A Service Learning Clinical Experience and its Effect on Nurses' Attitudes towards the Poor

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by

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We hereby certify that this dissertation, submitted by Holly L. Sandhurst, conforms to acceptable standards and fully fulfills the dissertation requirements for the degree of Doctor in Education from College of Saint Mary

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Table of Contents

LIST OF TABLES

LIST OF FIGURES

Abstract

The purpose of this phenomenological, qualitative study was to explore the impact that a nursing student clinical experience had on registered nurses' attitudes toward people living in poverty. It was determined that Ajzen's (1985) Theory of Planned Behavior was most relevant in order to frame an understanding of attitudes and behaviors. In this study the ultimate and desired behavior was providing quality care for those who are poor. Practicing, registered nurses who previously experienced a service-learning clinical experience, Positive Pregnancy Project, were interviewed. The data were studied and NVIVO8© was utilized to seek emerging themes. With the information obtained, four central and repeated themes were discovered. These themes were personal perceptions of the poor, personal growth, professional growth and working with those in the health system with different attitudes. The theme clusters were reduced into an exhaustive description. The descriptions were then collapsed into a concise statement integrating the significant ideas. Recommendations were offered to nursing educators such as to design clinical experiences allowing nursing students to be immersed into poor populations in order for a positive transformation of attitude to occur. Additionally, nursing educators were encouraged to conduct research focusing on populations with various medical conditions which may correlate negative attitudes or beliefs and may effect the quality of care such as; those who are obese, those who are homeless, or those who are ill with a severe mental health diagnosis. Ultimately, more exposure as a nursing student to vulnerable populations with the encouragement of committed faculty will result in quality nursing care.

Chapter I

Introduction

Understanding the meaning of poverty and its disturbing effects are, at times, a hard reality for nursing students. When practicing as a professional nurse the relationship between those living in poverty and the provision of quality health care is essential knowledge. Nursing educators are challenged to design and implement learning experiences that emphasize disparities that are present in vulnerable, poor populations. The World Bank (2008) describes poverty:

> Poverty is hunger. Poverty is lack of shelter. Poverty is being sick and not being able to see a doctor. Poverty is not having access to school and not knowing how to read. Poverty is not having a job, is fear for the future, living one day at a time. Poverty is losing a child to illness brought about by unclean water. Poverty is powerlessness, lack of representation and freedom. ("Overview", para 1)

The United States faces the reality of poverty. Data compiled by multiple sources confirm the urgency of the poverty dilemma. The prominent determinant of health is poverty and so it follows that nurses will care for those living in poverty regardless of the setting (Ruetter, Sword, Meagher-Steward, Rideout, 2004).

Purpose of the Study

The purpose of this phenomenological, qualitative study was to explore the impact that a nursing student clinical experience had on registered nurses' attitudes toward people living in poverty.

Research Questions

The following research questions guided this study:

1) What were the prior students' lived-experiences of engaging with poor pregnant women during the community nursing clinical experience?

2) How do personal and clinical experiences that registered nurses had as nursing students prepare nurses for the realities of caring for the poor?

3) How have previous clinical experiences of caring for poor as a nursing student impacted registered nurses' current attitudes towards the poor?

Definition of Terms

The operational definitions of terms used in this study were:

(a) Registered Nurses

Those who have completed a Bachelor of Science in Nursing degree and are practicing nursing in any health care setting.

(b) Nursing Student

Those enrolled in an accelerated baccalaureate nursing program at a Midwestern university.

(c) Clinical Experiences

Educational practicum environments designed for student learning; specifically, a community program that served impoverished pregnant woman in a Midwestern metropolitan area.

(d) Service Learning

"…a teaching and learning strategy that integrates meaningful community service with instruction and reflection to enrich the learning experience, teach

civic responsibility, and strengthen communities (National Service- Learning Clearinghouse, 2008, “What is Service-Learning,” para 1).

(e) Attitudes

Dispositions which respond with some degree of favorableness or unfavorableness to a psychological object such as groups, policies, products, or activities (as cited in Ajzen & Cote, 2008).

Background

Worldwide it is estimated that there are over one billion people living in poverty (World Bank, 2008). In the United States alone, the poverty rate is 12.3 percent, accounting for 3.6 million people (United States Department of Health and Human Services [USDHHS], 2008). In 2004, African Americans comprise 24.7 percent of the total of those living in poverty (National Poverty Center, 2008). The reality of poverty is not to be overlooked and is sometimes difficult to understand, especially to those who have had no previous exposure. “Poverty remains a persistent problem in many industrialized countries…” (Ruetter, et al. 2004, p. 300).

For decades it has been recognized that there are disparities in both health and health care when considering the welfare of people who face poverty everyday (USDHHS, 2000; Killbourn, Switzer Hyman, Crowley-Mataka & Fine, 2002; Asch, et al., 2006). “Health equity is everyone’s issue, and finding solutions will significantly benefit everyone. As the U.S. population becomes increasingly diverse, achieving a healthy, productive nation will depend even more on keeping *all* Americans healthy” (Cohen, Iton, Davis & Rodriguez, 2009, p. 2). Placing the issue of poverty into an acute health care situation Khan, et al. (1994) found that patients who are Black or from poor neighborhoods receive worse quality of care

and are more unstable at discharge than other patients. Furthermore, it is convincing that those who live in poverty have the perception that health care providers are not sensitive to their particular needs, situations, and concerns (Asch et al., 2006; Cricco-Lizza, 2006). As Kilbourne, Switzer and Hyman, outlined a framework advancing research and they described health care provider factors which contribute to health disparities such as: attitudes, bias knowledge and competing demands. These findings speak directly to an educational need. Understanding the issue of caring for the poor and the impact that this issue has on our nation's health is a considerable challenge.

Nursing and health care educators strive for students to gain experience caring for members of diverse populations, although the reality may be that students do not spend enough time with these populations to truly understand the realities. There is a good deal of literature which speaks to nursing students' sensitivities toward poverty. At the same time, according to Ruetter, et al. (2004), there have been few studies which focus on students' understanding of the significance of the relationship poverty and health. More significantly and adding to the relevance of this study, there is a gap in research which links nursing students' experiences and their subsequent attitudes when caring for the poor as professional health care providers.

Service learning.

The term service learning has been widely used by educational institutions to depict a teaching strategy which may expand students' views of the world. Significant learning occurs when students are involved in a combination of service and self-discovery reflection (Boss, 1999; Erickson, 2004; Hanks, 2003; Lashley, 2007; Kelly & Miller, 2008). Because of a transformational change that students may experience after involvement in service learning, a

change in perspectives or attitudes may also occur. Attitudes are significant predictors of behaviors (Azen & Kishbein, 2000).

Studies report that at the completion of service learning experiences, students' attitudes toward the poor are neutral although working with the poor is reported as admittedly frustrating (Hanks, 2003; Kovarna, 2006). Delashmutt (2007) found that students' societal and stereotypical attitudes are confronted when they are exposed to poor clients in the community setting, although only a few students understood the global implications of poverty. The literature includes a multitude of evaluations and reports regarding the service learning pedagogy and generally surmises that nursing students' actual experiences with the underserved or with vulnerable populations bring about a greater awareness of the relationship between poverty and health. (Kircham, Hofwegan & Harwood, 2005; Cruz, Breha & Harris, 2004; Lashley, 2007). Ruetter, et al. (2004) found that nursing students agreed that poverty leads to poor health.

Hunt (2007) stateed that there is a need for research that investigates service learning with methods other than surveys. Therefore, this study will enhance the literature by not using the survey as a data collection method. The participants in this study were practicing registered nurses who experienced service learning during their education.

Positive pregnancy project.

For purposes of this study, a specific nursing clinical experience was targeted. A midwestern university's school of nursing supported a successful community program which served impoverished pregnant women. The Positive Pregnancy Project, which was funded by the March of Dimes from 2007 through 2009, was a collaborative community effort. A parish located in a disadvantaged neighborhood provided a safe meeting space. Transportation, as

well as nutritious meals were provided for the pregnant women during each evening class. Two university faculty members directed the program, designed the basic curriculum and coordinated the details of implementation.

The Positive Pregnancy project offered three sessions per year with four weekly classes per session. Although the March of Dimes has focused on perinatal issues, including preterm birth since the 1960's, the organization has placed preterm labor and delivery as a priority initiative during the last five years (March of Dimes, 2010a). The rate of preterm births has risen in the United States earning our country a "D" on the annual March of Dimes Premature Birth Report Card (March of Dimes, 2010c).

The initiative to decrease premature births was the driving force of the Positive Pregnancy Project. The four weekly classes were titled:

1) Get the 411 before the 911: Warning Signs of Preterm Labor
2) It's Good for You & Baby Too: Nutrition During Pregnancy
3) Got (Mother's) Milk?: Breastfeeding Tips
4) Real Life Stress Reduction: During Pregnancy and Beyond

Every class reiterated the importance of avoiding of preterm labor. Poor nutrition and high levels of stress or the chronic stress that those living in poverty experience have been studied as factors that contribute to the high rate of preterm labor (Goldenberg & Culhane, 2007; Black, 2007; March of Dimes, 2010b)

For each session three to four students were assigned to the Positive Pregnancy Project as their community nursing clinical experience or practicum. Students at this particular university enter community nursing practica during their last semester of a one-year, accelerated baccalaureate program. During the six-week clinical experience students

were intensely involved in the design, planning, implementation and evaluation of the four weekly classes of a Positive Pregnancy Project session. Even though the skeleton curriculum was provided, each small group of students was responsible for recruiting women to attend, arranging for all teaching materials, communicating with other community agencies, organizing transportation, presenting creative and cost-effective proposals for the expenditure of grant monies, as well as teaching and being with the pregnant women. Additionally, the students spent time reflecting on their experiences and the meaning that it may have brought to their lives and to the lives of others. The community clinical experience mirrored the service learning modality.

