Spring 4-23-2012

Medical-Surgical Nurses' Attitudes Toward Patients who are Homeless: How Attitudes Develop and Transform

Lora Crowe

ACCEPTANCE

This dissertation, MEDICAL-SURGICAL NURSES' ATTITUDES TOWARD PATIENTS WHO ARE HOMELESS: HOW ATTITUDES DEVELOP AND TRANSFORM by Lora Crowe was prepared under the direction of the candidate's dissertation committee. It is accepted by the committee members in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Nursing in the Byrdine F. Lewis School of Nursing in the College of Health and Human Sciences, Georgia State University.

_____
Ptlene Minick, PhD, RN
Committee Chairperson

_____
Cecelia G. Grindel, PhD, RN, FAAN
Committee Member

_____
Karen Minyard, PhD, RN
Committee Member

_____
Date

This dissertation meets the format and style requirements established by the College of Health and Human Sciences. It is acceptable for binding, for placement in the University Library and Archives, and for reproduction and distribution to the scholarly and lay community by University Microfilms International.

_____
Joan Cranford, EdD, RN
Assistant Dean for Nursing
Byrdine F. Lewis School of Nursing and Health Professions

_____
Cecelia M. G. Grindel, PhD, RN, FAAN
Professor & Interim Dean
Byrdine F. Lewis School of Nursing and Health Profession

AUTHOR'S STATEMENT

In presenting this dissertation as a partial fulfillment of the requirements for an advanced degree from Georgia State University, I agree that the Library of the University shall make it available for inspection and circulation in accordance with its regulations governing materials of this type. I agree that permission to quote from, to copy from, or to publish this dissertation may be granted by the author or, in his/her absence, by the professor under whose direction it was written, or in his/her absence, by the Associate Director for Graduate Programs in Nursing, Byrdine F. Lewis School of Nursing, College of Health and Human Sciences. Such quoting, copying, or publishing must be solely for scholarly purposes and will not involve potential financial gain. It is understood that any copying from or publication of this dissertation which involves potential financial gain will not be allowed without written permission from the author.

_____

Lora Crowe

NOTICE TO BORROWERS

All dissertations deposited in the Georgia State University Library must be used in accordance with the stipulations prescribed by the author in the preceding statement.

The author of this dissertation is:

Lora Crowe
412 Hardwick Dr.
Macon, Georiga, 31216

The director of this dissertation is:

Dr. Ptlene Minick
Professor
Byrdine F. Lewis School of Nursing
College of Health and Human Sciences
Georgia State University
P.O. Box 4019
Atlanta, GA 30302-4019

Users of this dissertation not regularly enrolled as students at Georgia State University are required to attest acceptance of the preceding stipulations by signing below. Libraries borrowing this dissertation for the use of their patrons are required to see that each user records here the information requested.

NAME OF USER	ADDRESS	DATE	TYPE OF USE (EXAMINATION ONLY OR COPYING)

VITA

Lora Crowe

ADDRESS: 412 Hardwick Dr.
Macon, Georgia 31216

EDUCATION:

Ph.D.	2012	Georgia State University Atlanta, Georgia
M.S.N.	1997	Mississippi University for Women Columbus, Mississippi
B.S.N.	1992	Mississippi University for Women Columbus, Mississippi

PROFESSIONAL EXPERIENCE:

2008 - Present	Assistant Professor Georgia College & State University
2011 - Present	Family Nurse Practitioner Office of Charles Wells Jr., MD
2004 - 2008	Assistant Professor Macon State College
2005 - 2007	Family Nurse Practitioner Macon State College Student Health Clinic
2003 - 2004	Family Nurse Practitioner Medmark Inc. (Veterans Administration Contractor)
2001 - 2003	Family Nurse Practitioner, Director of Health Services Carlyle Place Retirement Community
1998 - 2001	Family Nurse Practitioner Hubbard Clinic
1994 - 1998	Registered Nurse North Mississippi Medical Center

1992-1994	Registered Nurse West Jefferson Medical Center

PROFESSIONAL ORGANIZATIONS:

2007 - Present	Southern Nursing Research Society
2001 - Present	United Advanced Practice Registered Nurses
1998 - Present	Sigma Theta Tau International (Zeta Rho Chapter)
1998 - Present	American Academy of Nurse Practitioners
1992 - Present	American Nurses Association

HONORS:

1996 - 1997	Mississippi Institutes of Higher Learning Scholarship
1996 - 1997	National Institutes of Health Stipend for Advanced Education

GRANTS:

2011	Georgia College & State University Faculty Development Grant for 'Medical-Surgical Nurses' Attitudes Toward Patients Who are Homeless: How Attitudes Develop and Transform.'
2010	Georgia College & State University Institutional Grant for 'Community Assessment of Historic Tindell Heights.'

RESEARCH:

Crowe, L & Minick, P. (2012). Acute care nurses perceptions of patients who are homeless. Western Journal of Nursing Research (Under review).

ABSTRACT

MEDICAL-SURGICAL NURSES' ATTITUDES TOWARD PATIENTS WHO ARE HOMELESS: HOW ATTITUDES DEVELOP AND TRANSFORM

by

LORA CROWE

People who are homeless rely heavily on acute health care facilities to meet basic health care needs. Medical-surgical nurses play a fundamental role in the health care and health outcomes of patients who are homeless. Health care providers' bias and stereotyping contribute to health disparities among marginalized and vulnerable populations. Because attitudes are linked to clinical decision making and behaviors, revealing how nurses' attitudes towards patients who are homeless develop and transform is paramount to improving health disparities of the homeless population. The purpose of this study was to explore nurses' clinical experiences with patients who are homeless in order to discover how attitudes toward care of the homeless develop and transform.

Interpretive phenomenology was used to describe and interpret the experiences of 11 medical-surgical nurses who cared for patients who were homeless and reported their attitudes toward this marginalized population had transformed. Nurses' clinical experiences ranged from 3 to 40 years. Audiotaped semi-structured interviews were conducted. Data analysis was ongoing throughout data collection as delineated by Diekelmann and Allen (1989) and expanded by Minick (1992). Five themes were revealed through interpretation of the rich data. The themes were 'Discovering homelessness,' 'Finding common ground,' 'Piecing it together,' 'A daily struggle,' and 'Relationships based on distrust.'

Nurses' attitudes were in constant development and transformation. Nurses' life and clinical experiences created opportunities for attitude transformations. Experiences associated with attitude transformation were identified. Nurses' experiences revealed how nurses enter practice with an established attitude toward this marginalized population. As nurses came to realization that homelessness was no longer an abstract, intangible concept rather homelessness existed and was present in their day-to-day nursing practices their attitudes began to transform. Nurses desired to find common experiences with patients who were homeless to create a sense of connectedness in nurse-patient relationships. Nurses described a daily struggle of maintaining positive, non-judgmental attitudes. Nurses shared how early experiences of negative encounters with patients who were homeless created feelings of distrust thus altering nurse-patient relationships with future patients who were homeless. This study contributes to nursing knowledge through revealing how medical-surgical nurses' attitudes develop and transform and experiences associated with attitude change. Recommendations for nursing practice, education, research are identified.

TITLE PAGE

MEDICAL-SURGICAL NURSES' ATTITUDES TOWARD PATIENTS WHO ARE HOMELESS: HOW ATTITUDES DEVELOP AND TRANSFORM

by

LORA CROWE

A DISSERTATION

Presented in Partial Fulfillment of Requirements for the
Degree of Doctor of Philosophy in Nursing in the Byrdine F. Lewis School of Nursing
in the College of Human and Health Sciences
Georgia State University

Atlanta, Georgia

2012

COPYRIGHT

ACKNOWLEDGEMENTS

I would like to express my sincere gratitude to Dr. Ptlene Minick for serving as my dissertation committee chairperson. Your knowledge as a qualitative researcher was invaluable as was your commitment and support in guiding me through this dissertation process. I would also like to thank my committee members, Dr. Cecelia Grindel and Dr. Karen Minyard, for sharing their expertise and time.

I would like to thank my research team, Dr. Debbie Greene and Dr. Regina Spratling. Your insight and dedication to data interpretation helped reveal the important findings of this research. A special thank you to Dr. Leslie Moore, my colleague and dear friend, for your constant encouragement, friendship, and late night edits.

I wish to acknowledge Georgia College & State University for the financial support of this dissertation.

I also wish to thank my mother, Dr. Maripat Curtis, for being the consummate role model for my life and labor. Your love and guidance helped to create my love of nursing and desire to learn. Thank you also to my sisters, Ann and Julie, and brother, James, for your humor, encouragement, and love. I am blessed to have you in my life and I love you.

This dissertation is dedicated to my husband, Ricky, and daughters, Rachel Alese and Emma Katherine. Your constant love and support gave me the strength needed to fulfill this endeavor. I share my joy and sense of accomplishment with you, I love you.

Finally, to the nurses who shared their experiences to further our understanding of nurse attitudes and patient care, thank you.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF ABBREVIATIONS

ASN	Associate of Science in Nursing
ATHI	Attitudes toward Homelessness Inventory
BSN	Bachelor of Science in Nursing
CDC	Centers for Disease Control and Prevention
HCP	Health care Provider
HHS	Department of Health and Human Services
IRB	Institutional Review Board
NCHS	National Centers for Health Statistics
NIH	National Institutes of Health
MSN	Master of Science in Nursing

CHAPTER I

INTRODUCTION

Little is known of medical-surgical nurses' attitudes toward patients who are homeless and how those attitudes develop and transform. This chapter provides a contextual background as to the role of negative attitudes and stereotyping in health disparities. The current health care providers' attitudes toward patients who are homeless will be presented. The focus of this inquiry, statement of purpose, and research questions will be revealed. Finally, the significance of this study as it relates to nursing will be addressed.

Focus of Inquiry

The foci of this inquiry are the formation of medical-surgical nurses' attitudes toward patients who are homeless and how those attitudes transform. Health care providers are often unaware of personal attitudes and may not understand how their attitudes and stereotyping influence their own professional behaviors (Betancourt & Ananeh-Firempong, 2003). There is evidence that negative attitudes and stereotyping (prejudices) have a direct effect on health care provider decision making (Aberegg & Terry, 2004; Fincher, Williams, & MacLean, 2004). Attitudes and stereotypes also contribute to health disparities among vulnerable populations (Institute of Medicine, 2003; Nyamathi, Koniak-Griffin, & Greengold, 2007; Van Ryn & Burke, 2000). If nurse researchers understood how nurses' attitudes toward patients who are homeless

develop and transform, interventions could be created to change negative attitudes and limit the role of prejudices in clinical decision making.

Background

The Role of Attitudes and Stereotyping in Health Disparities

Disparities in health are defined as preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations. Disparities in health are directly related to unequal distribution of social, political, economic, and environmental resources. Causes of health disparities include poor education, health behaviors, poverty, and environmental influences (Community Health and Program Services [CHAPS], 2008). Causes of disparities in health care relate to the quality of care provided and include provider/patient relationship, health care provider refusal of treatment, health care provider bias and discrimination, and patient variables of mistrust and refusal of treatment (Institute of Medicine, 2003).

Health disparities and health care provider bias toward racial and ethnic minorities are the focus of much research. Health care provider prejudices have been cited as contributing to health disparities in racial and ethnic minority patients (Institute of Medicine, 2003). Research literature supports that prejudices of non-white minority patients contributes to unequal clinical decision making resulting in fewer cardiac diagnostic and therapeutic procedures, less medication for pain control, fewer surgical treatments for lung cancer, and poorer quality of care when hospitalized (Ayanian, Weissman, & Chasan-Taber, 1999; Bach, Cramer, & Warren, 1999; Schulman et al., 1999; Weisse, Sorum, Sanders, & Syat, 2001).

The majority of research exploring health care provider bias and health disparities has focused on racial and ethnic minority groups, gender, and age. However, other sub-populations experience bias as they relate to health care delivery and health care provider decision making. Evidence exists about how socio-demographic characteristics such as physical appearance, age, gender, socioeconomic status, race, and ethnicity independently influence physicians' perceptions of patients (Bernbeim, Ross, Krumbolz, & Bradley, 2008; Van Ryn & Fu, 2003).

Perceptions of care provided to patients who were homeless were found to support the Institute of Medicine's (2003) assertion that health care providers' bias and patient variables of mistrust were associated with disparities. For example, negative perceptions were expressed by patients who were homeless through terminology such as mistrust, stereotyping, lack of communication, lack of control over health, and disrespect (Bhui, Shanahan, & Harding, 2006; Hudson, Nyamathi, & Sweat, 2008; Nickasch & Marnocha, 2009). Patients who were homeless also experienced feelings of unwelcomeness associated with perceptions of discrimination and being treated as an object. Feelings of unwelcomeness were also reported to influence a desire to avoid divulging personal health related information to the health care provider and in seeking health care in general (Wen, Hudak, & Hwang, 2007).

Health disparities among the homeless population. The homeless population has created significant social, policy, and health concerns for many decades. In 2009, it was estimated that as many as 600,000 to 2.5 million men, women and children were homeless in America (National Alliance to End Homelessness, 2009). This population has a higher incidence of morbidity and mortality (O'Connell, 2005; Zlotnick & Zerger,

2008) compared to the general population. People who are homeless have a higher premature mortality rate with an average age of death being 44.4 years as compared to 77.8 years for the general public (Ishorst-Witte, Heinemann, & Puschel, 2001; NCHS, 2007). The homeless population lacks access to the primary health care structure resulting in increased use of the emergency department, higher rates of hospitalization, and on average spend four days longer per inpatient hospitalization admission (D'Amore, Hung, Chiang, & Goldfrank, 2001; Salit, Kuhn, & Hartz, 1998) compared to their housed counterparts. As a result of health disparities, the homeless population experience frequent interaction with nurses who practice in acute health care settings.

Health Care Providers' Attitudes Toward the Homeless. Nurses' attitudes toward patients who were homeless have been the focus of little research. Research literature to examine nurses' perceptions and attitudes were descriptive and primarily qualitative in design. Nurses' attitudes toward patients who were homeless reflected both positive and negative experiences. Positive perceptions of care and attitudes toward patients who were homeless included making personal connections with and describing feelings of empathy toward those patients and viewing women who were homeless as hard working (Chung-Park, Hatton, Robinson, & Kleffel, 2006; Minick, Kee, Borkat, Cain, & Opara-lwobi, 1998;). Although positive perceptions and attitudes existed, nurses were found to have negative attitudes and employed stereotyping. For example, nurses expressed negative attitudes and feelings of being unappreciated after providing care to patients who were homeless (Minick et al., 1998). Common stereotypes of homeless people were identified such as being unemployed and mentally ill, unpopular patients, substance abusers, dirty, and non-compliant (Chung-Park et al., 2006; Kee, Minick, &

Conner, 1999; Ugarriza & Fallon, 1994). Zrinyi & Balogh (2004) found that only 61% of surveyed nursing students (n=220) would not refuse to care for patients who were homeless. Although 58% of students reported that homeless patients received the same care only 28% reported homeless patients received attention comparable to other clients.

In a qualitative study by Crowe, Meinnersmann, and Minick (2012), medical-surgical nurses' (n=12) described experiences of caring for patients who were homeless as being "the same as other patients" and "treating patients equally." However, all participants reported perceiving and observing other nurses as "segregating themselves" from patients who were homeless. For example, one nurse reported having no negative feelings toward patients who were homeless, however when sharing an experience about caring for a homeless patient who was readmitted to the hospital due to an surgical wound infection, she described telling the patient, "…well it's on you [the patient]; you [the patient] made this decision to live your life in the streets, instead of staying home and doing the right thing. You [the patient] chose drugs." The nurse was unaware that her communication with this patient reflected a negative attitude toward the patient blaming him for choosing to be homeless and causing the infection which lead to his readmission to the hospital.

Nurses' attitudes toward patients who are homeless are similar to the lay public. The general public considered homelessness a serious problem and expressed sympathy toward people who were homeless (Tompsett, Toro, Guzicki, Manrique, & Zatakia, 2006). However, public perceptions of causes of homelessness reflected a more negative tone and included substance addiction and mental illness (Gallup, Inc., 2007). Socially, the homeless population has been depicted as being undesirable and isolated from society

(Hatchett, 2004). Because some people who were homeless lived in public spaces, seemed to be more disruptive than other poverty stricken groups, and lacked access to basic needs such as bathing and grooming, the stereotyping of this population was more severe than other poor individuals (Phelan, Link, Moore, & Stueve, 1997). Social science researchers described or categorized people who were homeless as being vulnerable, marginalized, and stigmatized (Nyamathi, Koniak-Griffin, & Greengold, 2007).

Terminology associated with attitudes and stereotyping. Attitudes are personal views that place value on, reflect feelings toward, and influence behavior. According to Collins English Dictionary, the term attitude is defined as the way a person views something or tends to behave towards it, often in an evaluative way (Attitude, 2012). Social cognitive psychology is a subfield of psychology that explores how perceptions influence and shape attitudes, decisions, and behaviors. Several theories postulate how attitudes develop and influence behavior. One example is the Theory of Planned Behavior (Ajzen, 1985) which proposes that human action (behavior) is guided by behavioral beliefs, normative beliefs, and control beliefs. Behavioral belief is the belief about likely outcomes and evaluation of behavior. Behavioral belief is influenced by a favorable or unfavorable attitude toward the behavior. Normative belief is comprised of the expectations of others and the motivation to comply with those expectations. Control belief is conceptualized as the belief in the power to control factors that would facilitate or impede the behavior. Attitude towards the behavior is the degree to which performance of the behavior is valued (positively or negatively) (Ajzen, 1985).

Stereotyping is defined as the process by which people use social categories (e.g. race, gender, socioeconomic status) in acquiring, processing, and recalling information

about others (Institute of Medicine, 2003, p. 10). Devine (1989) found that stereotyping is automatically activated and exists in the minds of even low prejudiced people. Individuals tend to classify people who are in the out-group as being similar to one another. In contrast, people who are viewed as part of the in-group are viewed as having more individual characteristics (Linville, Fisher, & Salovey, 1989).

Negative attitudes and stereotypes are rooted in learned experiences that influence human behaviors, and are considered subsets of prejudice (Allport, 1935, 1965; Ajzen & Fishbein, 2000; Palmore, 1990). Prejudice is a conscious, knowledgeable prejudgment of an individual or group that may lead to unequal treatment (Fiske, 1998). Prejudice is defined in psychology as an unjustified negative attitude based on a person's group membership (Dovidio, Brigham, Johnson, & Gaertner, 1996). In addressing the concepts as subsets of prejudices, stereotypes are defined as "mistaken or exaggerated beliefs about a group, while attitudes reflect feelings about a group" (Palmore, 1990, p. 18). In studying ageism, Palmore contends that negative stereotypes generate negative attitudes, while negative attitudes reinforce negative stereotypes.

Interventions to address health care provider prejudices. The development of interventions to change health care providers' negative attitudes toward patients who are homeless is limited and shown to be ineffective in addressing health care provider prejudices in the health care setting. A small body of literature suggests that experiences in caring for patients who are homeless changes attitudes and perceptions. Nursing research studies indicate that experiences gained in health clinics caring for the homeless improves attitudes and perceptions toward people who are homeless. For example, Cruz, Brehm, and Harris (2004) found a statistically significant positive change in attitudes and

perceptions after nursing students completed clinical experiences in a homeless shelter based clinic. Similarly, Chung-Park et.al. (2006) found nursing students had a more positive perception of patients who were homeless after completing a clinical experience providing care at a homeless women's' transitional shelter. However, medical students had mixed results in perceptional and attitudinal changes. A statistically significant increase ($p=.001$) in positive attitudes was found in medical students who completed clinical experiences which focused on health care for the homeless (Buchanan, Rohr, Kehoe, Glick, & Jain, 2003; Buchanan, Rohr, Stevar, & Sai, 2007). Conversely, some negative attitudes were found to persist or remain unchanged. In another study, more negative attitudes were exhibited after medical students who completed clinical experiences in caring for patients who were homeless (Masson & Lester, 2003). In contrast, other studies supported the quality of the interaction between the health care provider and patient and increasing knowledge about the homeless population as effective interventions in altering negative perceptions and attitudes (Aberson & McVean, 2008; Kingree & Daves, 1997). As a result of mixed findings supporting effective interventions to address health care providers' prejudices, how to change attitudes toward patients who are homeless remain obscure.

According to the American Nurses Association's Code of Ethics for Nurses (2001), "the nurse practices with compassion and respect for the inherent dignity, worth and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems." Although these ethical standards are appropriate for and apply to all patient populations, patients who are homeless continue to experience nursing care that is influenced by negative attitudes and

stereotypes (Bhui, Shanahan, & Harding, 2006; Chung-Park et al., 2006; Martins, 2008; Nickasch & Marnocha, 2009; Ugarriza & Fallon, 1994; Zrinyi & Balogh, 2004).

Caring for patients who are homeless creates multiple challenges for health care providers such as limited time and financial resources to meet their needs (Hunter, Getty, Kemsley, & Skelly, 1991; Nickasch & Marnocha, 2009; Tracy & Stoecker, 1993). In addition, the patient has few, if any, resources to follow through with recommended health care due to unmet basic needs (Daiski, 2006; Gelberg, Browner, Lejano, & Arangua, 2004). Several structural barriers to care are not in direct control of the medical-surgical nurse. However, nurses have the ability to provide patients who are homeless with the best opportunity for positive health care outcomes by delivering non-prejudicial care.

Statement of Purpose

The purpose of this study is to explore nurses' clinical experiences with patients who are homeless in order to discover the development and transformation of their attitudes toward care of the homeless. The research questions guiding this study include:

1. What are the attitudes of medical-surgical nurses toward patients who are homeless?
2. Do medical surgical nurses' attitudes toward patients who are homeless transform over time? How?
3. What experiences seem to be associated with the development and transformation of medical-surgical nurses' attitudes?

Significance to Nursing

Due to limited access and other barriers to primary health care, people who are homeless rely heavily on emergency departments and acute health care facilities to meet their health care needs. Nurses in the acute care setting address the health needs of patients who are homeless every day. Because of their frequent interaction, medical-surgical nurses' play a fundamental role in the health care delivery and health outcomes of patients who are homeless. Medical-surgical units are busy environments with a rapid influx of acutely ill patients. These stressful, intense environments can foster negative attitudes and employ stereotypes to identify and group patients. Data indicate that negative attitudes and stereotypes of populations can have negative impact on health outcomes and exacerbate health disparities**.** Attitudes are linked to clinical decision making and behaviors. Therefore, it is important to understand how medical-surgical nurses' attitudes toward patients who are homeless are formed and transform.

This study revealed how medical-surgical nurses' attitudes developed and changed toward patients who were homeless. This study also revealed medical-surgical nurses' experiences associated with attitude transformation. Current nursing literature identified negative and positive attitudes among nursing students and faculty who care for patients who were homeless (Chung-Park et al., 2006; Cruz et al., 2004; Kee et al., 1999; Minick et al., 1998). However, no published studies focused on medical-surgical nurses' attitudes toward patients who were homeless and how those attitudes formed and transformed.

Significance of this study is the potential to strengthen the nurse patient/relationship. If nurses understand how attitudes form, interventions could be

developed to identify and transform negative attitudes. This would positively change the nurse/patient relationship through fostering non-judgmental care, promote positive health care outcomes, and reduce health disparities in patients who are homeless. Nurses could also develop a better understanding of the role that attitudes and stereotyping have on clinical decision making, behavior, and health disparity.

The significance of this study lies in its potential to fill the gap about what was known regarding how medical-surgical nurses' attitudes form and transform. Data from this study will be used to develop interventions designed to change negative attitudes and limit the role of stereotyping. This is the first step in a program of research to design effective interventions to transform negative attitudes toward patients who are homeless.

Summary

This chapter presents an introduction to the role of nurses' attitudes in providing patient care and influencing health disparities of patients who are homeless. The foci of this inquiry are the formation of medical-surgical nurses' attitudes toward patients who were homeless and how those attitudes transformed. The purpose of this study was to explore nurses' clinical experiences in caring for patients who were homeless to discover the development and transformation of their attitudes toward care of the homeless. The research questions that guided this study were identified. Understanding how nurses' attitudes develop and transform will move nursing science forward in creating effective interventions to change negative attitudes and reduce the use of stereotyping.

