

## Research paper

# Nurses' attitudes towards people who are homeless: a literature review

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### What is known on this subject

- As there are relatively large numbers of people who are homeless, and there is an established link between homelessness and poor health, most nurses are likely to care for a homeless person during their career.
- Recent political health policy has attempted to address the health inequalities between homeless and housed populations.
- Nurses' Standards of Professional Conduct, Performance and Ethics require nurses to show lack of discrimination or prejudice towards patients regardless of their economic status.

### What this paper adds

- People who are homeless are frequently viewed as objects or dehumanised by nurses.
- Nurses' negative attitudes may result in poorer-quality care being offered to people who are homeless, and may affect the willingness of homeless people to seek healthcare.
- Both personal experience of interacting with people who are homeless and formal education are important factors in improving nurses' attitudes towards homeless people.

## ABSTRACT

There is a well-established link between homelessness and poor health, so most nurses are likely to care for a homeless person at some point in their career. This literature review identifies and explores the attitudes of nurses and student nurses towards people who are homeless, and the subsequent impact that such attitudes may have on the quality of care. Although nurses are bound by professional codes of conduct to provide equality of care for all patients regardless of economic status, it is not known to what extent this is achieved with people who are homeless, or how nurses' attitudes affect barriers to accessing care. Online bibliographic databases were searched systematically, including CINAHL, ASSIA, Intute Health and Life Sciences, Cochrane, British Nursing Index, SCOPUS and NHS e-library, which incorporated Medline, Embase and PyscINFO. The search focused on nurse attitudes only. A systematic review of 242 abstracts and their refer-

ences identified 10 articles for review. Content analysis was used to code relevant themes. The findings showed that negative and dehumanising attitudes towards people who are homeless exist among some nurses. Although some studies suggested that these negative attitudes resulted in poorer-quality care being delivered, the results were inconclusive. However, negative attitudes acted as a barrier to accessing healthcare. There is limited evidence on which to base suggestions about ways to change nurses' negative attitudes towards people who are homeless. Collaboration between nurses and other health and social care workers who provide services for people who are homeless is important. The small number of studies available reinforces the need for further research in this area.

**Keywords:** health outcome, homelessness, nursing, prejudice, stigma

## Introduction

Homelessness is difficult to define, and there is no collectively agreed, worldwide definition. The European Federation of National Organisations Working with the Homeless (FEANSTA) acknowledges that homelessness is a complex phenomenon that includes those people who are roofless (rough sleepers, newly arrived immigrants, victims of fire and flood), houseless (with a place to sleep but using temporary institutions or shelters), living in inadequate, overcrowded or unsuitable accommodation, or living in insecure accommodation where they are threatened with eviction or violence (Edgar *et al*, 2003). A more comprehensive definition is outlined in the final report of the Homelessness Task Force, a group set up by the Scottish Government in 1999 to investigate homelessness in Scotland (Scottish Executive, 2002). This defines homeless persons as those 'who are without any accommodation, who cannot gain access to their accommodation or would risk domestic violence by living there, whose accommodation is unreasonable, overcrowded or a danger to health, or whose accommodation is a caravan or boat and they have nowhere to park it' (Scottish Executive, 2002, Appendix B). The definition also includes 'roofless persons without shelter of any kind, those persons living in emergency and temporary accommodation provided for people who are homeless, households residing in accommodation such as Bed and Breakfast premises' and 'those persons staying in institutions because they have nowhere else to go' (Scottish Executive, 2002, Appendix B). The definition also includes individuals who have insecure accommodation. A person is defined as *homeless* if they are 'likely to be evicted lawfully or unlawfully, have no legal rights or permission to stay in accommodation, or if they are involuntarily sharing accommodation with another household, on a long-term basis, in housing circumstances deemed to be unreasonable' (Scottish Executive, 2002, Appendix B). The definition with the most relevance to this review is that of the Scottish Government, as it is from this definition that official figures for homelessness are collated. Clearly, homelessness is much more far-reaching than the traditional image of a rough sleeper on a park bench or a beggar on the street (Wood, 2006).

Although at first glance the issue of homelessness may not appear to be of particular interest to nurses, there is a well-researched link between homelessness and poor health (Bines, 1994; Grenier, 1996). Official statistics from a study of 225 people who were homeless in Glasgow showed that 65% of them had a long-standing illness and 73% had experienced a neurotic symptom in the past week (Kershaw *et al*, 2000). A report by the Office of the Deputy Prime Minister

showed that rough sleepers have an average life expectancy of 42 years, compared with an average life expectancy of 74 years for men and 79 years for women (Griffiths, 2002). Rough sleepers are 35 times more likely to commit suicide and four times more likely to die from unnatural causes than the rest of the UK population (Shaw and Dorling, 1998; Griffiths, 2002).