With student involvement the Positive Pregnancy Project had a unique dynamic. Students interacted with the pregnant women on a weekly basis, if not more often, and the pregnant women responded optimistically and eagerly to the students' interest and enthusiasm. For each session, students developed new ideas for teaching and engaging with the population. Even with faculty direction, there were no two sessions that were identical. The students' creativity and commitment to excellence allowed the program to constantly and consistently evolve and improve.

Assumptions

The following assumptions were made by the investigator:

(a) The participants were honest and truthful in talking about their attitudes and perceptions of the poor.

(b) The participants encounter poor clientele in their current work environments.

Chapter II

Review of Literature

Introduction

This chapter will connect previous studies and findings with the significance of the current study. Findings which address the relationship between poverty and quality health care will be described. The review will provide a synopsis of selected and various studies which examined the educational value of service learning in nursing curricula as well as nursing students' learning and reactions related to the needs of vulnerable populations. Interestingly, a very limit body of literature was discovered when searching for studies which examined professional nurses' attitudes towards the poor. An exhaustive search found that there is a gap in the literature which associates nursing education curricula, including service learning and clinical experiences, to current nursing care of the poor. In keeping with the current study's quantitative phenomological tradition, a broad review of literature was conducted in order to prevent potential preconceived notions and to not contribute to bias.

Poverty and Quality Health Care

With a global perspective, it is commonly known that there is correlation between poverty, health, and health care. It is estimated that there are over a billion people living in significant poverty (World Bank, 2008). The United States Department of Health and Human Services (2008) determines annual poverty guidelines. For the past four decades the poverty measurements have not been updated, with the exception of inflation adjustments (National Poverty Center, 2008.). The guidelines state that a family of four earning $21,200 or less per year are considered by the government as poor. According to the United States Census Bureau (2008), the official poverty rate in 2006 was 12.3 percent accounting for 36.5 million

people. Of the population living in poverty, African Americans comprise 24.7 percent of the total (National Poverty Center, 2008).

It has been recognized for decades that there are disparities in both health and health care (United States Department of Health and Human Services [USDHHS], 2000; Kilbourne, Switzer, Hyman, Crowley-Matoka & Fine, 2006; Flaskerud, et al., 2002; Asch, et al.,2006). The USDHHS Healthy People 2010 (2008) initiative identified eliminating disparities in health and health care as priority. The definition of *health disparity* is unequal burdens in disease morbidity and mortality rates experienced by ethnic/racial groups compared to the dominant group. The origin of the disparities is grounded in poverty, environmental factors, health behaviors of the minority group, and poor education (USDHHS). A definition *of health care disparity* is based on the quality of care which is correlated to provider/patient relationships, provider bias and discrimination, health providers of the future and patient variables such as mistrust of the health care system (Baldwin, 2003). In 2002 the Institute of Medicine (IOM) reported that the most important predictor of the quality of healthcare across racial and ethnic groups is access to care, which includes insurance status and ability to pay. Attempting to separate access-related factors and social categories such as race and ethnicity is, at the least, difficult if not synthetic (IOM, 2002).

Patients' perceptions of health provision are important when considering health outcomes. Patients who are satisfied with care provided will be more likely adhere to recommendations and treatments, ultimately improving health outcomes (Joos, Hickman, Godon & Baker, 1996; Brown, Boles, Mullooly & Levinson, 1999; Harris, Mungal, & Tierney, 2000). Using two scales and a nationally representative sample (N= 32,929), Doescher, Saver, Franks and Fiscella (2000) found that racial or ethnic minority group

members have a less positive perception of physicians than do whites. The scales measured both trust and satisfaction with physician style. The authors speculated that many physicians have a misunderstanding of minority group members' views of signs and symptoms. Also noted is that some physicians may be influenced by unrecognized racial and ethnic biases which would effect interactions with minority patients. Ensign and Panke (2002) found that adolescent homeless females felt discouraged to return to certain clinics because of negative feelings, treatment and hostile health facilities.

Studies have found that Americans receive only fifty percent of the recommended medical courses of action. By utilizing 439 indicators of quality of care for chronic and acute conditions as well as disease prevention needs, it was found that there was a difference of 3.5 percentage points of quality care scores between families with incomes over $50,000 and families with less than $15,000 yearly incomes (McGlynn, et.al , 2003; Asch, et.al , 2006).

Khan, et al. (1994) suggested that patients who are Black or from poor neighborhoods receive worse quality of care and greater instability at discharge than other patients. The authors ascertain that those who receive care in urban teaching hospitals, which have been shown to provide better-quality care, offset the quality of care, since Black patients or those from poor neighborhoods are more likely to receive care at urban teaching hospitals. Werner, Goldman and Adams-Dudley (2008) compared safety-net hospitals (those that treat poor and the underserved) and nonsafety-net hospitals in relation to quality improvement and the quality of care. It was found that safety net hospitals have limited resources to invest in quality improvement resulting in a negative effect on the quality of care. The authors concluded that consequently there is a significant negative impact on vulnerable populations when considering the quality of care.

The complexity of socioeconomic status (SES) is considered a factor in the measurement of health care quality and outcomes. (Asch, et al., 2006; Gornic, Eggers & Reilly, 1996; Fiscella, Franks, Gold & Clancy, 2000; Fiscella, 2004). Bernbeim, Ross, Krumbolz, and Bradley (2008) reported that physicians struggle with personal and financial strains when caring for patients of low SES. The study included 18 physicians from various practice settings. Themes emerged including conflicting viewpoints about the effect SES has on clinical management. Additionally, findings indicated that the physicians' opinions varied in degree as to how changes in clinical management influenced low SES patients' outcomes. Thus, there may be reason to believe that health care professionals have some ambivalent feelings or attitudes toward caring for the poor and as a result it is questionable of how those attitudes affect health outcomes.

Service Learning and Nursing Students' Perceptions

It is evident that nursing and health care educators aim for students to gain experience caring for diverse populations. There is a good deal of literature which speaks to the nursing student's sensitivities towards poverty. Although according to Ruetter, et al. (2004) there have been few studies which focus on students' understanding of the significance of poverty and health. The term "service learning" has been widely used by educational institutions to depict a pedagogy strategy which expands students' views of the world. According to Bringle and Hatcher (1995), service learning can be defined as

> … course-based , credit-bearing educational experience in which students (a) participate in an organized service activity that meets identified community needs and (b) reflect on the service activity in such a way as to gain further understanding of

course content, a broader appreciation of the discipline, and an enhanced sense of civic responsibility (p.112).

Equal weight and equal value is directed both to service and to learning (Erickson, 2004). Traditional nursing clinical experiences have more specified objectives and outcomes, but some clinical experiences, especially in community nursing; may be designed using the foundations of service learning.

Bentley and Ellison (2005) describe a course designed with a service learning modality. By partnering with Early Head Start, students were provided opportunity to address the needs of pregnant teenagers, all of whom were African American and of low socioeconomic status. All of the students were white. During the 10 week course the students met six to eight times with their clients. Evaluation of the teaching strategy found that of the 20 students, 15 students felt that the experience made them more aware of their own biases and prejudices and 18 students indicated that they became more comfortable working with people different from themselves.

Research conducted by Hanks (2003) explored health disparities as well as the impact of service learning. The study involved a focus group of poor, single mothers and five undergraduate students. Results indicated powerful and contradictory student reactions to the experience. Students reported the experience as insightful, motivating, rewarding, as well as extremely frustrating. Zrinyi and Balogh (2004) utilized a quota sampling and determined that nursing students' attitudes towards homeless clients were neutral. More impressively, further analyses revealed that nursing students would decline to care for homeless clients in an assortment of situations.

On the contrary, a different clinical experienced designed for student interaction with the homeless and poor clients had positive outcomes on the nursing students' attitudes. (Delashmutt, 2007). At the start of the clinical experience, students reported stereotypical knowledge of the poor and did not have understanding of the impact that poverty has on health. Only a few of the students understood the global implications of poverty. At the conclusion of the clinical experience the students expressed a newly found respect for the poor. Hunt (2007) explored the lived experience of nursing students exposed to a homeless population while involved in a service learning clinical experience. The research concluded that students were confronted with the possibility that they held stereotypical views. After completing the clinical experience students reexamined and reconsidered their assumptions, perceptions and the societal stereotypes. This review included many similar evaluations and reports related to service-learning projects or clinical experiences which postulated that nursing students' actual experiences with underserved or vulnerable people bring about a greater awareness and may result in attitude changes (Kirkham, Hofwegen & Harwood, 2005; Cruz, Brehm & Harris, 2004; Lashley, 2007).