CHAPTER II

CONTEXT OF THE STUDY

The literary and theoretical context of this study is presented in this chapter. The literary context will include nurses' and physicians' attitudes toward patients who are homeless, as well as patients' who are homeless attitudes toward nurses, physicians, and the health care system. The theoretical context of this study is interpretive phenomenology. Interpretive phenomenology is used as a means to explore how medical-surgical nurses' attitudes form and transform toward patients who are homeless. Interpretive phenomenology as a methodology and a philosophy will be discussed.

Literary Context

Attitudes toward Patients who are Homeless

Nurses' attitudes. Nurses' attitudes toward patients who are homeless have been the interest of little scholarly investigation. Nurses' attitudes toward patients who are homeless are similar to the general public. Few research inquires have focused on nurses attitudes toward patients who were homeless. Of the studies identified, all were conducted in community based clinics, and most included participants functioning in a student role, or nursing faculty functioning in a clinical teaching environment. While little data exists, research suggests that nurses' attitudes toward patients who are homeless remain generally unchanged. Over the last two decades, nurses have reported

negative attitudes toward the homeless population and given examples of both positive and negative experiences in caring for patients who were homeless.

A study exploring nursing student and faculty attitudes toward patients who were homeless sought to determine if attitudes were different from those of the lay public and to identify factors that influenced attitudes (Kee et al., 1999). Using a descriptive, correlational study design, nursing students (n=377) and nursing faculty (n=45) completed the Attitude Scale, Semantic Differential Attitudes Scale, and McDonell's Knowledge about Homeless Scale (Morgan, 1984; Toro & McDonell, 1992). Findings indicated that nursing faculty had more positive attitudes compared to nursing students. There was a statistically significant difference among three items on the Attitude Scale between the participants' perceptions of homelessness and the lay public. Items reflecting the largest difference included mental illness as a cause for homelessness (p=<.001) (higher in nurses), illegal sources of income (p=<.001) (higher in lay public), and people who were homeless sleeping in shelters (p=<.001) (higher in lay public). Although this study supported a difference in some concepts associated with attitudes toward people who were homeless among nurses and the lay public, there were several methodological weakness including: the Attitudes Scale had little data which supported validity in assessing perceptions about the homeless population and focused specifically on the causes of homelessness; the Knowledge about Homeless Scale had no reliability coefficients reported and was supported by the researchers as an inaccurate indicator of knowledge; and the comparison data for lay public respondents were used from an older study.

While positive and negative attitudes towards patients who were homeless were reflected in nurses' experience, research suggests that nurses' attitudes can be transformed. Researchers used a hermeneutic phenomenological design to explore nurses' perceptions of patients who were homeless (Minick et al., 1998). Fifteen participants (11 nursing students and 4 licensed nurses) were interviewed. Interpretation of findings revealed that a positive transformation of attitudes was associated with experiences of making personal connections with patients who were homeless through listening and caring, expressions of empathy, and the realization that participants could become homeless themselves. Participants expressed personal satisfaction in caring for patients who were homeless. However, negative attitudes were expressed through the objectification of the patient and feelings of being unappreciated after providing care. Feelings of being unappreciated seemed to affirm negative stereotypes.

Student nurses' negative attitudes and the use of stereotypes were been revealed in a similar study. Researchers used a grounded theory approach to explore graduate nursing students' attitudes toward homeless mothers with children living in a transitional shelter before and after community health clinical experiences. Prior to clinical experiences, students reported (n=10) perceiving patients who were homeless as alcoholics, non-compliant, and drug addicts, common stereotypes of homeless individuals. However, after clinical experiences, students viewed patients who were homeless more positively and reported a change in their perception of the causes of homelessness. Participants also perceived homeless women as working to change their situations (Chung-Park et al., 2006).

Similarly, Cruz et al. (2004) used the Expectancy Value Model of Attitudes (Ajzen & Fishbein, 2000) to guide a mixed method study to discern the attitudes of fifteen (N=15) nurse practitioner students before and after providing care to patients who were homeless. The researchers used focus groups and a survey instrument, Attitudes Toward Homeless Inventory, to collect data regarding nurses' attitudes before and after caring for patients who were homeless (Kingree & Daves, 1997). The researchers concluded that nurse practitioner students had a statistically significant, positive change (p=.013) in attitudes toward patients who were homeless after providing direct care. Participants reported changing perceptions of causes of homelessness and reported feeling more comfortable around patients who were homeless. This study did not explore how nurses' attitudes were formed or why attitudes were transformed after clinical experiences.

Research inquiry exploring nursing students and their attitudes toward patients who are homeless suggests that attitudes can transform. Concepts associated with transforming attitudes seem to be providing direct patient care, making personal connections through listening and caring about the patient, and realizing vulnerability to becoming homeless. Current studies strengthen the argument that attitudes toward patients who are homeless may transform. However, how medical-surgical nurses' attitudes develop and subsequently transform remains unclear, thus supporting the purpose of this study.

Physicians' attitudes. An equally limited number of research studies were identified that sought to explore physicians' attitudes toward patients who were homeless. Attitudes toward patients who were homeless were explored in medical literature in terms

of curriculum evaluation and identifying perceived barriers to health care. Published studies focused on medical students' attitudes toward patients who were homeless as they relate to medical school curriculum. Researchers, using an interventional, pre/posttest study design, sought to determine if a primary care clinical rotation in a homeless shelter would change the attitudes of medical students (n=18). Using the Attitudes Toward Homelessness Inventory (ATHI), a statistically significant positive change (p=.001) in attitudes was noted following the completion of clinical experiences. No data were presented as to why attitudes changed (Buchanan et al., 2003).

In contrast, a study by Masson and Lester (2003) examined attitude change before and after completing medical school (n=211). A statistically significant increase in negative attitudes toward patients who were homeless was measured (p=.04) over time. These findings supported the supposition that the more experience the medical student gained in caring for patients who were homeless, the more negative attitudes became. However, the quantity of time spent with the patient who was homeless was not consistent among participants. In addition, physician mentors and faculty members reportedly exhibited negative attitudes that may have influenced students' attitudes and perceptions.

Although few studies supported the idea that physician attitude changes with clinical experience, no studies were identified that explore practicing physicians' attitudes. One study found that non-nursing health care providers (HCPs) did not view negative attitudes as a barrier to health care. Physicians, social workers, and hospital administrators (n=122) were asked to rate perceived barriers to care for patients who were homeless. Eighty two percent of respondents indicated the cost of serving the

homeless population as the largest barrier. Inadequate health insurance (67%), lack of safe places to discharge the patient who were homeless to after hospitalization and inability to follow through with care (79%) were also perceived as barriers to health care delivery. Negative attitudes were not viewed by non-nursing HCPs as barriers in providing health care to patients who were homeless (Hunter et al., 1991). These findings were in contrast to the Institute of Medicine's (2003) report which indicated prejudicial attitudes and behaviors negatively influenced patient health outcomes.

Limited research inquiry has been made as to the attitudes of health care providers toward patients who were homeless. Most scholarly inquiry of attitudes of health care providers has focused on nursing and medical programs evaluations of service learning programs or curricula addressing ethical issues related to health disparity and indigent health care. All research which explored nurses' attitudes toward patients who were homeless included nurses serving in a student role such as a graduate nursing student, an RN-to-MSN student, undergraduate nursing student, or nursing faculty. All studies identified were outpatient, primary care settings, which served indigent clients or people who were homeless, exclusively. The academic relationships and homogeneous settings limited the generalizability of the studies as attitudes may change when the students or nursing faculty functioned independently in acute care settings. No studies were identified that explored how nurses' attitudes toward patients who were homeless formed and transformed.

Patients' Attitudes toward Nurses and other HCPs

Attitudes of patients who were homeless toward HCPs and health services were limited in health research literature. The majority of studies identified were qualitative

research in design. Research inquiry about how homeless patients' perceived their general health status, structural barriers to health care, and overall care by health care providers were conducted (Bhui et al., 2006). Research representing system or structural barriers to health care was abundant and centered on access to care issues such as lack of transportation (Martins, 2008); lack of health insurance and financial resources (Daiski, 2006; Gelberg et al., 2004); limited referral resources for substance addictions (Darbyshire, Muir-Cochrane, Fereday, Jureidini, & Drummond, 2006); and limited scheduling hours and long waits at health clinics (Darbyshire et al., 2006; Greenberg, 2010). Perceptions of care received and of HCPs were less abundant and focused on complex issues surrounding the HCPs/patient relationship which included trust (McCabe, Macnee, & Anderson, 2001); stereotyping (Martins); discrimination (Thompson, McManus, Lantry, Windsor, & Flynn, 2006); disrespect (Nickasch & Marnocha, 2009; Wen et al., 2007); and lack of control of personal health (Darbyshire et al., 2006).

Attitudes toward HCPs. The perceptions of health care received and of HCPs as viewed by patients who were homeless were both positive and negative. Wen et.al. (2007), sought to describe the experiences of patients who were homeless with HCPs in five shelter-based health clinics (n=17). Using a qualitative research design, interpretation of the data revealed that participants experienced feeling of unwelcomeness and associated these feelings with discrimination and being treated as an object. Feelings of being unwelcome influenced a desire to avoid seeking health care and divulging personal health related information to the HCPs. However, some participants experienced feelings of welcomeness and described feelings of being valued as a person, listened to, and empowered to make health care decisions.

More positive perceptions and attitudes toward HCPs among patients who were homeless were identified by McCabe, Macnee, and Anderson (2001). Using a qualitative, phenomenological approach, researchers investigated the care provided to adults who were homeless and received services in a nurse managed primary health care clinic for the homeless (n=17). Interpretation of the findings revealed themes associated with satisfaction of health care including the perceptions of (a) trust within the HCPs/patient relationship, (b) not being judged or stereotyped, (c) being included in health care decisions, (d) being satisfied with the quality of health care delivered by HCPs, and (e) receiving services from HCPs who were committed to improving their health.

Positive perceptions of HCPs and of care provided were expressed by homeless youth. A study to determine the experiences of homeless youth receiving care at a community drop-in center was conducted using a qualitative design (n=60) (Thompson, McManus, Lantry, Windsor, & Flynn, 2006). Most participants described helpful providers who were supportive, encouraging, respectful, and trusted. Other attributes of HCPs identified included: understanding the cultural environment of living on the street, being pet friendly, and including the patient in health care decisions. However, some negative perceptions of HCPs emerged. Some participants suggested that HCPs were inflexible concerning health care instructions/requirements and believed that providers should be more understanding of their situation and not have unrealistic expectations. Others reported that providers were often disrespectful and condescending, thereby influencing the level of trust (Thompson et al., 2006).

More negative perceptions toward HCPs were identified by Nickasch & Marnocha (2009). Researchers sought to gain a better understanding of experiences and perceptions of care provided to patients who were homeless at a community health clinic. Using a grounded theory design, nine adults who were homeless were interviewed. All participants indicated a lack of control over their health and the health care provided. Major categories identified included: a lack of attainment of physical needs; a lack of health insurance and access to needed health resources; and a lack of compassion from HCPs. Participants believed that HCPs were not compassionate, were judgmental, and needed to ask more questions about the circumstances of health and illness.

In a similar qualitative study, researchers sought to identify perceptions of patients who were mentally ill and homeless about the health care they received (Bhui et al., 2006). Participants (n=10) expressed perceptions of being stigmatized and experienced prejudicial attitudes from HCPs. Participants also reported frustration with lack of control over health services such as being cared for by different HCPs, which made it difficult to build a relationship, and the difficulty of traveling to multiple locations for treatments or referrals. Overall findings identified barriers to seeking health care and negative perceptions of HCPs that impacted the HCPs/patient relationship.

Experiences of poor communication that impacted the HCPs/patient relationship were identified in a study of homeless youth. Using a qualitative design, ten homeless youth participants who received health services through a homeless youth outreach program were interviewed (Darbyshire et al., 2006). Several themes were identified by participants as negatively impacting health such as (a) lack of personal control over health, (b) feelings of being labeled by HCPs, (c) limited time and effort spent with

patient, (d) lack of involvement in health decisions, and (e) lack of explanation as to health care needed. The youth patients indicated that poor communication with HCPs fostered feelings of fear and exacerbated poor behavior. The participants suggested that trust, respect, listening, and being non-judgmental would contribute to a more positive relationship.

These findings were supported by a similar study conducted by Hudson et al. (2008). Researchers sought to identify perceptions of the interpersonal relationship between homeless youth and HCPs. Using a grounded theory approach, 54 homeless youth, who received health services through a shelter based clinic, were interviewed using focus groups. Data interpretation revealed categories representing mistrust, poor communication, and perceptions of poor quality of care that were viewed by participants as impeding health seeking behaviors.

Research concerning perceptions of patients who were homeless about health care and HCPs were limited. Studies that were identified sought to explore attitudes and perceptions of patients who were homeless toward health care and HCPs. In the studies, only participants who received health care in outpatient clinics were included. Patients who were homeless expressed mixed perceptions of health care services and HCPs citing both positive and negative experiences. Although positive attributes of HCPs were identified such as listening to the patient, inclusion the patient in health care decisions, and being non-judgmental, negative perceptions were more widespread. Negative perceptions were represented in terms of mistrust, stereotyping, lack of communication, lack of control over health, disrespect, and unwelcomeness.

Limited research has focused on factors to promote change in perceptions. Studies explored attitudes of patients who were homeless were limited by sample populations of predominantly homeless women and youth. Studies exploring attitudes of HCPs were largely female nursing students and male medical students. The homogeneity and small sample sizes of these studies limit the generalizability of the findings. Expanding the sample population to include nursing professionals who are functioning independently in an acute nursing care role would provide a more complete depiction of the attitudes of nurses caring for patients who are homeless and how those attitudes form and transform.

Research study settings were limited to outpatient, primary health care settings designed to provide care exclusively to patients who were homeless. Research in various health care settings is warranted as no studies have been found that identified attitudes of nurses who worked in acute care or emergent settings, which was where the research literature indicated most patients who were homeless sought care. Only one study was identified in the private primary care settings. Expanding the inquiry settings could provide insight about attitudes of medical-surgical nurses toward patients who are homeless, thus providing a more accurate depiction of nurses' attitudes formation and transformation.

Theoretical Context

Interpretive Phenomenology

The focus of phenomenology is the description of the world as experienced by the participant of the inquiry in order to discover the common meaning underlying empirical variations of a phenomenon (Baker, Wuest, & Stern, 1992). As described by Van Manen

(1997), phenomenology is the systematic attempt to uncover and describe the structures, the internal meaning structures, of the lived experiences. This phenomenological research, by design, allows for the discovery of the nature of the experiences and the attitudes that are associated with those experiences.

The description and interpretation of the meaning of the phenomena reveals the true meaning of a lived experience. Interpretive phenomenology was chosen because medical-surgical nurses have unique interactions and encounters that are associated with how they view their reality. Experiences are individualized and personal and reflect how one lives an experience. Interpretive phenomenology will reveal the attitudes of medical-surgical nurses which are hidden in their day-to-day lived experiences.

Interpretive Phenomenology as a philosophy. Interpretive phenomenology is based on the philosophy of Martin Heidegger. Heidegger proposed a phenomenological design which departed completely for the worldview of previous philosophers (Caelli, 2000). In his book '*Being in Time'* (1962), Heidegger questioned how humans understood and interpreted their world. According to Heidegger, one is a being in the world first, and then is conscious of one's being, which is different from previous philosophical views that believe that consciousness of the world is primary and perhaps the only reality. Heidegger asserted that one must understand what it means to be a person, to exist, before one can understand how one comes to know the world (Heidegger, 1962). In essence, the understanding of whom one is found in day-to-day experiences and in the context in which those experiences are lived. An interpretation of experiences offers insight into the meaning of being (Heidegger, 1962). Heidegger created the term "being in the world" to reflect the notion of how one experienced the

world, day-to-day, without pre-reflection or conscious thought. Benner (1994) describes this as "taken-for-granted", in that people fail to notice these everyday routine activities.

Medical-surgical nurses understand themselves and their experiences not just through the environmental and structural surroundings but also through their day-to-day nursing practices and patients they encounter. To understand the medical-surgical nurses' "being in the world" as it relates to the care of patients who are homeless and their attitudes toward patients who are homeless, the nurse researcher must first understand the lived experiences of the acute care nurses. Therefore, interpretive phenomenology is an appropriate philosophical underpinning for this current study.

Interpretive phenomenology as a methodology. How attitudes develop and change is conceptualized as taken-for-granted and revealed in day-to-day experiences. Interpretive phenomenology is uniquely suited to reveal meanings found in day-to-day experiences. Therefore this philosophy and method was chosen as the best methodology for this proposed study. Interpretive phenomenology explores a phenomenon through the eyes and voice of the person experiencing the phenomenon (Laverty, 2003). As described by Dreyfus (1991), Heidegger thought that an object could have no essence apart from its meaning within a specific context, and used interpretive phenomenology to interpret the shared meaning that one has for one's experiences. Interpretive phenomenology provides an overall understanding with a focus on meaning, in its full context, rather than on implementing a given set of methodological procedures (Pollio, Henley, & Thompson, 1997). Through interpretation, meaning is assigned to the day-to-day lived experience. Interpretive phenomenology as a methodology is appropriate for this current study of medical-surgical nurses' attitudes toward patients who are homeless.

Attitudes are reflective of the lived experiences including context and meaning. Interpretive phenomenology seeks to understand the meaning of the lived experience and thus reveal how medical-surgical nurses' attitudes form and transform.

Researcher as an interpreter of phenomenology. The interpretive researcher explores and identifies commonalities among lived experiences. The researcher relies on the participant to provide insight into their lived experiences. The interpretive researcher is viewed as an instrument that gathers participants' narratives of lived experiences and seeks to understand and find meaning of the lived experiences (Lincoln & Guba, 1985). The interpretive researcher is self-reflective and open to finding a broader understanding of the lived experienced rather than relying on her own past experiences and understandings. The researcher is part of the Hermeneutic circle and works to find the hidden meaning that is not evident or clear to the participant.

Tenets of Interpretive phenomenology. Heidegger articulated his views of how one is situated in the world and how one makes sense of it. People exist in a world where there is constant interaction with self, others, and environment. Things (e.g. objects, people, interactions) come into one's awareness or show up against the "background," which is the place where everyday activities and practices are situated (Conroy, 2003). Heidegger identifies essential concepts about being in the world. The concepts which are most important for this study include World and being-in-time (temporality).

World. World is the meaningful set of relationships, practices and language that we have by being born into a culture (Leonard, 1994, p. 46). According to Heidegger, the World is *a priori* meaning that one experiences the world before thinking about it. The world is revealed in one's cultural practices and history (Heidegger, 1962). The

World of an acute care nurse includes his/her relationships with family, peers, and patients; his/her day-to-day practice of caring for patients; social and cultural norms; and the verbal and nonverbal language used to communicate and assign meaning to experiences.

Temporality. The phenomenological view of a person includes being-in-time. Being-in-time is not a linear representation of time rather it gives us a notion of things existing in static (Leonard, 1994). Temporality, according to Heidegger (1927, 1962), is directional and relational and applies only to being, not to objects. The past is described as "having-been-ness" while the future is put in the context of "being-expectant". Being-in-time can only be studied in the context of past and future. To interpret the meaning of the lived experience of the acute care nurse's formation and transformation of attitudes, the interpretive investigator must bring in to the forefront the participant's past experiences ("having-been-ness") and future expectations ("being expectant"). The temporality of the interpretive researcher is also included in interpretive phenomenology as the researcher pre-understands influences how the text is interpreted and findings are revealed.

Heidegger describes three different ways individuals are in the world, "ready-at-hand", "unready-at-hand", and "present-at-hand." "Ready-at-hand" represents everyday practices that are aspects of ways of coping with the world. It is the unconscious interactions that are completed or performed out of habit. One develops "ready-at-hand" interaction through repeated performances. As one becomes proficient at performing the skill through repeated performances, the skill becomes second nature and the task can be completed without conscious attention or effort. Individuals interact with people and

things seemingly unaware of their actions. These everyday routine tasks and interactions are described as taken-for-granted knowledge as one interacts without deliberate thought (Benner, 1994). Taken-for-granted experiences are unique to each person and are shaped by culture, environment, and the routine tasks and interactions performed repeatedly. What is most significant in ones' life is not easily accessible to reflection or visible to intentionality (Conroy, 2003). Revealing the unique taken-for-granted experiences of acute care nurse caring for patients who are homeless will assist in understanding how attitudes form and transform.

Another level of interaction or being is "unready-at-hand." As one continues to interact with the environment and people, one encounters situations or people who are less familiar. This less familiar encounter causes more deliberate thought and awareness or "unready-at-hand." During "unready-at-hand, a disruption of one's "ready-to-hand" occurs, which causes problem solving to begin. This disruption or breakdown changes the level of awareness and way of interacting to change to fit the context. The third level is "Present-at-hand" thought (theoretical knowing). "Present-at-hand" requires reflection, thought, and deliberate concentration as to the meaning of an experience. When the acute care nurse reflects upon "ready-to-hand" and "unready-to-hand" experiences, she/he is brought into "present-at-hand" thought which may reveal how attitudes form and transform.

Assumptions

Interpretive phenomenology acknowledges the fore-structure or pre-understanding of the interpretive researcher and part of the phenomenological experience and interpretive process. This researcher's pre-understanding includes her World and

temporality and directs how she approaches and explores the meaning of the lived experiences of how medical-surgical nurses' attitudes form and transform.

1. Medical-surgical nurses are the experts of their own lives and practice.
2. Medical-surgical nurses strive to provide non-prejudicial care to patients who are homeless.
3. Attitudes are embedded in the day-to-day experiences and practices of nurses.
4. The attitudes of medical-surgical nurses are part of the culture in the work environment and society as a whole.
5. Medical-surgical nurses have unique experiences in caring for patients who are homeless which differ from caring for patients who are domicile.
6. Experiences that form and transform medical-surgical nurses' attitudes toward patients who are homeless are taken-for-granted knowledge.
7. Medical-Surgical nurses' attitudes toward patients who are homeless differ from nurses who practice in other settings.
8. Information on how medical surgical nurses' attitudes toward patients who are homeless form and transform are essential in developing interventions to identify bias and transform negative attitudes.

Acknowledging these assumptions as an interpretive researcher has begun the Hermeneutic Circle (Crist & Tanner, 2003). In this acknowledgment, the researcher will present the voices of the participants through interpretation as the meanings of their experiences are revealed.

Summary

Research focused on the attitudes of nurses, physicians, and other HCPs toward patients who were homeless were limited. Research related to attitudes has primarily been about attitudes of HCP who practiced in a primary care setting. Attitudes of HCP toward patients who were homeless were described as positive and negative. However, HCPs held common negative stereotypes toward the homeless population and had more negative than positive attitudes. Research supported the supposition that nurses' attitudes toward patients who were homeless changed. However, no studies were identified that explored how nurses' attitudes formed or transformed toward patients who were homeless. Homeless patients' attitudes toward HCP and health care services reflected both positive and negative experiences. Patients who were homeless expressed difficulty in accessing care due to the attitudes of HCP.

The theoretical underpinning of this research study was interpretive phenomenology. Interpretive phenomenology as a philosophy and methodology allowed the researcher to explore how nurses' attitudes formed and how those attitudes transformed as nurses cared for the patients who were homeless.

CHAPTER III

RESEARCH PLAN

A qualitative design using interpretive phenomenology as the method of inquiry was employed for this study. In this chapter, the researcher will discuss the proposed methodology to conduct this study about how medical-surgical nurses' attitudes toward patients who were homeless developed and transformed. The proposed research plan including the design, sampling, and study participants will be discussed as well as strategies for data generation, collection, and analysis. In addition, trustworthiness of interpretive phenomenology method will be addressed. Finally, the protection of human subjects also will be discussed. A qualitative design does not rely on a set of prescriptive methodological rules to explore and reveal what is unknown. Rather the nature of the experiences under investigation and evolving data provide the researcher and research team flexibility to allow what is unknown to be discovered. Therefore, Chapter three presents this study's proposed research plan and Chapter four will present the research plan as it evolved from the data.