Research by Crisis, a UK charity, suggests that of the estimated 310 000–380 000 people who are homeless, only 63% are registered with a GP, compared with 99% of the housed population (Crisis, 2003). People who are homeless are more likely to smoke than the housed population (Walker *et al*, 2002; Health Development Agency, 2004; Scottish Public Health Observatory, 2008). This factor, along with overcrowding and increased rates of HIV (D'Amore *et al*, 2001), predisposes people who are homeless to pneumonia, influenza, tuberculosis and upper respiratory tract infections (Raoult *et al*, 2001; Craig *et al*, 2007). In addition, substance abuse rates are high among people who are homeless, particularly among those aged 16–25 years. Home Office figures suggest that 95% of this group have used illegal drugs, compared with 51% of the general population (Ramsay *et al*, 2001; Wincup *et al*, 2003). In a recent Glasgow study, 78% of the sample group ( $n = 266$ ) were found to be drinking hazardously, and 61% met the criteria for lifetime alcohol addiction (Gilchrist and Morrison, 2005).

It has been recognised for some time that there is an 'inverse care relationship' between levels of deprivation and the quality of healthcare received. Tudor Hart first outlined the idea of the inverse care law where 'in areas with most sickness and death, general practitioners have more work, larger lists, less hospital support, and inherit more clinically ineffective traditions of consultation' (Hart, 1971, p. 412). Mercer and Watt (2007) recently proposed that the inverse care law continues to operate within the NHS, and confounds attempts to reduce health inequalities. Homelessness has been acknowledged by the Scottish Executive as one of the major causes of health inequalities. Policies highlight the need to improve the health of people who are homeless (Scottish Executive, 1999, 2000). In 2001, Health and Homelessness Guidance was issued to all NHS boards in Scotland. This requires the implementation of a range of initiatives, including joint working between housing and care providers, prevention of homelessness, and the prevention of inappropriate discharge from hospital of people who are homeless (Scottish Executive, 2001, 2005). Official statistics show that the number of households in Scotland officially recognised as newly homeless in 2007–2008 was 41 556, compared with 40 220 in 2002–2003 (data prior to 2002–2003 are estimated only), which suggests that, despite initiatives, homelessness remains a problem (Scottish Executive, 2009a).

The relationship between homelessness and health, combined with the size of the problem, makes homelessness a relevant subject for nurses.

However, any attempt to quantify homelessness is problematic. People move in and out of homelessness, so it is difficult to measure the number of people who are homeless at any one time (Edgar *et al*, 2003). Although official Scottish Executive figures range from 40 220 to 43 030 between 2002–2003 and 2007–2008 (Scottish Executive, 2009), these may not give the complete picture. Research by charities that work with people who are homeless shows that much homelessness is hidden and is therefore never included in the statistics (Crisis, 2004). For example, Crisis estimates that approximately 350 000 people in the UK are not recognised in official figures for homelessness (Crisis, 2009). Taking into account the large numbers of people who are homeless, and the link between homelessness and poorer health, it is inevitable that most nurses will come into contact with people who are homeless during their career, even if this is on an infrequent basis.

The International Council of Nurses (ICN) Code of Ethics clearly states that nursing care should 'be respectful of and unrestricted by considerations of age, colour, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status' (International Council of Nurses, 2005, p. 1). This requirement is reflected in the Nursing and Midwifery Council Standards of Conduct, Performance and Ethics (Nursing and Midwifery Council, 2008a), regulations which require nurses to show a personal and professional commitment to equality and diversity, and a lack of discrimination, regardless of the patient's economic status. However, some authors suggest that prejudice against people who are homeless does exist among nurses, and that it is a widespread international problem (Ugarriza and Fallon, 1994; Gooden *et al*, 2001; Myhrvold, 2006). Therefore a literature review was undertaken to examine nurse attitudes towards people who are homeless, and to propose recommendations for nursing practice.