Nursing Students' Attitudes

Sword, Reutter, Mageher-Stewart and Rideout's (2004) research explored nursing students' attitudes toward people living in poverty by surveying 740 nursing students and subsequently interviewing, via a focus group, 45 study participants. The participants' previous source of exposure to poverty was the news media. Data supported that exposure to poverty through coursework accumulated as students progressed through their nursing programs, although, analytically, there were suggestions by the study participants that there are insufficient opportunities for learning about poverty and its link to health. Utilizing the

Attitudes Toward Poverty Scale (Atherton & Gemmel, 1993) overall scores indicated neutral to slightly positive attitudes. With all variables considered simultaneously, the significant predictor for positive attitudes was the diversity of personal exposure. It is noteworthy that during focus group discussions some participants did adhere to an absolute definition of poverty; their perception did not change.

Kovarna (2006) investigated nursing students' attitudes toward people living in poverty and utilized the previously mentioned Attitudes Toward Poverty Scale. With 375 survey respondents, the researcher's findings were similar to Sword and colleagues' (2004) work. Overall, students' attitudes were deemed as neutral. In analyzing the separate items of the survey, there were four items that had low scoring means. Students strongly agreed that (a) a person receiving welfare should not have a nicer car than themselves (b) welfare recipients should not be able to spend their money as they choose (c) people on welfare should be made to work for their benefits and (d) there is a lot of fraud among welfare recipients. Again, a high number of students (56.0%) identified the news media as their main source of information about poverty.

It is worthy to mention medical students' attitudes towards the poor as well. Wear and Kuczewski (2008) found that most of the literature on medical students' attitudes toward the poor is sparse and aging. Fourth year medical students are less willing to provide care to indigent populations and they have more negative attitudes toward the poor (Crandall, Volk & Loemker, 1993.) The same researchers noted that medical students who receive training in public hospitals serving poor populations, which is usually the case, leads to students becoming bias toward those very patients. Wear, Aultman, Varly and Zarconi (2006) found redundancy in reports of medical students using derogatory and cynical humor which

surfaces from preconceptions about hygiene, insurance, job status, or probability of adherence.

Professional Nurses Caring for the Poor

With the growing diversity of people who are in need of health services, contemporary nurses and other health care providers must have advanced communication skills as well as insightfulness towards the unique needs of every patient (Capell, Veenstra & Dean, 2007). Educational experts recognize and strive for teaching cultural competence in hopes that professionals will demonstrate cultural competence throughout their practice (Leininger, 2002; Capell et al., 2007; Campinaha-Bacote, 1999).

It has been only in recent years that researchers have gone beyond variables such as gender, ethnicity, education, and socioeconomic status of the patient to explain health disparities. Provider attitude has become an additional variable which places health care systems as contributors to the issue (Cassata & Dallas, 2005). Although, an exhaustive search found that there is a limited body of research which examines professional nurses' perceptions or attitudes towards the poor. Minick, Kee, Borkat, Cain and Oparh-Iwobi (1998) and Ruetter, et al. (2004) agreed that nurses' views marginalized and homeless people as undesirable clients. Minick et al. (1998) found that nurses explained changes in personal beliefs were influenced by connecting with and understanding the clients. It was also noted, that when clients did not express appreciation or contradicted expectations nurses voiced feelings of negativity and frustration. According to Zrinyi and Balogh (2004), the likelihood of quality care and treatment of the homeless is related to experience and positive attitudes of health care providers. Another study indicated that 58% of the 192 nurse respondents believed that those receiving governmental assistance deliberately choose to become

pregnant. Thirty-five percent of nurses from the same study believed that homeless people earned a decent living from governmental benefits (Price, Desmond & Effot, 1989).

Kim (1998) identified three themes after interviewing nurses about caring for diverse clients: resistant care, generalist care and impassioned care. The nurses seen as being resistant ignored or resent the culturally diverse clients. The generalist nurses reported that they viewed culture as a non-issue. The generalists' cultural knowledge was based on generalizations and stereotypes but was over all positive. Although the generalist care nurses witnessed discriminatory behaviors, they did not feel empowered to address change. The third theme, impassioned care, was demonstrated by a high level of commitment both personally and professionally when providing cross-cultural care.

When considering nurses' attitudes towards the poor, it is interesting to note that researchers who examine perspectives or attitudes toward poverty often identify two frameworks of understanding: structural and individual (Kovarna, 2006). Vulnerabilities related to societal inequities such as differential power, socioeconomic status or system-level factors are parts of the structural view (Kilborourne, et al., 2006). Rush (2004) contends that structural framework of poverty is directly related to the result of demographic characteristics, social class and lack of human capital. Historically, the individual framework has driven attitudes towards the poor (Baldwin, 2003). Behavior or individual distinctiveness of the poor continues to be a prominent determent of attitude related to poverty today. The individual framework is based on behavioral characteristics suggesting that poor people are more likely to have higher rates of illness due to unhealthy lifestyles (Kovarna, 2006). Multiple researchers report that attitudes towards the poor are based on views of laziness, limited education, and inability.

Theoretical Framework

In phenomenological research the participants' lived experiences build the description of the selected phenomenon and no specific theory may drive the research (Creswell, 2003). In this study, however, a specific theory was utilized. Several theories and conceptual frameworks were examined by the researcher. Some of theories considered were Expectancy-Values Theory (as cited in Cruz, Brehm & Harris, 2004), Dissonance Theory (Festinger**,** 2010), Self-Efficacy Theory (Banduras, 1977), Transcultural Nursing Theory (Leininger, 2002), Adult Learning Theory (Speck, 1996), Theory of Reasoned Action (Fishabein & Ajzen, 1975) and the Transtherorectical Model of Behavior (Prochaska & DiClemente, 1983). The reviewed theories each have components that reflect important elements of this study. The Theory of Planned Behavior (TpB) (Ajzen, 1985) can be associated with many of the aforementioned theories and TpB clearly suggests how attitudes and beliefs might change. Therefore, Ajzen's (1985), TPB theory, was selected as the theoretical framework for this study.

The TpB theory has three main constructs of human behavior: (a) Beliefs and attitudes toward a desired behavior are developed by the influence of parents, peers, and exposure or lack of exposure to experiences (b) Normative beliefs and subjective norms equate to social pressures and lead one to perform or not to perform a behavior (c) Control beliefs and perceived behavioral control are the personal, perceived capability to perform the behavior.

In the context of this study the desirable behavior was providing quality nursing care to the poor. The participants' beliefs and attitudes toward the poor preceding the clinical experience were highly influenced be their parents, peers, experiences as well as by

influential people in their lives, such as teachers, and social pressure. The clinical experience provided opportunities for the participants to interact with and provide care for impoverished pregnant women. It became apparent to the participants that the women had stories to tell and that the women were in need of resources and assistance. Authentic relationships of caring were formed during the clinical experience and the study participants believed that they could control their behavior and want to provide quality care. As registered nurses, the participants in this study verified that they continue to have the same belief.

Summary

The literature strongly supports the question of a lower quality of healthcare that is received by those who are poor. Researchers have recently begun to examine the role that health care providers may have in the quality care or lack of quality of care for vulnerable patients. An extensive review found no literature published which links student experiences to nursing practice and expertise in caring for the poor. Service-learning is a teaching modality which provides students an opportunity to experience different views and allows for self reflection. Although there is substantial research supporting service-learning in nursing education, the effect of those experiences toward lasting attitudes and behaviors is extremely limited. After an extensive consideration of theories, Ajzen's (1985) TpB theory was relevant to this study. The theory provides a "lens" to view the findings since the TpB theory hypothesizes how attitudes and beliefs develop and effect behavior.

Chapter III

Methodology

Introduction

This chapter addresses the rationale for selecting the phenomenological design, the planning, the actions taken to collect data, the rigors of attending to ethical considerations. Attention given to the analysis of the data and the endeavors to create a clear vision of this study is also discussed in this chapter.

Research Design

The design of this study was phenomenological, in which a common phenomenon is identified and an essence of experiencing that phenomenon is interpreted and described (Rudestram & Newton, 2007). More specifically, the study can be categorized as hermeneutical phenomenology which has been extensively described by van Manen. Creswell (2007) stated, "…he [van Manen, 1990] described research as oriented toward lived experience (phenomenology) and interpreting the "texts" of life (hermeneutics)" (p.59). This study sought others' lived experiences of caring for the poor with the purpose of interpreting meaning of attitudes towards the poor. Rudestram and Newton (2007) stated, "More than any other forms of inquiry, phenomenology attempts to get beneath how people describe their experience to the structures that underlie consciousness, that is, to the essential nature of ideas" (pg. 40). In this study, the experiences explored were related to involvement with the Positive Pregnancy Project and how that involvement has influenced the participants' professional nursing practice, more specifically, caring for the poor.

All phenomenology studies are deeply rooted in a philosophical perspective where there is a natural current of consciousness and the associated wisdom is accepted without

judgment (Creswell, 2007). It is duly noted that this study can be categorized as axiological, where the researcher openly accepts and declares his or her own biases (Creswell, 2007). Because of this investigator's personal involvement with the Positive Pregnancy Project there is an added depth to the research.

Therefore, it may be an impossibility to set aside this investigator's personal perspective of the Positive Pregnancy Project as well as the potential impact and influences which may have developed from student experiences. This investigator's experiences with the project are all parts of the whole. This perspective is deemed as important to the study and maintained a sense of commonality to the phenomenon and keeps within the scope and uniqueness of the selected modality of inquiry. Creswell (2003) stated that qualitative research methods continue to evolve with increased interactive processes between the researcher and participants allowing for a more humanistic approach of discovery.