Research Design

A qualitative design using phenomenological methods to describe and explore the meaning of the lived experiences of medical-surgical will be employed for this study. A qualitative design was chosen because data about medical-surgical nurses' attitudes toward patients who were homeless and the experiences associated with how those attitudes developed and transformed were unknown. Attitudes are subjective in nature

and can be found in personal experiences, feelings, and practices. To reveal the meaning of medical-surgical nurses' attitudes toward caring for patients who are homeless, one must attempt to understand the medical-surgical nurses' situatedness or context. Uncovering how medical-surgical nurses' experiences develop and transform attitudes, in context, toward patients who are homeless is best achieved through an interpretive phenomenological method approach. Interpretive phenomenology is uniquely suited to reveal meaning embedded in taken-for-granted experiences such as attitudes. The population of interest will include nurses practicing in a medical-surgical hospital setting who cared for patients who were homeless and reported that their feelings or experiences toward patients who were homeless transformed or changed.

Sampling and Recruitment

Purposive sampling will be employed to access potential participants. The potential participants will be recruited by networking with professional nursing organizations in the state of Georgia. The Georgia Nurses' Association (GNA) is Georgia's largest professional nursing association for registered nurses in all practice settings (GNA, 2011). GNA represents six geographical regions of the state of Georgia. Each regional coordinator will be contacted by the student researcher to request if recruitment flyers can be electronically mailed to regional chapter members. A recruitment flyer will also be electronically mailed to Georgia State University nursing doctoral student network. Network sampling will ensure representation from a diverse group of nurses practicing in acute health care settings.

To identify additional nurses, snowball sampling technique will be employed. Nurses who are known to and referred by other participants will be selected based on eligibility criteria as well as level of interest, diversity in years of experience as a

registered nurse, ethnicity, and gender. Snowball sampling technique will provide access to potential participants who are viewed by their peers as being knowledgeable of and having cared for patients who were homeless. These sampling techniques will increase the likelihood of obtaining rich data from multiple views.

The sample size will be determined by data saturation. Data saturation occurs when new participants reveal no new findings and meanings and pervious narratives become redundant (Benner, 1994). Previous nursing research that employed phenomenology revealed attitudes and perceptions included sample sizes ranging from nine to twenty-four. In this researcher's previous pilot study, data saturation was obtained after 12 participant interviews. The sample goal of this study is 15 eligible participants.

Sampling criteria

Inclusion and exclusion criteria will be used as sampling criteria to obtain a representative sample of medical-surgical nurses' attitudes toward patients who are homeless. Inclusion criteria for the sample population will include medical surgical registered nurses who (a) practice in a hospital setting for a minimum of 8 hours per week, (b) report their feelings toward patients who are homeless or experiences in caring for patients who are homeless has transformed, (c) are between the ages of 22 to 65 years, male or female gender, of any race or ethnic background, and (d) report the ability to read, understand, and speak English. The purpose of this study is to explore how medical-surgical nurses' attitudes toward patients who are homeless develop and transform. Therefore, only nurses who are currently employed in an acute health care setting can provide insight as to the lived experiences in caring for patients who are homeless. To understand how medical-surgical nurses' attitudes form and transform, the

lived experiences of nurses whose attitudes have transformed must be revealed. A variety of ages, racial and ethnic backgrounds, and both genders will be included in the study to provide a diverse representation of medical-surgical nurses. Exclusion criterion is medical-surgical registered nurses who are enrolled in nursing school or employed as nursing faculty. Attitudes and perceptions may be influenced by mentors or persons serving in a preceptor role (Masson & Lester, 2003). Therefore, to provide an untainted and accurate interpretation of medical-surgical nurses' attitudes, only registered nurses practicing independently will be included in the study.

Data Generation Strategies

Approval from the Georgia State University institutional review board (IRB) and Georgia College and State University IRB will be obtained prior to data collection. Potential participants will be screened for inclusion and exclusion criteria. Participants will be asked if they are interested in participating in research about how medical-surgical nurses' attitudes toward patients who were homeless developed and transformed. Potential participants will be advised that interviews will take approximately one to one-and-a-half hours. Participants who provide written informed consent (see Appendix B), complete a Participant Information Form (see Appendix C), and answer a pre-interview Events History Calendar (see Appendix E) will then be interviewed by the principal investigator in a private, quiet location chosen by the participants. The Participant Information Form will ascertain general demographic data including: age, ethnicity, educational level, year of experience as a registered nurse, and years of experience working in the acute care setting. Other questions needed to obtain relevant data regarding experiences in caring for patients who were homeless include: the frequency of caring for patients who were homeless and whether someone in your personal life

experienced homelessness. Information gleaned from the Participant Information Form will be used to describe the sample and provide a personal context for data interpretation. The Events History Calendar will allow the participant to reflect on general timeframes in which exposure to patients who were homeless first occurred, when the participant first cared for patients who were homeless. Time frames will be represented as before attending nursing school, while attending nursing school, during the first year of practice, after the first year of practice, after the second year of practice, after the third year of practice, and after the fifth year of practice.

Data Collection

The interpretive phenomenological method is concerned with interpreting the meaning of the lived experience. Data for the lived experience can only be revealed by participants who have experienced the reality being explored. Data sources include participants' verbal descriptions and narratives and non-verbal communications. Therefore, in-depth, face-to-face, semi-structured interviews will be the primary data collection instrument. Face-to-face interview encounters will allow the researcher to observe and record non-verbal communication and environmental setting. The researcher also will employ field notes and journaling as adjunct sources of data. Prior to data collection, the informed written consent (see Appendix B), Participant Information Form (see Appendix B), and Events History Calendar (see Appendix E) will be completed.

An interview guide (see Appendix D) will be used to initiate discussion and elicit rich data. The narrative form of data were chosen because nurses' personal account or story of a time when they cared for a patient who was homeless corresponds with the structure of day-to-day living, and thus is the most suitable form of expression to capture everyday experiences (Benner, Tanner, & Chesla, 1996). The interview guide will be

used to help develop a conversation and elicit personal stories. This semi-structured format will allow the participant to describe experiences from the nurses' view of being in the *World* and level of interaction including "ready-to-hand," "unready-to-hand," and "present-at-hand."

The interview will begin with informal, unstructured dialogue about general care of patients who are homeless. The purpose of the general, unstructured dialogue is to establish rapport and trust of the participant. To elicit the "ready-to-hand" and "unready-to-hand" experiences of caring for patients who are homeless, the participant will then be asked to "Tell me about the first time when you were aware of someone who was homeless." This question will allow the participant to recall an experience that was meaningful and allow them to describe the situation in context. The goal is for the participant to describe events, what they did, who or what else was happening as if it is being re-lived. Therefore, recalling the situation brings it from the past into the present as it was lived. The situation is remembered not in the past and not on a time line but in a "temporal sense", a term Heidegger uses to describe a notion of time that is prior to or more original than our common senses of time as linear succession of now (Leonard, 1994). By asking the nurse to recall a time, prior to attitudes transforming, when he/she first became aware of homelessness, the researcher hopes to elicit data representing unexamined, ready-to-hand and unready-to-hand practices. Nurses' tacit knowledge of these experiences are hidden in the background of their actions, events, and the contexts of the events. Because attitudes are not always brought through consciousness, they are conceptualized to be embedded in the tacit knowledge of the nurses. Therefore, the "ready-to-hand" and "unready-to-hand" are essential to uncovering the formation of attitudes.

Further prompts will be used to elicit details about the experience, and reveal the full context. Silence will be used to allow reflection of participants' story and probes such as "tell me more about that" will be asked to get the participants to fill in unclear aspects or details of the story (Benner, 1994). The participants will then be asked "Tell me about a time when you first cared for a patient who was homeless." This question, similar to the first, allows the participants to access ready-to-hand and unready-to-hand experiences. The participants will then be asked if they "Can remember a time when your experiences with a patient who was homeless was different?" followed with "Tell me about that time." These questions, again similar to the previous, keep the participants in the narrative, and allow for direct access to the experiences (Benner et al., 1996) that is associated with the transformation of participants' attitude. These questions also keep the participants in "ready-to-hand" and direct thought to the "unready-to-hand" event. The participants will then be asked "When do you think there was a turning point in the way you felt?"; "Do you think it was associated with a specific experience?"; "Tell me about that." This series of questions allows the participants to move to the "present-at-hand" thoughts that focuses on reflection of the lived experiences and may reveal how attitudes transform. The participants are then asked to look over the information they provided on the Events History Calendar. The participants are asked; "Can you tell me more about this time of change" while the principal investigator points to the areas on the Events History Calendar where change was indicated. This question allows the participants to stay in the narrative and provides context to the transformation. The participants then are asked, "Can you summarize what the most important parts of what you have shared?" This question allows the participants to reflect on experiences and prioritize important views associated with attitudes formation and transformation. The final interview

question, "Can you think of anything that I have not asked you that would help me to understand your feelings about caring for patients who are homeless?" This question allows the participants an opportunity to share information that the researcher failed to ask due to personal assumptions or experiences that may have been taken-for-granted by the researcher. In appreciation of the participants' time a $25 gift card will be provided upon completion of the interview. This incentive amount is designed to encourage nurses to participate, however the amount is not substantial enough to coerce participation.

Data Analysis

The data analysis method of Diekelmann and Allen (1989) and expanded by Minick (1992) will be employed for this study. Data analysis will occur over several stages and be ongoing throughout data collection. Analysis for phenomenological data is a retrospective interpretation of the text and ongoing throughout data collection, transcription, and repeated reading of the text (McCann & Clark, 2002).

A research team will be employed to provide an accurate interpretation of the textual data. The research team will consist of two PhD prepared nurses who have completed interpretive phenomenological studies, doctoral dissertation committee, and the student principal investigator. Faculty experienced in research and vulnerable populations and who serve on the dissertation committee will provide peer review through discussion of interpretations. The research team and peer reviewers will help prevent the over or under interpretation of the text.

Data analysis is a circular process of constant comparison and validation. Initially the tape recorded interview will be transcribed verbatim. The tape will be listened to and the transcriptions will be reread to ensure accuracy. A written summary of each individual interview will be prepared to capture what the person was trying to convey.

Each member of the research team will view the text as a whole. This allows a critical review of the interview, the researcher's techniques, and the identification of missing or unclear data (Benner et al., 1996). The text will then be read and reread so an overall understanding of the fundamental meaning or main significance of the text can be identified. The initial summary will be read and discussed with the research team. When there is a disagreement about the summary, the team will return to the original transcription, read it in context, and come to a consensus. Each interview transcript will be coded line by line. The viewing of the text line by line will identify a deeper, richer understanding (Diekelmann & Allen, 1989). A constant comparative analysis of coding will continue as each interview transcript is read and reread. For example, interview one will be summarized and coded, then the second interview will be summarized and coded. The team will then return to interview one to evaluate whether information was missed that was revealed in interview two. As each interview is transcribed, summarized, and coded, the previous interviews will be reevaluated, reviewed, and recoded. This constant comparison continues throughout data collection, analysis, interpretation, writing, and re-analysis and provides a structure of reading and re-reading to reveal the meaning. Viewing the text from whole to parts and parts to whole allows the interpreter to confront and develop new interpretive questions and identify meaningful patterns rather than elemental units such as words and phrases (Benner, 1994).

Further analysis of the text will continue as research team members compare interpretation of categories. Categories will be clarified by the text and supported by examples. Next, themes will be identified. Themes provide structure to experience (Van Manen, 1997) or order of the text. Interpretation of the text will continue as constitutive patterns emerge. A pattern is a recurring event or singular thread that was evident

throughout the text (Sandelowski & Barroso, 2002). Patterns and themes are supported by exemplars to facilitate a better understanding of meaning. Exemplars are prominent excerpts that characterize specific common themes or meanings across participants (Crist & Tanner, 2003).

After the research team has agreed upon the emerging themes, patterns and exemplars, peer reviewers will be debriefed regarding the interpretation of the text. Peer reviews provide validation of the analysis (Diekelmann & Allen, 1989). The researcher will return to the participants to validate that the findings reflect their perceptions and experiences (Colaizzi, 1978). The interpretive phenomenological data analysis approach of Diekelmann and Allen (1989) is most appropriate for the interpretation of meaning of how medical-surgical nurses' attitudes toward patients who are homeless form and transform.

Trustworthiness

To demonstrate rigor in qualitative research, the researcher should clearly describe and justify each step of sampling, data collection, and data analysis (Sandelwoski, 1986). According to Lincoln & Guba (1985), tenets of trustworthiness of qualitative inquire are credibility, dependability, confirmability, and transferability. Credibility is present when descriptions and interpretations of the human experience are recognized by the people who had the experiences. Dependability and confirmability establish the process and product of inquiry as being valid and the findings are consistent with data. Transferability suggests that sufficient information about the context of study was provided so that the reader can determine whether the findings are applicable in new or different situations.

For this study, trustworthiness will be addressed through ensuring accurate data and interpretation. Accurate data will be supported through (a) the researcher keeping field notes of all participants encounters, (b) researcher journaling, (c) thick descriptions of the research settings, contexts of experiences and information about the participants, and (d) audio taping and transcribing verbatim of all interviews. Ensuring accurate interpretation of the data will be supported through (a) peer review, (b) member checking, (c) external oversight by doctoral dissertation committee, and (d) constant comparative method of data analysis. Member checking tests data interpretation by allowing the participant to validate the interpretation of the text (Tuckett, 2005). In addition, findings for this study will be validated with the research team to obtain multiple viewpoints and prevent over interpretation of the text (Lincoln & Guba, 1985).

Protection of Human Participants

Prior to data collection, approval from Georgia State University IRB and Georgia College and State University IRB will be obtained. No risk to participants is anticipated for participation in this study. Potential participants will be given an oral description of the study and assurance of confidentiality of all responses. Only potential participants who provide informed consent will be enrolled in the study. A copy of the consent will be provided to the participants. Confidentiality will be maintained through each participant being assigned a unique identification number on the Participant Information Form and the use of a pseudonym on all transcripts. A roster of participants names with corresponding pseudonyms and identification numbers, and all endorsed consent forms will be stored in a locked cabinet separate from data. Only the primary researcher and faculty advisor will have access to the locked cabinet. Transcribed data will be kept in a firewall protected and password-protected file. The participant roster and all audiotapes

will be destroyed one year after study completion. Inclusion of ethnic and gender minorities in nursing will be assured by sharing the intent to include minorities when networking with peers to recruit participants. Data collection will require a minimum of 60 minutes to a maximum of 90 minutes of the participants' time. Participants may be asked to complete a second interview to clarify or validate interpretation of the data. Data will be collected over a six-month period of time.

Summary

The qualitative research approach of interpretive phenomenology is an appropriate method of inquiry to understand the phenomena of how medical-surgical nurses' attitudes form and transform as they care for patients who are homeless. Personal experiences are subjective in nature. The aim of interpretive phenomenology inquiry is to provide an understanding of the meaning of the lived experience. Because nurses' experiences in caring for patients who are homeless influence their attitudes, to understand how nurse's attitudes form and transform one must first understand the lived experiences. Interpretive phenomenology design allows the voice and view of the participants to provide meaning to the lived experiences through interpretation. To yield rich data, purposive sampling will provide greater access to participants whose attitudes toward patients who are homeless have transformed and therefore is the most efficient and effectual method of sampling. Face-to-face interviews are an effective approach for data collection as interviews allow for the use of open-ended questions thus eliciting narratives of the lived experience in the participants own words. The data analysis method of Diekelmann and Allen (1989) and expanded by Minick (1992) will provide a stepwise approach to data analysis while allowing for flexibility in interpretation of the text. Interpretive phenomenology methodology allows the researcher to interpret the text

and provide structure to the meaning in the form of themes, categories, and patterns. Researcher bias and protection of human subjects are addressed.

CHAPTER IV

RESEARCH PROCESS

In this chapter, the process of research inquiry including the research design, participants, and data generation techniques is discussed. A qualitative design using interpretive phenomenology as the method of inquiry was employed for this study. A phenomenological perspective was maintained throughout data collection and data analysis. Measures to ensure trustworthiness of the research process were implemented. Finally, the protection of human subjects was observed and ensured throughout the research process.

Research Design

A qualitative design using phenomenological methods to describe and explore the meaning of the lived experiences of medical-surgical nurses was employed for this study. A qualitative design was chosen because data about attitudes of medical-surgical nurses toward patients who were homeless and the experiences associated with how those attitudes developed and transformed were unknown. The purpose of this study was to reveal how medical-surgical nurses' attitudes form and transform.

Setting

Eligible participants were recruited from medical-surgical units in acute care hospitals in the Southeast United States. Acute health care hospitals included for-profit,

Not-for-profit, and federally operated facilities. Hospital setting sizes ranged from 132 beds to 604 beds. Individual face-to-face interviews were conducted in private homes and in public settings such as the public libraries, hospital conference rooms, and corner coffee shops. Participants chose the mutually agreeable settings.

Participants

Participants were chosen based on interest and experiences in caring for patients who were homeless. A purposive sample was employed to access participants. Participants were recruited by networking with professional nursing organizations in the state of Georgia. The Georgia Nurses' Association (GNA) is Georgia's largest professional nursing association for registered nurses in all practice settings (GNA, 2011). All GNA members received an electronic mail with an attached recruitment flyer. A recruitment flyer was also electronically mailed to Georgia State University nursing doctoral student network.

The snowball sampling technique was employed to identify additional medical-surgical nurses. Nurses who were known to and referred by other participants were selected based on eligibility criteria as well as level of interest, diversity in years of experience as a registered nurse, ethnicity, and gender. The snowball sampling technique provided access to potential participants who were viewed by their peers as being knowledgeable of and having cared for patients who were homeless. Sampling techniques increased the likelihood of obtaining rich data from multiple views.

The sample size was determined by data saturation. Data saturation occurred when new participants revealed no new findings, meanings and pervious narratives became redundant (Benner, 1994). Previous nursing research which employed

phenomenology revealed attitudes and perceptions from sample sizes ranging from nine to twenty-four. In this researcher's previous pilot study, data saturation was obtained after 12 participants interviews. The sample goal of this study was 15 eligible participants. Saturation was obtained after eleven interviews.

Sampling Criteria

Inclusion and exclusion criteria were used as sampling criteria to obtain an accurate reflection of medical-surgical nurses' attitudes toward patients who were homeless. Inclusion criteria for the sample population included medical-surgical registered nurses who (a) practiced in a hospital settings for a minimum of 8 hours per week; (b) reported their feelings toward patients who were homeless or experiences in caring for patients who were homeless had transformed; (c) were between the ages of 22 to 65 years, male or female gender, of any race or ethnic backgrounds; and (d) reported the ability to read, understand, and speak English. The purpose of this study was to explore how medical-surgical nurses' attitudes toward patients who were homeless developed and transformed. Therefore, only medical-surgical nurses who were employed in acute health care settings could provide insight as to the lived experiences in caring for patients who were homeless. A variety of ages, racial and ethnic backgrounds were included in the study which provided a diverse representation of medical-surgical nurses. Exclusion criterion was medical-surgical, registered nurses who were enrolled in nursing schools or employed as nursing faculty. Attitudes and perceptions may be influenced by mentors or persons serving in a preceptor role (Masson & Lester, 2003). Therefore, to provide an untainted and accurate interpretation of medical-surgical nurses' attitudes, only registered nurses practicing independently were included in the study.

Data Generation Strategies

Approval from the Georgia State University institutional review board (IRB) and Georgia College and State University IRB were obtained prior to data collection. Potential participants were screened for inclusion and exclusion criteria. Participants were asked if they were interested in participating in research about how medical-surgical nurses' attitudes toward patients who were homeless developed and transformed. Potential participants were advised that interviews would take approximately one to one-and-a-half hours. Participants who provided written informed consent (see Appendix B), completed a Participant Information Form (see Appendix C), and answered a pre-interview Events History Calendar (see Appendix E) were interviewed by the principal investigator in private, quiet locations chosen by the participants. The Participant Information Form ascertained general demographic data including age, ethnicity, educational level, and number of years of experience as a registered nurse. Other questions needed to obtain relevant data regarding experiences in caring for patients who were homeless included: the frequency of caring for patients who were homeless and whether someone in the participants' personal life experienced homelessness. Information gleaned from the Participant Information Form was used to describe the sample and provided a personal context for data interpretation. The Events History Calendar allowed the participants to reflect on general time frames in which exposure to patients who were homeless first occurred, when the participants first cared for patients who were homeless, and when perceptions reflected positive, negative or neutral attitudes. Time frames were represented as before attending nursing school, while attending nursing school, during the first year of practice, after the first year of practice,

after the second year of practice, after the third year of practice, and after the fifth year of practice.

Data Collection

The interpretive phenomenological method is concerned with interpreting the meaning of the lived experience. Data for the lived experience can only be revealed by participants who experienced the reality being explored. Data sources included participants' verbal descriptions and narratives and non-verbal communications. Therefore, in-depth, face-to-face, semi-structured interviews were the primary data collection instrument. Face-to-face interview encounters allowed the researcher to observe and record non-verbal communications and environmental settings. The researcher also employed field notes and journaling as adjunct sources of data. Prior to data collection, the informed written consent (see Appendix B), Participant Information Form (see Appendix C), and Events History Calendar (see Appendix E) were completed.

The interview guide (see Appendix D) was used to initiate discussion and elicit rich data. The narrative form of data was chosen because nurses' personal accounts or stories of when they cared for patients who were homeless corresponds with the structures of day-to-day living, and thus was the most suitable form of expression to capture everyday experiences (Benner, Tanner, & Chesla, 1996). The interview guide helped to develop a conversation and elicit personal stories. This semi-structured format allowed the participants to describe experiences from a view of being in the *World* and level of interaction including "ready-to-hand," "unready-to-hand," and "present-at-hand," as described in Chapter two.

The interview began with informal, unstructured dialogue about the general care of patients who were homeless. The purpose of the unstructured dialogue was to establish rapport and trust of the participants. To elicit the "ready-to-hand" and "unready-to-hand" experiences of caring for patients who were homeless, the participants were then asked to "Tell me about the first time you were aware of someone who was homeless." This question allowed the participants to recall experiences that were meaningful and allowed them to describe the situations in context. The goals were for the participants to describe events and what else was happening as if it were being re-lived. Therefore, recalling the situations brought it from the past into the present as it were lived. The situations were remembered not in the past and not on a time line but in a "temporal sense", a term Heidegger used to describe a notion of time that is prior to or more original than our common senses of time as linear succession of now (Leonard, 1994). By asking the nurses to recall a time, prior to attitudes transforming, when they first were aware of homelessness, the researcher elicited data representing unexamined, ready-to-hand and unready-to-hand practices. Nurses' tacit knowledge of these experiences was hidden in the backgrounds of their actions, events, and the contexts of the events. Because attitudes were not always brought through consciousness, they were conceptualized to be embedded in the tacit knowledge of the nurses. Therefore, the "ready-to-hand" and "unready-to-hand" were essential to uncovering the formation of attitudes.

