The current economic climate of the United States has contributed to the crisis in health care delivery services. As a result, an increasing number of individuals present as poor and vulnerable. Currently, poverty rates in the United States are climbing, with literature clearly reflecting an association between poverty and ill health. With a number of economic barriers to health care, it has been suggested that health care providers' attitudes and subtle prejudices have also contributed to access. These preconceived negative attitudes can shame and embarrass vulnerable, homeless, immigrant, and poor individuals from attempting to access care. This research attempted to identify preconceived attitudes that second-degree baccalaureate nursing students possess prior to clinical exposure to poor and homeless populations through qualitative and quantitative investigative methods. Senior-level community health students preparing to deliver health care at a suburban homeless day shelter were asked to describe their experiences and opinions relative to homeless and poor persons before and after their actual contact with this population. Collected data suggest that there are subtle stereotyping and negative attitudes regarding the plight of overtly impoverished individuals before rendering care. After an 8-hour clinical experience with the aforementioned population, attitudes toward the vulnerable slightly improved, suggesting that clinical and didactic exposure to the plight of poor populations may assist to sensitize student nurses to exude compassion through a holistic therapeutic nurse–client relationship. (Index words: Impoverished; Homeless health care; Preconceived Student attitudes toward homeless; Health care barriers; Barriers to health care access; Nursing care for the homeless and poor; Nursing education) J Prof Nurs 29:309–317, 2013. © 2013 Elsevier Inc. All rights reserved.
Bureau, 2011). A recent Harvard study reported that an estimated 45,000 die each year because of lack of health insurance. In other words, one person dies every 12 minutes (Wilper, Woolhandler, Lasser, McCormick, Bor, & Himmelstein, 2009).

Without resources, individuals and families have fewer choices regarding health care and often rely upon free clinics for assistance. Despite the availability of free health care in a number of communities, it has been further reported that the poor and marginalized have had disappointing experiences with the medical industry because of negative attitudes such as perceived stereotyping, prejudice, and biases displayed by health care professionals causing further health disparities (Harrison & Falco, 2005; Zrinyi & Balogh, 2004). Accessing free care can be a humbling and humiliating experience for any person. Facing cold stares, long lines, and apathetic health care providers can exacerbate the situation to the point where people avoid health care altogether until a crisis erupts. The negative provider attitudes can thereby influence individuals’ desires to try to access health care or continue with follow-up studies or tests. Individuals do not want to be ignored, embarrassed, or marginalized. With the refusal to seek health care services for health promotion and acute illnesses, the result is an increase in chronic illnesses that could have been prevented with routine health care visits (Parkinson, 2009).

Based on the effects of the economy and its impact on poor persons, health care disparities, and disappointing interactions associated with health care providers, this research sought to examine one of the potential problems that can exist for indigent persons needing to access care, most notably, the attitudes of health care workers. This pilot study attempted to identify what preconceived attitudes toward the poor and the homeless are present in second-degree student baccalaureate nurses before actual contact with overtly poor persons. The results may serve as an initial step in gathering much needed data on a growing aggregate in the United States and direct educators to develop programs that dispel myths that negatively influence student and future nurses’ behaviors and attitudes.

**Literature Review**

The literature abounds with information about disparities leading to chronic illness and death in vulnerable populations (Centers for Disease Control & Prevention [CDC], 2008). There is also evidence of solutions within communities that allay such disparities (Benkert, Peters, Tate, & Dinardo, 2008). However, there is little research to investigate if health care workers possess preconceived attitudes toward the poor and the homeless. “In part, efforts to alleviate poverty in women and men will depend on an understanding of the attitudes that Americans hold toward the poor” (Cozzarelli, Tagler, & Wilkinson, 2002, para 3). Therefore, it is the purpose of this pilot study to determine if senior second-degree bachelor of science in nursing (BSN) students possess preconceived attitudes toward the poor and the homeless and whether personal exposure to the populations in a clinically supervised setting can identify and perhaps alter the aforesaid attitudes.

