability for disabled nurses to practise successfully.

Accommodating Disabled Nurses' Needs

According to the Conference Board of Canada (2015), Canada's workforce is changing. A key emerging trend is the increase in the number of younger workers under 25 and mature workers over 45. Over the next decade, a key consideration for employers will be how to foster supportive work environments that are responsive to the accommodation and work design needs of both cohorts of nurses. Within the literature, several scholars (e.g., Carroll, 2004; Matt, Fleming, & Maheady, 2015; Wood & Marshall, 2009) have discussed this trend in relation to disability and the nursing workforce. Carroll (2004) notes that there is growing advocacy for disabled people to enter nursing programs. This, coupled with an interest and need to increase enrollments in nursing programs, suggests that employers can expect an increase in the number of young disabled people in the nursing workforce. Additionally, Wood and Marshall (2009) note that technologies are now readily available to facilitate accommodating disabled people in the workplace. Matt et al. (2015) have also highlighted that as nurses age, employers

can expect a higher prevalence of injuries and disability. The physically demanding nature of nursing work make this more likely.

The findings of the current study suggest that disabled nurses' needs for accommodation are not being adequately met. Study participants expressed challenges dealing with bureaucratic structures related to accommodation. Participants reported negative experiences, including having to fight to get accommodations they were due and not asking for accommodations because of negative past experiences. Participants also reported making modification on their own because it was easier than engaging the official accommodation process. Additionally, inflexibility in nursing work and the physical environment of the workplace were identified as barriers to practice.

There is a dearth of previous research examining the accommodation of disabled nurses in the workplace. Although the previous work was conducted in the US, they lend support to the current study's conclusion that disabled nurses are not being adequately accommodated in the workplace. The findings of previous research emphasize disabled nurses' underutilization of accommodations (e.g., Matt, 2008; Neal Boylan, 2012; Neal-Boylan & Guillet, 2008a). Matt's (2008) study of disabled nurses' experiences in the workplace found that nurses were reluctant to request accommodations because of their perception that others would think they were being given an advantage. Participants in that study described the negative outcomes of not asking for accommodations. Participants also reported coming to terms with the fact that they needed accommodations and then self-advocating for them. Neal-Boylan (2012) interviewed disabled nurses and physicians and found that both cohorts often did not request accommodations, preferring to find their own ways to compensate for what they could not do easily. In another study (Neal-Boylan & Guillet, 2008a) nurses identified

workplace redesign and organizational flexibility (e.g., flexibility in scheduling, understanding needs) as modification that would support their ability to participate in the profession. Neal-Boylan and colleagues' (2011) study of nurses with sensory disability suggests that whether a nurse can be accommodated or make modifications to continue to work depends on the extent to which a disability impacts a nurse's ability to carry out their role functions in the work setting. This study found that nurses with severe hearing impairments and those working in hospitals were at greater risk for job retention problems. These previous findings and those of the current study related to accommodations correspond with Baldrige and Veiga's (2001) proposed framework for accommodation requests. The framework posits that an employee's request of an accommodation is influenced by variables associated with three key factors: characteristics and attributes of the employee (e.g., type and severity of disability), the work context (e.g., disability climate), and the accommodation (e.g., costs). While this framework has yet to be empirically validated, it offers a jumping-off point towards understanding the complexities of accommodating disabled nurses in the workplace.

The findings of the current study also suggest there is some dissonance between the ideals and goals of accommodation in the workplace and actual practices and employees' experiences. Canadian law prohibits discrimination based on 11 grounds that include disability (Government of Canada, 2017). At the provincial level, legislation such as the Ontarians with Disabilities Act and the Ontario Human Rights Code focus on removing barriers for disabled people so they can participate in work and other aspects of mainstream society. These laws make it clear that employers have a duty to accommodate employees' needs to "make sure they have equal opportunities, equal access and can enjoy equal benefits" (Ontario Human Rights Commission, nd, para 1).

However, there is a difference between a work environment articulating accommodation policies and espousing a commitment to equity and making a substantive effort to ensure needs are met. A recent Conference Board of Canada (2015) report of roundtable discussions with employers and other stakeholders indicates that while there is impetus to recruit and retain disabled employees, employers report struggles to adequately accommodate employees and, more broadly, create disability-friendly workplace cultures, which they acknowledge as critical to ensuring healthy and productive work. The accommodation-related challenges identified included misconceptions and myths about accommodating employee (e.g., belief that accommodations are expensive and that they “prop up” employees not fit to work), lack of support from administration, and lack of evidenced-based information (Conference Board of Canada, 2015).