Further prompts elicited details about the experiences, and revealed the full contexts. Silence allowed for reflection of the participant's story and probes such as "tell me more about that" were allowed participants to fill in unclear aspects or details of their

stories (Benner, 1994). The participants were then asked "Tell me about a time when you first cared for a patient who was homeless." This question, similar to the first allowed the participants to access ready-to-hand and unready-to-hand experiences. The participants were then asked "Can you remember a time when your experiences with patients who were homeless were different?" followed with "Tell me about that time." These questions kept the participants in the narrative, and allowed for direct access to the experiences (Benner et al., 1996) that were associated with the transformation of participants' attitude. These questions kept the participants in "ready-to-hand" and direct thought to the "unready-to-hand" events. The participants were then asked "When do you think there was a turning point in the way you felt?"; "Do you think it was associated with a specific experience?"; "Tell me about that." This series of questions allowed the participants to move to the "present-at-hand" thoughts that focused on reflection of the lived experiences and revealed how attitudes transformed. The participants were then asked to look over the information they provided on the Events History Calendar. The participants were asked "Can you tell me more about this time of change" while the principal investigator pointed to the areas on the Events History Calendar where changes were indicated. This question allowed the participants to stay in the narrative and provided contexts attitude transformation. The participants were then asked, "Can you summarize what the most important parts of what you have shared?" This question allowed the participants to reflect on experiences and prioritize important views associated with attitude formation and transformation. The final interview question, "Can you think of anything that I have not asked you that would help me to understand your feelings about caring for patients who were homeless?" This question allowed the

participants an opportunity to share information that the researcher failed to ask due to personal assumptions or experiences that were taken-for-granted by the researcher. Data collection and data analysis occurred simultaneously. After initial interpretations were made the researcher validated pervious medical-surgical nurses' meanings and experiences with subsequent interviews. For example, the researcher said, "some medical-surgical nurses indicated that work environment played a role in their attitude transformation…has that been your experience or was it different for you?" Prompts were also used as a member checking technique to illuminate emerging themes. A follow up interview with one participant was conducted to clarify and validate interpretation of the data.

Data collection was anticipated to last 60 to 90 minutes. Interviews were typically 45 minutes in length with one interview lasting 25 minutes and four interviews lasting greater than 60 minutes. In appreciation of the participant's time a $25 gift card was provided upon completion of the interviews. This incentive amount was designed to encourage nurses to participate, however the amount was not substantial enough to coerce participation.

Data Analysis

The data analysis method of Diekelmann and Allen (1989) and expanded by Minick (1992) was employed for this study. Data analysis occurred over several stages and was ongoing throughout data collection. Analysis for phenomenological data was a retrospective interpretation of the text and ongoing throughout data collection, transcription, and repeated reading of the text (McCann & Clark, 2002).

A research team provided an accurate interpretation of the textual data. The research team consisted of two PhD prepared nurses who completed interpretive phenomenological studies, the doctoral dissertation committee, and the student principal investigator. Doctoral dissertation committee members experienced in qualitative research and vulnerable populations provided peer review through discussion and interpretations. The research team and peer reviewers helped prevent the over or under interpretation of the text.

Data analysis was a circular process of constant comparison and validation. Initially the tape recorded interviews were transcribed verbatim. Each tape was listened to and the transcription reread to ensure accuracy. A written summary of each individual interview was prepared to capture what the person was trying to convey. Each member of the research team viewed the text as a whole. This allowed a critical review of the interview, the researcher's techniques, and the identification of missing or unclear data (Benner et al., 1996). The text was then read and reread so an overall understanding of the fundamental meaning or main significance of the text was identified. The initial summary was read and discussed with the research team. When there was a disagreement about the summary the team returned to the original transcription, read it in context and came to a consensus. Each interview transcript was coded line by line. The viewing of the text line by line identified a deeper, richer understanding (Diekelmann & Allen, 1989). A constant comparative analysis of coding was continued as each interview transcript was read and reread. For example, interview one was summarized and coded, then the second interview was summarized and coded. The team then returned to interview one to evaluate whether information was missed that was revealed

in interview two. As each interview was transcribed, summarized, and coded, the previous interviews were reevaluated, reviewed, and recoded. This constant comparison continued throughout data collection, analysis, interpretation, writing, and re-analysis and provided a structure of reading and re-reading that revealed the meaning. Viewing the text from whole to parts and parts to whole allowed the interpreter to confront and develop new interpretive questions and identify meaningful patterns rather than elemental units such as words and phrases (Benner, 1994).

Further analysis of the text continued as research team members compared interpretation of categories. Categories were clarified by the text and supported by examples. Next, themes were identified. Themes provided structure to experiences (Van Manen, 1997) or order of the text. Themes were supported by exemplars to facilitate a better understanding of meaning. Exemplars were prominent excerpts that characterized specific common themes or meanings across participants (Crist & Tanner, 2003).

After the research team agreed upon the emerging themes and exemplars, peer reviewers were debriefed regarding the interpretation of the text. Peer reviews provided validation of the analysis (Diekelmann & Allen, 1989). The researcher returned to the participants to validate that the findings reflected their perceptions of their experiences (Colaizzi, 1978). The interpretive phenomenological data analysis approach of Diekelmann and Allen (1989) was most appropriate for the interpretation of meaning of how medical-surgical nurses' attitudes toward patients who were homeless formed and transformed.

Trustworthiness

To demonstrate rigor in qualitative research, the researcher clearly describes and justifies each step of sampling, data collection, and data analysis (Sandelwoski, 1986). According to Lincoln & Guba (1985), tenets of trustworthiness of qualitative inquiry are credibility, dependability, confirmability, and transferability. Credibility is present when descriptions and interpretations of the human experiences are recognized by the people who had those experiences (Lincoln & Guba, 1985). Dependability and confirmability establishes the process and product of inquiry as being valid and the findings are consistent with data collected (Guba & Lincoln, 1981). Transferability suggests that sufficient information about the context of study is provided so that the reader can determine whether the findings are applicable in new or different situations (Lincoln & Guba, 1985).

For this study, trustworthiness was addressed through ensuring accurate data and interpretation. Accurate data were supported through: (a) researcher kept field notes of all participants' encounters, (b) researcher maintained a journal, (c) thick descriptions of the research settings, contexts of experiences and information about the participants were provided, and (d) audio taped interviews were transcribed verbatim. Accurate interpretations of the data were ensured through (a) peer review, (b) member checking, (c) external oversight by doctoral dissertation committee, and (d) constant comparative method of data analysis. Member checking tested data interpretation. In addition, findings for this study were validated with the research team to obtain multiple viewpoints and prevent over interpretation of the text (Lincoln & Guba, 1985).

Protection of Human Participants

Prior to data collection, approvals from Georgia State University IRB and Georgia College and State University IRB were obtained. No harm was experienced by participants for participation in this study. Potential participants were given an oral description of the study and assured confidentiality of all responses. Only potential participants who provided informed consent were enrolled in the study. A copy of the consent was provided to each participant. Confidentiality was maintained through each participant being assigned a unique identification number on the Participant Information Form and the use of a pseudonym on all transcripts. A roster of participants' names with corresponding pseudonyms and identification numbers, and all endorsed consent forms were stored in a locked cabinet separate from data. Only the primary researcher and faculty advisor had access to the locked cabinet. Transcribed data were kept in a firewall protected and password-protected file. The participant roster and all audiotapes will be destroyed one year after study completion. Inclusion of ethnic and gender minorities in nursing was assured by sharing the intent to include minorities when networking with peers to recruit participants. Data were collected over a six-month period of time.

Summary

The qualitative research approach of interpretive phenomenology was an appropriate method of inquiry to understand the phenomena of how medical-surgical nurses' attitudes formed and transformed as they cared for patients who were homeless. Personal experiences were subjective in nature. The aim of interpretive phenomenology inquiry was to provide an understanding of the meaning of the lived experience. Because nurses' experiences in caring for patients who were homeless influenced their attitudes, one had to first understand the lived experiences to understand how nurses' attitudes

formed and transformed. Interpretive phenomenology design allowed the voices and views of the participants to provide meaning to the lived experiences through interpretation. To yield rich data, purposive sampling provided greater access to participants whose attitudes toward patients who were homeless transformed and therefore were the most efficient and effectual method of sampling. Face-to-face interviews were an effective approach for data collection as interviews allowed for the use of open-ended questions thus eliciting narratives of the lived experiences in the participants own words. The data analysis method of Diekelmann and Allen (1989) and expanded by Minick (1992) provided a stepwise approach to data analysis which allowed for flexibility in interpretation of the text. Interpretive phenomenology methodology allowed the researcher to interpret the text and provided structure to the meaning in the form of themes and categories. Researcher bias and protection of human subjects were addressed.

CHAPTER V

FINDINGS AND DISCUSSIONS

Medical-surgical nurses' experiences in caring for patients who were homeless revealed how their attitudes formed and transformed. Their rich experiences also brought into focus experiences associated with attitude transformation. Themes emerged from the descriptions and interpretations of experiences of medical-surgical nurses caring for patients who were homeless in acute health care settings. Pseudonyms were used to protect the identities of the participants.

Participant Characteristics

The sample for this study included eleven medical-surgical nurses who cared for patients who were homeless in acute health care settings and reported their feelings transformed toward patients who were homeless. Participants lived in the Southeastern United States in both urban and rural areas. Three participants identified themselves as African-American, and eight identified themselves as Caucasian. Participants' ages ranged from 24 to 63 years with a mean age of 43.27 years (*SD* 11.96).

All of the participants were licensed registered nurses at the time of the interviews. One nurse indicated her highest degree earned was a master of science in nursing. Three nurses reported a bachelor in science in nursing as their highest degree earned. Seven nurses reported having an associate degree in nursing.

Participants reported varying years of experience and caring for diverse populations of patients. Participants' years of experience ranged from 2-3 years to greater than 10 years. One nurse reported having 2-3 years of nursing experience. Two nurses reported having 5-10 years of nursing experiences. The majority of nurse participants (n=8) reported having greater than ten years of nursing experiences. Medical-surgical nurse participants also reported caring for multiple types of patients in clinical settings. Participants' clinical experience included caring for pre- and post-surgical patients and patients with cardiovascular, orthopedic, oncology, neurological, and endocrine disorders. Other areas of clinical experience were identified as women's health, critical care, pediatrics, and the emergency department. All participants reported working in medical-surgical environments at the time of the interviews.

All participants reported caring for patients who were homeless with frequency of encounters ranging from daily to every two months. Three medical-surgical nurse participants reported caring for patients who were homeless on a daily basis. Two participants indicated caring for patients who were homeless on a weekly basis. Most participants (n=4) reported monthly encounters with caring for patients who were homeless. One participant reported caring for patients who were homeless approximately every two months. One participant indicated caring for patients who were homeless as being "frequently."

Participants were asked if someone in their personal life experienced homelessness. The majority of participants (n=9) indicated they did not personally know someone who was homeless. Two participants reported knowing someone in their

personal life who was homeless. No participants reported having experienced homelessness.

Themes

The data revealed five themes (Table 1). Data were collected using an interview guide which presented questions in a timeline format. As such, the experiences shared by participants reflected experiences gained over the course of their nursing practice. Participants revealed how new attitudes toward patients who were homeless formed as they began their nursing practices and how those attitudes changed overtime and with clinical experiences. Therefore, the themes will be presented in a logical time format beginning with how new attitudes developed, factors associated with the transformation of attitudes, and how nurses struggle to maintain positive working and caring environments for patients. One theme reveals how nursing bias alters the nurse/patient relationship to such a degree as to impede the nurses' ability to care for patients.

Table 1

Themes

Discovering homelessness
Finding common ground
Piecing it together
A daily struggle
Relationships built on distrust

The theme ‘Discovering homelessness’ describes how new nursing professionals begin to merge personal attitudes toward homeless people and with their new role of caring for patients who are homeless. Previously held notions are compared to new experiences in caring for patients who are homeless. The new nurse begins to interact with and learn to care for patients who are homeless. Prior to becoming a nurse, most experiences with homeless people were from a distance. During this time of discovery, nurses develop new attitudes toward patients who are homeless.

The theme ‘Finding common ground’ reveals how medical-surgical nurses identify commonalities among themselves and patients who are homeless. The mutual life experiences of nurses and patients create a shared bond. The common ground which the nurses are able to find fosters attitude transformation. For some medical-surgical nurses ‘Finding common ground’ represents the realization of their own vulnerability to homelessness. For others ‘Finding common ground’ means the transformation of viewing patients as objects of nursing care to patients being cared for.

The theme ‘Piecing it together’ describes factors associated with attitude transformation. ‘Piecing it together’ reveals how medical-surgical nurses learn to care for patients who are homeless. This theme reveals the important role of nursing knowledge and how skills needed to care for patients who are homeless reduce negative attitudes and create an atmosphere of understanding. This theme also explores specific nursing skills required to adequately care for patients who are homeless such as communication, listening, and gathering information.

The theme ‘A daily struggle’ expresses the continuous evaluation and reevaluation of medical-surgical nurses’ attitudes. As medical-surgical nurses continue to gain

experiences in caring for patients who are homeless, the nurses' ability to recognize and set aside personal bias matures. The theme 'A daily struggle' reveals how nurses make an effort to approach each patient with a sense of a new beginning in an attempt to limit personal bias in patient care. This theme reveals the daily toils medical-surgical nurses experiences in trying to provide non-judgmental nursing care and how nurses can create an atmosphere of support and acceptance in work environments to foster positive attitudes.

The theme 'Relationships built on distrust' reveals how medical-surgical nurses' feelings of distrust influence the nurse/patient relationships. The nurses' feelings of distrust and betrayal by the patient lead to a different approach in caring for patients who are homeless. Nurses who experience more negative encounters with patients who are homeless create a protective distance between them and the patients. Medical-surgical nurses who experience 'Relationships built on distrust' focus on the physical care needs of the patients who are homeless but remain emotionally detached. This theme also shares the experiences of one medical-surgical nurse who had such pronounced feelings of resentment and blame that the data were retained for interpretation. The attitude of being homeless as a choice is prominent with this participant. 'Relationships built on distrust' reveals how some medical-surgical nurses' experiences unique relationship with patients who are homeless. This theme also exemplifies how negative attitudes influence nurses' behaviors and nursing care provided to patients who are homeless.

The themes revealed in this study reflected medical-surgical nurses' unique challenges of providing nursing care to a vulnerable group of patients. The participants' experiences revealed how attitudes among medical-surgical nurses formed and transformed toward patients who were homeless (Table 2).

Table 2

Descriptions of Participants and Exemplars in Support of Themes

Participants	Themes and Exemplars	Themes supported by Participant Data
Alice Forty year old Caucasian female with 18 years experience as a nurse. She has a MSN degree. Alice cared for patients who were homeless monthly and did not know anyone in her personal life that was homeless	**'Discovering homelessness'** *"It's real people, real situations, not just something you imagine."* *"I just remember questioning in my mind, wondering could he have been abused as a child? Did his parents die when he was young? What brought him to this point [homelessness]?"* *"When I was younger and had no experience, I had a very sheltered life. I think I was geared to have negative feelings toward people who are homeless. But then as I matured and gained experience in nursing, I think I began to think outside the box a little bit. You realize that some circumstances may not be avoidable such as drug use and that kind of thing. But people still deserve a certain amount of respect just because they're a human being."* **'Finding common ground'** *"We [Alice and her co-worker] would get so aggravated with him [patient who was homeless]. And I remember her [co-worker] saying to me that when she had patients like that, she said she thinks of her son and the fact that one day that might be him laying in that bed, for whatever reason drug use, loss of job, dementia, or natural causes. It kind of made me think differently about it. I think because I look at my sons and think, well if they were in that situation, I would want someone to have compassion and be nice to them."* **'A daily struggle'** *"I think it is probably experience and age. With experience as a nurse you also gain experience in life. Maybe you become a parent, maybe you don't, but you still experience more lessons in life."*	• 'Discovering homelessness' • 'Finding common ground' • 'A daily struggle' • 'Piecing it together'

Table 2 continued		
Brenda Sixty-three year old Jamaican -American female with 40 years of experience as a nurse. She immigrated to the United States as an adult. She has an ASN degree. Brenda cared for patients who were homeless monthly and knew someone in her personal life who was homeless.	**'Piecing it together'** *"I would think, for the most part, if we [nurses] listen to their [patients who were homeless] story it will help us to care better for them and not to draw conclusions….They [nurses] can change if they listen."*	• 'Discovering homelessness' • 'Finding common ground' • 'Piecing it together'
Claire Fifty-eight year old African American female with 38 years of experience as a nurse. She immigrated to the United States as an adult. She has a BSN degree. Claire cared for patients who were homeless monthly and did not know anyone in her personal life that was homeless.	**'A daily struggle'** *"Once you realize that you have to have compassion to work with homeless patients, your attitude changes and you feel more compassion towards them."*	• 'Discovering homelessness' • 'A daily struggle' • 'Piecing it together'
Darlene Thirty-nine year old Caucasian female with 8 years experience as a nurse. She as an ASN degree. Darlene cared for patients who were homeless monthly and did not know anyone in her personal life who was homeless.	**'A daily struggle'** *"We [nurses educators] try to get more information out there to them [nurses]."* *"The process of changing that [attitude] or my thought process changing was really slow because it was a process, it was a daily thing."* **'Relationships built on distrust'** *"I mean, despite all the education that we [medical-surgical nurses] gave him, he still went out and did the same thing."*	• 'Discovering homelessness' • 'A daily struggle' • 'Piecing it together' • 'Relationships built on distrust"
Emily Fifty-eight year old Caucasian female with 21 years of experience as a nurse. She has an ASN degree. Emily cared for patients who were homeless monthly and did not know anyone in her personal life that was homeless.	**'Relationships built on distrust'** *"You're [patient who was homeless] getting the best care that we can give you… as good of care as anybody and yet you don't do anything."* *"I have to fight with my insurance to get them to do things that I need. And my husband and I both have insurance. People who come in off the streets [patients who were homeless] get better…as good or better care with nothing. And I think that's when I really became so negative towards them."* *"I think drugs and life just had done that [being homeless] to her [patient who was homeless]. But again, you know and I know it, it's a sickness [drug*	• 'Relationships built on distrust"

Table 2 continued	*and alcohol addiction] but it's a choice. We make choices and I think her choosing that lifestyle is exactly why she was where she was. I mean, you don't have to choose it."* *"You can't even see about your patients. And sometimes, I get so angry that I do only what I have to do. And I'm sure they feel that, that hostility, because I do resent that [caring for the patient who was homeless] – that I can't care for really sick patients, just catering to you [patient who was homeless]. And some of them [patient who was homeless], you know they have attitudes."* *"I had a girl [patient who was homeless] come in one night. I was asking her questions. She would not even answer me. I said, 'Well, if you're not going to answer [admission questions] then there's no need in trying to do this assessment.' So I got up, rolled my computer out the door, and she said, "I must can't have nothing to eat" I said, 'You must can't talk [mocking the patient's broken English].' I walked right on out the door. You are going to make my job harder. I'm trying to help you. Yea, it [bias] does come through. She could talk when she wanted something to eat."* *"A lot of them will tell you, I just don't want to work. I mean and sometimes I just deliberately or whatever, I'll say, So, where do you work? And I know they don't work. I don't work, is what they'll say. I don't work."*	
Felicia Thirty-two year old Caucasian female with 12 years of experiences as a nurse. She has a BSN degree. Felicia cared for patients who were homeless "frequently" and did not know anyone in her personal life who was homeless.	**'Discovering homelessness'** *"That's [becoming a nurse] really when I started to really come out of my shell and even acknowledge that, 'Oh my goodness there are people out there who this is life for them [homelessness]."* *"Sometimes you think of homeless people as being the guy under the bridge but sometimes they might have a home but no functioning water or electricity, which is pretty much the same thing as being homeless."* *"I think another one of the big obstacles [barrier to attitude change] for a new graduate [new nurse] is that you come out of nursing school with these high hopes of saving the world and you're going to help everyone."* *"…just realizing you can't save the world. This is not something you can do."*	• 'Discovering homelessness' • 'Finding common ground' • 'A daily struggle' • 'Piecing it together' • 'Relationships built on distrust"

Table 2 continued	**'Piecing it together'** *"Homeless people they never come out and just spill the beans, and tell you everything. It's kind of like you just have to piece it together… they never volunteer anything so you [the nurse] ask a little question here and a little question there and then slowly it all comes out."* *"Don't you [nursing student] dare ask them [the patient who is a prisoner] what they did. Because it [knowing why they are a prisoner] will impair you."* *"The first guy [incarcerated patient who as homeless] told me that he had molested a child and I said 'Oh God', I don't think I can take care of this man anymore. I learned my job is to take care of the patient. My job is not to investigate their life and find out whether they're innocent or guilty or what you did in the past. I honestly don't want to know. Because it will affect how you [the nurse] care for that patient. It changes your opinion and you don't need to do that. Your job is to take care of the patient, that's what you're here to do. Do that job."* **'A daily struggle'** *"The most important thing is just to realize that there is something there, try not to make passing judgments. I'm not going to pass judgment. And I always, always practice this every day. "*	
Gail Twenty-four year old Caucasian female with 3 years experience as a nurse. She has an ASN degree. Gail cared for patients who were homeless monthly and did not know anyone in her personal life who was homeless.	**'Relationships built on distrust'** *"They [patients who were homeless] won't try to get a primary care doctor or anything like that, that's just disheartening. You [the medical-surgical nurse] kind of get frustrated sometimes, with those patients."*	• 'Discovering homelessness' • 'Piecing it together' • 'Relationships built on distrust"
Heather Thirty-seven year old Caucasian female with 6 years experience as a nurse. She has an ASN degree. Heather cared for patients who were homeless weekly and knew someone in her personal life who was homeless.	**'Discovering homelessness'** *"I just enjoyed his company. He sat for a very long time and talked to me about how judgmental people were…He was having trouble holding [a] job down because people judged him….I don't guess it was for me to decide whether I agreed with his choices or not, but by the end of the day I really liked this guy. I would have liked to have been able to offer him a job somewhere. I would have liked to have been able to make those concessions for him because he convinced me that*	• 'Discovering homelessness' • 'Finding common ground' • 'A daily struggle' • 'Piecing it together' • 'Relationships built on distrust"

Table 2 continued	*what he was doing was not wrong. It was surprising to me that he turned my mind around that way."* **'Finding common ground'** *"I have a hard time understanding. I mean it's terrible. I almost feel like I could understand better if there was something wrong with her. If she had an addiction or something, I could understand it, but I don't understand."* **Relationships built on distrust'** *"I guess what pushed me at arm's length was the gentleman [patient who was homeless] who tried to kill himself. I just felt like he had been given a second chance and we [medical-surgical nurses] had done everything we could think of to try to help him, including getting him involved in things after he was discharged. He wasn't willing to stick with it. He wasn't willing to take that chance that was given to him. I certainly got to the point where I was more jaded in what people told me to my face as long as you were able to give and do for that person and provide more incentive to them. They were willing to accept and participate in it. But, as soon as your outlook didn't match theirs… wrote you off. You couldn't help them."*	
Irene Forty-one year old Caucasian female with 13 years experience as a nurse. She has an ASN degree. Irene cared for patients who were homeless daily and did not know anyone in her personal life who was homeless.	**'Discovering homelessness'** *"Over that course of those first two years as a nurse realizing how naive I was and that not everybody was at least middle-class and that not everybody had everything that they needed or at least food and shelter. I can remember being surprised by it all…I knew all that existed in my head, but to really be face to face with it was, I mean, it was reality."* **'A daily struggle'** *"It's like when you [medical-surgical nurse] walk in that door that first time it's like a clean slate. And first impressions do matter. But you kind of wipe the slate clean with a brand new patient."* *"If you stay and work in that environment [medical-surgical unit as at teaching hospital]…that will broaden their horizons for the rest of their nursing practice…It will level the playing field so you don't have bias."* *"I see bias in specialty areas where they [nurses who work in specialty areas] don't have to deal with certain populations and they come with a set of bias."*	• 'Discovering homelessness' • 'A daily struggle' • 'Piecing it together'

Table 2 continued		
Judy Thirty-eight year old Caucasian female with 15 years experience as a nurse. She has a BSN degree. Judy cared for patients who were homeless weekly and did not know anyone in her personal life who was homeless.	**'Finding common ground'** *"She [patient who was homeless] cried about that and worried about him because he as a teenager…. That kind of hit me because as a mom, I worry about my children. I worry about my children all the time. Can you imagine being homeless and then having a child and then having to leave your child out there, as a teenager all alone on the streets? You [medical-surgical nurse] realize that there are things that go on in everybody's life. In the blink of an eye anybody can probably be homeless. Sometimes just an unfortunate event, such as somebody losing their job or going through a divorce or something like that can leave you on the street.*"	• 'Discovering homelessness' • 'Finding common ground'
Kelly Fifty-eight year old African-American female with 26 years experience as a nurse. She has an ASN degree. Kelly cared for patients who were homeless daily and did not know anyone in her personal life who was homeless.	**'A daily struggle'** *It's hard, it's very hard. You don't want to judge these people about anything because everybody didn't have what you had growing up…then you find yourself sometimes judging them. I have to pray…Because I think if you let that kind of stuff stay on the inside of you, you'll find yourself dealing with them unfairly and harshly*.	• 'A daily struggle' • 'Piecing it together' • 'Relationships built on distrust"

'Discovering homelessness'

This theme reflected the participants' experiences as new nurses and how attitudes were redefined from attitudes toward people who were homeless to attitudes toward patients who they must now care for. New nurses experienced the realization that patients were homeless. The discovering of homelessness occurred as new nurses developed clinical experiences in caring for different patient populations. Rather than avoiding homelessness, as they had been able to do in their personal lives, nurses faced new thoughts and feelings as now homelessness affected their professional lives. This theme exhibited how new nurses discovered homelessness as medical-surgical nurses. One

participant described the realization of discovering homelessness as a nurse as "it's real people, real situations, not just something you imagine." This theme also revealed how medical-surgical nurses discover the culture of homelessness and how they began to learn to provide nursing care to this vulnerable population.