**Poverty and Homelessness**

According to the U.S. Department of Housing and Urban Development (2007), homelessness is defined as the state of being without a fixed or adequate nighttime residence, which includes those temporarily housed in shelters or welfare hotels. Reasons for homelessness include, but are not limited to, poverty, mental illness, and addictions. In addition, a poor person may demonstrate a need that cannot be satisfied by personal resources and result in medical, financial, or social crisis. The need may include housing, finances, health care, employment, or any number of issues that cause dependency on society for assistance. Specific poverty guidelines are available through the U.S. Census Bureau; however, based upon recent statistics, the official poverty rate has climbed from 14.3% in 2009 to 15.1% in 2010. Presumably with escalating numbers of poor persons living in the United States, increasing incidents of ill health will be experienced by the poor who will struggle to overcome a number of barriers to access and health disparities.

**Health Disparities**

Health disparities that are evident by differences in health outcomes can be related to social standing, demographics, environment, and geographic location. According to the CDC (2008): “Health disparities are prevalent differences in the burden of disease, injury and violence, or opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other populations groups and communities. These disparities are unjust, unfair and directly related to the historical and current unequal distribution of social, political, economic, and environmental factors” (para 2). Similarly, the National Partnership for Action to End Health Disparities (NPA), an organization created by the U.S. Department of Health and Human Services (2010), defines health disparities pertaining to the gaps evident between the care of minorities and nonminorities. Consequently, intrinsic and extrinsic factors contributing to health disparities include, but are not limited to, poverty, environmental threats, physical access to health care, individual and behavioral factors, rural versus urban locations, gender, neighborhood features, and educational inequalities (Anderson, 2010; CDC, 2011).

In essence, the current data on minority health reflect the results of a health care system that denies access to care through poor planning, provider ignorance, provider attitudes, and inadvertent tolerance of discriminatory practices. Part of the issue can be related to health care provider education. Further, the health care beliefs of different cultures may be poorly understood by frontline nurses causing fear and misunderstanding (Maze-Martino, 2005).

Yet, the more accurate determinant of the nation’s health assesses outcomes as a result of care. Improved health outcomes such as decreasing mortality rates of
Barriers

The NPA (U.S. Department of Health and Human Services, 2010) articulated a list of barriers to include economic, geographic, linguistic, cultural, and health care financing. In 2009, KFF (2010) reported that the most significant health care barriers among the non- and underinsured included no usual source of primary care, postponing or not seeking needed care due to cost, and inability to afford medication. Conversely, the Institute of Medicine (IOM; 2002) suggested that health care disparities can be due to the subtle differences in the ways that health care providers care for the poor and marginalized. In other words, issues of affordability, access, location, language barriers, and providers’ discriminatory practices such as attitudinal displays seem to resonate throughout the literature (Flores, 2006; Hwang, 2001; Johnson, 2001; Robert Wood Johnson, 2009; Van Ryn & Pu, 2003).

Poverty is a situation or way of life that impacts the person and family in a holistic manner. The mind, body, emotions, environment, and spirit are affected in ways that can only be reported by individuals who have had personal experience. With the lack of an adequate income or advocate, the person and family are at the mercy of a system that is fraught with barriers preventing them from accessing health care. The barriers limit the individual’s access to preventive services, diagnosis, treatment, and follow-up care. For example, the lack of health insurance (Hwang, 2001) caused by extreme poverty can be considered a major risk factor leading to homelessness, premature death, delays in seeking care, noncompliance with therapy, and cognitive impairment. Consequently, Hatton, Kleffel, Bennett, and Nancy Gaffrey (2001) suggest that homeless people have a more difficult time accessing health care than families who are poor. Further, the stigma of homelessness itself can be considered a barrier to health care access.

Once patients have had access to health care, the attempt to maintain a healthy lifestyle is further met with barriers. The poor and homeless may not be able to follow dietary suggestions or restrictions because of inadequate funds. In addition, they may not be able to afford prescription or over-the-counter medications because they do not have health insurance. Without discretionary funds, individuals and families cannot pay for insulin, medications, or medical supplies (Hwang, 2001).

Johnson (2001) further asserts that because of language or educational barriers, many do not understand documents or written instructions. Cultural and language barriers are evident through the misinterpretation and/or miscommunication between health care provider and patient (IOM, 2002; Flores, 2006). Poverty and political inaction contribute to access issues, yet once a person is able to access health care, the attitudes of workers may pose as a preventable barrier that dismisses the impoverished as unworthy of treatment.