With respect to accommodations, the available research about disabled nurses confirms some of the issues and challenges reported by employers described above. In 1990, Winland-Brown and Pohl reported that personnel administrators held stereotypical views about the role of nursing as primarily task-oriented. Consequently, they were unwilling to hire nurses in wheelchairs. Decades later, the findings of similar studies indicate that employers remain reticent about incorporating and accommodating disabled nurses in the workplace. Neal-Boylan and Guillet (2008a) reported that nurse recruiters perceived that the accommodations they made for disabled nurses were unfair to others. They were also of the opinion that staff perceived these accommodations as unfair. However, Wood and Marshall’s (2009) study of a significant sample of nurse leaders found they readily used a variety of effective accommodations to address the needs of nurses with a wide range of disabilities. Interestingly, Wood and Marshall’s (2010) study also revealed that many nurse leaders harboured concerns about disabled

nurses' ability to competently and safely provide care. The concern over the risk to patient safety posed by disabled nurses supports the premise that misconceptions and myths about this population related to accommodation are a factor in the challenges employers face with recruiting, retaining, and accommodating of disabled employees. In the next section I explore the influence of others' knowledge and awareness about disability in the workplace on disabled nurses' work experiences.

Knowledge and understanding of disabled nurses' experiences

Within the literature focusing on disabled nurses there is wide support for educational and awareness-raising interventions as a means of addressing stigma, discrimination, and the lack of support and comradery disabled nurses experience in the workplace (e.g., Joyce et al., 2007; Matt, 2008; Neal-Boylan, & Guillet, 2008a,2008b, 2008c; Neal-Boylan et al, 2011). In the current study, some participants highlighted the lack of knowledge about disability and the need for greater understanding and awareness of disability as a barrier and facilitator, respectively. Education and awareness were suggested by participants as possible ways of addressing the lack of support and responsiveness to their needs in the workplace. These findings confirm other previous studies' findings in which disabled employees provided similar recommendations (Neal-Boylan, 2012; Neal-Boylan & Guillet, 2008a; Guillet et al., 2007; Harpur, 2014). Guillet and colleagues (2007), reported that to enhance the ability of disabled nurses to participate in the profession of nursing, disabled nurses recommended that their colleagues should be made aware of the existence of disabled nurses, their desire to work, and of their decision to hide their disability because of stigma. Harpur (2014) interviewed disabled professionals and found that they used tactics, such as openly addressing their disabilities during interviewing and rebutting misconceptions and

erroneous information in the work environment, to address the negativity they encountered in the workplace and support a disability-friendly environment for all disabled employees.

Several studies about disabled nurses (e.g., Matt, 2008; Neal-Boylan, 2012; Pohl & Winland-Brown, 1992) assert that the involvement of nurse supervisors and managers in interventions and initiatives to improve awareness and knowledge is critical. Matt (2008) reports that disabled nurses believed it was critical to gain the support of supervisors because of their influence on their peers. In their study of disabled nurses' experiences, Pohl and Winland-Brown (1992) concluded that nurse administrators should foster caring environments that balance disabled nurses' needs with the needs of the workplace. However, a key finding of the current study is that disabled nurses reported interpersonal difficulties and challenges in dealing with their managers and administrative personnel regarding accommodations. These nurses also reported a sense that their managers and supervisors did not understand their experiences. These findings suggest that managers and nurses themselves need education and awareness raising about disabled nurses before they can act as allies and advocates of disabled employees. It cannot be assumed that because individuals are healthcare professionals or in leadership roles that they are equipped to address disability issues and support disabled employees.

Study findings in Relationship to Theorizing Disability

Finally, that nurses struggle to work because of their impairments is evidenced by the findings of the current study. However, resoundingly, the narratives of participants demonstrate that factors relating to the workplace milieu impede nurses' ability to practise and fully participate in work. From the perspective of theorizing disability, much

speaks in favour of social and post-social models of disability as broad frameworks to understand the practice experiences of disabled nurses. While there is not a model of disability that is a panacea to explain all things disability, what this research demonstrates is that individualized approaches to understanding disability that conceptualize disability as an individual, private matter (whether embodied or not) are inadequate in capturing the lived experience of working with a disability. More practically, thinking about the experience of disability in the workplace as an individual responsibility does not help us as a society move closer towards our ambitious goal of full participation for all in work and social life to the extent of everyone's own merits and abilities being accepted.