New nurses discovered homelessness as they began to care for patients who were homeless. Alice was a forty-year-old medical-surgical nurse with eighteen years of experience. Alice recognized that as a young nursing student her perception of patients who were homeless changed. She began to reflect on why and how someone became homeless. Alice shared how she cared for a patient who was mentally ill and homeless. She found that she had questions as to how and why someone would be homeless. Alice recalled: "I just remember questioning in my mind, wondering could he have been abused as a child? Did his parents die when he was young? What brought him to this point [homelessness]?" Alice had many questions as to why someone would be homeless. For Alice, causes of homelessness included experiencing abuse as a child and being orphaned. Alice related homelessness to abuse and abandonment. She seemed to be searching for a rational explanation for the patient's homelessness.

Heather was a thirty-seven year old medical-surgical nurse with six years of experience. Heather also discovered homelessness as a nursing student. Heather recalled how caring for a patient who was homeless began to change her attitude. She was surprised that the patient was able to change her mind about common stereotypes of homeless people including being lazy, unintelligent, and choosing to be homeless. Heather reflected on how it was important for her to know the patient as a person and how she concluded that regardless of why the patient was homeless she had a responsibility to

provide care. Her commitment to being a good nurse was more important to her than the negative attitude that she held. Heather described her patient as being "bright and interesting." Heather shared:

> I just enjoyed his company. He sat for a very long time and talked to me about how judgmental people were…He was having trouble holding [a] job down because people judged him….I don't guess it was for me to decide whether I agreed with his choices or not, but by the end of the day I really liked this guy. I would have liked to have been able to offer him a job somewhere. I would have liked to have been able to make those concessions for him because he convinced me that what he was doing was not wrong. It was surprising to me that he turned my mind around that way.

Heather gave herself permission to not pass judgment about the patient's life choices, which was in conflict with her personal beliefs. She articulated that she was surprised that she was able to put her personal bias aside and related to the patient as a human being with real feelings and desires. For Heather, this encounter was a turning point when she was able to relate to the patient rather than just see a homeless person. Heather had a positive first encounter with patients who were homeless. She was open to listening to his life's story and although she may not have agreed with his lifestyle choices she found herself encouraging him in the end. She was able to view the patient as an individual with his own story rather than just a homeless person. Heather looked past her own bias to get to know him as a person.

Alice, the nurse with eighteen years experience, recognized that prior to becoming a nurse her feelings toward people who were homeless were biased. She attributed her

negative perceptions to surrounding herself with people who had similar beliefs and backgrounds while limiting her exposure to people outside of her sphere. She credited the change in perception to maturity and professional experience.

> When I was younger and had no experience, I had a very sheltered life. I think I was geared to have negative feelings toward people who were homeless. But then as I matured and gained experience in nursing, I think I began to think outside the box a little bit. You realize that some circumstances may not be avoidable such as drug use and that kind of thing. But people still deserved a certain amount of respect just because they're a human being.

Alice shared that because of her sheltered view of the world she had negative perceptions of people who were different than her. She seemed to acknowledge that all patients were not the same and that regardless of the circumstances; the patients were no less than a human being. She attributed maturing and experience as the catalysts for changing the way she viewed her patients. Alice now views all patients as human beings worthy of care. She pointed out that her feelings changed as she began to care for patients who were homeless and that this change required her to think differently or outside of what she learned as a child.

Felicia was a thirty-two year old medical-surgical nurse with twelve years of experience. Felicia recalled that after becoming a nurse she realized that homelessness was a real problem. Felicia recalled: "That's [becoming a nurse] really when I started to really come out of my shell and even acknowledge that, 'Oh my goodness there are people out there who this is life for them [homelessness].'" For Felicia, becoming a nurse created a circumstance in which she faced the reality that everyone did not have the same life

experiences. The experience of being homeless was so different than what she experienced in her personal life. This experience exemplified how new nurses discovered homelessness as a new nurse. Felicia's experiences in caring for patients who were homeless caused her to begin to question previously held beliefs.

Felicia also began to change her negative perception of homeless people to viewing patients who were homeless as needing care. Prior to providing care to patients who were homeless, Felicia's attitude reflected common stereotypes of homeless people. After caring for patients who were homeless, her definition and understanding broadened. Felicia shared: "Sometimes you think of homeless people as being the guy under the bridge but sometimes they might have a home but no functioning water or electricity, which is pretty much the same thing as being homeless." As Felicia's nursing experiences with caring for patients who were homeless expanded, her perceptions were refined. Felicia's understanding of homelessness had broadened and reflected a more inclusive understanding of homelessness that was more complex than she originally thought.

Felicia described the process of reforming her attitude as slow. Her new attitude began to occur during her first year as a nurse and continued to change into her second year. Felicia recalled having an idealistic outlook of the role of a nurse. Felicia stated: "I think another one of the big obstacles [barrier to attitude change] for a new graduate [new nurse] is that you come out of nursing school with these high hopes of saving the world and you're going to help everyone." Felicia compared her previous held notion of nursing and how to care to patients who were homeless to the new reality of caring for patients who were homeless. Felicia perceived her naïve view of nursing and nursing care as an obstacle to transforming attitudes toward caring for patients who were homeless.

Over time, Felicia realized that the practice of nursing had limitations. Felicia's ability to recognize her limitations as a nurse helped to transform her attitude toward caring for patients who were homeless. Felicia described her perception of caring for patients as "frustrating" and how it was difficult for her to realize that she was unable to change her patients' circumstances or health outcomes. Felicia shared "just realizing you can't save the world. This is not something you can do." As a new nurse, Felicia recognized that the homeless population had complex health care needs and the process of addressing those needs was a process that the nurse did not have control over.

Similarly, Irene, a forty-one year old medical-surgical nurse with thirteen years of experience, described a "cultural shock" when she began to care for patients who were homeless. She recalled that during her first couple years of nursing, she came to the realization that not everyone had the same culture and background as she. She recalled knowing that people experienced homelessness. Irene shared:

> Over the course of those first two years as a nurse realizing how naive I was and that not everybody was at least middle-class and that not everybody had everything that they needed or at least food and shelter. I can remember being surprised by it all…I knew all that existed in my head, but to really be face-to-face with it was, I mean, it was reality.

For Irene, the reality of homelessness was not experienced until she became a nurse. Irene described her astonishment that her patients experienced homelessness. Until Irene became a nurse, her life experiences did not include people who were different than her. Irene's worldview was limited. Irene's experiences as a new nurse changed her worldview to include a group of people who were different than her. Similar to Felicia,

Irene understood that her background and upbringing influenced her perception of patients who were homeless. The face-to-face encounters with patients who were homeless caused Irene to re-evaluate her previous held beliefs and view homelessness as reality.

The theme 'Discovering homelessness' revealed how becoming medical-surgical nurses created an opportunity for new nurses to discover homelessness through the eyes and experiences of nurses. The first two years as a nurse was a vulnerable period of time as old notions and perceptions were challenged. For many medical-surgical nurses, the first year of nursing practice put them in direct contact with a patient population whom they may not have encountered in their personal lives. As medical-surgical nurses entered the workforce, new experiences began to shape their view of patients who were homeless. Through clinical experiences, the new nurse developed a more personal view of patients rather than objects of care.

'Finding Common Ground'

The theme 'Finding common ground' revealed how some participants' ability to identify common experiences with patients who were homeless contributed to positive attitude transformations. 'Finding common ground' highlighted the nurses' need to relate to their patients. Each time nurses talked about finding common ground, they related the patients' experiences to their own personal experiences. Nurses who were able to find common ground described patients who were homeless in compassionate, understanding ways.

Alice, the nurse with eighteen years of experience, believed that finding common ground with patients who were homeless allowed her to be more compassionate and

changed her attitude. Alice recalled how she and a co-worker were working with a patient who was homeless. The patient was confused and yelled out frequently during the shift. Alice said:

> We [Alice and her co-worker] would get so aggravated with him [patient who was homeless]. And I remember her [co-worker] saying to me that when she had patients like that, she said she thinks of her son and the fact that one day that might be him laying in that bed, for whatever reason drug use, loss of job, dementia, or natural causes. It kind of made me think differently about it. I think because I look at my sons and think, well if they were in that situation, I would want someone to have compassion and be nice to them.

Alice's co-worker told her how to turn a frustrating situation with a difficult patient into a situation where the nurse respected the patient as if he was someone's son. Alice remembered this event as a turning point in her attitude toward patients who were homeless. She felt that she began to personally relate more to the patient through focusing on common experiences. This humanization of the patient caused Alice to realize that she and her family members were also vulnerable to becoming homeless and she would want her family member to be treated with respect and dignity. Because Alice now viewed the care provided to all patients as valued as the care she would like her children to receive, it was essential for her to treat patients with compassion.

Similar to Alice, Judy's role as a mother was the common ground she found when caring for a patient who was homeless. This experience changed her once negative perception of homeless people to being less judgmental and empathetic toward patients who were homeless. Judy, a thirty-eight year old nurse with fifteen years of experience,

shared her experience in caring for a female patient who was homeless. She described how the patient had three teenage children and because the hospital rooms were semi-private the patient's male son was unable to stay overnight causing him to return to the streets each night without her to protect him. Judy recalled:

> She [patient who was homeless] cried about that and worried about him because he as a teenager…. That kind of hit me because as a mom, I worry about my children. I worry about my children all the time. Can you imagine being homeless and then having a child and then having to leave your child out there, as a teenager all alone on the streets?

Judy related to the patient as a mother who also worried about her children. For a moment, Judy allowed herself to imagine her children as homeless, living out in the streets. She identified with the anxiety and angst a mother felt when worrying about a child. Judy found common ground with the patient who was homeless. Judy described how this patient encounter changed her perception of patients who were homeless and forced her to recognize her own vulnerability to homelessness. Judy continued to share her experience. Judy stated:

> You [medical-surgical nurse] realize that there are things that go on in everybody's life. In the blink of an eye anybody can probably be homeless. Sometimes just an unfortunate event, such as somebody losing their job or going through a divorce or something like that can leave you on the street.

Judy's willingness to find common ground with the mother who was homeless led her to the realization that she was also vulnerable to becoming homeless. This encounter changed her perception of patients who were homeless. This patient was a mother who

like Judy had common worries and concerns about her children and wanted something better for them. Judy's experience allowed her to begin to develop empathy and find value and worth in patients who were homeless.

In contrast, Heather, the nurse with six years of experience, struggled to find common ground. She desired to understand why someone would be homeless when they had the financial means or family support to live in a home. She described the struggle she experienced as she tried to relate to a patient who was homeless. "I have a hard time understanding. I mean it's terrible. I almost feel like I could understand better if there was something wrong with her. If she had an addiction or something, I could understand it, but I don't understand." Heather was unable to rationalize why someone would become homeless. Heather desired to find common ground with a patient who was homeless. She seemed to need a diagnosis of addiction or mental illness to blame rather than the patient. She did not want to place blame on the patient. However, without a diagnosis she was left with the patient choosing to be homeless. Heather struggled to find something in common with someone who "chooses" to be homeless.

The theme 'Finding common ground' reflected the medical-surgical nurses' desires to make a personal connection with patients who were homeless. Common ground was found in the nurses' realization that they were also vulnerable to homelessness or that the patients who were homeless had a mother who cared for them. Medical-surgical nurses' ability to find common ground allowed the nurses to develop compassion and more positive attitudes toward patient who were homeless.

'Piecing it together'

The theme ‘Piecing it together’ reflected medical-surgical nurses’ ability to piece together information needed to manage the care of and change attitudes about patients who were homeless. Participants shared experiences that helped them establish positive rapports and positive attitudes toward patients who were homeless. Medical-surgical nurses seemed to be open to creating a better understanding, increasing knowledge, and developing specific skills to care for this patient population. ‘Piecing it together’ revealed important factors that play a role in transforming attitudes towards patients who were homeless.

Felicia’s experiences brought her to regard communication as a critical factor in caring for patients who were homeless. Felicia, the nurse with twelve years of experience, also viewed communication with patients who were homeless as being different than other patient populations. She recalled learning how to communicate and gather data from patients who were homeless. Felicia perceived interviewing and data gathering as a learned process that developed after she was able to “get to know” her patients. Felicia noted that patients who were homeless were not going to give information willingly and were distrusting of some nurses. Felicia shared:

> Homeless people they never come out and just spill the beans, and tell you everything. It’s kind of like you just have to piece it together… they never volunteer anything so you [the nurse] ask a little question here and a little question there and then slowly it all comes out.

Felicia described how she learned to piece together the information she needed to care for patients. She had to use other skills to gather the information she needed to provide care. For Felicia, gathering data on patients who were homeless were different

than other populations. Felicia recognized that patients who were homeless were often distrustful of health care providers. She experienced that patients who were homeless were reluctant to share information that caused her to rely on other skills to gather data such as observation and constant comparison. The reluctance of patients to share pertinent health information means that only nurses who have developed specific skills for gathering information from this population could collect an adequate health history. Felicia shared that patience and trust were also important to data gathering because if the patient felt rushed or suspicious of the nurse they would not share information. Felicia found that many patients who were homeless were distrustful of nurses, so she had to gather health histories in small bits of information and piece it together. This type of history taking was very different than gathering information from a patient who was trusting of the health care provider.

Felicia understood that nurses, by nature of their profession, were in a constant state of gathering data and making judgments regarding patient care. She described a conversation she had with a student nurse who was assigned to caring for a prisoner. Felicia said: "Don't you [nursing student] dare ask them [the patient who is a prisoner] what they did. Because it [knowing why they are a prisoner] will impair you." Felicia understood that nurses make judgments about patients. She compared the negative causes of a patient's incarceration to negative causes of homelessness and understood that knowing this information would create a negative perception. Felicia believed that some data would alter the nurses' perceptions and change the nurses' ability to provide non-judgmental care to patients. For Felicia, this skill was learned by trial and error as she

recalled the first time she asked a prisoner, who was also homeless, why he was incarcerated. Felicia described the situation:

> The first guy [incarcerated patient who as homeless] told me that he had molested a child and I said 'Oh God', I don't think I can take care of this man anymore. I learned my job is to take care of the patient. My job is not to investigate their life and find out whether they're innocent or guilty or what you did in the past. I honestly don't want to know. Because it will affect how you [the nurse] care for that patient. It changes your opinion and you don't need to do that. Your job is to take care of the patient, that's what you're here to do. Do that job.

Because the patient shared the reason he was incarcerated, Felicia recalled being unable to provide non-judgmental care to the patient. Felicia's experience changed her approach to caring for patients who were incarcerated and how she mentored new nurses. She recognized that not all information was needed to provide nursing care. She learned how knowing information that was morally objectionable to her changed her ability to effectively care for patients. Felicia's biases were so strong, she felt knowing this information affected her judgment and ability to care for patients.

Brenda, a sixty-three year old medical-surgical nurse with forty years of experience, felt that the skill of listening was more important for patients who were homeless than other groups of patients. Listening allowed Brenda to understand how to provide effective nursing care and limited stereotyping of the patient. Brenda said: "I would think, for the most part, if we [nurses] listen to their [patients who were homeless] story it will help us to care better for them and not to draw conclusions….They [nurses] can change if they listen." Brenda believed that nurses judge or "draw conclusions" about

the patients they care for. She believed that listening to the patients' own words about the circumstances of their life would lead nurses to be less judgmental about the patients' choices and behaviors. Brenda's experiences in caring for patients who were homeless lead her to the conclusion that listening was a learned skill that was not inherent in all nurses. Brenda believed that listening required the nurse be open to the patient and willing to change personal ideas.

The theme 'Piecing it together' revealed experiences associated with medical-surgical nurses' attitude transformations and factors nurses believed to be critical in reducing bias toward patients who were homeless. Some participants found that knowledge about the patient population reduced negative feelings. Other nurses believed that knowing too much about patients circumstances created negative feelings and lead to the nursing bias. Participants also identified specific skills such as listening, communication, and assessment that reduced negative feeling.

'A daily struggle'

The theme 'A daily struggle' reflected the medical-surgical nurses' daily efforts to recognize personal biases and desires to remain non-judgmental in order to provide non-judgmental care to patients who were homeless. Medical-surgical nurses incorporated self-awareness checks and caring frameworks into their daily routines. They surrounded themselves with like-minded nurses to keep them focused on patient care. 'A daily struggle' also suggested that medical-surgical nurses' attitudes were not fixed or stagnant rather nurses' attitudes continue to transform over time and with new experiences. 'A daily struggle' revealed important factors that played a role in attitude transformation towards patients who were homeless.

Felicia, the nurse with twelve years of experience, was never free of personal bias. She described a daily, conscious effort to be non-judgmental. Felicia recognized that remaining non-judgmental and sustaining a positive attitude required self-awareness and a willingness to self-reflect daily. Felicia believed that nurses who have negative perceptions were making judgments and that, in order to fulfill the nurses' role, nurses must be nonjudgmental. For example, Felicia summarized the most important aspects about her attitude and perception: "The most important thing is just to realize that there is something there, try not to make passing judgments. I'm not going to pass judgment. And I always, always practice this every day." Felicia was aware of personal bias and believed that nurses' must set bias and stereotypes aside to provide patient care. For Felicia, the process of being non-judgmental was a daily part of her professional life. She recognized that making judgments about patients negatively affects patient care.

Irene, the nurse with 13 years experience, also took a day-to-day approach to patient care. She described her perceptions of patients who were homeless as in a constant state of adaption. Irene shared that she had positive and negative experiences with caring for patients who were homeless. However, she understood that negative feelings toward one patient might alter her ability to care for other patients. She described how having a fresh start or new beginning everyday with her patients helped her to set aside previous feelings. Irene shared: "It's like when you [medical-surgical nurse] walk in that door that first time it's like a clean slate. And first impressions do matter. But you kind of wipe the slate clean with a brand new patient." Irene's day-to-day, patient-by-patient approach helped her to set negative feelings and experiences aside and care for patients without bias. Irene tried to enter the nurse/patient relationship without bias. Irene was also careful

to qualify that the reception she received from patients played a role in patient care. The daily evaluation of self and patient care allowed Irene to limit the influences of previous negative feelings and experiences and provided patients an opportunity to engage in positive nurse/patient relationships.

Kelly too described her day-to-day struggles with being non-judgmental. Kelly was a fifty-eight year old medical-surgical nurse with twenty-six years of experience. She shared how she grew up in a family and environment where judging others was not accepted yet she still struggled to provide non-judgmental care. Kelly reminded herself daily not to judge her patients who were homeless. Kelly talked about trying to remain non-judgmental:

> It's hard, it's very hard. You don't want to judge these people about anything because everybody didn't have what you had growing up…then you find yourself sometimes judging them. I have to pray…Because I think if you let that kind of stuff stay on the inside of you, you'll find yourself dealing with them unfairly and harshly.

Kelly described her struggles with being non-judgmental and empathetic toward patients who were homeless. Kelly viewed her personal background and experiences as being different from her patients who were homeless. She perceived that patients who were homeless may not have had the same opportunities as she and because of this difference she felt compelled to respond with empathy. However, thoughts of being judgmental were always present in her day-to-day practice. Kelly made a daily, conscious effort to avoid thoughts of being judgmental toward her patients. She relied on prayer and daily self-reflection to keep her personal bias contained.

Darlene, a thirty-nine year old medical-surgical nurse with eight years of experience, shared how time and experience helped transform her negative attitude. Darlene expressed that her attitude changed over a period of time and after caring for many patients who were homeless. Darlene stated, "The process of changing that [attitude] or my thought process changing was really slow because it was a process, it was a daily thing." Darlene's comment reflected that her once negative attitude toward patients who were homeless was not fixed. Rather, her attitude transformation was a daily process to which time and experiences contributed.

Similarly, Alice, the nurse with eighteen years experience, was asked what she believed lead to the change in her perceptions of patients who were homeless. She shared that the transformation of her attitude was a combination of maturity (time) and her experiences as a nurse. Alice said: "I think it is probably experience and age. With experience as a nurse you also gain experience in life. Maybe you become a parent, maybe you don't, but you still experience more lessons in life." For Alice, aging, becoming a parent, and clinical experiences as a nurse changed her perception of patients who were homeless. As a new nurse Alice viewed patients who were homeless through a negative lens, over time and with experience, she perceived patients who were homeless as someone's child.

Medical-surgical nurses' daily struggles contributed to the atmospheres of work environments. Nurses who described daily struggles with being non-judgmental identified daily work environments as being influential in attitude transformations. Supportive, compassionate co-workers contributed to positive atmospheres in daily work places. For example, Irene, the nurse with fourteen years experience, described her environment as

being a key contributor to her attitude transformation. She shared that as a nursing student she worked in a private hospital and after graduating she worked in a large not-for-profit hospital. She described the hospital as a teaching facility where a large population of indigent patients received health care services and where nurses cared for all patient populations regardless of the patients' backgrounds. She believed that working in a teaching, not-for-profit environment created an opportunity for her to interact with patients who were different than her and where she was surrounded by nurses who cared for all patients. She described this experience as "leveling the playing field" which allowed her to develop empathy. She shared that the experiences in this environment continue to guide her nursing practice. Irene described her conversation with a family member who was a new nurse: "If you stay and work in that environment [medical-surgical unit as at teaching hospital]…that will broaden your horizons for the rest of your nursing practice…It will level the playing field so you don't have bias." Irene continued and described negative attitudes that she encountered in other areas of nursing practice. For example, Irene said, "I see bias in specialty areas where they [nurses who work in specialty areas] don't have to deal with certain populations and they come with a set of bias." Irene experienced bias in other areas of nursing practice. She felt strongly that her work environment as a new nurse played a pivotal role in the transformation of her attitude and her ability to care for patients who were homeless. The experience Irene gleaned from working in a medical-surgical unit influenced her attitude towards patients who were homeless. She expressed that her experiences in a large hospital, where diverse populations were cared for, broadened her understanding of what it was to be a nurse and the role personal bias played in patient care.

Similarly, Darlene, the nurse with eight years of experience, attempted to help transform other nurses' negative attitudes and improve thier abilities to care for the homeless population through changing the work environment. Darlene shared how she lead nurse education endeavors to inform unit nurses of community resources available to patients who were homeless. Darlene stated, "We [nurse educators] try to get more information out there to them [nurses]." She felt that by providing information and resources to nurses about how to care for patients who were homeless, nurses were less frustrated and became more familiar and comfortable with providing care.