Attitudes

In 2002, groundbreaking information was released by the IOM after studying potential causes of health disparities (IOM, 2002). Data gleaned from the review of 100 national studies suggest that bias, prejudice, and stereotyping were some factors that contribute to health disparities. Through the secondary analysis of existing data, it was determined that disparities exist more as a result of inaction by health care providers rather than refusal of service or noncompliance by minorities.

Prejudice and discrimination can be construed as environmental factors that make a physiological impact on their targets. The aforementioned bigotry and bias can affect the quality of rendered care. Further, a psychological barrier formed by mistrust between the patient and the health care provider may emerge and impact the outcome. As a result, the indigent have fewer options and are more likely to postpone screenings leading to preventable illnesses (Ackerson & Gretebeck, 2007; The Henry J. Kaiser Family Foundation, 2010). Parkinson (2009) concurs and suggests that negative attitudes displayed by nursing professionals toward the indigent may ultimately affect their willingness and desire to seek health care for either preventive or acute and chronic illnesses. Also to be considered with these results is that health care workers may not be aware of their subtle prejudices or nonverbal behaviors such as facial expressions, which may cause them to stereotype patients (IOM, 2002; U.S. Department of Health and Human Services, 2010). Studies profiled by the IOM give reason for a need to investigate attitudes of health care workers toward indigent populations. Despite an awareness of the barriers to health care access, Van Ryn and Pu (2003) assert that health care providers may intentionally or unintentionally communicate lower expectations for disadvantaged patients, which may further contribute to the disparities and ultimately affect the outcomes of treatment. The IOM (2002) suggests the need for research on how a patient’s race or ethnicity influences health care providers’ decision making and quality of care. According to the IOM, “…there is considerable evidence that even well-intentioned whites who are not overtly biases and who do not believe that they are prejudiced typically demonstrate unconscious implicit negative racial attitudes and stereotypes” (p. 4). Cozzarelli et al. (2002) studied 200 middle-class college students’ attitudes toward the poor, stereotypes, and attributions for poverty and whether their thoughts and feelings toward poor women were different than poor men. Data disclosed that the studied population had negative attitudes toward the poor, especially the men.

Similarly, impoverished participants in various studies experienced some degree of negative attitudes in conjunction with difficulty in accessing care or communicating care needs (Johnson, 2001; Wetta-Hall, Ablah, Dismuke, Fredrickson, & Berry, 2005).
This further underscores the need to investigate the attitudes health care workers may possess, as they may logically interfere with care, thus becoming another barrier to service.

Published in a Hungarian study, Zrinyi and Balogh (2004) questioned whether student nurses would fail to provide care to a homeless client. Alarming, some student nurses admitted to withholding care from homeless individuals. The findings suggested that the respondents with lower education tended to be less tolerant of immigrant populations. Consequently, data highlight the ongoing need for diversity education that leads to improved and innovative care solutions.

Two separate studies using pretest assessment of attitudes toward indigent populations in conjunction with a practical experience and post experience testing of attitudes demonstrated improved attitudes toward indigent persons following clinical opportunity for their care (Buchanan, Rohr, Stevak, & Sat, 2007; Rose, Miller, Lyons, & Cormman-Levy, 2003). Smedley, Stith, and Nelson (2003) suggest that faculty develop cross-cultural curriculum to educate students using case studies. Further, the addition of a clinical practicum that is supervised by faculty and rigorously evaluated can prepare the students to ultimately care for a population that has been ignored and deserving of quality health care. Therefore, socialization of the nurse during the educational process and the examination of values and attitudes that impact professional practice may be integral in preparing the graduate to identify and perhaps alter preconceived negative attitudes toward the poor.