Evaluation of the Research

Strengths of the Study

The primary strength of this study is its congruence between the research topic, research aims, and the methodology used. Within the literature, very little attention has been given to the research topic. Within the small body of research focusing on the topic of disabled nurses' practice experiences, very few rich portrayals of the practice and workplace experiences of nurses in their own language exist. The available research is virtually void of the voices of Canadian disabled nurses. The aims of this study specifically addressed these gaps by seeking to produce, from their perspective, a descriptive account of the practice and work-life experiences and perceptions of disabled nurses practising in Ontario. The research methodology chosen was the most appropriate for investigating the topic area and accomplishing the study's primary aim. Sandelowki (2000, 2010) states that while other qualitative methodologies fall into the descriptive domain, they are also used and better suited for other purposes and aims

such as explaining phenomena. Basic or fundamental qualitative description is exclusively in the descriptive domain and has as its goal a comprehensive summary of events in the everyday terms of those events. Additionally, although qualitative description is not free of interpretation, it “entails a kind of interpretation that is low-inference,” staying close to the data and to the surface of participants’ narratives (Sandelowski, 2000, p. 334).

An additional strength of this research is studying a topic for which limited research has been conducted. Little is known and understood about nurses with disabilities and their experiences in the workplace. This study helps to further illuminate the topic. It uniquely contributes to the literature through findings that represent a thick description of nurses’ practice and workplace experiences within a Canadian context. The findings also provide a platform for research on several aspects of disabled nurses’ experiences and perceptions. For example, the findings of this research signal that emotions, particularly negative emotions, are an important aspect of disabled nurses’ practice experiences and their perceptions of themselves and others in the work environments. This emotio-spacial hermeneutic invites further research on the emotionality of disabled nurses’ experiences in the workplace.

An additional strength of this research is that it includes several strategies that support the trustworthiness of the study. As previously outlined in Chapter 3, this study employed a variety of strategies throughout the research process. These strategies addressed the four criteria of trustworthiness identified by Lincoln and Guba (1985): credibility, transferability, dependability, and confirmability. The strategies used included checking accuracy of data during interviews, providing detailed descriptions of the research methods and contextual information, inclusion of participant vignettes in

the representation of findings, and documentation of decisions and activities. Additionally, I engaged in researcher reflexivity, which not only supports the trustworthiness of the research, but also promoted changes within myself as a researcher, which Sheldon (2017) argues is an important aspect of the formal validity of a study.

Limitations of the Study

A limitation of this study is the inability to generalize the finding to the larger population of disabled nurses and other groups such as other healthcare professionals with a disability because the findings represent only the experience of the study participants. However, the discourse relating to achieving rigour in qualitative research suggests that this lack of generalizability is neither evidence of poor rigour or the usefulness of findings. Considered through the lens of transferability, it is the reader who determines if and what connections exist between elements of the study and their own experience. For example, reflecting the findings related to disabled nurses' interactions with others in the workplace, a nurse manager might apply these findings by reflecting on their own interpersonal relationships with disabled employees. Moving further out, the manager might choose to review the practices on the unit related to requests for accommodation.

The credibility and reliability of the results of this study could have been enhanced had participants been involved in verifying the data analysis or findings or both for accuracy. Nagel, Burns, Tilley, and Aubin (2015) express the belief “that co-construction, as a fundamental principle of constructivism, requires some form of involvement of participants beyond just the initial data collection (e.g., first interview)” (p. 375). Incorporating a carefully crafted process for involving participants in the analysis of data that was contextually

appropriate would be consistent with the constructivist philosophy underpinning this study and might add to the stability of the study. However, as previously discussed, several scholars have raised concerns, for one reason or another, with the process of member checking (Carlson, 2010; Glaser, 2002; McConnell-Henry, Chapman, & Francis, 2011). Carlson (2010) has commented that member checking may threaten, rather than support, the stability of a study. The process may also impact the researcher/participant relationship. Further, it can be argued that member checking is inconsistent with interpretative research. McConnell-Henry et al. (2011) remind us that in interpretive research there is no directive to prove or generalize, arguing that the idea of validation is illogical. The authors note that, “by definition, an interpretation can alter, depending on the context in which it is viewed. . . . Therefore [how will the researcher know] when the ‘right’ interpretation has surfaced” (p. 30). Furthermore, member check appears not to be compatible with the beliefs that underpin constructivist methodologies (i.e., that multiple truths exist, individuals construct meaning from their own realities, and data is co-constructed and bound to context and time).

The lack of representation of men in the sample of this study is another limitation. Although the study sample was diverse in characteristics, all the participants identified as female. In recent decades, the percentage of men in nursing has increased; males represent about 5–10% of the population of nurses. The practice experiences of men in nursing may differ from that of female nurses because of several factors such as individual and structural gender differences. Wilson (2005) identifies men in nursing as a minority group with unique experiences. Additionally, several authors highlight that gender biases exist in the profession of nursing, which may shape the experiences of nurses. For example, recent research findings reveal that men in nursing outearn women

(Muench, Sindelar, Busch, & Buerhaus, 2015; Muench, Busch, Sindelar, & Buerhaus, 2015). Rochlen, Good, and Carver (2009) found that, among others, male nurses' perception of gender-related work barriers, and comfort in physical and emotional expression with other men, were variables predictive of career and life satisfaction. While the size of the population of disabled male nurses is unknown, including the narratives of participants from this sub-group is warranted given the likelihood of gendered differences in practice experiences. Additionally, including male nurses would also further contribute to the richness and depth of the account of disabled nurses' practice experiences.