Clair also recognized that nursing environments played a role in how nurses attitudes transformed. Claire was a fifty-eight year old medical-surgical nurse with thirty-eight years of experience. Claire incorporated Jean Watson's Theory of Caring to help other medical-surgical nurses focus on patients and provide more compassionate care. Claire felt strongly that Jean Watson's Theory of Caring helped her change her attitude to provide more compassionate care to patients who were homeless. Claire shared that she attended a Jean Watson Conference. She felt the information gleaned from the conference enhanced her ability to express compassion toward patients and changed her nursing practice. She said, "Once you realize that you have to have compassion to work with homeless patients, your attitude changes and you feel more compassion towards them.

Claire felt strongly that incorporating Jean Watson's Theory of Caring into her daily practice positively influenced her attitude toward her patients and provided a peaceful work environment, time for self-reflection, and increased her sense of compassion toward her patients. She changed her medical-surgical work environment by incorporating Jean Watson's Theory of Caring into the nursing unit's daily culture.

The theme ‘A daily struggle’ represented medical-surgical nurses’ acknowledgment of negative attitudes and bias in the nursing profession. Nurses struggled to keep negative attitudes at a distance and focused on non-judgmental care of patients who were homeless. Nurses also valued the awareness of personal bias and incorporated daily self-reflection into their practices in an effort to provide unbiased nursing care. Other nurses found that time, experiences and work environments played a role in transforming negative attitudes toward caring for patients who were homeless.

‘Relationships built on distrust’

‘Relationships built on distrust’ symbolized how negative perceptions created distrust and emotional distance within the nurse/patient relationship. Negative experiences in caring for patients who were homeless were associated with the medical-surgical nurses’ feelings of distrust toward patients. A ‘relationship built on distrust’ was associated with nurses limiting emotional involvement with patient care, having low expectations of patients, and predicting poor health outcomes. Nurses who limited self-involvement and kept an emotional distance tended to focus on short term health care goals and restricted care to patients’ physical needs.

Heather, a nurse with six years of experience, shared a story about a patient encounter that she felt negatively influenced her attitude and willingness to become emotionally involved when caring for other patients who were homeless. She believed that this patient’s choices and actions created a lasting desire for her to distance herself from patients who were homeless. Heather attributed her change in attitude to altering how she cared for patients who were homeless. Heather shared:

> I guess what pushed me at arm's length was the gentleman [patient who was homeless] who tried to kill himself. I just felt like he had been given a second chance and we [medical-surgical nurses] had done everything we could think of to try to help him, including getting him involved in things after he was discharged. He wasn't willing to stick with it. He wasn't willing to take that chance that was given to him. I certainly got to the point where I was more jaded in what people told me to my face as long as you were able to give and do for that person and provide more incentive to them. They were willing to accept and participate in it. But, as soon as your outlook didn't match theirs… wrote you off. You couldn't help them.

Heather noted that she and her co-workers provided excellent care and went, what she described as above and beyond the traditional nursing care provided on a medical-surgical unit. She felt unappreciated for the care she provided and in a sense helpless to change the health outcomes of the patient, regardless of what she did. Heather felt that she and her co-workers upheld their end of the 'agreement' in providing care to the patient and the patient did not uphold his end. She felt like she had been betrayed because he accepted care yet he did not work hard enough to live. Heather felt the need to protect herself from future disappointments and began to treat patients who were homeless with less personal interest and emotional support. Heather described her overall perceptions of patients who were homeless as positive. However, this single event changed her relationships with patients who were homeless. Although she continued to provide care she was less trusting and more likely to focus only on the patients' immediate physical needs rather than longer-term goals such as rehabilitation, shelter, and acclimation into society.

Darlene, a nurse with eight years of experience, also felt an overall sense of disappointment with caring for patients who were homeless. Darlene shared her experience in caring for a patient who was homeless who had multiple motorcycle accidents and subsequent admissions to her unit. Although she expressed personal satisfaction in caring for this patient, she described feelings of frustration because the patient failed to follow through with his part of the patient/nurse relationship. Darlene stated, "I mean, despite all the education that we [medical-surgical nurses] gave him, he still went out and did the same thing." Darlene's comment reflected her feelings of frustration and sense of failure in not positively affecting the patient's health outcome. Darlene's comment also reflected the same frustration and disillusionment Heather experienced after becoming emotionally close to a patient who died despite of the care provided. Nurses' sense of inability to cure or change patients' health outcomes influenced future nurse/patient relationships with patients who were homeless.

Similar to Heather and Darlene, Gail also recognized the strained relationship among medical-surgical nurses and patients who were homeless. Gail was a twenty-four year old medical-surgical nurse with three years of experience. Gail described how her relationships with patients who were homeless were different from other patients. She experienced frustration with the poor health outcomes and what she perceived as a lack of involvement by the patients to improve their health. For example, Gail stated, "They [patients who were homeless] won't try to get a primary care doctor or anything like that, that's just disheartening. You [the medical-surgical nurse] kind of get frustrated sometimes, with those patients." Gail expressed her frustrations with caring for patients who were homeless. She had low expectations that patients who were homeless would

contribute to their own well-being and experience positive health care outcomes. She seemed to believe that regardless of her actions as a nurse the outlook for this population regarding health and life was bleak. Darlene and Gail felt that the poor health outcomes experienced by patients who were homeless reflected negatively on the care they provided.

The theme 'Relationships built on distrust' reflected how attitudes influenced nursing behaviors and nurse/patient relationships. One medical-surgical nurse experienced such strong feelings of distrust and betrayal that her bias impeded her ability to provide nursing care. Emily began her nursing practice experiencing feelings of distrust toward people who are homeless. Her early experiences reflected similar notions found with other nurses who experienced 'Relationships built on distrust.' However, Emily's negative feelings escalated overtime to reflect feelings of resentment and distain. Emily's negative attitude was difficult to conceal and was sensed by other nurses and revealed in her experiences and behaviors. She described feelings of "being taken advantage of" and experienced feelings of deep resentment and blame toward patients who were homeless. Emily was acutely aware of her bias although she did not perceive that her bias influenced her nursing practice.

Emily, a forty-eight year old nurse with twenty-one years of experience, expressed strong feelings of resentment toward patients who were homeless. She felt her resentment stemmed in part from her belief that patients who were homeless were taking advantage of the health care system specifically her hospital of employment and her time at work. Emily expressed her feelings of the care provided to patients who were homeless. Emily stated: "You're [patient who was homeless] getting the best care that we can give you…

as good of care as anybody and yet you don't do anything." Emily believed that all patients who were homeless did not work or pay for the health care services. She felt justified in her feelings of resentment and qualified her nursing care to patients who were homeless as being the same as other patients. Emily had an expectation of receiving something in return for the care she provided. Emily's feelings of being taken advantage of and resentfulness were intensified as she noted that her family struggled to pay for health care. She explained how she worked hard to earn a living and was expected to pay for health care but this expectation did not hold true for patients who were homeless. Emily said:

> I have to fight with my insurance to get them to do things that I need. And my husband and I both have insurance. People who come in off the streets [patients who were homeless] get better…as good or better care with *nothing*. And I think that's when I really became so negative towards them.

Emily briefly shared her personal struggles with the health care system. Her experience seemed to reflect a sense of unfairness and resentment. Emily felt that she worked to support herself and her family and viewed patients who were homeless as doing nothing to contribute to their own health care needs. She felt very strongly that people who do not contribute to their own personal and financial wellbeing should not depend on others to support them. She had homogeneous view of patients who were homeless in that all were able to work and pay their own way but chose not to.

Emily felt that becoming homeless was a "lifestyle" choice regardless of the circumstances which precipitated homelessness. For example, Emily expressed:

> I think drugs and life just had done that [being homeless] to her [patient who was homeless]. But again, you know and I know it, it's a sickness [drug and alcohol addiction] but it's a choice. We make choices and I think her choosing that lifestyle is exactly why she was where she was. I mean, you don't have to choose it.

Emily blamed the patient for choosing addictions over living a productive, healthy lifestyle. She viewed addictions and homelessness as a choice the patient made. Emily's experience reflected her feelings of the patient making a choice and now the patient has to live with the consequences. Although Emily understood that drug and alcohol addiction were medical conditions, her feelings of blame overshadowed her logic. According to Emily, drug and alcohol addictions were reduced to choosing to do drugs or alcohol or not, regardless of physical and psychological dependence.

Emily's feelings of frustration were intensified when she perceived she was unappreciated, treated with disrespect or had increased demands on her time. These feelings of 'being taken advantage of' and resentment were reflected in behaviors toward patients. For example, Emily expressed frustration and anger because she was unable to care for other patients whom she perceived as being more worthy of care. Emily said:

> You can't even see about your patients. And sometimes, I get so angry that I do only what I have to do. And I'm sure they feel that, that hostility, because I do resent that [caring for the patient who was homeless] – that I can't care for really sick patients, just catering to you [patient who was homeless]. And some of them [patient who was homeless], you know they have attitudes.

Emily continued to recall her experiences with patients who were homeless. She provided a specific example of how her feelings of frustration spilled over into her nursing practice. Emily stated:

> I had a girl [patient who was homeless] come in one night. I was asking her questions. She would not even answer me. I said, 'Well, if you're not going to answer [admission questions] then there's no need in trying to do this assessment.' So I got up, rolled my computer out the door, and she said, "I must can't have nothing to eat" I said, 'You must can't talk [mocking the patient's broken English].' I walked right on out the door. You are going to make my job harder. I'm trying to help you. Yea, it [bias] does come through. She could talk when she wanted something to eat.

Emily refused to care for her patient. She withheld food because the patient would not give her the information she needed to complete her task. Emily valued and prioritized the needs of patients who were not homeless above the needs of patients who were homeless. Although she was clear that her behaviors were influenced by her negative perceptions, she blamed the confrontational encounter on the patient. Emily felt justified in withholding care from the patient because the patient would not respond to her questions causing her to be unable to complete her nursing task. Emily did not seek more information as to the rationale of the patient's behavior rather she punished her by withholding food. Emily felt that patients who were homeless made her job more complex and rather than incorporating the care of the patients who were homeless into her shift, she became angry and resentful.

Most participants described neutral or negative perceptions that transformed as they continued to care for patients who were homeless. However, Emily had such strong negative feelings toward patients who were homeless that the more encounters she had with this population her negative biases were increased and reinforced. For example, Emily used her position of power as a nurse to belittle patients:

> A lot of them will tell you, I just don't want to work. I mean and sometimes I just deliberately or whatever, I'll say, So, where do you work? And I know they don't work. I don't work, is what they'll say. I don't work.

As she experienced frequent contact with patients who were homeless, her view took on more negative tones such as being lazy and unemployed with no desires to work. Her negative feelings were reaffirmed every time she asked patients who were homeless where they worked. Regardless of the patients' response, Emily lacked trust in this patient population to answer the questions honestly. Emily used her position of power to goad patients because they were homeless.

The theme 'Relationships built on distrust' represented some medical-surgical nurses strained nurse/patient relationships experienced with patients who were homeless. Some medical-surgical nurses experienced distrust and felt the need to protect themselves from disappointment when caring for this population. Medical-surgical nurses' comments reflected low expectations of health improvement among patients who were homeless and due to previous negative experiences, felt the need to distance themselves emotionally from patients. Nurses described this distance as "not getting attached;" "not getting involved;" "focusing on the physical needs of the patient;" and "keeping the patient at arm's length." These notions of distance reflected actions to prevent frustration and

personal disappointment. One nurse experienced such strong feelings of distrust that her bias negatively impacted her ability to care for patients who were homeless. Emily's feelings of "being taken advantage of," either as a medical-surgical nurse working at the bedside or as part of a larger health care system, fostered feelings of resentment and blame. As Emily gained clinical experience her strong negative attitude of resentment and blame toward patients who were homeless created a hostile environment for both her and the patients.

Summary

In this chapter, themes revealed in interviews with medical-surgical nurses were presented. The themes were revealed through the description and interpretation of the experiences of medical-surgical nurses who cared for patients who were homeless. All of the medical-surgical nurses shared personal experiences of how their attitudes toward patients who were homeless formed as they became new nurses and how their attitudes continued to transform as they practiced. All participants acknowledged that negative attitudes toward patients who were homeless existed within the nursing profession and the nurse/patient relationships were influenced by nurses' bias. However, participants shared that attitudes were not permanent; rather, attitudes were adaptable and could be transformed.

How attitudes formed was the focus to the theme 'Discovering homelessness.' This theme revealed that some nurses came into nursing with formed attitudes toward people who were homeless. However, new nursing attitudes were formed toward patients who were homeless as nurses engaged in care.

The themes ‘Finding common ground,’ ‘Piecing it together’ and ‘A daily struggle’ revealed factors that were associated with how attitudes were transformed. The themes ‘Finding common ground’ revealed how nurses searched for something in common with patients who were homeless. The theme ‘Piecing it together,’ revealed factors which allowed nurses to provide effective care to patient who were homeless. Participants identified factors needed to care for patients who were homeless such as communication skills, physical assessment skills, and listening. The theme ‘A daily struggle’ described medical-surgical nurses’ daily struggles to remain non-judgmental while caring for patients who were homeless. ‘A daily struggle’ also revealed factors associated with the transformation of medical-surgical nurses’ attitudes including time, clinical experiences, and environments.

The theme ‘Relationships built on distrust’ revealed how medical-surgical nurses’ bias impacted nurse/patient relationships. In this theme, nurses experienced negative encounters in caring for patients who were homeless. Negative experiences created distance and distrust between nurses and patients. ‘Relationships built on distrust’ also revealed how one nurse’s feelings of distrust and betrayal intensified over time and brought about feelings of resentment and distain that impeded her ability to care for patients who were homeless.

CHAPTER VI

CONCLUSION AND RECOMMENDATIONS

The purpose of this study was to explore medical-surgical nurses' clinical experiences with patients who were homeless in an effort to discover the development and transformation of attitudes toward care of the homeless. Eleven medical-surgical nurses who cared for patients who were homeless were interviewed. Interpretive phenomenology was used to describe and interpret the lived experiences of nurses who cared for patients who were homeless. The process delineated by Diekelmann and Allen (1989) and expanded by Minick (1992) was used to analyze the data. In this chapter, conclusions from the findings will be discussed in conjunction with recommendations for nursing practice, education, and research. In addition, limitations of the study will be presented.

Research Questions and Conclusions

The data were obtained from rich, descriptive stories of the participants which provided insight as to medical-surgical nurses' experiences with caring for patients who were homeless and revealed how nurses' attitudes formed and transformed. Five themes were identified from the data. The research questions were: (a) What are the attitudes of medical-surgical nurses toward patients who are homeless? (b) Do medical surgical nurses' attitudes toward patients who are homeless transform over time and how? and (c) What experiences seem to be associated with the development and transformation of

medical-surgical nurses' attitudes? In the following section the research questions are presented and answers found in the data are described.

Research Question One: What are the attitudes of medical-surgical nurses toward patients who are homeless?

Interpretation of the data revealed that medical-surgical nurses' attitudes toward patients who were homeless were not resolute. Rather, attitudes were in constant transformation and representated of a continuum of feelings and perceptions. Initially, nurses were asked to categorize their attitudes as discrete measurements of positive, negative, or neutral. However, nurses' descriptions and experiences reflected a continuum of feelings and perceptions that were adjusted with each patient encounter. Represented toward the 'negative' direction on the continuum were nurses' attitudes articulated as anger, blame, and resentment. In contrast, nurses' used descriptors such as empathetic, connection, and interested toward the 'positive' direction on the continuum. As nurses experienced caring for patients who were homeless, their attitudes were refined and became more complex regardless of the directional change.

Nurses reported established attitudes toward people who were homeless prior to beginning their career. As nurses encountered caring for patients who were homeless, attitudes began to transform. Prior to caring for patients who were homeless, nurses' attitudes were articulated as negative or neutral toward people who were homeless. This pre-nursing attitude reflected a distant perception of a marginalized population. The first years of nursing practice were shown to be a time of discovery and realization for nurses that were reflected in their experiences and attitude transformations. The theme 'Discovering homeless' revealed how most new nurses realized that homelessness was

not an abstract, intangible concept. Rather, homelessness existed and was present in their day-to-day nursing practices. Nurses' initial experiences began to transform attitudes to more positive attitudes toward caring for patients who were homeless.

Participants indicated that attitudes toward caring for patients who were homeless continued to transform over the course of clinical practices. All participants shared positive and negative experiences of caring for patients who were homeless. However, most participants established individual connections with patients based on mutual experiences. Participants who established connections described patients with empathy and reported more positive attitudes toward caring for patients who were homeless. In contrast, participants who were not able to establish personal connections with patients focused on the physical aspects of care, used more stereotypical descriptors of patients, and reported more negative attitudes. Most participants were willing to establish some level of connection or personal interest in patients who were homeless, as revealed in the theme 'Finding common ground.' According to participants, patients' receptions of nurses were also associated with nurses' willingness to connect with patients. For example, if nurses felt unappreciated or did not trust patients, nurses were more likely to use descriptors such as blame and non-compliant. Participants experienced different attitudes toward different patients which suggested nurses' attitudes transformed in response to individual patient encounters. Thus, for most nurses attitudes about caring for patients who were homeless were in constant development and transformation. This study's finding of nurses' attitudes transforming with each patient further supported the notion that new experiences may not erase old attitudes or perceptions but rather add new attitudes to already existing attitudes (Gregg, Seibt, & Banaji, 2006; Petty, Tormala,

Brinol, & Jarvis, 2006; Ratliff & Nosek, 2011; Rydell & Gawronski, 2009; Rydell & McConnell, 2006). The terms transformation and change do not imply leaving or setting aside previously held attitudes and replacing with new attitudes. Rather, attitudes from new experiences were added to or layered over the attitudes from old experiences. All the participants' experiences (positive and negative) in caring for patients who were homeless continued to form and transform attitudes that were founded in old experiences and refined with new experiences. Regardless of the nurses' attitude transformation, nurses were able to adopt different attitudes about this patient population because of experiences in providing care.

Stereotyped and biased attitudes were evident in the theme ''Relationships built on distrust.' One nurse's experiences reflected an attitude toward patients who were homeless transformed from negative to more negative. This nurse's experiences formed an attitude founded on the appraisal of the patient as a member of a larger group rather than an individual with a unique health needs. Stereotypes are defined as cognitive structures that contain knowledge and expectation about a group (Hamilton & Trolier, 1986; Van Knippenber & Dijksterhuis, 2000). The nurse categorized patients by group membership (homeless) and attributed characteristics of the group to individual patients (e.g. unemployed, mentally ill, drug addicted). For this nurse, an attitude based on stereotypically associated traits of group membership obstructed her ability to interact on a personal level with patients and hindered her ability to provide care. Research supports negative attitudes, prejudices, and stereotyping influences human behaviors (Allport, 1935, 1965; Ajzen & Fishbein, 2000).

Medical-surgical nurses' attitudes toward patients who were homeless were in a constant state of transformation. Overall, nurses' attitudes reflected complex feelings and perceptions that represented a continuum of attitudes. Positive and negative attitudes were reflected in the nurses' descriptions and experiences of care. Although nurses' initial attitudes toward the homeless population were more negative and reflected stereotypical descriptions of this marginalized population, some nurses learned from their experiences and developed more complex, positive attitudes. Understanding attitudes and when attitudes transform provides opportunities to positively influence nurses' attitudes. Experiences of caring for patients who were homeless provided nurses' opportunities to make connections with patients as individuals and increased the likelihood of positive attitude transformations.

Research question two: Do medical-surgical nurses' attitudes toward patients who were homeless transform over time? How?

Medical-surgical nurses indicated that attitudes transformed over what they described as time. However, time as a linear measurement of sequencing events was not reflected as nurses' impetus for change. Rather, nurses described how perceptions changed as life experiences and understanding of people from different situations or backgrounds broadened. For example, some nurses noted that motherhood changed their perceptions of caring for patients who were homeless. The life experience of motherhood and maturity created a new context for the nurse to view the patient who was homeless. Nurses' personal life experiences provided frameworks for attitude transformations toward patients who were homeless.

Clinical experiences in caring for patients who were homeless were also revealed as a catalyst for attitudinal transformations. As most nurses gained familiarity, most attitudes transformed from neutral or negative to positive. In contrast, one nurse's attitude reflected an increasingly negative transformation over time. As this nurse gained personal life and clinical experiences, her biases were reinforced. Regardless of the direction of attitudinal transformation, research literature supports clinical experiences as a factor associated with attitude transformations (Buchanan et al., 2003, 2007; Chung-Park et.al, 2006; Cruz et al., 2004; Loewenson & Hunt, 2011).

All nurses reported their attitudes transformed over time. However, life and clinical experiences of nurses created opportunities for nurses' attitudes to change. Attitude transformation occurred over time rather than as a result of time. Nurses' experiences gained over time provided diverse frameworks to perceive and interact with patients. Based on this premise, nurses who do not gain clinical experiences in caring for patients who are homeless would not be expected to change their attitude simply due to the passage of time.

Research question three: What experiences seem to be associated with the development and transformation of medical-surgical nurses' attitudes?

Medical-surgical nurses shared many experiences perceived as being instrumental in the development and transformation of attitudes toward patients who were homeless. Nursing experiences associated with the formation and transformations of attitudes are presented in the context of the theme in which they were revealed.

The theme 'Discovering homelessness' supported how nurses' initial transformation in attitudes reflected new nurses' realization of homelessness as part of

their new nursing practices. This theme also revealed that gaining clinical experiences provided nurses with opportunities to change perceptions of people who were homeless from a nameless member of the homeless population to an individual patient. The theme 'Discovering homelessness' revealed that new nurses were aware of homelessness as a social issue; however, no participants interacted with people who were homeless prior to practicing. In their professional role, new nurses had opportunities to form relationships with patients who were homeless. Clinical encounters allowed new nurses to become more familiar with patients. Nurses learned from patients through listening to the patients' personal stories and experiencing the day-to-day interactions between nurses and patients. As nurses' attitudes transformed the development of empathy and personal identification with patients who were homeless occurred. In the current study, clinical experiences were associated with attitude transformations which were consistent with previous research (Buchanan et. al., 2004; Cruz et al., 2004; Hunt, 2004; Kee et al., 1999; Sensenig, 2007). Regardless of the direction of attitude transformations, clinical experiences were supported as being associated with attitude transformations.

The theme 'Finding common ground' revealed how nurses attempted to find common life experiences with patients who were homeless. Finding commonalities seemed to be associated with positive changes in attitudes and an increased sense of empathy toward patients. The nurses' sense of having something in common with patients and the concept of connectedness were noted in nursing research literature. Connectedness was described as a type or subset of caring (Benner & Wrubel, 1989; Halldorsdottir & Hamrin, 1997). Sherwood (1997) described ways of making or finding connections in the context of nursing care of patients. However, the relationships

between connectedness and attitude transformations are marginally understood. One study identified nurses who found common ground with patients who were homeless experienced a transformation in attitudes. Minick et.al. (1998) used a hermeneutic phenomenological design to explore nurses' perceptions of people who were homeless. Interpretation of the findings revealed that positive transformation of attitudes were associated with experiences of making personal connections with patients who were homeless through listening, expressions of empathy, and the realization that participants could become homeless themselves.

The theme 'A daily struggle' revealed the toil nurses experienced in their clinical practices. Some nurses' experienced ethical conflicts when their overall perceptions of homelessness as a social problem were negative but their egalitarian views of patient care were expected. Nurses described experiences of conflicting feelings as "trying to be non-judgmental" and "reminding myself daily, to not judge." Nurses' struggled to be non-judgmental provided a background of day-to-day awareness of ethical comportment and ethical judgment. Psychological research supports that people ascribe more stereotypical traits to groups that they are not a part of (out-group; e.g. homeless people) than groups they are a part of (in-group; e.g. middle class, Christian, health care provider) (Quattrone & Jones, 1980). However, people generally want to be fair and do not wish to judge others (Banaji & Bhaskar, 2000; Ranganath & Nosek, 2008). In a recent study, Ratliff & Nosek (2011) conducted multiple experiments examining negative out-group biases and attitude formations and transfers. One conclusion derived from the data was that participants desired to avoid negatively evaluating out groups. Ratliff & Nosek's

research findings were congruent with medical-surgical nurses' daily struggles to be non-judgmental and provide unbiased nursing care.

