**Towards a cautious use of a social model of disability in general nursing.**

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**Abstract**

This paper acknowledges that disability related discrimination is widespread and that nursing, as a profession, has had limited involvement in challenging this. It explores the instrumentality of disability models in enhancing nurses' role in challenging disability discrimination at both patient and societal levels. First it is argued that nurses should be aware of conceptualisations and models and their own practice in relation to disabled people when they enter a patient role because of the real potential that they serve to deny full access to health care and prepare them for a social role as 'perpetual patients'. Critique of a Social Model, the antithesis of the medical model, as unashamedly political, intending to 'legitimise one way of thinking over another' is expounded along with some of its limitations in terms of a blanket application to nursing. Inroads and related claims of the impact this model into nursing, are outlined exposing the danger of 'thinking in one paradigm while acting in another'. It will be argued that professional nursing faces three key issues if it is to become part of the solution to disability discrimination, rather than remaining a relatively silent partner in sustaining the problem.

1. There is a need for evidence of all kinds to show the extent and nature of the problem in nursing, since a majority view may still be that the idea that nurses could be implicated in discriminating against disabled patients would be seen as a preposterous notion

2. Disability cannot easily be viewed as both a medical condition, still the prevailing paradigm within health care professions, and at the same time an equal opportunity issue. There is a pressing need to convince those within the profession that disability should be conceptualised within a rights framework.

3. More evidence is needed to show the value or potential of

models of disability in nursing and as a way of creating cognitive dissonance and thus challenging discrimination. Advocacy has been described as little a- that which concerns itself with individuals, and big A- concerning itself with wider social illnesses or issues. This up streaming, correcting the bigger picture issues before they impact on individuals, is something an early nurse writer alluded to in suggesting that we need a model of advocacy which extends our concerns beyond the institution 1989). The possibility of nursing as social advocacy, along with other implications are examined in this paper.

Slide 1

I have been working on this ‘project’ for a number of years and in spite of the claims that a Social Model has past its sell-by date- I’m convinced that in some spheres it maintains its radical edge and has potential.

2

I’m delighted to be here to discuss this topic with you because I have good reason to suspect I will find honey- Like Pooh who expects best honey from the jar! Well if not honey, then gems of collective wisdom to help my thinking. I attended the first UK Conference back in 2003 and have followed subsequent proceeding via the web site.

3

Inside me, across my career as a nurse and mostly as a nurse educator, I have a thing about disability- and MAYBE, like the forming ideas carried around in Pooh bear’s mind- it will look very different when exposed to the scrutiny of others. So I come as a learner. But one who subscribes to the goal of “radical socio-political transformation” (Kellner 1998;7). *The thing is* I think health professionals, nurses included, who are cast as contributors to the problems faced by many disabled people; MAY become part of the solution to disability discrimination.

4

In his recently revised ‘Understanding Disability’ Michael Oliver (2009;176-7) warns that, contrary to appearances, nurses are not to be viewed as allies, since they “are the beast itself”. However, as we are in Lancaster, an academic institution, so far I feel fairly safe admitting that I am on the UK Nursing register.

It may be useful to outline the UK system of Nursing

The title is protected by law.

Midwifery is NOT nursing!

There are different branches

* Child
* Mental Health
* Learning Disability
* Adult

My background and focus today is this last category- the most populous, the general one. This type of nurse is found on the end of the NHS-direct telephone advice line (incidentally- some of whom are blind, others wheelchair users and some have well earned bad backs), in the GP surgery (the quicker and more human option compared to the GP perhaps), Occupational health departments, the general hospital wards where you may find yourself if you have a physical aliment, and of course on our UK TVs in ER and Holby City or Casualty.

ALL branches have daily contact with legally-defined disabled people- though most do not realise it.

5

Some see Adult nurses like this.... Nurses play a role in the production line of disability. Model citizens, [people who have, or aspire to health], from time to time acquire impairments – curtsey of Leprosy, Laddish behaviours (often around cars, sports or alcohol) or various Long-term conditions (depending of course on where you live).

They eventually enter a health /medical setting where nurses conspire, with others, via a socialisation process, to change the citizen’s identity [which may traverse Victim, Patient, Disabled Person] (Morse and O’Brien 1995)

The citizen emerges from this sausage-machine as a medical failure, dependent, deviant and rather devalued regarding their citizenship.

[Dwyer (2004;115) examined the concept of citizenship and concluded that “Citizenship rights for disabled people remains firmly anchored in rhetoric rather than reality”] .....thus disabled people emerge as a 'perpetual patients‘.

The slightly paranoid amongst us will now question the motives of nurses and all health professionals; but should we actually question a professionally qualified nurse they would be horrified at the preposterous notion that they are implicated in ‘disabling people’ in this way – there is little of consciousness in the process- it’s in their social and professional genes- furthermore the citizens who are thus processed into ‘perpetual patients’ themselves have no real cause to notice the process- they have yet to be enticed or converted by the radical social model of disability.