Lastly, personal relationships with some of the study participants may have impacted the information that they were willing to provide.³⁰ While closeness has become more acceptable and desirable amongst qualitative researchers and is viewed as important to obtaining viable data (Maier & Monahan, 2009), it is possible that participants in this study felt less comfortable sharing their experiences with someone they knew. Participants may have experienced greater vulnerability than they would have discussing their experiences with a stranger. Additionally, although several efforts were made to establish trust and balance closeness and detachment, power dynamics within the participant-researcher relationship and interaction can significantly impact research findings and raise a number of ethical concerns (Karnieli-Miller et al., 2009). In this study, power differences due to personal entanglements may have resulted in participants' uncertainty about assurances of confidentiality, limiting or otherwise affecting the information they provided.

³⁰ The influence of the participant-researcher relationship on the research was discussed in greater detail in Chapter 3 and is briefly highlighted here.

Contributions to Knowledge

Contribution to Critical Disability Studies

This study represents a significant contribution to the discipline of critical disability studies, a key aim of which is to “deconstruct ideas about disability and to explore how they have come to dominate our approaches to the subject and how the ideologies, policies and practices that surround disability have been constructed” (Vehmes, & Watson, 2014, p.639). The significance of the study arises because of the historical and contemporary experiences of disabled people with health care providers and within the health care system. This study disrupts the binary categories of nurse (disciplined body) and patient (undisciplined body), and unsettles the notion of disabled people as only recipients of health and social services. By occupying both the role of patient and care provider, the disabled nurses in this study blur and problematize the sharply demarcated line between these two identities and the narratives established through hegemonic masculinity.

A further aim of critical disability studies is to allow for “disability . . . to be understood from the perspective of the person who experiences it” (Reaume, 2014, p. 1248). Documenting experiences is an important aspect of examining and critically engaging with how disability is interpreted in our societies. This study portrays the experience of practising nursing with a disability as it is perceived and understood by nurses who work with disabilities. In doing so, it creates space in critical disability studies for a deconstructive discourse about nursing and disability, and a reinterpretation of what it means to be a nurse.

Contribution to Existing Knowledge

The results of this study contribute meaningfully to the literature on the topic of disabled nurses and work in several ways. First, the current study confirms the findings of previous studies on this topic thus helping to build a body of knowledge and provide insights into a group that has been largely ignored by researchers in nursing and the field of disability studies. Second, this study contributes by addressing the dearth of detailed accounts of nurses' experiences with a disability within the literature. This study provides a rich and thick description of disabled nurses' experiences that is not available in the previous studies published. The findings not only explicate disabled nurses' experience in their own voices, they also provide a more fulsome sense of the participants through vignettes that describe the interview interaction between the participant and myself as the researcher.

Third, as the first study of its kind conducted in Canada, the current study lends support towards a more universal understanding of disabled nurses' practice experiences that is not US centred. The study reveals that, like the disabled nurses in the US, disabled nurses in Ontario face numerous barriers but have limited resources to help them practise and integrate into the work environment successfully. As a result, disabled nurses perceive that they must work harder than their colleagues to compensate for their embodied limitations and manage perceptions of their abilities.

Understanding the experiences of nurses with a disability has implications for the broader disability community given that significant role nurses may have in the lives of many disabled peoples, particularly older adults with impairments and disabling illness and conditions. Understanding disabled nurses' experiences and their interactions with colleagues and others provides insights into a lifeworld that both disabled and non-

disabled people rarely can access. Such knowledge can be a powerful tool to help inculcate a paradigm shift in the profession of nursing about disability that can benefit disabled people in their interactions with nurses. It follows from contact theory (Pettigrew et al., 2011) that helping nurses to “listen to the voices” of their disabled colleagues can potentiate their ability to listen and make meaningful connections with other disabled people.

Implications and Recommendations for Practice

Workplace Policies and Programs

In Ontario and many jurisdictions in Canada, employers are required to address disability in the workplace, including providing mechanisms for accommodating the needs of disabled employees such as nurses. It is evident from the stories shared by participants in this study that such programs and other measures have been implemented in the organizations and institutions that employ nurses. However, this study’s findings also suggest that sufficient attention is not being given to the needs of disabled nurses. Participants recalled negative confrontations relating to the implementation of the various policies and programs that are supposed to support them to practise and participate fully in work. These findings signal that the organizations and institutions that employ disabled nurses need to be more responsive to their situations.