Participants also described the day-to-day experiences with co-workers as being associated with attitude transformations in the theme 'A daily struggle.' For example, one nurse described how a comment by a co-worker caused her to view a patient who was homeless as someone's son rather than a nameless, homeless man. Another nurse described how "everyone who worked on our unit" contributed to clothes closet and petty cash fund which helped patients who were homeless. In contrast, one nurse shared an experience of receiving report from a nurse who used stereotypes such as dirty, lazy or frequent flyers to describe patients who were homeless. Nurses, co-workers, and the general climate of medical-surgical unit were associated with attitude transformations. One study was identified which supported that attitudes of physician preceptors influenced the attitudes of medical students. Masson & Lester (2003) conducted a study to determine attitude changes among medical students toward patients who were homeless. Researchers' findings supported that preceptors' negative attitudes toward patients who were homeless were associated with negative changes in medical students' attitudes toward patients who were homeless. Researchers described this influence as professional socialization. The concept of professional socialization is evident in the nursing literature. Du Toit (1995) defined professional socialization as a process through which novice practitioners merged into the profession. Part of socialization included the adaptation of the attitudes and values of the organization (Hunt, 2004). Research supports the influences of professional socialization and attitude transformation.

The theme ‘Piecing it together’ revealed that nurses’ attitude transformations were associated with increased knowledge and skill in how to care for patients who were homeless. Participants described nursing knowledge about health disparities, barriers to health care experienced by the homeless population and local resources that were available helped to reduce frustrations and negative attitudes toward care. Participants also expressed that the specific skills of assessment, communication, and listening were essential to patient care. For example, one nurse described that patients who were homeless were reluctant to share health information or were suspicious when asked common assessment questions. She tailored her assessment technique by using a non-judgmental tone, establishing a mutual respect prior to beginning an assessment, and providing rationales for all questions. Specific skills noted by participants were essential tools needed by nurses to provide care. No research was identified that discussed specific nursing skills in caring for marginalized populations and reducing nurses’ negative attitudes. Nurses have professional and ethical obligations to recognize and incorporate individual patient needs into care.

The theme ‘Relationships built on distrust’ revealed the role of trust in the nurse-patient relationship. Nurses who experienced distrust toward patients who were homeless described them as non-compliant and taking advantage of the health care system. The lack of trust experienced by nurses permanently altered the nurse-patient relationships. The nurse-patient relationships based on distrust were associated with nurses limiting care to just the physical needs of the patients, having low expectations of health improvements, and limiting self-involvement in care. The concepts of trust and distrust as influencing the health care provider relationships were supported in previous clinical

research literature (Belcher & Jones, 2009; Benkert et al., 2009; Hillen, de Haes, & Smets, 2011; Saha, Jacobs, Moore, & Beach, 2010). However, the influences of trust and the relationship health care providers experience with patients were sparse. In general, trust was found to be an essential component of nursing practice (Sellman, 2006) and described in the nursing literature as an attribute of connectedness (Phillips-Salimi, Haase, & Kooken, 2011), being able to depend on others (Barber & Schluterman, 2008; Edwards, Wetzel, & Wyner, 2006; Hupcey, Penrod & Morse, 2000), and a sense of comfort when interacting with others (Karcher 2005; Waters, Cross, & Runions, (2009). Arnold and Boggs (2003) identified key concepts of trust as good communication, knowledge, respect, honesty and commitment. When nurses trusted patients to make their own health decisions a successful care-giving relationship were formed (Thorne and Robinson, 1988). One study explored the concept of moral obligation of physicians in trusting patients and found that physicians' trust in patients enhanced patients' trust in physicians (Roger, 2002). The concepts of patient trust toward the health care provider and trust in the context of patient-health care provider relationship have been explored in the research literature. However, there has been little investigation of the role of trust as it relates to the health care providers' attitudes toward patients.

Recommendations for Nursing Practice

Several recommendations for nursing practice were gleaned from the current study's findings. Some participants were unaware that attitudes toward patients who were homeless were bias, reflected common stereotypes, and influenced the delivery of care. Therefore, reflections upon attitudes toward and the quality of the relationship established with patients who are homeless are essential to transforming attitudes and

providing non-judgmental care. Asking self-reflective questions can assist nurses to become more aware of bias and negative behaviors which impact health outcomes and create opportunities for negative attitude transformations.

Participants expressed that co-workers influenced attitudes about caring for patients who were homeless. Experienced medical-surgical nurses are in a unique position to encourage and mentor new nurses in their development as professional nurses. Experienced nurses should share positive experiences in caring for patients who are homeless. Experienced nurses should mentor new nurses as they learn to care for patients who are homeless to reduce negative experiences and mentor experienced nurses who are struggling with negative attitudes. Experienced nurses should also model professional nursing through ethical comportment and skilled competencies when caring for patients who are homeless. Through mentoring and modeling professional nursing, new nurses may be more likely to experience positive encounters with patients who are homeless thus positive attitude transformations may result.

Participants shared that as new medical-surgical nurses, they had unreasonable expectations of patients who were homeless. New nurses need to be prepared to understand that nursing is not about "saving the world." Unreasonable expectations of nursing care and patient outcomes can lead to feelings of disappointment, distrust, and blame. For some nurses, feelings of distrust and blame were a turning point in creating negative attitudes toward caring for patients who were homeless. Increasing knowledge about the homeless population will provide nurses with a better understanding of health disparities and barriers to health care those patients who are homeless experience. Knowledge about this marginalized population will assist nurses in setting reasonable

health goals and provide a general understanding that caring for patients who are homeless is a long-term commitment.

Recommendations for Nursing Education

This study's findings revealed a critical period of time when new nurses' attitudes were being reassessed and nurses experienced the realization that caring for patients who were homeless was complex and sometimes led to feelings of disappointment or frustration. The role of nurse educators in preparing nursing students to provide care to patients who are homeless is paramount. Nursing curriculums should reflect the complex knowledge and skill needed to care for patients who are homeless. Clinical and classroom experiences should include caring for patients who are homeless, student self-reflections, and faculty positive role modeling. Through an understanding of the homeless population, student nurses can learn to adapt specific clinical skills (communication, assessment, listening) needed to care for this population. An understanding of health care barriers and health needs experienced by patients who are homeless may reduce the student's level of disappointment or frustration when quick, positive health outcomes are not experienced. Ethical comportment, formation of nurse attitude, and character should be incorporated in the didactic and clinical learning environment. Learning experiences for student nurses should include experiences with patients who are homeless. Caring experiences based on meaningful relationships with patients who were homeless were more likely to positively alter the nurses' attitudes and lead to holistic, individualized care. In contrast, experiences based on distrust and blame were biased and stereotypical in nature, resulted in barriers to care, and negatively influenced health outcomes. Therefore, increasing opportunity for nurses to create

meaningful, connected relationships with patients who are homeless is essential in nurse attitude transformations. Nurse educators have an opportunity to prepare nursing students for this transitional time into practice as well as increase the possibility that medical-surgical nurses have a positive attitude toward caring for patients who are homeless.

Recommendations for Nursing Research

This study was the first step in exploring how medical-surgical nurses' attitudes developed and transformed. There were few studies that focused on how nurses' attitudes transformed. Expanding this study to include other geographical areas would contribute to nursing knowledge and allow nurse researchers to then develop a conceptual or theoretical framework to define and illustrate the complex relationships among medical-surgical nurses and patients who are homeless. Future studies could provide further data on the dynamics of nurses' attitude transformations toward patients and the role of trust and distrust in nurse-patient relationships.

This study's findings revealed how medical-surgical nurses' attitudes developed and transformed. Another area of nursing research would be to explore how nurses' attitudes form and transform toward patients who are homeless in other health care settings. For example, nurses who practice in the emergency department may have different perceptions of patients who are homeless and those attitudes may transform differently than medical-surgical nurses. Finding common threads among attitudes of nurses practicing in different practice areas would further expand nursing knowledge.

Most medical-surgical nurses' attitudes toward patients who were homeless were found to transform. Nursing knowledge regarding nurses' attitudes could be expanded

through the development of an instrument to measure nurses' attitudes and attitude changes. In addition, interventional studies focusing on attitude transformation should be explored by nurse researchers.

Strengths and Limitations

The strengths of this study included the use of Heideggerian hermeneutic phenomenology to reveal the background structures that may have otherwise been invisible. Also, the use of face-to-face interviews provided rich, descriptive data about medical-surgical nurses' attitudes towards patients who were homeless and how those attitudes developed and transformed. Another strength of the study was the rich experiences the medical-surgical nurses provided and the multiple years of experience the participants brought with those experiences. The rigor of the study was supported through the use of field notes which helped preserve the full-meaning of participants' stories, the use of a research journal which provided an audit trail to follow the research process, and the knowledge and experiences of the research team which provided data interpretation.

Limitations for the study included (a) sample selection, (b) geographic location and (c) the sensitive subject of medical-surgical nurses' attitude toward one subpopulation of patients. The sample was selected from registered nurses who were members of one state nursing organization or registered nurses who were known to or associated with doctoral nursing students at one state university. This distinct group had similarities and differences based on their experiences working in the medical-surgical environments and their experiences of caring for patients who were homeless thus limiting the diversity and variations of the data. The geographical location was limited to

one state located in the Southeastern United States. Medical-surgical nurses from other geographical locations may have had different experiences in caring for patients who were homeless. The sensitive subject of nurses' attitudes may have deterred some nurses from participating in the study or limited some participants from sharing extremely negative attitudes for fear of negative perceptions of the nursing profession. Some participants may have presented experiences with a more positive description for fear of being perceived as unethical or having negative attitudes toward patients who were homeless by the researcher.

Summary

This study contributed to the nursing knowledge of medical-surgical nurses' attitude development and transformation toward patients who were homeless. Through the medical-surgical nurses' description of their experiences, insights as to how attitudes form and transform emerged. Medical-surgical nurses also illuminated experiences associated with nurses' attitude transformations. Further inquiry is needed to explore the role of trust and connectedness in the nurse-patient relationship and the association between nurses' work environments and attitude transformations. Through revealing how nurses' attitudes toward patients who were homeless developed and transformed and identifying experiences associated with attitude transformations, there are opportunities for enhancing nursing care of this vulnerable population.

REFERENCES

Aberegg, S. K., & Terry, P. B. (2004). Medical decision-making and health care disparities: The physician role. *Journal of Laboratory and Clinical Medicine, 144*, 11-17.

Aberson, C. L., & McVean, A. D. (2008). Contact and anxiety as predictors of bias toward the homeless. *Journal of Applied Social Psychology*, *38,* 3009-3035.

Ajzen, I. (1985). From intentions to actions: A theory of planned behavior. In J. Kuhl & J. Beckman (Eds.), *Action-control: From cognition to behavior* (pp. 11-39). Heidelberg: Springer.

Ajzen, I., & Fishbein, M. (2000). Attitudes and the attitude-behavior relation: Reasoned and automatic processes. In W. Stroebe & W. Hewstone (Eds.), *European review of social psychology* (pp. 1-33). Chichester, England: Wiley and Sons.

Allport, G. W. (1935). Attitudes. In C. Murchinson (Ed.), *Handbook of social psychology* (pp. 798-844). Worchester, MA: Clark University Press.

American Nurses Association website. (2001). http://www.nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/2110Provisions.aspx

Attitude. (2012). In *Collins English Dictionary: Complete and Unabridged 10th Edition*. Retrieved March 13, 2012 from Dictionary.com website: http://dictionary.reference.com/browse/attitude.

Arnold, E., & Boggs, K. U. (2003). *Interpersonal relationships: Professional communication skills for nurses.* Elsevier Saunders, St. Louis, Missouri.

Ayanian, J. Z., Weissman, J. S., & Chasan-Taber, S. (1999). Quality of care by race and gender for congestive heart failure and pneumonia. *Medical Care, 37*, 1260-1269.

Bach, P. B., Cramer, L. D., & Warren, J. L. (1999). Racial differences in the early-stage lung cancer. *New England Journal of Medicine, 341*, 1198-1205.

Baker, C., Wuest, J., & Stern, P. N. (1992). Method slurring: The grounded theory/phenomenology example. *Journal of Advanced Nursing, 17*, 1355-1360.

Banaji, M. R., & Bhaskar, R. (2000). Implicit stereotypes and memory: The bounded rationality of social beliefs. In D. L. Schacter & E. Scarry (Eds.), *Memory, brain and belief* (pp. 139-175). Cambridege, MA: Harvard University Press.

Barber, B. K., & Schluterman, J. M. (2008). Connectedness in the lives of children and adolescents: A call for greater conceptual clarity. *Journal of Adolescent Health*, 43, 209-216.

Belcher, M., & Jones, L, K. (2009). Graduate nurses experiences of developing trust in the nurse-patient relationship. *A Journal for the Australian Nursing Professional*, *31*, 142-152.

Benkert, R., Hollie, B., Nordstrom, C. K., Wickson, B., Bins-Emerick, L. (2009). Trust, mistrust, racial identity and patient satisfaction in urban African American primary care patients of nurse practitioners. *Journal of Nursing Scholarship, 41*, 211-219.

Benner, P. (1994). The tradition and skill of interpretive phenomenology in studying health, illness and caring practices. In P. Benner (Ed.), *interpretive phenomenology embodiment, caring, and ethics in health and illness* (pp. 99-127). Thousand Oaks, CA: Sage Publishing.

Benner, P., Tanner, C., & Chesla, C. (1996). Appendix A. In P. Benner, C. Tanner, & C. Chesla (Eds.), *Expertise in Nursing Practice: Caring, Clinical Judgment and Ethics* (pp. 351-372). New York.

Benner, P., & Wrubel, J. (1989). The primacy of caring: Stress and coping in health and illness. Boston, Massachusetts, Addison-Wesley.

Bernbeim, S. M., Ross, J. S., Krumbolz, H. M., & Bradley, E. H. (2008). Influence of patient socio-economic status on clinical management decisions: A qualitative study. *Annals of Family Medicine*, *6*, 53-59.

Betancourt, J. R., & Ananeh-Firempong, O. (2004). Not me! doctors, decisions, and disparities in health care. *Cardiovascular Rev Rep*., *25*, 105-109.

Bhui, K., Shananan, L., & Harding, G. (2006). Homelessness and mental illness: A literature review and a qualitative study of perceptions of the adequacy of care. *International Journal of Social Psychiatry, 52*(2), 152-165.

Buchanan, D., Rohr, L., Kehoe, L., Glick, S. B., & Jain, S. (2003). Changing attitudes towards homeless people. *Journal of General Internal Medicine, 19*, 566-568.

Buchanan, D., Rohr, L., Stevar, L., & Sai, T. (2007). Documenting attitude changes toward homeless people: Comparing two standardized surveys. *Medical Education*, *41*, 346-348.

Caelli, K. (2000). The changing face of phenomenological research: Traditional and American phenomenology in nursing. *Qualitative health Research*, *10*, 366-377.

Chung-Park, M., Hatton, D., Robinson, L., & Kleffel, D. (2006). RN-to-MSN students' attitudes toward women experiencing homelessness: A focus group study. *Journal of Nursing Education, 45*, 317-322.

Colaizzi, P. (1978). Psychological research as the phenomenologist views. In R. Valale & M. King (Eds.), *Existential-phenomenological alternatives for psychology* (pp. 48-71). New York: Oxford University Press.

Community Health and Program Services. (2008). *Health Disparities* (Fact Sheet). Retrieved from Center for Disease Control website: http://www.cdc.gov/Healthyyouth/healthtopics/disparities.htm

Conroy, S. A. (2003). A pathway for interpretive phenomenology. *International Journal of Qualitative Methods*, 3(4), 1-43. http://www.ualberta.ca/~iiqm/backissues/2_3final/pdf/conroy.pdf

Crist, J. D., & Tanner, C. (2003). Interpretation/analysis methods in Hermeneutic interpretative phenomenology. *Nursing Research, 52*, 202-205.

Crowe, L., Meinnersmann, K., & Minick, P. (2009). *Medical-surgical nurses' attitudes toward patients who are homeless*. Unpublished manuscript.

Cruz, F., Brehm, C., & Harris, J. (2004). Transformation in family nurse practitioner attitudes toward homeless individuals after participation in a homeless outreach clinic. *Journal of the American Academy of Nurse Practitioners*, *16*, 547-554.

D'Amore, I., Hung, O., Chiang, W., & Goldfrank, L. (2001). The epidemiology of the homeless population and its impact on the urban emergency department. *Academic Emergency Medicine, 8*, 1051-1055.

Daiski, I. (2006). Perspectives of homeless people on their health and health need priorities. *Journal of Advanced Nursing*, *58*, 273-281.

Darbyshire, P., Muir-Cochrane, E., Fereday, J., Jureidini, J., & Drummond, A. (2006). Engagement with health and social care services: Perceptions of homeless young

people with mental health problems. *Health and Social Care in the Community*, *14*, 553-562.

Devine, P. G. (1989). Stereotypes and prejudice: Their automatic and controlled components. *Journal of Personality and Social Psychology*, *56*, 5-18.

Diekelmann, N. L., & Allen, D. (1989). A hermeneutic analysis of the NLN criteria for the appraisal of baccalaureate programs. In N. Diekelmann, D. Allen, & C. Tanner (Eds.), *The NLN Criteria for Appraisal of Baccalaureate Programs: A Critical Hermeneutic Analysis*. New York: National League of Nursing Press.

Dovidio, B. F., Brigham, J. C., Johnson, B. T., & Gaertner, S. L. (1996). Stereotyping, prejudice, and discrimination: Another look. In N. Macrae, C. Stangor, & M. Hewstone (Eds.), *Stereotypes and stereotyping* (pp. 276-319). 1996: Guilford.

Dreyfus, H. L. (1991). *Being-in-the-world: A commentary on Heidegger's being and time, Division I*. Cambridge, MA: The MIT Press.

Du Toit, D. (1995) A sociological analysis of the extent and influence of professional socialization on the development of nursing identity among nursing students at two universities in Brisbane, Australia. *Journal of Advanced Nursing*, *21*, 164-171.

Edwards, D. A., Wetzel, K., & Wyner, D. R. (2006). Intercollegiate soccer: Saliva cortisol and testosterone are elevated during competition, and testosterone is related to status and social connectedness with teammates. *Physiology and Behavior*, *87*, 135-143.

Fincher, C., Williams, J. E., & MacLean, V. (2004). Racial disparities in coronary heart disease: A sociological view of the medical literature on physician bias. *Ethnicity and Disease, 14*, 360-371.

Fiske, S. T. (1998). Stereotyping, prejudice, and discrimination. In D. T. Gilbert & S. T. Fiske (Series Ed.), *The handbook of social psychology*: *Vol. 2*. *4th edition*, (pp. 357-411). New York, New York: McGraw-Hill.

Gregg, A. P., Seibt, B., & Banaji, M. R. (2006). Easier done than undone: A symmetry in the malleability of implicit preferences. *Journal of Personality and Social Psychology*, *90*, 1-20.

Gallup, Inc. (2007). *Homelessness in America: Americans' perceptions, attitudes and knowledge* [White paper]. Retrieved from Fannie Mae Web site: http://www.fanniemae.com/media/pdf/GP_Citiesfinal.pdf

Georgia Nurses Association. (2011). Retrieved December 3, 2010: http://www.georgianurses.org/

Gelberg, L., Browner, C. H., Lejano, E., & Arangua, L. (2004). Access to women's health care: A qualitative study of barriers perceived by homeless women. *Women and Health*, *40*, 87-100.

Greenberg, G. A. (2010). An evaluation of an initiative to improve coordination and service delivery of homeless services networks. *Journal of Behavior Health Services Research*, *37*, 184-196.

Guba, E. G., & Lincoln, Y. S. (1981). *Effective evaluation*. San Francisco, CA: Jossey-Bass.

Halldorsdottir, S., & Hamrin, E. (1997). Caring and uncaring encounters within nursing

and health care from the cancer patient's perspective. *Cancer Nursing, 20*, 120-129.

Hamilton, D. L., & Troiler, T. K. (1986). Stereotypes and stereotyping: An overview of the cognitive approach. In J. Dovidio & S. Gaertner (Eds.), *Prejudice, discrimination, and racism* (p. 127-163). Orlando, FL: Academic Press.

Hatchett, B. F. (2004). Homelessness among older adults in a Texas border town. *Journal of Aging and Social Policy, 16,* 35-56.

Heidegger, M. (1962). *Being and time* (J. Macquarrie & E. Robinson Trans.). New York, NY: Harper and Row. (Original work published 1927)

Hillen, M. A., de Haes, H. C., & Smets, E.M. (2011). Cancer patients trust in their physician-a review. *Psycho-Oncology, 20,* 227-41.

Hudson, A. L., Nyamathi, A., & Sweat, J. (2008). Homeless youth's interpersonal perspectives of health care providers. *Issues in Mental Health Nursing, 29,* 1277-1289.

Hunt, G. (2004). The ethics of silence. *Nursing Ethics, 11*, 108-109.

Hunter, J., Getty, C., Kemsley, M., & Skelly, A. H. (1991). Barriers to providing health care to homeless persons: A survey of providers' perceptions. *Journal of Health Behaviors, Education and Promotion, 15*(5), 3-11.

Hupcey, J.E., Penrod, J., & Morse, J.M., (2000). Meeting expectations: Establishing and maintaining trust during acute care hospitalizations. *Scholarly Inquiry for Nursing Practice, 14*, 227-242.

Institute of Medicine. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, D.C.: The National Academies Press.

Ishorst-Witte, F., Heinemann, A., & Puschel, K. (2001). Morbidity and cause of death in homeless persons. *Archiv Kriminol, 208*(5-6), 129-138.

Karcher, M. J. (2005). The effects of developmental mentoring and high school mentors; attendance on their younger mentees' self-esteem, social skills, and connectedness. *Psychology in the Schools*, 42, 65-77.

Kee, C. C., Minick, P., & Conner, A. (1999). Nursing student and faculty attitudes toward people who are homeless. *American Journal of Health Behavior, 23*, 3-12.

Kingree, J. B., & Daves, W. F. (1997). Preliminary validation of the attitudes toward homelessness inventory. *Journal of Community Psychology, 25*, 265-288.

Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods, 2*, 1-29.

Leonard, V. (1994). A Heideggerian concept of person. In P. Benner (Ed.), *Interpretive Phenomenology: Embodiment, Caring, and Ethics in Health and Illness* (pp. 43-63). Thousand Oaks, CA: Sage Publications.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage Publications, Inc.

Linville, P. W., Fisher, G. W., & Salovey, P. (1989). Perceived distributions of the characteristics of in-group and out-group members: Empirical evidence and a computer simulation. *Journal of Personality and Social Psychology, 57*, 165-188.

Loewenson, K. M., & Hunt, R. J. (2011). Transforming attitudes of nursing students: Evaluating a service-learning experience. *Journal of Nursing Education, 50*, 345-349.

Martins, D. C. (2008). Experiences of homeless people in the health care delivery system: A descriptive phenomenological study. *Public Health Nursing*, *25*, 420-430.

Masson, N., & Lester, H. (2003). The attitudes of medical students toward homeless people: Does medical school make a difference? *Medical Education, 37*, 869-872.

McCabe, S., Macnee, C. L., & Anderson, M. K. (2001). Homeless patients' experience of satisfaction with care. Archieves of Psychiatric Nursing, 15, 78-85.

McCann, T. V., & Clark, E. (2002). Grounded theory in nursing research: Part 1-Methodology. *Nurse Researchers*, *11*(2), 7-18.

Minick, P., Kee, C., Borkat, L., Cain, T., & Opara-lwobi, T. (1998). Nurses' perceptions of people who are homeless. *Western Journal of Nursing Research, 20*, 354-369.

Morgan, B. S. (1984). A semantic diffential measure of attitudes toward black American patients. *Research in Nursing Health, 7,* 155-162.

National Alliance to End Homelessness. (2009). Homelessness counts: Changes in homelessness form 2005-2007. Retrieved from www.endhomelessness.org/files/2158_file_counts_2_final.pdf.