## Methods

A literature search was performed using the following databases: CINAHL, ASSIA, Intute Health and Life Sciences, Cochrane Library (Wiley), British Nursing Index, SCOPUS, University of Dundee Library Catalogue and NHS e-library (which incorporates Medline, Embase and PsycINFO). The time frame was unrestricted in order to ensure that seminal work would not be excluded from the results. Research from the homeless charities Crisis, Shelter and the Simon Community was also examined. Only published research

was included. Although this is not ideal, due to the risk of publication bias (where journals tend to publish studies with positive outcomes rather than those with negative or no outcomes) (Aveyard, 2007), it was necessary for reasons of practicality. The search was restricted to English-language articles. The following keywords were used: *nurse, nursing, homeless, homelessness, health, healthcare, health outcome, attitude, prejudice, stigma, bias, view* and *perception*. All research study methods were included. Literature on children as a specific group was excluded, although research incorporating adolescents and families was included. Homelessness is prevalent among single adults. Of the 57 304 applications to Scottish local authorities in 2008–2009, 61% were from adults without children (Scottish Executive, 2009b). Therefore nurses are more likely to come into contact with single homeless adults during their career. Furthermore, the review focused on nurses' attitudes towards people who are homeless, rather than on the complex issues of child poverty and child homelessness.

The initial search produced a total of 242 articles. All of the abstracts were read, and articles were rejected if they did not meet the following criteria. The article had to focus on nurses only. Articles that made reference to the attitudes of health providers, doctors or other health professionals, but which provided no evidence that nurses were included in the research, were excluded. Prior to exclusion, they were examined in full, to minimise the risk of losing data. However, it is accepted that as a result of this approach, some data may have been lost. Articles about general investigations of vulnerable populations, marginalised groups or disadvantaged groups were excluded, unless demographic data were available to show that the focus of the research was on people who are homeless. This ensured that the topic referred specifically to nurses and people who are homeless.

There were two exceptions to the above criteria. The first was an article which related specifically to nurse prejudice and the poor. Although poor people are not necessarily homeless, it was felt that poverty was present among the majority of people who are homeless, and that similar attitudes towards people who are homeless would therefore be revealed. The second article was included because, although it did not just relate to the attitudes of nurses, it included significant data relating to nurses within the transcripts. It was also the only article that focused specifically on the attitudes of nurses towards people who are homeless, from the homeless person's viewpoint. If the principal focus of the study was a health problem that was common in people who are homeless (e.g. drug use, HIV rates, mental health problems), and if homelessness was a secondary issue, the study was excluded. Articles relating to general access to healthcare for people who are homeless were also excluded, with the

exception of articles that focused on nurses' attitudes as a barrier to care. Only primary research was included in the review, as it was felt that this provided stronger evidence in addressing the aim of the review (Aveyard, 2007). Therefore discussion papers were disregarded, following scrutiny of their reference lists for additional primary research.

The search resulted in a very limited body of research being discovered. A total of eight articles were sourced. From the reference lists of these articles, two other relevant studies were obtained, resulting in a total of ten articles. A systematic approach to analysis of the data was used. Each article was read in detail and summarised (see Table 1). Each was then critically analysed using both the Public Health Resource Unit's Critical Skills Appraisal Programme (Public Health Resource Unit, 2007) and Polit and Beck's model for critiquing qualitative and quantitative research (Polit and Beck, 2006). In order to extract themes from the literature, the studies were re-examined and each relevant idea or argument was assigned a code. For example, negative attitudes towards people who are homeless acting as a barrier to healthcare was coded as *barriers to healthcare*. Nurses being able to personally identify with people who are homeless following experience of working in a shelter was coded as *experience/personal identity*. When the coding process was complete, recurrent themes were extracted. The codes were distributed under each theme. This process was based on content analysis techniques that enable the researcher to 'identify patterns, categories, and/or themes in recorded language' (Waltz *et al*, 2005, p. 239). Although it was simplified for the purposes of this review, content analysis enabled a systematic approach to comparing and contrasting the literature.

## Results

Following coding, five main themes were identified:

- the existence of negative attitudes among nurses towards people who are homeless
- people who are homeless being regarded as objects and dehumanised
- how nurses' attitudes predict behaviour
- nurses' prejudice as a barrier to the homeless accessing healthcare
- how to change nurses' negative attitudes.

### The existence of negative attitudes

Following a qualitative content analysis of 17 interviews with homeless men and women residing in five shelters in Toronto, it was proposed that nurses' negative attitudes may be due to the fact that people

who are homeless have a higher prevalence of mental illness, substance abuse and traumatic experiences, which lead people who are homeless to misinterpret nurses' attitudes (Wen *et al*, 2007). Of the articles analysed, strong negative attitudes among nurses towards people who are homeless were identified in 6 of the 10 studies. The earliest study of nurses' attitudes towards the poor (Price *et al*, 1989) was also the largest and geographically most wide-ranging study of those reviewed ( $n = 240$ ). The results showed that 58% of nurses believed that homeless women often became pregnant in order to claim welfare payments, 43% believed that the homeless were taking advantage of the healthcare system, and all nurses believed that a certain proportion of people who were homeless were on benefits for dishonest reasons (Price *et al*, 1989).