Nursing Education

Nurse educators develop curriculum and implement clinical experiences that “prepares the graduate nurse to meet the demands of the current health care arena” (Clark, 2004, p. 347). With the changes in health care and society, the curriculum is dynamic, fluid, and revised to accommodate shifts in health care, reimbursement, population changes, and needs of system itself. With that said, professional socialization of the student is an essential component of this formative process. Students do not enter college, an associate degree, or hospital-based nursing program as “blank slates.” They arrive with preconceived thoughts and ideas about health care, people, and nursing that are either accurate or need to be challenged. Therefore, the socialization process can be instrumental in helping to develop professional values (Rognstad, Nortvedt, & Aasland, 2004). Educators prepare the students to meet the rigors of the program and socialize the student to become a graduate nurse with critical thinking skills and professional values prepared to enter into practice. Therefore, faculty, curriculum, classrooms discussions, and clinical experiences are essential tools in guiding students’ value-based approach to health care while incorporating investigative tools to measure the effectiveness.

Need

Nearly 50.7 million people or 16.7% of the U.S. population were without health insurance in 2009 (U.S. Census Bureau, 2011). With the growing number of uninsured and poor people, the ability to access primary health care services or necessary prevention and follow-up care has been limited. This entity in tandem with homelessness can further lead to health care disparities, which can be defined as differences in the quality of care received related to ability to pay, race, culture, age, gender, place in society, or sexual orientation (Harrison & Falco, 2005). The harsh reality is that the poor have more evidence of chronic disease and a higher mortality rate than those who have the advantage of consistent access to the range of health services (CDC, 2008). The literature reflects evidence of health care disparities that could be interpreted as discrimination (Harrison & Falco, 2005; Williams, 2007) and can affect the quality of patient care especially among minority patients. However, once the underlying prejudice or attitudes have been identified, they may be altered with mentoring and education. For this reason, identifying underlying biases and preconceived attitudes toward the poor and homeless among student baccalaureate nurses may prevent further discrimination and eliminate a preventable barrier to care.

Problem Statement

Professional nurses provide health care in multiple settings as they interface with members of the general population in a number of ways from physical care to health promotion activities. Furthermore, overly poor populations face numerous barriers to health care, which include, but are not limited to, negative attitudes displayed by health care providers. It stands to reason that with escalating numbers of poor persons, nurses will be involved with rendering care or making decisions that impact access to care. By identifying students’ preconceived attitudes toward the aforementioned population, faculty can create curricula and immersion experiences exposing students to the truth and issues that plague the homeless and poor, thereby potentially eliminating a preventable barrier to health care.

Research Question

Based on data supporting negative attitudes displayed by health care professionals posing a preventable barrier to health care access, the researchers pose the question: What are the preconceived attitudes of second-degree senior baccalaureate nursing students toward the poor? What is the impact of an 8-hour immersion clinical experience on those attitudes?

Limitations

This pilot study may be limited by analysis of a small convenience sample of student baccalaureate nurses from a small liberal arts and sciences Christian University completing a community health clinical in a suburban day room for the homeless and poor. A study
that compares a more heterogeneous population of student nurses in city, rural, and suburban settings may be more generalizable.

**Methods and Procedures**

A mixed-method research design has been implemented for the collection of data pertinent to this study. As such, there has been simultaneous collection of qualitative and quantitative data resulting in methodological triangulation. The co-investigators recognized that study participants may hold a variety of opinions related to poor populations relative to their own life experience up until this point in time. It is with this understanding that the co-investigators conducted taped interviews bracketing personal beliefs about the poor and homeless to elicit honest responses from participants. The research commenced with institutional review board approval. Other preliminary details included author’s permission to use the Survey on Social Issues (Guzewicz & Takooshian, 1992) and individual participant written consent with permission to disengage from the research at any time.

The research proper began with participants’ completion of a pretest survey (prior to clinical exposure), a personal interview (immediately prior to clinical exposure), clinical experience in a homeless day shelter, post clinical survey (upon completion of 1-day experience with indigent and homeless), and post care conference. A focus group discussion was conducted at the end of the following semester (6 months after completion of shelter experience) to present the emerging themes gleaned from personal interviews.

**Participants**

A convenience sample was recruited for the pilot study. Fall semester, senior, second-degree BSN students matriculated in a Christian University were gathered before the beginning of the required community health class and associated clinical practicum. After explanation of the research, survey, interview, and focus group, 100% of the class (N = 14) agreed to participate.