That there were numerous and interconnected influencing factors related to workplace milieu signifies the extent of the challenges that employers and other stakeholders — e.g., unions, providers, employee/employer advocacy group and associations — must address. The implication for these stakeholders is that the way forward towards enabling healthy and productive work must reflect this complexity and requires a multi-faceted approach that is collaborative in nature. This is echoed by a

recent Conference Board of Canada (2015) roundtable that identified multiple challenges to supporting disabled people in the workplace, many of which correspond with the key findings in this study.

Participants' narratives about their return-to-work experiences and difficulties obtaining accommodations and having them implemented provide direction as to where improvements are needed regarding disability-related policies and programs. The findings of this study suggest that the process of establishing return-to-work plans and accommodating disabled nurses can be adversarial and conflict ridden, adding to an already challenging situation for the nurse returning to work or seeking accommodation. Employers should calibrate aspects of their disability-related policies, procedures, and programs, such as return-to-work interventions, to shift focus to a collaborative and more individualized approach. This can be done by examining and adjusting: 1) how policy related to disability is developed and implemented; 2) the role of supervisors, managers, and program administrators; and 3) the procedural aspects of the programs and initiatives that are in place to support disabled nurses' work (Franche, Baril, Shaw, Nicolas, & Loisel, 2005).

Disability Climate and Disclosure

As discussed previously, several factors emerged from this study that are indicative of the concept of disability climate proposed by Matt and Butterfeild (2006). These factors included supportive programs and resources, organizational policies and processes related to return to work planning, ease of obtaining accommodations, and support from colleagues, supervisors, and administrative personnel. In this study, participants' narratives and perceptions relating to these factors suggest disability climates in their workplaces that are more negative than positive. Employers and other

stakeholders should recognize the influence organizational policies and programs, and the attitudes and behaviours of managers, administrators, and other employees have on the disability climate and work to contribute positively to the disability climate in the workplace. This can be accomplished by moving beyond simply focusing on accommodation policies and processes for disabled employees and taking a comprehensive disability-friendly approach to human resource processes. Specifically, employers and other stakeholders should focus on addressing factors that comprise the disability climate. To develop a positive disability climate, employers need to shift to thinking about how they can develop a workplace culture that is fair and responsive to meeting the needs of all employees. This could involve adopting a universal design approach that goes from thinking about disabled people as a small specialized group to thinking that each employee may potentially need supports and accommodations at any point in their employment to continue to feel and be productive in the workplace (The Conference Board of Canada, 2015).

In addressing issues with disability climate, the impact of others' negative attitudes and beliefs about disabled employees and their ability to contribute in the workplace should not be underappreciated. A key finding from the analysis in this study was that interpersonal interactions in the workplace, particularly between disabled nurses and their managers and administrative staff, were important to nurses' experiences of practising with a disability and perceptions of what would support their ability to practise. Nurses identified several interactional factors as barriers, including the negative attitudes of others, being treated poorly, and experiencing stigma. Further, the study found the corollary to be true, that working in a supportive atmosphere, being able to relate to others, having helpful colleagues and receiving support from similar

others and human resource personnel were identified by participants as facilitative of their ability to successfully practise nursing.

Developing a positive disability climate involves creating and disseminating disability-friendly policies, procedures, educational activities and communication across all human resource processes: human resource planning (e.g., recruitment, orientation, training, promotion), performance management and employee remuneration and benefits administration. To drive such organizational changes, organizations should take a participatory approach. Participatory human resource management practices that involve all employees at different levels of the organization in decision-making and planning change can benefit employee wellbeing and improve organizational and system performance. However, a significant challenge for employers is ensuring that they include employees belonging to marginalized groups. Recent research reveals that marginalized employees tend to have fewer opportunities to participate in practices such as organizational decision-making (Paisna, Smith, Ross, Rubery, Burchell, & Rafferty, 2013). In this regard, employers are faced with a “chicken-and-egg” dilemma. In this study, participants reveal apprehensions about disclosing, did not disclose, and/or selectively disclosed in the workplace because they feared negative consequences relating to the factors that comprise the disability climate (e.g., unsupportive supervisors and colleagues). If the disability climate in a workplace discourages employees from self-disclosing their disabilities, how then can employers facilitate disabled employees’ participation in practices intent on improving the disability climate that exists. Addressing this and other issues undoubtedly will require creativity, and employers may need to look to external supports, such as disability organizations, for guidance.