All of the Positive Pregnancy Project sessions were co-directed by this investigator. Although some sessions included an additional faculty member who evaluated the prior students' clinical performances, it is important to note that this investigator had a significant role in the development, operation and actual implementation of the Positive Pregnancy Project. With this in mind, it is would be difficult to negate how meaningful the program is to the investigator.

The issue of the relationship between the investigator and the participants had an effect on planning the details of the study's methodology and is worthy of discussion. This investigator had a previous, well-established instructor-student relationship with each of the participants. Even if the prior students were not being evaluated by the researcher during their experiences with The Positive Pregnancy Project, there were periods of time during the

students' tenures at the midwestern university when the investigator held a teaching role which included evaluation. Therefore, it was important for the investigator to fastidiously enter a new relationship with the participant. Creating a fresh and different collegial relationship with each participant was crucial to the integrity of the data collection.

Ethical Considerations

The College of Saint Mary's Institutional Review Board approved the study. Confidentiality was maintained and numerals were assigned to each interviewee. Completed transcripts were kept together in a locked office file cabinet. There were no known risks for those who participated in the study and there was no compensation for participation. A consent form was signed by each participant (see Appendix A). *The Rights of Research Participants,* a document published by College of Saint Mary was also provided (see Appendix B). All participants had the right to withdraw from the study at any time or to ask questions of the investigator or of the investigator's advisor.

Because the participants were former students, contemplation was given regarding the risk of perceived coercion or risk that a participant was seeking to fulfill an expected response. These risks were managed by spending time visiting with each participant in a manner that allowed a collegial level of relationship to develop between the investigator and the participants. Assuring the participants that their honesty was imperative to the results of the research was important.

Data Collection Procedures

By utilizing purposeful convenience sampling, eight participants joined the study. Creswell (2007) stated that purposeful sampling allows the investigator to inform participants of the research problem and create a shared awareness of the phenomenon that is being

studied. Involvement of the participants is imperative to the phenomenological method (Creswell, 2003). The participants in this study were not randomly selected and they were not considered vulnerable, as they were no longer students. The inclusion criteria were as follows:

a) Bachelor of Science of Nursing graduates from a midwestern university school of nursing
b) Licensed as registered nurse
c) Practicing in any area of nursing, regardless of their exposure to poor or underserved populations
d) Past experience with the Positive Pregnancy Project, a service-learning educational clinical

All participants were contacted by either telephone or by electronic mail (e-mail) and invited to be part of the study. This investigator had maintained contact with several of the nurses and had contact information because of the ongoing relationships after the nursing students' graduation. A brief description of the purpose of the study was presented as well as the initial time commitment involved, which was to be no longer than one hour for the interview. There was no incentive offered except for an opportunity to be involved in a research study and to discuss past experiences with the Positive Pregnancy Project. The nurse participants expressed a contagious excitement to talk about the Positive Pregnancy Project and eagerly suggested names who met the study's participant criteria. This demonstrated the snowball effect of recruitment (Groenewald, 2004). Demographic data were requested from the participants during initial telephone conversations or e-mails (See Appendix C). Table 1

provides data regarding the year participants graduated from nursing school and the area of current practice.

Table 1

Demographic Data of Participants

Participant	Graduation Date	Area of Current Practice
1	August 2007	Cardiac/Telemetry
2	August 2008	Intensive Care
3	August 2008	Orthopedic/Medical-Surgical
4	August 2008	Neonatal Intensive Care
5	August 2006	Labor and Delivery
6	December 2007	Medical-Surgical
7	August 2007	Pediatric Intensive Care
8	December 2008	Pediatric Intensive Care

After agreeing to participate, a follow-up e-mail was sent to each nurse, which offered a more detailed explanation of the study as well as a confirmation of the date and time of the interview. Often the date and time of the interview were rescheduled because of unforeseen conflicts or work schedule changes. Folders for each participant were created and numbered. The folders were used to file all written or e-mailed communications as well as the investigator notes. Numerals were used when communicating with the transcriptionist or with others during consultation.

This investigator was motivated by the participants as their expressed interest in the study was obvious. Often the participant would ask for additional information about the study. Some asked if they could read the proposal, which the investigator reasoned as acceptable since this type of expressed interest falls within the phenomenological research methodology where the participant truly embraces an active role in the study (Creswell, 2003).

Interviews

The interviews were conducted at the participant's convenience. No interviews were conducted during a time that the participant was working nor were they held at the place of the participant's employment. Careful planning and consideration was given to the participant's' schedule. For example, if the participant worked nights, the interview was not scheduled during a time directly following a night shift. Details such as this prolonged the data collection process, but were found to be valuable in that the participants were not rushed or overly tired. Each interview was timed to establish a refreshed, collegial, and trusting relationship with each participant. The interviews were conducted at public libraries in quiet study rooms, at the participants' homes, or via telephone, if the participant had a distant residence.

It was clearly explained to each participant that the interview would be recorded and that the recording would be transcribed. The consent form was reviewed and signed at the time of the interview meeting or, if necessary, the consent form was sent to the participant prior to establishing the interview date. If the consent was sent to a participant, a self-addressed, stamped envelope was provided for return of the signed document. For those who were interviewed by telephone, a brief statement was verbalized to remind the participant of the signed consent. The investigator consistently reiterated the participant's choice to withdraw from the study at any time

A semi-structured interview format was utilized with the participants (see Appendix D). Rudestam and Newton (2007) stated, "Although the interview itself may be quite loosely structured and flexible, phenomenological researchers generally prepare some questions in advance, preferring to alter them if it seems appropriate as the interview progresses" (p.109).

Open-ended questions that would generate thought and discussion were carefully selected Creswell (2007) affirmed that the interview process is challenging and that patience is required in order for the participant to arrive at and then discuss the true meaning of an experience. Each interview took its own path although the vast majority of participants consistently returned to similar themes.

During this study's series of interviews, it was surprising to hear participants state that some questions were "hard" or "difficult" as the investigator waited for a response. The questions were not "hard" in the manner of searching for facts; rather, the open-ended questions were posed in such a way that the interviewee may have had to search for a deeper meaning of the experience and what effect that experience had on the participant's perspective of poverty. As is typical with phenomenological studies, it was explained to the participants that the interview would not be solely based on questions that the investigator had formulated. The participants were encouraged to freely interject thoughts, feelings, beliefs, and perceptions as conversations evolved and meanings emerged. The investigator was prudent about monitoring time to remain loyal to the participant's commitment. Although, even with prompts from the investigator such as, "We are coming to our agreed upon time limit," it is estimated that half of the participants continued to talk about the Positive Pregnancy Project and their personal experiences as nurses. The interviews were approximately one hour in length and there were some that lasted beyond an hour if the participant so wished. Interviewing skills were implemented including maintaining eye contact, listening intently, asking for the interviewee to elaborate, and asking for clarification.

Procedure

During face-to-face interviews, two recorders were utilized: one digital and one cassette. The recorders were tested prior to each interview. With telephone interviews, a digital recording device was used. A transcriptionist worked from digitalized files, with the exception of one interview which was transcribed using cassette tape. The transcribed interviews were returned to the investigator electronically and were then printed for beginning stages of analysis.

Data Analysis

As the completed transcriptions were returned the investigator read and scrutinized each with detailed attention. Notes were recorded to assist with identifying significant quotes as well as repetitive meanings. An immersion into the data began so that it became familiar, memorable, and comfortable to manage. The transcripts were sent electronically to the participants with a request for a member check, including corrections, additions or any other input. An audit trail was created through notes and communications which were added to the files of each participant's electronic folder and hard copy folder. Changes, new thoughts or emerging patterns noted by the investigator were stored in separate folders. Peer review was offered by the investigator's committee chair as well as others who volunteered to read and to discuss ideas and progression throughout the study. One colleague who was familiar with Positive Pregnancy Project was important to the peer review.

The transcripts were entered into NVivo8© to assist with coding. By utilizing Colaizzi's (1978) method of coding (as citied in Creswell, 2007) further organization to process the data was achieved and the method served as a means to present the data for

discussion (Creswell, 2003). As coding advanced, findings were sorted into three domains; see Figure 1

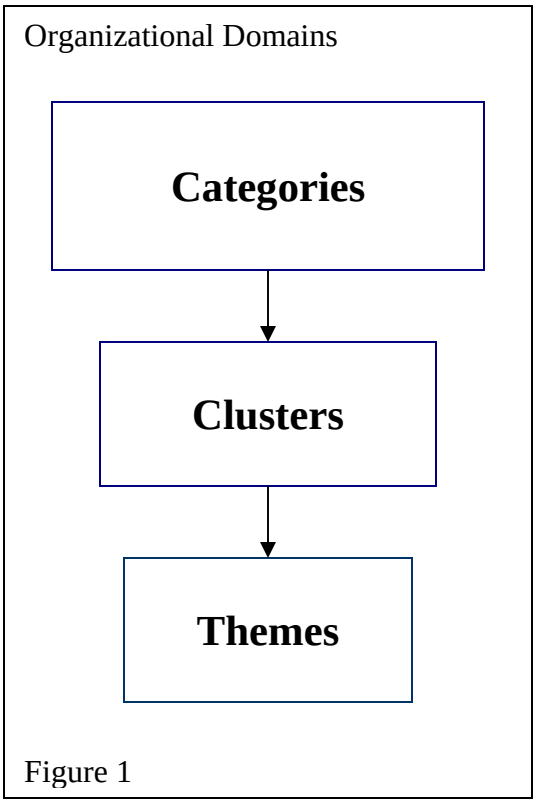

Figure 1

Further grouping within clusters and themes were added, arranged and rearranged as the analysis proceeded. Going back to the interviews and searching for ideas, thoughts and opinions as they emerged was essential in verifying clusters and themes. Themes were repeated and some were outstandingly unique, which mirrored the lived experiences of the participants.