6

Since, as we know, most legally disabled people want nothing to do with the label, it may show nurses to be *surprisingly enlightened* to note that only around 75% dismiss the rights dimension of disability (Scullion 1999) and view the concept as akin to illness!

7

As nursing aspires to professional status (certainly there is considerably more autonomous practice in the past 10 years) and follows the lead of Evidence Based Medicine (which has been conceived by some as Eminence Based Medicine) and its sister Evidence Based Nursing; we need

* Facts of science- Statistics and counts
* Facts of Experience- the deadly impact of diagnostic overshadowing
* Nurses to engage WITH disabled people in research
* Surveys, Historical, Ethnographies, Phenomenology, Participatory Action research, Evaluations, Narratives, National Enquiries, Case Study, RCTs

However, rather than an eclectic mess, above all we need CRITICAL THEORY, AND in line with an overarching aim of critical theory nurses should work to “free people from overt and covert forms of domination” (Johnson and Buberley 2003;120), via their research and their practice.

8

There is a pressing need to convince the nursing profession that disability should be conceptualised within a rights framework; *Because*, as in many areas of life, disabled people, irrespective of their own identities, face discrimination- including in the area of healthcare

We need nurses to be disturbed and confused as opposed to contented or complacent! People are losing their lives, diagnostic overshadowing gives others poorer quality healthcare, the expectations of nurses is picked up, almost by osmosis, by people in transition (on the Production-Line). In just the sort of environment where one may expect a safe haven of disability-friendly attitudes (Harrison 1999), disabled people actually face poor access to primary care, denial of treatments, human rights violations, lack of dignity and a medically dominated socialisation process which leaves those with acquired impairments accepting that their problems almost entirely stem from their own dysfunctional bodies or minds (Bowers, 2003; Brett, 2002; Carter and Markham 2001; Harrison, 1999; Northway, 2003; Scullion, 2000a).

9

However ‘Disability’ cannot easily be both illness and equality issue. The following list may disturb adult nursing and create some cognitive dissonance if these issues get air time in the curriculum;

* Legal requirements- DDA 2005 DES- Public bodies to promote equality
* Rights agenda- e.g. Non-optional reasonable adjustment, Full-Person, Human citizenship even for disabled people
* Studies showing experiences of healthcare- EBN agenda
* Champions- Some disabled nurses- others allies [LD MH]
* Barriers- Social Model / Ten minute test
* Advocate role- fairly well established in MH & LD, not Adult (more later)

10

WHAT may be useful is Becky (the wheelchair user Barbie Doll) – this is the thing inside which seems *very thingish* (Potentially Powerful). It is of course the Social Model of Disability- a spanner or imprecise tool to fix the problem.

Oliver (2009) agrees that it is simply a tool- and I wish to use it to fix adult nursing- to “legitimise one way of thinking over another”, or at least to challenge disability discrimination.

11

So WHY do we need to use this tool with caution?

* Partial coverage-neglects those with learning disabilities (Scullion JAN 2010)
* Impairment has significance for many

*“impairments are painful, debilitating or even fatal” (Beckett 2006;116)*

* Many seek solutions to troublesome impairments

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Advocacy: does Nursing have a role?

* little a- that which concerns itself with individuals,

*during crisis, Illness, onset of acquired impairments, while temporarily incompetent*

* and big A- concerning itself with wider social illnesses or issues.

(Brandon et-al 1995). At a period when the gold-standard ‘Self-Advocacy’ is not even on the menue.

* Nurses need to extend their concerns beyond the institutions’ walls / away from the clinical focus (Fowler 1989).

13

Nursing and the ‘Disability Movement’

* Could it be possible for Nursing to join the ranks of the ‘disability movement’ ?
* *a loose collective of organisations and individuals seeking to accomplish social change; its’ various strands being* “united in their view that we live in a ‘disabling society’ in which many people with impairments are socially excluded in a number of ways” (Beckett 2006;17)
* while castigated by the ‘disabled people’s movement’ (Oliver 2009)

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Nursing as a force; Challenging Discrimination

* Nursing as Social Advocacy
* Disabled people as nurses
* Champions within
* Merging / collaboration with Disability Studies (cross teaching / book following template of Goodley and Lawthom (2006) in Psychology
* Curriculum to incorporate Social Model
* Role of Disabled people in the curriculum
* Further studies (e.g. impact of Social model)

For adult nursing to arrive at a position of readiness to accept and embrace a role in challenging discrimination, to join the disability movement; requires a giant leap away from the medical model. As adult nursing is gradually persuaded of the need; the denial of human rights, exclusion from the profession and much more widely, the perpetuation of negative images of disabled people in society, will not halt overnight. However moving towards a social model of disability represents a small step in the right direction.

Like the forming ideas carried around in Winnie the Pooh’s head- I wonder if using the social model in general nursing looks very different when exposed to the scrutiny of others?

I thank you for your attention and I invite your help.

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