**Survey**

The investigators incorporated the 20-item Survey on Social Issues, which assesses public attitudes toward homeless (PATH) as depicted in Table 1. Each item is answered as agree strongly, agree, no or mixed opinions, disagree, or disagree strongly. The intention of PATH is to measure six personality factors that include “attitude toward homeless, attitudes toward the poor, achieving tendency, just world, authoritarianism, and the need for

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**Table 1. Survey on Social Issues**

For each item below, please circle one: A (Agree strongly), a (Agree), n (No or mixed opinions), d (Disagree), or D (Disagree strongly).

Of course there are no right or wrong answers, only personal opinions. Save any comments for the end of the survey, This survey is anonymous. **THANK YOU!**

**About poor people**

1. a A N D d Though I know that their condition is not always their own fault, I find poor people unpleasant to be around.
2. a A N D d I can’t understand why some people make such a fuss over the disadvantaged state of the poor. Most of them could improve their condition if they tried.
3. a A N D d Although we don’t like to face it, most people on welfare are lazy.
4. a A N D d I am in favor of a government guaranteed minimum annual income - so nobody would receive less than a certain income per year.
5. a A N D d Kindness, generosity, and love are characteristics found more among the poor than among the rich.

**About homeless people**

6. a A N D d Society is responsible for people being homeless.
7. a A N D d Many homeless have themselves to blame.
8. a A N D d Society should not have to support or house homeless people.
9. a A N D d Society is turning away and letting down the homeless.
10. a A N D d A nation should be ashamed of its homeless problem.

**About people in general**

11. a A N D d Human nature being what it is, there will always be war and conflict.
12. a A N D d People cannot be trusted.
13. a A N D d A few leaders could make this country better than all the laws and talk.
14. a A N D d Most people who don’t get ahead just don’t have willpower.
15. a A N D d An insult to one’s honor should not be forgotten.
16. a A N D d If one works hard enough, he is likely to make a good life for himself.
17. a A N D d Anyone who is able and willing to work hard has a good chance of succeeding.
18. a A N D d A distaste for hard work usually reflects a weakness of character.
19. a A N D d The one who can approach an unpleasant task with enthusiasm is the one who gets ahead.
20. a A N D d People who fail at a job usually have not tried hard enough.

**Please describe yourself:**

26. (Optional) Please write any comments you have on these issues. (More space on back).
approval” (Guzewicz & Takooshian, 1992, p. 70). The first 10 items of the PATH “about poor people” and “about homeless people” were analyzed by the research investigators. The internal reliability has been reported as $\alpha = .74$, whereas construct validity had demonstrated a consistent pattern. The survey was completed before clinical exposure in the day room and immediately after the 8-hour clinical intervention.

**Interview**

After the pretest was completed and placed in an envelope, each participant individually met with a co-investigator and asked the following questions:

a. Have you had personal experience with homelessness?

b. Are the homeless and/or poor responsible for his or her plight?

c. Is the public responsible to help the poor?

d. Why are so many people homeless and/or poor?

Although the questions were not open ended, participants were encouraged to add personal comments during the interview to explain their answers.

**Focus Group**

Six months after the completion of the pre- and post-PATH surveys, clinical practicum, and compilation of interview data, the participants met for 45 minutes in a university classroom as a focus group to affirm the emerging themes and data extrapolated from the study’s methodology. Notes, taken verbatim, were transcribed while the focus group was videotaped. The clinical instructor and co-investigator conducted the focus group.

**PATH Results**

As depicted in Table 2, a paired-samples $t$ test was conducted to evaluate the impact of the intervention on participants’ scores on the first 10 items of PATH. Results indicated that there was no statistically significant differences between the means before and after the intervention (Time 1: $M = 16.9$, $SD = 3.6$; Time 2: $M = 17.2$, $SD = 3.8$), $t(13) = -0.19$, $P = .85$. Table 3 represents paired sample $t$ test. As displayed in tabular format, there was no significant difference between means of the groups; however, there was a slight increase between the pre- and posttest mean.

**Interviews**

Interviews conducted after the pretest PATH survey were completed and generated the following data.

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**Have You Had Personal Experience With Homelessness?**

Most (71.5%) of the participants did not have any personal experience with homelessness, whereas 28.5% responded that they had some personal experience.