Summary

This study utilized a phenomenological design. Eight nurses participated and interviews were semi-structured, recorded, and transcribed. The transcribed interviews were

read multiple times and then entered into a computerized program to assist with coding. Coding continued to develop into more concise themes.

Creswell (2003) agreed that unlike quantitative studies reliability and ability to generalize; qualitative studies do not have these attributes. Therefore, the member check, peer reviews, recognition of bias, and auditing by additional readers who were knowledgeable regarding qualitative research were vitally important to the process.

Chapter IV

Findings

Introduction

The coding, exploration and deliberation required to arrive at a true essence of the lived experience of the clinical experience and perspectives of poverty is explained in this chapter. Phenomenological researchers agree that the analysis process is the most challenging in creating a thorough and quality product (Colaizzi, 1978; Creswell, 2007).

All of the participants in this study spoke passionately and extensively about their experience with the Positive Pregnancy Project during the interviews. Therefore, arriving at themes required not only multiple readings of original transcripts, but also studying the NVivio8© entries and results. Changes and additions were frequent as new interviews were added and as new meanings emerged.

Extraction of Significant Statements

Each interview was filled with unique and interesting insights, although some commonalities were obvious. One challenge faced was not to leave a participant's experiences behind because of interpretation. Using Creswell's (2007) explanation of a "data analysis spiral" (p. 151), the investigator was able to manage the data and classify it during the process of analysis. Throughout the analytical phase many charts and drawings were utilized by the investigator. A succinct organization structure was created during the early stages of interviewing and analysis processing. This enabled the investigator to identify significant statements that could be categorized that evolved into emerging themes. Refer to Figure 2 for the data organizational structure and to Table 2 for the significant statements that evolved into relevant themes.

Data Organizational Structure

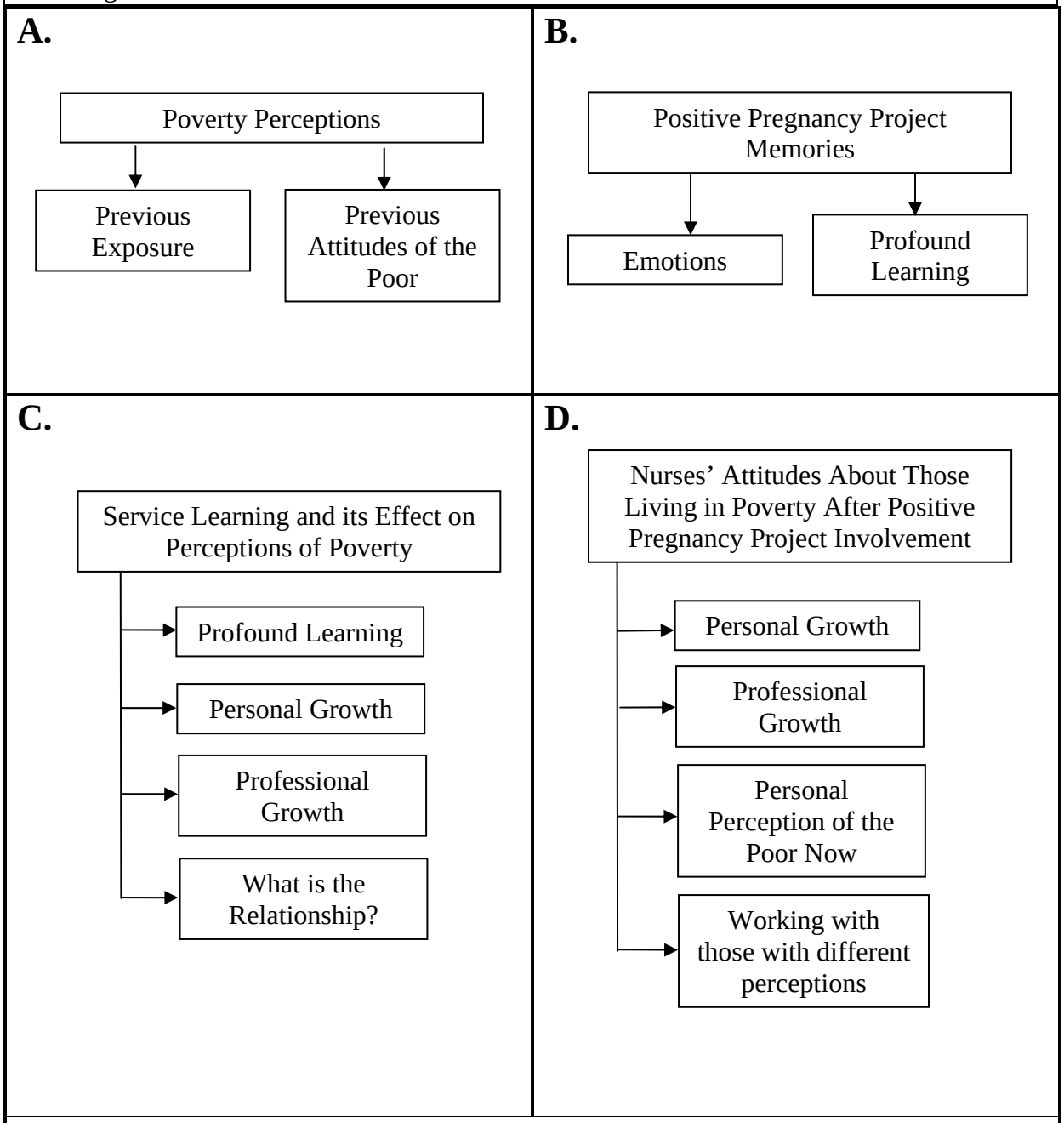

Figure 2.

Table 2

Significant Statements

Quotes from participants' interviews
1. You don't have to go overseas to help people.
2. I felt like I was doing what I wanted to do; it makes sense.
3. I've always wanted to be a fully equipped person who has resources to help.
4. The biggest thing was my eyes were opened to things that were happening in my community.
5. I was just so thankful for my experience (pause) or just for my walk in life.
6. I just think a lot of people my age and probably other people as well; they think that the poor did this to themselves.
7. I've been pretty sheltered my whole life….
8. I had never known the depths that (pause) the poverty depths that people have lived at.
9. I may not understand it fully, but I've definitely gained insight.
10. You kind of got more of a feeling what their lives were like.
11. I was sad for her because I don't think she knew what it could be like.
12. I can drive to this part of town where these girls live-no problem and it is completely different than where I live.
13. A lot of them opened up and kind of told you about their personal lives and how they lived from day to day.
14. I've always been blessed with a roof over my head and food and never really worried about money (pause) it never really was an issue.
15. You have to have community service. We see everybody – nurses see everybody – all walks of life.
16. I learned how to approach different populations when I wasn't feeling so confident about it – feeling really insecure.
17. The gratification at the end (pause) I mean it takes so many little pieces to make something, even one session to turn out the way that it did.
18. They're not used to having people care for them and be nice to them and go out of their way to help them.
19. I think it changed my teaching.
20. Within the first week, they were getting so close to us and we were getting so close to them.

It became apparent by analyzing the selected significant statements that the actual themes were built into the original organizing structure that the researcher created. Themes that resulted are (a) personal perceptions of the poor (b) personal growth (c) professional growth and (d) working with those in the health system with different attitudes.

Personal Perceptions of the Poor

The participants described their personal experiences and all told the investigator of their backgrounds, prior perceptions and attitudes of those who live in poverty. There were no participants who considered themselves poor at anytime during their lives. One participant talked honestly about her previous attitude about those living in poverty:

> Well, this is very shameful, but I just thought (pause) just (pause) I think growing up, like in high school, I thought people (pause) if poor people wanted to make a difference, they could (pause) they just would have to go to school and do it and I just felt like maybe they were being lazy and that's all it was—just a case of laziness. I just thought that they maybe just needed to take a little bit more responsibility of their getting a job or, you know, doing stuff like that because where I'm from, everybody (pause) if you wanted a job you just went to the mall or you just went, you know, to the store and you got a job; but we had cars to get us to those jobs, you know, we had parents who could pick us up and take us there. We had, you know, other people to watch our brother and sister, you know, so (pause) and we were getting jobs because we wanted to get the new jeans, you know, it was just different and so I think that that was my (pause) and I thought, "Well, if I have to get a job, couldn't the poor people get a job?" It was a very negative attitude now reflecting back on to it.

Another participant talked about her background and prior exposure to poverty:

> I lived in a very nice neighborhood and didn't really experience poverty, especially in my neighborhood. I rarely saw people on the streets asking for money. It was nothing like that until this experience.