Implications for Education

The findings of this study have implications for the formal and informal education of nurses and other employees in the workplace. As discussed, the findings of this study confirm findings of previous research indicating the attitudes and behaviours of nursing colleagues, supervisors, and other individuals in the workplace, which strongly influences nurses' self-concept and contributes to the negative practice experiences reported by disabled nurses. In this study and others, participants identified that improvement in the supportive behaviours of others and the organization in general would facilitate their ability to practise. Participants also identified a need to increase others' knowledge and understanding about the experience of disability in the workplace. At the individual employee level, these findings encourage nursing colleagues and others in the work environment to engage in self-reflection to identify their perceptions and attitudes towards disabled people, and begin to address them.

At an organizational level, these findings suggest that formal education and awareness raising is needed to support a disability-friendly culture and climate. In the literature focusing on disabled nurses' work experiences, there is widespread support of formal and informal education and awareness interventions. Research evidence demonstrates that disability education and awareness interventions can have positive impacts on attitudes towards disabled people (e.g., Kleynhans & Kotze, 2017; Li, Wu, Y, Ong, 2014; Lindsay & Edwards, 2003; Pugh, 2008). While educational intervention can be effective, there is the risk that they can veer in the direction of tokenism (Finlay, 2015) or become routinized on par with other mandatory activities (Mythen & Janice, 2011) rather than committed action leading to real change. An educational and awareness

program ideally should represent part of a broader agenda of long-term planned organizational transformation in relation to disability.

Recommendations for Future Research

This research study sought to produce a descriptive account of the practice and work-life experiences and perceptions of 12 disabled nurses from their perspectives. Previous work on this topic is very limited in number and was completed outside of Canada. The findings of this study offer thick description of the work experiences of disabled nurses in a Canadian context, their perceptions, and thoughts about what helps and hinders their ability to practise. This study adds dimension to a small but growing body of research about disabled nurses as a population. While the findings align with a universal narrative emerging from this literature, further work is needed.

First, the study should be repeated with a more diverse sample of participants to provide a fulsome account of nurses' experiences, and uncover any findings that are divergent from those identified in this study and previous research. For example, given some of the differences between the experiences of male and female nurses reported in the literature, it would be important to include the voices of disabled nurses who identify as male. Further, a future study should endeavour to include nurses working outside of urban environments. The sample in this study consisted of nurses who worked in urban areas. The discourse about locality and nursing work suggests there are significant differences between urban and rural work environments (e.g., Baernholdt, & Mark 2009; Macleod, Kulig, Stewart, Pitbaldo, & Knock, 2004). Given these differences, including or independently studying this sub-population is warranted. Additionally, it may be prudent to conduct separate inquiries based on disability type. The findings of this study and previous work suggests there are nuanced differences between the experiences of

nurses with hidden and visible disability, as well as for nurses with mental health illness. A key consideration in pursuing research with these sub-sub-populations will be how to recruit participants with specific characteristics among an already hard-to-reach group. Sampling may prove very challenging and will likely require innovative sampling methods and recruitment strategies.

Second, new research should explore key findings of this study in greater depth. Sandelowski (2000) puts forth that the descriptive summary derived from a qualitative descriptive study can “yield the working concepts, hypotheses and thematic moments for future grounded or phenomenologic study” (p. 339). In this study, the data collected from interviewing disabled nurses has generated numerous sub-experiences and topics for discussion, including the emotionality of practising nursing with a disability, and disabled nurses’ experiences of disclosing in the workplace and the consequences of such disclosure. These topics can be explored through qualitative and quantitative methodologies. Previous work focusing on these topics has virtually ignored disabled nurses as a population of interest.

Third, as Sandelowski (2000) suggests, the findings of this study can serve as the basis for theory generation about the experience of practising nursing with a disability. Very few studies have theorized about the experiences of disabled nurses. (e.g., Pohl & Winland-Brown, 1992; Matt, 2008). In this regard, a study could be conducted using grounded theory methodology to enhance understanding of and provide further insight into the experience of practising nursing with a disability or sub-experiences such as nurses’ disclosure of disability in the work environment.

Fourth, future studies should focus on the relationship between disabled nurses’ ability to practise and aspects of the workplace milieu (workplace culture and climate,

employer-employee relations, disability-related support services, policies, and procedures). In this study, it is clear from the findings that aspects of workplace milieu played influential (if not determining) roles in participants' perceptions of and experiences working with a disability. A key topic that should be examined is workplace support of disabled nurses. On this topic research could be conducted that assesses disabled nurses' perceptions of workplace supports and their attitudes towards the employer in this context. For example, a study could be conducted to explore how disabled nurses feel they are treated by their employer and their responses to this treatment. On this topic, quantitative research can also be undertaken to model the factors affecting the treatment of disabled nurses in an organization.

