Nurses Should Not Have to be Heroes – How Nurse Heroics Contributes to Ableism in Healthcare

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Think back through your nursing career. Have you ever worked a double shift to cover staffing? Have you taken a dose of cold medicine to help you get through? Have you had very little, if anything, to eat or drink for 12 hours, which helps because then you do not need to use the bathroom? Traits like these are often viewed as badges of honor and a sign of strength within nursing but hint at something much more ominous — a professional culture where self-care is often viewed as a weakness, known as nurse heroics. Nurse heroics is "the culture nurses have created wherein one is supposed to go above and beyond what is reasonable in fulfilling one's duties" (Neal-Boylan & Guillett, 2008, p. 165). These principles are often introduced within academic environments, pass into transition to practice programs, and follow us through our professional careers. They do not stop with frontline nursing, and many other nursing roles perpetuate the same foundation of putting your work and others before your own needs.

While we can all recognize the challenges this may cause to current and future nurses, there is a unique group for which this culture is particularly harmful: nurses with disabilities. The barriers created by nurse heroics for nurses who live with disabilities and chronic illnesses are significant and multifacted, operating at structural, individualized, and internalized levels of ableism. Ableism is the "discrimination of and social prejudice against people with disabilities based on the belief that typical abilities are superior… it classifies entire groups of people as 'less than' and includes harmful stereotypes, misconceptions, and generalizations of people with disabilities" (Eisenmenger, 2019, Introduction section). Structurally, nurse heroics exist due to the nursing culture and underlying principles and values held deeply within the profession (Neal-Boylan & Guillett, 2008).

Individualized and internalized barriers occur as nurses hold themselves and each other to standards beyond the actual role expectations and assign a sense of pride in neglecting personal care (Cameron et al., 2024). Nurse heroics create environments where ableism thrives through judgment, stigma, and bias from colleagues and feelings of inadequacy and exclusion from disabled nurses (Cameron et al., 2024; Lindsay et al., 2022; Thomson & Winsor Murray, 2023).

For nurses with disabilities, lack of self-care is often less sustainable. It holds consequences, such as increased recovery time, higher baseline pain levels, and extreme mental and physical fatigue (Neal-Boylan & Guillett, 2008; Thomson & Winsor Murray, 2023). This leads to a mismatch between the sustainable capacity and the spoken and unspoken expectations of the work, known as work instability (Gilworth et al., 2007). The greater the work instability, the greater the likelihood of leaving the role and the profession of nursing overall (Gilworth et al., 2007; Neal-Boylan, 2014).

Nurses who acquire disabilities during their careers and are enculturated into Nurse Heroics often feel their best option is to leave the profession (Lindsay et al., 2023; Matt, 2008). This impacts the nursing shortage and worsens the experience-complexity gap, contributing exponentially to future challenges in healthcare quality and outcomes (Westhead & Paiewonsky, 2023).

While nurses are often trained to identify and focus on what is unexpected or different and to think of that as a negative attribute, nurses with disabilities bring unique contributions to healthcare. Their exceptional critical thinking, proactive evaluation, advocacy, and creativity are invaluable (Cameron et al., 2024). By creating a representative workforce with lived experience of disability, we can support high-quality care and outcomes for all individuals, specifically for the 27%

of United States adults who are currently disabled and face health disparities due to inequity in healthcare access, quality, and cost (CDC, 2023).

Through a culture of nurse heroics, disabled nurses are being implicitly and explicitly told that they do not belong. Disabled nurses are experts at adapting, but the entire healthcare culture in the United States is too large to tackle individually. By shifting to a culture that emphasizes team-based strengths, honors individual needs, and values every person's unique lived experiences and contributions, we can support health equity for disabled nurses and the disabled community seeking care (Cameron et al., 2024).

This shift requires each of us to examine our ableism through the biases and assumptions we each hold around what a nurse is, does, looks like, and should regularly push through, not just for disabled nurses but for all nurses. By creating a more accessible and equitable culture within nursing, it can become a profession which recruits and retains a diverse, representative workforce and leads the way for reducing health disparities, including within the disability community. ■

References online:
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The Importance of Federally Qualified Health Centers and Nurse Practitioners in Advancing Equity, Diversity, and Inclusion

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Equity, Diversity, and Inclusion (EDI) have become central principles in healthcare, aiming to provide comprehensive and accessible care for all populations, regardless of race, ethnicity, or geographic location. Ohio, like many states, faces significant healthcare disparities, particularly in rural and underserved urban areas. Federally Qualified Health Centers (FQHCs) and Nurse Practitioners (NPs) are essential to addressing these disparities and ensuring equitable healthcare delivery to underserved communities. This article explores how FQHCs and NPs collaborate to advance EDI and improve access to primary care, particularly for Ohio's vulnerable populations.

Advancing EDI and Healthcare Access

FQHCs are community-based, nonprofit healthcare organizations that provide comprehensive primary care services to underserved populations, regardless of their insurance status. These centers are vital in both the urban and rural landscapes in Ohio where many residents have uneven access, and encounter barriers when trying to access affordable and culturally appropriate care. According to the Health Resources and Services administration (HRSA, 2024) FQHCs serve over 30 million individuals annually, many from vulnerable populations who face significant hurdles to accessing healthcare. In Central Ohio alone, FQHCs like Lower Lights Health provide care to over 200,000 patients, 60% of whom are racial or ethnic minorities (Lower Lights Christian Health Center [LLCHC], 2023).

The funding that FQHCs receive is often dependent on the performance metrics associated with Value-Based Care (VBC) models. These models reward healthcare providers for improving patient outcomes, reducing health disparities, and providing cost-effective care. As part of the VBC structure, FQHCs are required to meet quality metrics, such as improving patient satisfaction, increasing preventive care, reducing hospital readmissions, and managing chronic conditions effectively. These quality indicators are crucial in ensuring that FQHCs continue to receive the financial support needed to operate and provide services to underserved populations. This performance-based funding model not only helps ensure that FQHCs can continue operating, but also encourages the delivery of high-quality, cost-effective care to underserved communities (HRSA, 2024).

By offering a sliding fee scale, based on income, and providing comprehensive services including dental, vision, mental health, and pharmacy care, FQHCs reduce healthcare disparities. These centers are specifically equipped to meet the needs of marginalized communities, offering culturally competent care, language assistance, and health education programs (HRSA, 2024)

Culturally competent care can improve patient satisfaction and adherence to treatment. Fostering an inclusive