Reflecting upon the clinical experience this participant spoke of "privileged perspective":

> Having been with Positive Pregnancy and having spoken with these women and heard their stories and heard their living environments, it really makes me think, you know, you can't just assume and you can't just expect that you understand the circumstances or that if you were in their circumstances you would have done things differently, because truly, we don't know. Because what's it like? Well, I would get a job. Well, do you know what it's like to have three kids at home and a husband that tells you that you can't do it or a boyfriend that tells you, you can't do it? You know, to not have nutritious food in your body to make you healthy. I mean, these types of things are all encompassing. Not to have parents that told you, "Of course, you're going to go to college," but to have parents that work together or didn't encourage you to do anything. You know, like, it's a privileged perspective to say, "Well, I would have gotten a job," or "I would have raised my kids differently." You can say that because you were raised with an example, because you are a healthy person, because you've gotten to see what works and what doesn't work from a privileged perspective; but, if you don't have that, if you've seen nothing but bad examples all around you, what are you supposed to do?

One participant disclosed how sheltered she was when growing up and the lack of exposure to poverty she had during her life. She said:

> Yes, it was nothing. I mean nothing. My mom wouldn't even let me drive on the Interstate.

When asked about her encounters and previous experiences related to poverty a participant responded:

> So, as far as growing up in poverty, I don't know anything about it. I do know just from volunteering I've always kind of had a heart for poor people. I went to Africa when I graduated from my first degree in biology. I went to Africa for six months and lived with a family and really got to sink deep into what poverty was about then. It's interesting because I thought I had to go to Africa to see poverty and I just had to go to [The University], turns out, and head north one-half mile.

The same participant added:

> I'm not sure if there was a specific moment or if it was just a series of "drop me dead in my tracks. Did that just happen? Did she just say that? Is that her outfit? Is this what a funeral is supposed to look like? Is that what that kid is eating right now?" You know, I feel like there were several moments where I would just stop (pause) where I just stopped and I just thought, "I can drive to this part of town where these girls live—no problem and it is completely different than where I live."

Personal Growth

Bentley and Ellison (2005) stated "Structured opportunities that link service to self-reflection, self-discovery and the acquisition and comprehension of values, skills, and knowledge content are critical to service-learning" (p. 287). The participants in this study voiced transformations or a search for meanings that were personal and in some cases emotional. For example one participant said:

> I think I learned that with a little education and just people that truly desire to make a difference in people's lives (pause) those women's lives can be made different. But I think, like, growing up I always thought, "Oh, just give people some money, that's it." But I think it's not. What I learned is it's a dedication and a lot of hard work to help these women.

Another participant shared her newly acquired awareness:

> Well, I think now I'm starting to realize, well, (pause) and the reason I contacted you in the first place was wanting to work with under-serviced populations. I think I'm kind of knowing that about myself….

Several of the participants spoke of frustrations that were experienced during their involvement with the service-learning project, although the following quote is telling of how the frustration actually created a clearer view of her perspective:

> It was a huge point of growth for me as far as really being frustrated at one point and feeling like (pause) feeling a resentment or why do I have to give them all these things for them to come? Why isn't it important? Why don't they, you know, a projection on my part, why don't they appreciate this? Why don't they, you know, understand that this is important and affects their baby and than coming full circle, which very much had to deal with: what is their day-to-day life like? What is getting through the day look like for them and so what kind of concessions does it take to come to something like this [Positive Pregnancy] and how do we engage them?

The following statement describes one participant's reflection regarding her personal growth after her experience with Positive Pregnancy Project:

> I think my eyes were opened more to what's going on in this world and to see where I fit in to helping out, you know, just on a personal level, you know, what I can do in my community at home when I'm not working or going to school, but I think the biggest thing was my eyes were opened to things that were happening in my community.

Professional Growth

Ultimately, clinical experiences designed with the service-learning modality are intended to allow students to step into their profession with a broader perception. The nurses who participated in this study shared their insights and how the experience contributed to their professional growth. One participant spoke of being judgmental:

> These experiences like Positive Pregnancy and that's how we all, I mean that's (pause) as much as I can learn that makes me a better nurse. I mean, I may not understand it fully, but I've definitely gained insight. It does shape my views, but it's more a view of trying to be open-minded and understand the reasons behind poverty and not make initial judgments, even though we still do. I mean, I think to some (pause) like, I would make initial judgments during Positive Pregnancy and have frustrations like, "Gosh, why don't you just, you know, quit having babies? This is your fourth baby. Why don't you quit having babies and then you'll have more money for your babies you've got now?!" you know, like that initial judgment. I mean, maybe when I went home that day or when I talked to that woman about her life or whatever, I mean, maybe it was (pause) maybe there was more to the story, like that was kind of all she knew - just to have babies.

Another nurse talked about the significance of being in the community:

> Those women taught me way more than I taught them anything. They were awesome. That was probably the coolest part of nursing school for me was getting to get into the community. I mean, that was more nursing-related than any, you know, pharmacology or anything we learned. That was awesome.

Importantly, the participants were able to relate their clinical experience to their current work as registered nurses and apply meaning. As is the case with the following participant:

> Well, I think I learned some little nuances, maybe, not that I just learned that in Positive Pregnancy, but some things that really also made (pause) evidence to me were just like the small obstacles of doing things like the travel and the daycare, those sorts of things that I didn't ever think of being (pause) well, because I wasn't ever like trying to plan something for people who might be below the poverty level. You know, you just don't think of those things. Most people have cars and, you know, it's not (pause). And, I guess in my job, you see a lot of people fall through the cracks. People who you just can't get everything coordinated—diabetic patients need special diabetic shoes and you can't get everything coordinated before they're discharged and then it's just, you know, they'll probably come back in weeks with worse ulcers on their feet. You just…you see people just fall through the cracks, I guess. Just (pause) I mean, it's hard to design a healthcare anyway. We're a reactive society not a proactive society; so people come back with things that could have been prevented.

One participant spoke of an issue that that nurses grapple with in today's healthcare settings:

> Access to resources - how do people get what they need if they can't buy it themselves or if they can't (pause) if it's not something that's purchasable, if that's a

> word. Kind of that opportunity - what you need to have, even the intellectual skills to know what you might yet need, but you don't have.

Educating those who lack resources was brought to the forefront in many of the interviews. One example:

> It's a fine line to us because some moms need to hear - you need (pause) [to say] if you don't take that medicine (pause) if you don't regulate your blood sugar you can lose this pregnancy and you can't (pause) it's really hard. It's super hard because you want to be mad and you want to save them from themselves, but at the same time, you just have to keep in mind that that is a privilege; that is an educated point of view.

Another example was when a participant talked of teaching health needs when basic needs may be the more immediate issue:

> So, I think that's one of the biggest challenges that nursing has is trying to get things that we think really matters to them when, you know, they don't have their basic needs met. Why do they care about like taking blood sugar when these little pieces of paper cost, like, so much they could probably eat for two months off of that? How do you get your priorities, their priorities to mesh together if they're cold?

A nurse talked about coming "full circle" in her professional development and described it in this way:

> You know, working in the PICU, there's lots of technical stuff—there's lots of really important, high-acute moments and I've found that those are great and I really like the ICU because of that; but, sometimes I just want to give a bed bath and (pause) it's funny because I've kind of come full-circle from that and I think about nursing school

> and I think about everything we learned and just throughout our curriculum from, you know, drugs, to vitals, to community, to psych, to everything. We've learned so much, you know, that there is so much about nursing and I really think that sometimes it's the bed bath, sometimes it's the Positive Pregnancy class, sometimes it's just holding somebody's hand and talking to them that is (pause) what changes people and not the compressions and pushing an IV drug - doing those things. Those are very important but sometimes it's just the bed bath that is huge. Yeah. Just touching somebody and loving them and giving them dignity.

Working with Others in Health Care with Negative Attitudes about the Poor

As the interviews moved toward the nurses' current work situations the topic of working with others with differing attitudes about the poor were discussed. A theme emerged about how the nurses handled what can be considered difficult situations with their co-workers. One participant remarked:

> Yeah, I've heard them say that, "Oh, this lady's back again, you know, living off of our tax dollars" or whatever. "She doesn't have insurance" and I've heard them repeatedly complain about (pause) there's one or two patients that come back pretty frequently to get dialysis from another country that can't afford their medications and there's another (pause) I can think of a patient right off the top of my head that goes home and doesn't take his blood pressure or other heart medications because he can't afford them and we're sitting here judging him, like, "Oh, he's back." I've heard them say, "Oh, he's back again. He didn't take his medication. He's not taking care of himself." They just kind of seem annoyed that he's back but, you know, from Positive

> Pregnancy I can tell that maybe they don't have the means to go home and be healthy and get their medications.

Another participant made a connection to her service-learning experience and talked about nurses that she works with saying:

> Like in Positive Pregnancy the struggle just to (pause) just to get transportation. I think that every nurse I work with takes their transportation as guaranteed and it's just not. I mean, you know, or to understand where their next meal is coming from. I think it's good for me to remember that. It's good for me (pause) this is great for me to reflect back on that so I can be a better nurse every time I work because I sometimes I think we forget. We hurry, hurry, hurry and check the charts and we forget our patient is a person sometimes and we just, you know, we just want to get our task done when there's so much more. …we see patients truly at their most vulnerable; whether they've just had a baby or they've just had surgery or something, but I don't know we (pause) I wish that we would all take in, like, everybody's background and do that.