Lastly, it would be prudent to examine the workplace disparities that disabled nurses face and their outcomes. The constellation of negative findings of this study (e.g., experience of stigma, ill-treatment, discrimination, negative consequences of disclosure, interpersonal and workplace culture barriers; physical environment as a barrier) strongly suggest that participants were treated differently in the work environment in comparison to their non-disabled counterparts. While research evidence of the nature of disparities between disabled and non-disabled employees exists at a broad level and within specific labour markets, there is an absence of work focusing on nursing. Research to identify the disparities experienced by disabled nurses is critical to meeting the needs of disabled nurses and the future needs of an aging nursing workforce in which disability is likely to be more prevalent (Matt, Fleming, & Maheady, 2015).

Summary

According to the Canadian Survey on Disability (CSD) published in 2012 by Statistics Canada (2017), one in seven Canadians aged 15 years or older report having a disability that limits their daily activity. The CSD also found that the prevalence of disability rises with age, with the average age of onset at age 43. These statistics, when considered with trends in the Canadian nursing workforce, strongly indicate that the population of nurses with a disability is significant and growing. At the same time, little is known and understood about disabled nurses. Only a handful of studies have been published that focus on the characteristics of this population and their experiences in the workplace.

In this research, I sought to address the gaps in previous work through a qualitative descriptive study exploring the practice and work-life experiences and perceptions of disabled RNs. The primary aim was to produce a descriptive account of the practice and work-life experiences and perceptions of disabled nurses from their perspective. This study found that disabled nurses' experience of practising with a disability is multi-faceted and involves both positive and negative aspects. Participants shared they were challenged by changes in working due to their disability. These challenges were confounded by barriers in their work environments including negative interactions with others and difficulties meeting their needs for accommodation. While they desired more resources and factors, such as support from others, these nurses used what resources and supports they had available to maintain working to their level best.

Overall, the results of this study contribute to the literature by providing further support to the findings of previous studies. This study also adds dimension to the body of literature on the topic in that it focused on the experiences of disabled nurses in a

Canadian context. Lastly, the finding builds on the available data by providing a thick description of nurses' experiences of practice. The study reveals details that can inform nurses in practice, educators, and employers seeking to understand and support disabled nurses in their organizations. It is hoped that the findings will also inspire additional research to address the gaps that remain and expand our knowledge of disabled nurses as a population.

Fundamentally, this study was about stories being told by voices that are seldom heard. In this context, the question that comes to mind is, what story is being told by this study? I believe this study shines a light on this point in time of a yet unfinished and unwritten story. In moving forward, it can illuminate a path instead of us stumbling in the darkness.

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Appendices

Appendix A: Interview Guide and Reference list

1. Describe the nature of the work you do as a nurse.
2. In what way do you consider yourself disabled? (cue: definition of disability used in the recruitment material will be provided)
3. Tell me about your disability.
4. Describe your experience of working as a nurse with your condition/disability.
Prompt question: How has your disability influenced your ability to do your work as a nurse, if at all?
5. Beyond your performance, how has/does having a disability influenced other aspects of working as a nurse? (cues: relationships, interactions with others).
6. How do you think others perceived you and your ability to work as a nurse? (cue: colleagues, administrators, patients).
7. What, if any, barriers to practice do you see as a nurse with a disability?
8. What, if any, facilitators to practice do you see as a nurse with a disability?
9. Is there anything else you would like to share?

Reference List

1. Employer Services

Employer Assistance Programs (EAP)
e.g., Shepell.fgi 1-888-833-7690

* Offered as part of employee benefit programs, EAP programs provide confidential counseling and support for employees and their families.

2. Non- profit Social Services

Family Services Toronto (Toronto, Scarborough, North York, South Etobicoke, Rexdale)
(416) 595-9230

*Fee sliding scale based on income and number of dependents

Toronto Distress Centre

416-408-HELP

* Anonymous, confidential and free telephone support available 7 days a week.