National Center for Health Statistics [NCHS]. (2007). *Deaths: Final data for 2004* [Data file]. Available from CDC website: http://www.cdc.gov/nchs/products/pubs/pubd/hestats/finaldeaths04/finaldeaths04.htm

Nickasch, B., & Marnocha, S. K. (2009). Health care experiences of homeless. *American Academy of Nurse Practitioners*, *21*, 39-46.

Nyamathi, A., Koniak-Griffin, D., & Greengold, B. A. (2007). Development of nursing theory and science in vulnerable population's research. In J. J. Fitzpatrick, A.

Nyamathi, & D. Koniak-Griffin (Eds.), *Annual Review of Nursing Research* (pp. 3-26). New York, NY: Springer Publishing Company.

O'Connell, J. J. (2005). *Premature mortality in homeless populations: A review of the literature* [White paper]. Retrieved from National Health care for the Homeless Council, Inc. web site: http://www.nhchc.org/PrematureMortalityFinal.pdf.

Palmore, E. B. (1990). *Ageism, negative and positive*. New York: Springer Publishing Company.

Petty, R. E., Tormala, Z. L., Brinol, P., & Jarvis, W. B. G. (2006). Implicit ambivalence from attitude change: An exploration of the PAST model. *Journal of Personality and Social Psychology, 90,* 21-41.

Phelan, J., Link, B. G., Moore, R. E., & Stueve, A. (1997). The stigma of homelessness: The impact of the label "homeless" on attitudes toward poor persons. *American Sociological Association, 60,* 323-337. http://www.jstor.org/stable/2787093

Phillips-Salimi, C.R., Haase, J.E., & Kooken, W.C. 2011). Connectedness in the context of patient-provider relationships: A concept analysis. *Journal of Advanced Nursing*, May, 230-245.

Pollio, H. R., Henley, T. B., & Thompson, C. J. (1997). *The phenomenology of everyday life* (1st Ed.). Cambridge, United Kingdom: Cambridge University Press.

Quattrone, G. A., & Jones, E. E. (1980). The perception of variability within in-groups and out-groups: Implications for the law of small numbers. *Journal of Personality and Social Psychology, 38,* 141-152.

Ranganath, K. A., & Nosek, B. A. (2008). Implicit attitude generalization occurs immediately, explicit generalization takes time. *Psychological Science, 19,* 249-254.

Ratliff, K. A., & Nosek, B.C. (2011). Negativity and out-group biases in attitude formation and transfer. *Personality and Social Psychology Bulletin, 37,* 1692-1703.

Rogers, W.A. (2002). Is there a moral duty for doctors to trust patients? *Journal of Medical Ethics, 28,* 77-80.

Rydell, R. J., & Gawronski, B. (2009). I like you, I like you not: Understanding the formation of context-dependent automatic attitudes. *Cognition and Emotion, 23,* 1118-1152.

Rydell, R. J., & McConnell, A. R. (2006). Understanding implicit and explicit attitude change: A system of reasoning analysis. *Journal of Personality and Social Psychology, 91,* 995-1008.

Saha, S., Jacobs, E.A., Moore, R.D., & Beach, M.C. (2010). Trust in physicians and racial disparities in HIV care. *AIDS Patient Care & STDs, 24,* 415-20.

Salit, S., Kuhn, E., & Hartz, A. (1998). Hospitalization costs associated with homelessness in New York City. *New England Journal of Medicine, 338,* 1734-40.

Sandelowski, M., & Barroso, J. (2002). Finding the findings in qualitative studies. *Journal of Nursing Scholarship, 34,* 213-219.

Sandelwoski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science, 8,* 27-37.

Sellman, D. (2006). The importance of being trustworthy. *Nursing Ethics, 13*,105-115.

Sensenig, J. (2007). Learning through teaching: empowering students and culturally diverse patient at a community-based nursing care center. *Journal of Nursing Education, 46,* 373-379.

Schulman, K. A., Berlin, A. J., Harless, W., Kerner, J. F., Sistrunk, S., Gersh, B. J., Williams, S. (1999). The effect of race and sex on physicians' recommendations for cardiac catheterization. *New England Journal of Medicine, 340,* 618-626.

Sherwood, G. (1997). Meta-synthesis of qualitative analyses of caring: Defining a therapeutic model of nursing. *Advanced Practice Nursing Quarterly, 3,* 32–42.

Thompson, S. J., McManus, H., Lantry, J., Windsor, L., & Flynn, P. (2006). Insights from the street: Perceptions of services and providers by homeless young adults. *Evaluation and Program Planning, 29,* 34-43.

Thorne, S. E., & Robinson, C. A. (1998). Reciprocal trust in health care relationships. *Journal of Advanced Nursing, 13,* 782-789.

Tompsett, C. J., Toro, P. A., Guzicki, M., Manrique, M., & Zatakia, J. (2006). Homelessness in the United States: Assessing changes in prevalence and public opinion, 1993-2001. *American Journal of Community Psychology, 37,* 47-61.

Toro, P. A., & McDonell, D. M. (1992). Beliefs, attitudes, and knowledge about homelessness: A survey of the general public. *American Journal of Community Psychology, 20,* 53-80.

Tracy, E., & Stoecker, R. (1993). Homelessness: The service providers' perspective of blaming the victim. *Journal of Sociology and Social Welfare, 44,* 43-59.

Tuckett, A. G. (2005). Rigour in qualitative research: Complexities and solutions. *Nurse Researcher*, *13*(1), 29-42.

Ugarriza, D. N., & Fallon, T. (1994). Nurses' attitudes toward homeless women: A barrier to change. *Nursing Outlook*, *42*, 26-29.

Van Knippenberg, A., & Dijksterhuis, A. (2000). Social categorization and stereotyping: A functional approach. *European Review of Social Psychology*, *11*, 105-144.

Van Manen, M. (1997). *Researching Lived Experience* (2nd ed.). Ontario, Canada: Althouse Press.

Van Ryn, M., & Burke, J. (2000). The effect of patient race and socio-economic status on physicians' perceptions of patients. *Social Science Medicine*, *50*, 813-828.

Van Ryn, M., & Fu, S. S. (2003). Paved with good intentions: Do public health and human service providers contribute to racial/ethnic disparities in health? *American Journal of Public Health*, *93*, 248-255.

Waters, S. K., Cross, D.S., & Runions, K. (2009). Social and ecological structures supporting adolescent connectedness to school: A theoretical model. *Journal of School Health*, *79*, 516-524.

Weisse, C. S., Sorum, P. C., Sanders, K. N., & Syat, B. L. (2001). Do gender and race affect decisions about pain management? *Journal of General Internal Medicine*, *16*, 211-217.

Wen, C. K., Hudak, P. L., & Hwang, S. W. (2007). Homeless people's perceptions of welcomeness and unwelcomeness in health care encounters. *Journal of General Internal Medicine*, *22*, 1011-1017.

Zlotnick, C., & Zerger, S. (2008). Survey finding on characteristics and health status of clients treated by the federally funded health care for the homeless program. *Health and Social Care in the Community, 17*(1), 18-26.

Zrinyi, M., & Balogh, Z. (2004). Student nurse attitudes toward homeless clients: A challenge for education and practice. *Nursing Ethics, 11*, 334-348.

APPENDIX A

INSTITUTIONAL REVIEW BOARD APPROVAL

INSTITUTIONAL REVIEW BOARD

Mail: P.O. Box 3999
Atlanta, Georgia 30302-3999
In Person: Alumni Hall
30 Courtland St, Suite 217
Phone: 404/413-3500
Fax: 404/413-3504

April 21, 2011

Principal Investigator: Minick, M Ptlene

Student PI: Lora Crowe

Protocol Department: B.F. Lewis School of Nursing

Protocol Title: Medical-Surgical Nurses' Attitudes Toward Patients Who are Homeless: How Attitudes Develop and Transform

Funding Agency: Georgia College and State University

Submission Type: Protocol H11416

Review Type: Expedited Review

Approval Date: April 21, 2011

Expiration Date: April 20, 2012

The Georgia State University Institutional Review Board (IRB) reviewed and approved the above referenced study and enclosed Informed Consent Document(s) in accordance with the Department of Health and Human Services. The approval period is listed above.

Federal regulations require researchers to follow specific procedures in a timely manner. For the protection of all concerned, the IRB calls your attention to the following obligations that you have as Principal Investigator of this study.

1. When the study is completed, a Study Closure Report must be submitted to the IRB.

2. For any research that is conducted beyond the one-year approval period, you must submit a Renewal Application 30 days prior to the approval period expiration. As a courtesy, an email reminder is sent to the Principal Investigator approximately two months prior to the expiration of the study. However, failure to receive an email reminder does not negate your responsibility to submit a Renewal Application. In addition, failure to return the Renewal Application by its due date must result in an automatic termination of this study. Reinstatement can only be granted following resubmission of the study to the IRB.

3. Any adverse event or problem occurring as a result of participation in this study must be reported immediately to the IRB using the Adverse Event Form.

4. Principal investigators are responsible for ensuring that informed consent is obtained and that no human subject will be involved in the research prior to obtaining informed consent. Ensure that each person giving consent is provided with a copy of the Informed Consent Form (ICF). The ICF used must be the one reviewed and approved by the IRB; the approval dates of the IRB review are stamped on each page of the ICF. Copy and use the stamped ICF for the coming year. Maintain a single copy of the approved ICF in your files for this study. However, a waiver to obtain informed consent may be granted by the IRB as outlined in 45CFR46.116(d).

All of the above referenced forms are available online at https://irbwise.gsu.edu. Please do not hesitate to contact Susan Vogtner in the Office of Research Integrity (404-413-3500) if you have any questions or concerns.

Sincerely,

Susan K. Laury

Susan Laury, IRB Chair

INSTITUTIONAL REVIEW BOARD

Mail: P.O. Box 3999
Atlanta, Georgia 30302-3999
In Person: Alumni Hall
30 Courtland St, Suite 217
Phone: 404/413-3500
Fax: 404/413-3504

April 2, 2012

Principal Investigator: Minick, M Ptlene

Protocol Department: B.F. Lewis School of Nursing

Protocol Title: Medical-Surgical Nurses' Attitudes Toward Patients Who are Homeless: How Attitudes Develop and Transform

Submission Type: Continuing Review #1 for H11416

Review Type: Expedited Review

Approval Date: April 21, 2012

Expiration Date: April 20, 2013

The Georgia State University Institutional Review Board (IRB) reviewed and approved the above referenced study in accordance with 45 CFR 46.111. The IRB has reviewed and approved the research protocol and any informed consent forms, recruitment materials, and other research materials that are marked as approved in the application. The approval period is listed above.

Federal regulations require researchers to follow specific procedures in a timely manner. For the protection of all concerned, the IRB calls your attention to the following obligations that you have as Principal Investigator of this study.

1. For any changes to the study (except to protect the safety of participants), an Amendment Application must be submitted to the IRB. The Amendment

Application must be reviewed and approved before any changes can take place

2. Any unanticipated/adverse events or problems occurring as a result of participation in this study must be reported immediately to the IRB using the Unanticipated/Adverse Event Form.

3. Principal investigators are responsible for ensuring that informed consent is properly documented in accordance with 45 CFR 46.116.

4. For any research that is conducted beyond the approval period, a Renewal Application must be submitted at least 30 days prior to the expiration date. The Renewal Application must be approved by the IRB before the expiration date else automatic termination of this study will occur. If the study expires, all research activities associated with the study must cease and a new application must be approved before any work can continue.

5. When the study is completed, a Study Closure Report must be submitted to the IRB.

All of the above referenced forms are available online at https://irbwise.gsu.edu. Please do not hesitate to contact the Office of Research Integrity (404-413-3500) if you have any questions or concerns.

Sincerely,

Shelia L. White, IRB Member

Federal Wide Assurance Number: 00000129

May 16, 2011
From: Doug Keith
To: Lora Crowe
Subject: Protocol Approval

Dear Lora Crowe:

The IRB has reviewed the proposal you submitted. "Medical-Surgical Nurses' Attitudes Toward Patients Who are Homeless: How Attitudes develop and Transform" has been granted approval by the Georgia College & State University Institutional Review Board. You may proceed but are responsible for complying with all stipulations described under the Code of Federal Regulations 45 CFR 46 (Protection of Human Subjects). This document can be obtained from the following web address.

http://ohsr.od.nih.gov/guidelines/45cfr46.html

The approval period is for one year. After that time, an extension may be requested. It is your responsibility to notify this committee of any changes to the study or any problems that occur. You are to provide the committee with a summary statement. Please use the enclosed statement to request an extension, for reporting changes, or reporting the completion of your study.

Yours sincerely,

Douglas Keith, PhD
Chair, IRB

APPENDIX B

INFORMED CONSENT/HIPAA AUTHORIZATION

Georgia State University
School of Nursing
Informed Consent

Title: Medical-Surgical Nurses' Attitudes Toward Patients Who are Homeless: How Attitudes develop and Transform

Principal Investigator: Dr. Ptlene Minick
Lora Crowe

Sponsor: This study is partially funded through a Faculty Research Grant from Georgia College and State University

I. Purpose:

You are invited to participate in a research study. The purpose of this study is to explore nurses' clinical experiences with patients who are homeless in order to discover the development and transformation of their attitudes toward the care of the homeless. You are invited to participate because you are a registered nurse, who currently practices in a medical-surgical hospital setting. You will be asked to describe your feelings toward and experiences with patients who are homeless. A total of 15-24 participants will be recruited for this study. Participation will require 60-90 minutes of your time. You may be asked for a second interview if clarification or interpretation of data collected is needed. The second interview, if required, will last approximately 15-30 minutes.

II. Procedures:

If you decide to participate, you will be asked to complete a brief Participant Information Form, an Event History Calendar, and answer questions in a face to face interview. The interview will be conducted at a predetermined site selected by you and will last at a minimum of 60 minutes to a maximum of 90 minutes. You may be asked to participate in a second interview if clarification of information you provided in your first interview is needed. The interview will be audiotaped. After completion of your first interview, you will receive a gift card worth $25.00 in appreciation for your participation and time.

III. Risks:

In this study, you will not have any more risks than you would in a normal day of life.

IV. Benefits:

Participation in this study may not benefit you personally. Overall, we hope to gain information about how medical-surgical nurses' attitudes toward patients who are homeless develop and transform.

V. Voluntary Participation and Withdrawal:

Participation in this research is voluntary. You do not have to be in this study. If you decide to be in the study and change your mind, you have the right to drop out at any time. You may skip questions or stop participating at any time. Whatever you decide, you will not lose any benefits to which you are otherwise entitled.

VI. Confidentiality:

We will keep your records private to the extent allowed by law. Information may also be shared with those who make sure the study is done correctly (GSU Institutional Review Board, the Office for Human Research Protection (OHRP) and/or Georgia College and State University Institutional Review Board). Confidentiality will be maintained through each participant being assigned a unique identification number on the Participant Information Form and the use of a pseudonym on all transcripts. A roster of participants names with corresponding pseudonyms and identification numbers, and all endorsed consent forms will be stored in a locked cabinet separate from each other and separate from the data. Only the primary investigator and student investigator will have access to the locked cabinet. Transcribed data will be kept in a firewall protected and password protected file. The participant roster and all audiotapes will be destroyed one year after study completion.

VII. Contact Persons:

Call Dr. Ptlene Minick at 404-413-1155, Pminick@GSU.edu or Lora Crowe at 478-952-1355, lora.crowe@gcsu.edu if you have questions about this study. If you have questions or concerns about your rights as a participant in this research study, you may contact Susan Vogtner in the Office of Research Integrity at 404-413-3513 or svogtner1@gsu.edu.

VIII. Copy of Consent Form to Subject:

We will give you a copy of this consent form to keep.

If you are willing to volunteer for this research and be audio recorded, please sign below.

_____ _____

Participant Date

_____ _____

Principal Investigator or Researcher Obtaining Consent Date

Consent Form Approved by Georgia State University IRB April 21, 2011 - April 20, 2012

APPENDIX C

PARTICIPANT INFORMATION FORM

Participant Information Form

Please answer the following questions by filling in the blank or circling the best answer.

1. Age ? _____
2. Gender?_____
3. What do you consider to be your ethnic background?
    - 3.1. African American
    - 3.2. Caucasian
    - 3.3. Hispanic or Latino
    - 3.4. Other_____
4. What is your highest degree earned?
    - 4.1. Associate in Nursing (ASN)
    - 4.2. Bachelor in Nursing (BSN)
    - 4.3. Masters in Nursing or related field (MSN)
    - 4.4. Doctoral or terminal degree
5. How many years have you been in nursing practice?
    - 5.1. Less than one year
    - 5.2. 1-2 years
    - 5.3. 2-3 years
    - 5.4. 3-5 years
    - 5.5. 5-10 years
    - 5.6. Greater than 10 years
6. What type of patients do your generally care for (Circle all that apply)?
    - 6.1. Cardiac
    - 6.2. Diabetic
    - 6.3. Women's Health
    - 6.4. Oncology
    - 6.5. Post operative
    - 6.6. Orthopedic
    - 6.7. Other _____

7. How often do you care for patients who are homeless?
    7.1. Daily
    7.2. Weekly
    7.3. Monthly
    7.4. Every 2 months
    7.5. Every 4 months
    7.6. Every 6 Months
    7.7. Annually
    7.8. Other_____
8. Have you or someone you know in your personal life ever been homeless?
    8.1. Yes
    8.2. No

APPENDIX D

INTERVIEW GUIDE

1. Tell me about the time when you were first aware of someone who was homeless?
2. Probe: Can you tell me more about that?
3. Do you have other, similar experiences with someone who was homeless that stand out as important? Tell me what happened.
4. Can you tell me about a time when you cared for a patient who was homeless?
5. Can you remember a time when your experience with a patient (s) who was homeless was different?
6. Followed up with: Tell me about that.
7. When do you think there was a turning point in the way you felt? Do you think it was associated with a specific experience? Can you tell me about that?
8. Looking over the information you provided in your Event History Calendar gives me a general idea of how your experiences shaped your feelings toward caring for someone who is homeless. Can you tell me more about _____? (Point to the areas that the participant has not discussed)?
9. Thinking back over what we have discussed today, can you summarize what you think are the most important parts of what you have shared?
10. Can you think of anything that I have not asked you that would help me to understand your feelings about caring for patients who are homeless?
11. Can you think of anything that I have not asked regarding how your feelings have changed (about caring for patients who are homeless) that would help me understand that process of change?

APPENDIX E

EVENTS HISTORY CALENDAR

EVENTS HISTORY CALENDAR

	Before Attending Nursing School	While Attending Nursing School	During First Year of Nursing Practice	After First Year of Nursing Practice	After Second Year of Nursing Practice	After Third Year of Nursing Practice
Generally what year:						
Aware that people experience homelessness						
Meet/spoke with someone who was homeless						
Provided care to someone who was homeless						
Experience neutral feelings toward someone who was homeless						
Experienced negative feelings toward someone who was homeless						
Experienced positive feelings toward someone who was homeless						
When your feelings changed						

Topics that you would like to discuss to convey your feelings about caring for people who are homeless:

Comments:

*Adapted from Martyn, K. K., & Belli, R. F. (2002). Retrospective data collection using event history calendars. *Nursing Research*, *51*, 270-274.

APPENDIX F

ELECTRONIC COMMUNICATION AND FLYER

GEORGIA NURSES ASSOCIATION
energizing experiences. empowering insight. essential resources.

GEORGIA NURSES ASSOCIATION

2011 GNA Professional Development Conference & Membership Assembly (formerly known as Convention) – Want to be notified when registration goes live?

Event registration is just around the corner for the 2011 GNA Professional Development Conference (October 19-20) & Membership Assembly (October 21), formerly known as Convention. If you would like to be notified of when GNA Conference registration goes live, click **HERE** and enter your name & email address. You will be notified via email when it's time to register for the 2011 GNA Conference.

You can plan for the event by reserving your room at the Atlanta Marriott Northwest, where all of this year's Conference sessions & events will take place! Once again, GNA has secured a very affordable room rate for members. Click **HERE** to reserve your room in the GNA room block at the Atlanta Marriott Northwest, or call 770-952-7900. Please mention the GNA room block when calling.

Visit http://www.georgianurses.org/conference.htm for information on this year's program, which will feature CE topics for your professional development on:

Structural Empowerment	Optimizing Simulation
Shared Governance	Patient Care Outside the Hospital
Professional Practice Models	Nursing Informatics
Building Capacity for Evidence-Based Practice	Emotional Intelligence
Healthy Workplaces	Healthy Workforces
International Nursing	Local IOM Update

GNA Call for Poster Presentations

The Georgia Nurses Association (GNA) will sponsor a poster session during the 2011 GNA Professional Development Conference & Membership Assembly (formerly known as Convention) at the Atlanta Marriot Northwest in Atlanta, GA, on Wednesday, October 19, 2011 from 4:30-5:30 p.m. Posters presented may focus on findings from traditional research or on the development of new tools and processes by nurses for improvement of patient care within an organization. The Poster Session will provide an opportunity for discussion of your project with attendees of the 2011 GNA Conference.

To submit your proposal, please provide the following information:

- Completed biographical data forms for each presenter (file attached)
- A cover sheet with the title of your poster presentation, a description of your project of no more than 250 words and one objective for your presentation. Objective statements must be measurable and should complete the sentence "At the end of this presentation, the learner will be able to..."

All submissions should be sent to Marcia Noble at marcia.noble@georgianurses.org by Friday, August 19, 2011. Due to onsite space limitations, a limited number of posters will be accepted. Notification of acceptance will be sent by September 2, 2011.

Posters must be free-standing for placement on a table occupying a space no larger than 3 feet in length by 2 ½ feet in width. All poster presenters must register for the GNA Conference. All travel, hotel, registration and other expenses associated with the 2011 GNA Professional Development Conference & Membership Assembly will be the responsibility of the poster presenter(s).

GNA member issues Call for Research Participants
Medical-surgical nurses are needed to explore nurses' experiences in caring for patients who are homeless

The purpose of this study is to explore nurses' clinical experiences with patients who are homeless in order to discover the development and transformation of their attitudes toward care of the homeless.
If you participate, you will receive a $25 gift card as a thank you.

Looking for:

- Registered nurses working at least 8 hours per week in a medical-surgical unit
- Age 22-65 years
- Report your feelings toward patients who are homeless have changed over time
- Report your experiences in caring for patients who are homeless have changed over time
- Able to read, write and speak English

Participants will be asked to complete a face-to-face interview, which will last approximately 60-90 minutes. Some participants may be asked for a second interview.

For information about this study, contact: Lora Crowe, RN, at 478.952.1355 or lora.crowe@gcsu.edu. See attached flyer for detail.

You will not have any more risks for participation in this study than you would in a normal day of life. This research study has been approved by Georgia State University.

GNA Offices closed Monday, July 4th
Members please note that GNA Headquarters in Atlanta will be closed on Monday, July 4 in observance of the Independence Day holiday. Normal office hours will resume Tuesday, July 5 at 8:00 a.m. We'd like to wish all of our members a wonderful July 4th holiday!

Georgia State University

Call for Nursing Research Participants

Medical-surgical nurses needed to explore nurses' experiences in caring for patients who are homeless.

The purpose of this study is to explore nurses' clinical experiences with patients who are homeless in order to discover the development and transformation of their attitudes toward care of the homeless.

Looking For:

*Registered nurses working in a medical-surgical unit.

*Working at least 8 hours per week.

*Age 22-65 years.

*Report your feelings toward patients who are homeless has changed over time.

*Report your experiences in caring for patients who are homeless has changed over time.

*Able to read, write, and speak English.

If you participate, you will receive a $25 gift card as a thank you.

Participants will be asked to complete a face-to-face interview.

The interview will last approximately 60-90 minutes.

Some participants may be asked for a second interview.

For information about this study:
please reply to this email
or
contact: Lora Crowe RN @
478-952-1355
or
Lora.crowe@gcsu.edu

You will not have any more risks for participation in this study then you would in a normal day of life.

This research study has been approved by Georgia State University &

Georgia College & State University Institutional Review Board.