Most of the participants who talked about their co-workers and do speak up on behalf of the poor patient agreed that it is not always an easy situation and that there are times that it takes previous experience to truly understand their patient's situation. Such is the case is the following example:

> That's hard because it does create, you know, a little tension but it's usually during report, over-the-bed report, you know, you're talking about your patient and then we'll say, "Oh" and then the social issue is mom doesn't care. I think something you can say to that is, "Well, you know, she does care. I've seen her here and I think she's got a lot going on." Present just a comment like that, you know, I'll admit I have

> definitely taken on where I think I'm "defending" my patient by being upset with the parents and really, that doesn't defend, you know, an infant. All it does is create a hostile environment for the nurse that is coming on and I think it's really—how nurses give and leave report—really leaves a taste in the mouth for the next shift and if you start with that negative perspective on the family, they're not going to get a warm welcome when they come in the room from that nurse. That nurse already has assumed that they're bad parents; so, I think stopping that right off the bat and just saying, "No, I think that they do care" or "I think that they're dealing with a lot" can stop a nurse and make her kind of think, "Wow! That's not very loving or how am I coming off? Why am I so jaded?" It's not good. It's not good.

A participant told a story about promising to wash a client's hair the previous shift and because she became so busy it did not get done. She said,

> "You know, tomorrow if you're here, if I have you, most likely, I will get it done." So that day, of course, you know, I said in my head, I thought I will stay after. I'll clock out and stay after and wash her hair because it had been four days, I think. I asked night shift and it didn't happen and day shift didn't know anything about it so, of course, they didn't ask her if she had bathed or showered … and I had told the CNA [Certified Nursing Assistant] multiple times I had said, "Will you help me with that? Like, if we do this together we can do it quickly." Like, I did not want to leave tonight without this happening. It's just was an abomination that we didn't have time to do this for her.

Again, the nurse became very busy with her other high risk patients and as she went to clock out in preparation to wash the client's hair …

The CNA came up to me and she just said, “I washed her hair.” I swear to God I started crying. I just thought, you know, that’s what matters (pause) that’s what matters. I think that’s what it comes back to. This idea of because you’re not in this situation, that woman, who I’m sure does live in poverty, she’s a field worker but her poverty was so palpable.

Summary

After creating an organizational system for coding and categorizing data significant statements were extracted. Four themes were formulized following an extensive immersion into the data: (a) personal perceptions of the poor (b) personal growth (c) professional growth and (d) working with those in health care with differing attitudes.

Although the data were dense and rich, the investigator selected quotes from the interviews which substantiated the themes and connected to the original research questions. As is discussed in the following chapter a relationship to the theoretical framework also became apparent.

Chapter V

Discussion

Introduction

This final chapter will draw relationships between the research questions and the theoretical concept. Additionally, recommendations for educational practice will be made as well as opportunities for future research. Weaknesses in this study will also be addressed.

Research Questions

The research questions which compelled this study were (a) What were the prior students' lived-experiences of engaging with poor pregnant women during the community nursing clinical experience? (b) How do personal and clinical experiences that registered nurses had as nursing students prepare nurses for the realities of caring for the poor? (c) How have previous clinical experiences of caring for poor as a nursing student impacted registered nurses' current attitudes towards the poor?

The participants talked openly about their lived experience of engaging with the poor women during the clinical experience. Of the eight participants all said that it was a good experience even though there were times of frustration. The nurses had memories and stories to share about their experience and they related those experiences to their personal growth and their professional growth. All of the participants talked about what they did not previously know about the poor and that the clinical experience did prepare them for realities that they face as registered nurses.

The most important inquiry was to determine if there were changes in attitudes towards the poor. During the interviews it was obvious that two of the eight participants had previous immersion experiences with the poor and their attitudes were affected by those in a

positive way. Although those nurses had no experience with the poor who lived in the local area and the Positive Pregnancy Project changed their attitude about the poor who live in their own city which had an impact on their nursing practice.

Another participant had a previous immersion experience with the poor, but Positive Pregnancy Project was effective in her ability to talk about the poor and to talk about how important clinical experiences such as Positive Pregnancy Project are in nursing education. This participant said that she wants to be a “fully equipped” person and nurse, although she also talked about the frustrations she feels when working with the poor at work.

The other five participants clearly had no exposure to poor populations before their involvement with Positive Pregnancy Project. During those interviews they spoke of a greater understanding and change in attitude. Each of these five participants said that the clinical experience prepared them in some way to care for the poor clientele that they now care for as registered nurses. Two of the participants spoke of starting a Positive Pregnancy Project in their community.

Theoretical Framework

Ajzen’s (1985) TpB theory is relevant to this study. The participants did talk about their previous attitudes and beliefs (normative and subjective), the influence of the clinical experience and then their ability to control their behavior when caring for the poor and ultimately providing quality care for the poor as a registered nurse (see Figure 3).

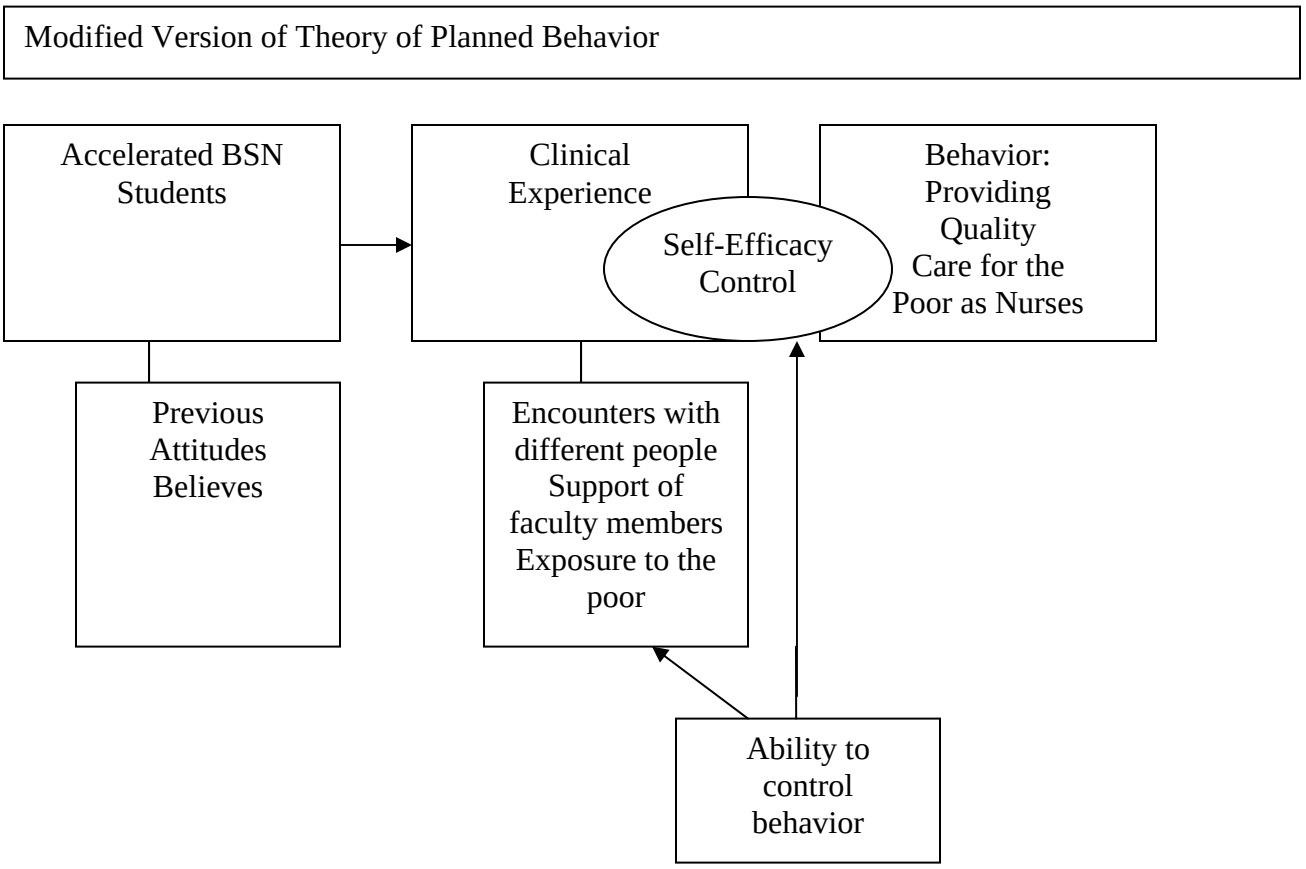

Figure 3

Discussion

In conducting and then studying the interviews for this study, it became apparent that the participants were intellectually prepared for the clinical experience. However, to care for the poor emotionally, some were not prepared to interact with the poor during the clinical experience. As the participants reflected on the experience, they spoke of a transformation from simply caring for the poor to knowing the poor and what it actually means to care for the poor. Some of the participants talked about the meaning that was added to their own lives as they experienced this transformation.

Every participant spoke of learning (“ah-ha”) moments regarding knowing the pregnant women who attended Positive Pregnancy Project and the poverty that those women face, whether it be the lack of transportation, lack of childcare, lack of education, or lack of other needed resources. The nurses stated that this associative learning has impacted their nursing practice and the care that they provide to clientele who are poor. The statement of identification that related to this study was: The lived experience of being involved with the service-learning clinical experience was instrumental in a positive attitude change towards the poor which extended into providing quality care to the poor as registered nurses.