**Are the Homeless and/or Poor Responsible for His or Her Plight?**

When asked if the homeless and/or poor are responsible for his or her own plight, 78.5% of the participants answered “yes.” During an interview, one student suggested, “Some people take advantage of free services and do not pursue steady work.”

**Is the Public Responsible to Help the Poor?**

All of the participants (100%) suggested that the public is responsible to help the homeless and poor. A theme that emerged from interview analysis is society can be judged according to how it treats its homeless population. Further, society, such as government/religious groups, is responsible and has a duty to care for the homeless.

**Why are So Many People Homeless and/or Poor?**

When asked why so many people are homeless and/or poor, participants’ answers varied from controlled substance abuse, mental and physical illness, unemployment, divorce, or lack of family support. In addition, lack of education, unemployment, and sparse community resources may increase numbers of homeless. Also mentioned during interviews were additional reasons such as the effects of “bad friends, irresponsible spending, and unhealthy lifestyles” and discrimination against poor people can lead to homelessness.

**Focus Group**

Based on the emerging themes generated by the focus group, students commented that the clinical exposure with the poor in the homeless day room was a “positive experience” for them. The students verbalized that they were “shocked by a shelter” in the suburbs. They had no idea what to expect and could not tell the difference between the people who were homeless and the staff because the homeless in the day shelter looked “normal.” Students further commented that many individuals and families are “one paycheck away” from being homeless.

Another theme that emerged was the students did not fully understand the actual role of the nurse in such a setting. They did not know how to approach the clients and were unsure about their role, especially with immigrants and feel language was a considerable barrier. Yet, many concurred that nursing care in shelters such as the day room is necessary work.
Discussion

There was a very slight and not statistically significant decrease in negative attitudes based on PATH results indicating that an 8-hour clinical experience may not be enough time to make a difference in preconceived negative attitudes toward the homeless and poor. The lack of statistical significance can be attributed to the small sample size; however, the qualitative data demonstrate the beginnings of changed attitudes among participants.

The preclinical interview data suggested students were confused by the shelter's location in an affluent region as well as the homeless presenting as normal people, as evident by the statement: “I did not know who was working there and who was homeless.” In addition, the role of the nurse and interacting with individuals who could not speak English were also considered sources of stress for the students, as evidenced by, “…there are many language barriers…” and “I am not sure how to care for undocumented aliens.”

Based on the triangulation of collected data, which included focus group analysis, the 1-day clinical exposure with an overtly poor population resulted in fewer focus group negative statements about attitudes, fear, poverty, and homelessness as well as a budding empathy as evidenced by the statements, “It was a good idea to include the experience in community education” and “It was an eye opening experience….It’s a perspective we need to see…. “Empathy emerged as a dominant theme as another student shared with the focus group: “Someone was brought in after spending a cold night sleeping under a tractor trailer. I complain when I have to walk the dog in the cold.” Participants further suggested poverty seems to be multifaceted and complex, thereby accessing health care can prove to be challenging. Based on focus group data, students articulated an understanding and compassion.

Focus group statements such as, “There is an awareness of the vulnerability…you take it on…this could be me…. and “They had a tenuous hold on their dignity…..” suggested the impact of face-to-face contact with people in need was valuable to the educational process. Furthermore, with an 8-hour clinical experience as a study intervention, students verbally expressed a greater understanding to the plight of the indigent. One student said: “I had no idea what to expect. I was surprised that everyone looks the same….the homeless looked the same as the volunteers. …you have an image in your mind of what a homeless person looks like…usually they are sleeping on a grate in the city…..” Similarly, a participant remarked: “I was nervous.” Another student concurred and commented: “I was shocked that an affluent community had a shelter and clinic. I did not think that they had homeless people.”

As the focus group data were analyzed, students verified that the internal and external factors are associated with homelessness. Internal factors include the use of drugs and alcohol and mental illness. In contrast, external factors listed by the students included unemployment, inadequate community resources, discrimination, language barriers, and undocumented citizenship status. Further, participants' perspectives seemed altered with comments such as, “Society had a duty to care.” The focus group data demonstrated an evolving compassion toward the homeless and immigrant patient care but also suggested the need in the shift of responsibility toward personal wellness.