Mental Health Helpline

1-866-531-2600

*Ontario wide service providing information about counseling service supports across Canada, education, and in-the-moment support

Gerstein Centre

Crisis line, (416) 929-5200

*Crisis intervention for adults living in the City of Toronto

Canadian Mental Health Association

Mental health Services

1-866-531-2600

3. OHIP Services

General Practitioner Psychotherapy, Psychiatrists, and Social Workers

*Accessed through referral from healthcare practitioner (e.g., Physician, Nurse Practitioner)

4. Fee for Service Counseling support

Ontario Psychotherapy and Counseling Referral Network

905-937-0088, 416-920-9355

Appendix B: Study Consent Form

Nurses with Disability Research Study Informed Consent Form

Study Name: Work Experiences of Nurses with Self-identified Disabilities

Researchers: Charles Anyinam Doctoral Candidate, Graduate Program in Critical Disability Studies, York University Room 007, Health, Nursing & Environmental Studies (HNES) Building Mobile: 647-308-8541 Email: anyinac@yorku.ca

Purpose of the research: The purpose of this research is to produce a descriptive account of the practice and work experiences and perceptions of registered nurses (RN) that self-identify as having a disability or either a physical, medical, psychological/mental, and cognitive impairment/condition. Information will be gathered through face-to-face interviews that will be recorded and then exactly typed out. The information collected will be compared and combined to generate common themes. Non-identifying quotes will be used to support these themes. The results of this research will be reported in a doctoral thesis and may be published in academic journals or books and/or presented at conferences.

What you will be asked to do in the research: As a participant in this study you will meet the researcher for a face-to-face interview and asked open-ended questions about your perceptions and experiences practicing as a RN in a work environment. The interviews will take 60 to 90 minutes and will be digitally recorded to ensure that there is an accurate record of the information you provide. At the end your interview you will be provided with information about the study and encouraged to pass it on to others who you think may be interested or eligible. You have the right to decline to accept the information and/or pass it on to others. At a later date you will be sent a description and summary of the information you provided and asked verify that is accurate. After the interview you may also be contacted and asked additional questions to clarify the information you provided. For participating in the interview you will receive a \$20 Starbucks Coffee Company gift card.

Risks and discomforts: The interview discussion is likely to be interesting and thought provoking; however, it is possible that you will feel uncomfortable or become

emotionally upset during the interview session. To minimize this possibility the researcher will use his skills as a RN to assess for cues signaling emotional upset and intervene by providing support, stopping the interview and/or offering referral to counseling and crisis intervention services. Additionally, all participants will be provided with a list of counseling and crisis intervention services and resources. As well, you have the right to decline to answer any question or to end the interview.

Benefits of the research and benefits to you: This research will add new knowledge about disability that will help to instill others with knowledge and understanding about nurses with disabilities. The benefits to you as a participant include: 1) the opportunity to gain knowledge and an understanding about yourself and your situation; 2) the satisfaction of potentially helping others by contributing to knowledge about nurses with disabilities; 3) the satisfaction of potentially helping others through changes in attitudes, practice and policy resulting from the application of study findings; and 4) an enhanced self-worth from making a contribution.

Voluntary participation: Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer will not influence the relationship you may have with the researchers or study staff or the nature of your relationship with York University either now, or in the future.

Withdrawal from the study: You can stop participating in the study at any time, for any reason, if you so decide. If you decide to stop participating, you will still be eligible to receive the promised \$20 Starbucks coffee company gift card. Your decision to stop participating or to refuse to answer particular questions during the interview will not affect your relationship with the researchers, York University, or any other group associated with this project. In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible.

Confidentiality: All information you supply during the research will be held in confidence. Confidentiality will be provided to the fullest extent possible by law. Only the researcher will have access to your identifying information (e.g., name, contact information). Your identifying information will not appear in any report or publication of the research. The information you provide during the interview will be coded and kept

separately at all times from your identifying information. Your identifying information will be stored to an encrypted data storage device and locked in a separate cabinet. The information you provided during the interview, if in electronic format, will be saved to an encrypted folder on an encrypted data storage device and locked in a cabinet in a secure room. Any information in hard copy will also be locked in a cabinet in a secure room.

Your identifying information will be destroyed immediately after all the data has been collected and analyzed. After the study, the information you provided during the interview will be securely stored for 5 years. After this period the data will be permanently destroyed.

Questions about the Research? If you have questions about the research in general or about your role in the study, please feel free to contact me or my Graduate Supervisor, Dr. Geoffrey Reaume by telephone at (416) 736-2100, extension 22058 or by e-mail (greaume@yorku.ca). You may also contact my Graduate Program - Critical Disability Program, Faculty of Graduate Studies, Health, Nursing and Environmental Studies Building, 416, (416) 736-2100 x 22058 (Voicemail).

This research has been reviewed and approved by the Human Participants Review Sub-Committee, York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, you may contact the Senior Manager and Policy Advisor for the Office of Research Ethics, 5th Floor, York Research Tower, York University, telephone 416-736-5914 or e-mail ore@yorku.ca

Legal Rights and Signatures:

I _____, consent to participate in the *Work Experiences of Nurses with Self-identified Disabilities* study conducted by Charles Anyinam. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Signature _____ **Date** _____
Participant

Signature _____ **Date** _____

Principal Investigator