Study Limitations

Although the phenomenological tradition does not dictate the number of participants in a study in order to consider validity, this study had eight participants. Including additional prior students would have strengthened this study.

The design of the study created time gaps that were unavoidable. Some of the participants had difficulty remembering the details of their clinical experience until they were prompted by the interviewer. The participants were then able to recall and make associations to their current work situations.

Recommendations

This study is important to health care educators, especially in today’s climate of predicted health care change. Educators need to consider clinical placement for students which allows for immersion into different and vulnerable populations. Using a service-learning strategy will allow students to learn from the clientele about different life-styles and life situations which the students may not have familiarity. Formulated attitudes may be positively affected by creating clinical experiences which are carefully planned in order to

stretch the student experience beyond brief encounters which are more traditional in nursing education.

Furthermore, nursing educators are challenged today for clinical space for students. By creating a clinical site which not only serves a deserving population, but also meets the students' learning objectives can result in additional benefits such as lasting positive attitudes and the provision of quality care as registered nurses.

Research for the Future

Further research that examines poverty is necessary since it is recognized that there are disparities both in health and in health care among the poor. Additionally, this research could be expanded to other populations that have been identified as those who are not receiving quality care. Today, researchers are challenged to examine the providers' role in quality care instead of the characteristics of the population or the client's diagnosis alone. Ajzen (2008) stated, "It is assumed that because prejudicial attitudes and discriminatory behavior with respect to racial and ethnic minorities are frowned upon in contemporary American society, many people try to inhibit their expression" (p. 294). This assumption was pivotal to this study and may be for future studies. Professionals inhibit their behavior if it is based on discrimination or poor attitude. For example, a study that focuses on care providers' attitudes about obese clients would be appropriate since our country's obesity rates continue to rise. The homeless and those who are diagnosed with mental illness are also at risk for others, including nursing students, to have negative beliefs and attitudes about them. Continued research about the effectives that nurses' attitudes have on clinical outcomes will become increasingly important as healthcare continues to stay in the national spotlight.

Appendix A

IRB # CSM 08-71
Date Approved 12/2/08
Valid Until: 12/2/09

IRB #08-71

THE EXPERIENCE OF SERVICE-LEARNING CLINICAL EXPERIENCE AS A STUDENT AND ITS EFFECT ON PRESENT CLINICAL EXPERTISE AND ATTITUDES TOWARDS THE POOR

Invitation
You are invited to take part in this research study. The information in this form is meant to help you decide whether or not to take part. If you have any questions, please ask.

Why are you being asked to be in this research study?
You are being asked to be in this study because you are a graduate of Creighton University School of Nursing and you are a registered nurse. You also were involved in a service learning/clinical experience, Positive Pregnancy Project, during the time you were a nursing student.

What is the reason for doing this research study?
It is worthwhile to know how a nursing clinical experience impacts the attitudes of registered nurses. Nursing education is consistently searching for meaningful clinical experiences for nursing students.

What will be done during this research study?

a. You will be asked to discuss your views, opinions, and feelings about service learning/clinical experiences. The interview will be no longer than one hour in length. The interview will either be conducted by telephone or a convenient, mutually decided upon location. Data will be audio taped for later transcription and notes will be taken during the interview to record your verbal and non-verbal communication.
b. Audio tapes and notes will be destroyed at the conclusion of the analysis of data.

What are the possible risks of being in this study?
There are no known risks to you from being in this research study.

What are the possible benefits to you?
The information obtained from this study will be shared with you. However, you may not get any direct benefit from being in this research study

What are the possible benefits to other people?
The information obtained from this study is intended to assist in the design of nursing clinical and service learning experiences.

What are the alternatives to being in this research study?
Instead of being in this research study you can choose not to participate.

What will being in this research study cost you?
There is no cost to you to be in this research study.

Will you be paid for being in this research study?
You will not be paid or compensated for being in this research study.

What should you do if you have a problem during this research study?
Your welfare is the major concern of every member of the research team. If you have a problem as a direct result of being in this study, you should immediately contact one of the people listed at the end of this consent form.

How will information about you be protected?
Reasonable steps will be taken to protect your privacy and the confidentiality of your study data. The only persons who will have access to your research records are the study personnel. Your identity will be kept strictly confidential.

What are your rights as a research participant?
You have rights as a research participant. These rights have been explained in this consent form and in *The Rights of Research Participants* that you have been given. If you have any questions concerning your rights, talk to me, Holly Coffey Sandhurst, 402.689.9449. hbcoffey@creighton.edu

What will happen if you decide not to be in this research study or decide to stop participating once you start?
You can decide not to be in this research study, or you can stop being in this research study ("withdraw") at any time before, during, or after the research begins. Deciding not to be in this research study or deciding to withdraw will not affect your relationship with the investigator, or with College of Saint Mary.
You will not lose any benefits to which you are entitled.

If the research team gets any new information during this research study that may affect whether you would want to continue being in the study, you will be informed promptly.

Participant's initials_____

Documentation of informed consent

You are freely making a decision whether to be in this research study. Signing this form means that (1) you have read and understood this consent form, (2) you have had the consent form explained to you, (3) you have had your questions answered and (4) you have decided to be in the research study.

If you have any questions during the study, you should talk to one of the investigators listed below. You will be given a copy of this consent form to keep. If you are 19 years of age or older and agree with the above, please sign below.

Signature of Participant: _____Date_____Time_____

My signature certifies that all the elements of informed consent described on this consent form have been explained fully to the participant. In my judgment, the participant possesses the legal capacity to give informed consent to participate in this research and is voluntarily and knowingly giving informed consent to participate.

Signature of Investigator _____Date_____

Authorized Study Personnel

Principal Investigator: Holly Coffey Sandhurst, MSN RN Phone No: 402.689.9449

Appendix B

THE RIGHTS OF RESEARCH PARTICIPANTS*

AS A RESEARCH PARTICIPANT AT COLLEGE OF SAINT MARY YOU HAVE THE RIGHT:

1. TO BE TOLD EVERYTING YOU NEED TO KNOW ABOUT THE RESEARCH BEFORE YOU ARE ASKED TO DECIDE WHETHER OR NOT TO TAKE PART IN THE RESEARCH STUDY. The research will be explained to you in a way that assures you understand enough to decide whether or not to take part.

2. TO FREELY DECIDE WHETHER OR NOT TO TAKE PART IN THE RESEARCH.

3. TO DECIDE NOT TO BE IN THE RESEARCH, OR TO STOP PARTICIPATING IN THE RESEARCH AT ANY TIME. This will not affect your relationship with the investigator or College of Saint Mary.

4. TO ASK QUESTIONS ABOUT THE RESEARCH AT ANY TIME. The investigator will answer your questions honestly and completely.

5. TO KNOW THAT YOUR SAFETY AND WELFARE WILL ALWAYS COME FIRST. The investigator will display the highest possible degree of skill and care throughout this research. Any risks or discomforts will be minimized as much as possible.

6. TO PRIVACY AND CONFIDENTIALITY. The investigator will treat information about you carefully and will respect your privacy.

7. TO KEEP ALL THE LEGAL RIGHTS THAT YOU HAVE NOW. You are not giving up any of your legal rights by taking part in this research study.

8. TO BE TREATED WITH DIGNITY AND RESPECT AT ALL TIMES.

THE INSTITUTIONAL REVIEW BOARD IS RESPONSIBLE FOR ASSURING THAT YOUR RIGHTS AND WELFARE ARE PROTECTED. IF YOU HAVE ANY QUESTIONS ABOUT YOUR RIGHTS, CONTACT THE INSTITUTIONAL REVIEW BOARD CHAIR AT (402) 399-2400.

*ADAPTED FROM THE UNIVERSITY OF NEBRASKA MEDICAL CENTER, IRB WITH PERMISSION

7000 Mercy Road • Omaha, NE 68106-2606 • 402.399.2400 • FAX 402.399.2341 • www.csm.edu

Appendix C

General Participant Data

Today's Date

Participant ID #

Name

Address

Telephone #

BSN Graduation Date

Area of Practice

Appendix D

Guide for semi-structured interviews with study participants

1) Tell me what you remember about the *Positive Pregnancy Project*?

2) What thoughts and emotions were generated during your experiences with the *Positive Pregnancy Project*?

3) What is the most profound learning or "ah-ha" moments that you experienced during your involvement with *Positive Pregnancy Project*?

4) Tell me about what you knew about people living in poverty before your *Positive Pregnancy Project experience*?

    a) How do you think those impressions were formed?

5) Was there anything that you disliked about the *Positive Pregnancy Project*?

    a) If there were negative experiences, did they alter your perception of the community being served?

6) Can you describe a relationship between your community nursing experience and your views of poverty?

6) Tell me about any personal growth that you have gained by your involvement in the *Positive Pregnancy Project*?

7) What do you know now about poverty?

8) Can you give me examples of how your professional knowledge may have changed while involved with the *Positive Pregnancy Project*?

9) Will you talk about how the community nursing clinical, *Positive Pregnancy Project*, may have influenced your current nursing practice?

10) Please describe a specific example in your current nursing practice of caring for a patient who was experiencing poverty.

11) Will you talk about any relationship to caring for the poor and your experience with the *Positive Pregnancy Project*?

12) In thinking about nurses caring for the poor, is there anything you would like to share with me?

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