Recommendations

Based on the results of the mixed-methods pilot study that focused on identifying preconceived attitudes of senior baccalaureate student nurses toward the poor and homeless in a suburban homeless day room, faculty mentoring and personal interaction with the overtly impoverished in a clinical or shelter setting can create an opportunity for students to understand the impact of poverty on health and wellness and therefore potentially alter existing preconceived attitudes. According to Peplau's Theory of Interpersonal Relations, therapeutic nursing care begins with establishing a rapport with the patient and family and building a trusting nurse–patient relationship (George, 2010). The personal interactions give the formerly anonymous a face and name, thereby shifting perceptions of the reality of homelessness and poverty.

Furthermore, it behooves student nurses to have clinical exposure and theoretical instruction regarding poverty and homelessness (Buchanan et al., 2007; Rose et al., 2003). It may be in the best interest of students and poor persons to educationally plan experiences that allow the student to develop realistic, positive, and compassionate attitudes that lead to the initial step toward asking and receiving health care. This may ultimately assist in eliminating additional health care access barriers. Data from PATH showed a slight shift in negative attitudes toward positive, although the findings were not significant; however, with an increase in the number of opportunities to care for the poor, attitudes may significantly be altered as evidenced by the students' ability to place names and personalities to the formerly anonymous.

Once the 8-hour clinical experience was over, students articulated more reasons for homelessness and poverty. Yet, the aforesaid list offered by participants for homelessness and poverty was not complete. Therefore, analysis of issues that plague poor populations in health care can be integral constructs within prelicensure nursing programs. In addition, the building of class content with case studies and clinical exposure focusing on the unique needs of the poor begin the process of constructing a foundation of knowledge that may challenge preexisting attitudes toward any population in preparation for professional practice.

On the basis of concerns articulated by students during the focus group, participants were unsure what their role was with poor immigrant populations and therefore
suggest that additional education in cross-cultural nursing care is warranted. Adding conversational Spanish as an elective, seminar, or workshop would be helpful in eliminating some of the aforementioned language barriers (Flores, 2006) and promoting understanding while facilitating communication.

Lastly, the results of the research demonstrated a need to alter the investigative method of the next study to include PATH pretest and interview with open-ended questions during program orientation rather than waiting for the community health clinical. The posttest would be distributed at the end of the 2-year program to graduating seniors along with gathering for a final focus group on the subject. The population recruited for the sample should be larger with a more heterogeneous population of students. The goal of the impending research will be to ascertain whether the BSN program itself, rather than one 8-hour clinical experience, can initially identify and consequently impact students’ preconceived attitudes toward the poor and homeless.

Conclusion

Society has a duty to care for all populations based upon the American Nurses Association (2001) and values embraced by the nursing profession. This research with a limited study population continues the process of understanding how preconceived student attitudes toward the poor and homeless can begin and ultimately transfer into a dysfunctional nontherapeutic nurse–patient relationship upon graduation. Students enter education with preconceived attitudes regarding a number of issues. However, with lecture, case studies, and clinical exposure focusing on marginalized and vulnerable populations, faculty have the opportunity to attempt to alter existing attitudes. The actual socialization process takes years of formation, yet nursing faculty with curriculum deliberately focused on poverty and health-related issues have a unique opportunity to impact the development of positive, nonjudgmental professional attitudes. Through mentoring and education, graduates can make a difference in the way the poor and homeless are treated in the realm of health care through careful self-reflection. As some attitudinal health care barriers are fractured within the small studied population, graduate nurses can focus on changing a system through political activism, volunteerism, and communication. By caring for society’s vulnerable citizens, nurses can lead the way to change and health care reform. Nursing students in numbers alone have the capacity to make a societal impact and advocate for human rights and justice.

On the basis of the results of this investigation, the researchers suggest the continued building of scientific knowledge supporting compassionate nursing care for all populations. Nurse educators are called to offer a comprehensive, multidisciplinary curriculum that spans all ages, races, ethnicities, and socioeconomic standing in communities as a holistic approach to nursing care begins with a positive attitude toward the treatment and care of all individuals.

References