In a recent Hungarian study, Zrinyi and Balogh (2004) also reported negative attitudes among nurses ( $n = 220$ ). Although they acknowledged that the initial results appeared to indicate neutral attitudes, detailed analysis showed that only 61% of nurses agreed strongly with the statement 'I never refuse to provide care for a homeless person' (Zrinyi and Balogh, 2004, p. 239). Therefore 39% of nurses did not feel able to agree strongly with this statement. In addition, only 9% of nurses said that physical abuse of people who are homeless was entirely against their beliefs, and 63% approved of the unconditional use of force. Although these results appear discouraging, it should be noted that the researchers were unable to confirm the validity of the scale that was used, and they acknowledged that Hungary had not recently updated its system for educating nurses in ethics. Therefore these factors limit the extent to which the study can be generalised.

A study of the attitudes of ten nursing students in the USA prior to and after a clinical placement in a homeless shelter revealed that before the placement began, students made statements that included emotive words such as 'disgusting' and 'dirty', although this view was not unanimous (Chung-Park *et al*, 2006, p. 319). One student felt that homeless people were difficult to recognise, and another reported feeling completely at ease with a homeless person he knew in his neighbourhood. The results of the study suggested that the variations in students' attitudes were influenced by previous encounters and the degree of exposure that they had experienced with people who are homeless (Chung-Park *et al*, 2006). This suggestion was supported by a further study of 14 nursing students in the USA, who had spent time working with homeless families and who expressed positive views about people who are homeless. As in the study by Chung-Park *et al* (2006), exposure to homeless people had changed their attitudes (Hunt, 2007). Similar changes in attitudes as a result of direct experience of working with homeless people were also reported in a third study (Dela Cruz *et al*, 2004).

**Table 1** Summary of literature

| Reference  | Aim   | Participants   | Method  | Findings   |
|--|---|--|---|--|
| Price J <i>et al</i> (1989) Nurses' perceptions regarding health care and the poor. <i>Psychological Reports</i> 65:1043–52.             | To determine whether prejudice against the poor existed, and if so to what extent.  | A US-based study. 240 registered nurses from 6 different hospitals (40 from each institution).                 | A survey using a self-completed questionnaire consisting of 35 items. Responses were obtained with 7-point Likert-type scales, ranging from 'strongly agree' to 'strongly disagree.' Response rate was 80%. Data analysis was performed using descriptive statistics. | Significant prejudice against poor people was present in the findings. 58% of nurses believed that poor women got pregnant in order to obtain welfare payments. 36% of nurses believed that people were poor due to lack of effort or an unwillingness to take opportunities that arose. |
| Jezewski MA (1995) Staying connected: the core of facilitating health care for homeless persons. <i>Public Health Nursing</i> 12:203–10. | To explore the influence that nurses have in facilitating healthcare for homeless people. This includes examining nurse attitudes as a barrier to care, and building relationships with homeless people, as well as exploring other ways in which nurses stay connected with homeless patients. | A US-based study. 5 nurse practitioners, 5 community health nurses and a social worker, in a nurse-led clinic. | Grounded theory. Data collection methods included participant observation, in-depth, semi-structured, formal interviews and transcriptions of field notes and informal interviews.  | Nurses were found to be advocates between homeless people and other healthcare providers. Results showed that they would intervene to sensitise other healthcare professionals to the homeless patient's needs.  |

Table 1 Continued

| Authors   | Aim  | Participants   | Method   | Findings  |
|---|--|--|--|---|
| Minick P <i>et al</i> (1998) Nurses' perceptions of people who are homeless. <i>Western Journal of Nursing Research</i> 20:365–9.                       | To explore nurses' perceptions of homeless people and to describe transforming experiences   | A US-based study. 15 nurses (5 nurses, 3 Masters nursing students and 2 nursing faculty members).                    | Hermeneutic phenomenology - an interpretive research design. In-depth interviews with the participants | Negative attitudes among nurses towards homeless people were identified and explored. Listening, connecting with and understanding homeless people were important in order to change negatively held beliefs of nurses.   |
| Kee CC <i>et al</i> (1999) Nursing student and faculty attitudes toward people who are homeless. <i>American Journal of Health Behavior</i> 23:3–10.    | To explore the attitudes of nursing students and faculty members towards homeless people and to determine whether they differ from attitudes found among the lay public. To identify factors that might influence attitudes. | A US-based study. A convenience sample of 377 students and 45 faculty members.                                       | A descriptive, correlational study design.   | Nurses' attitudes were generally positive, negating the findings of some other research studies. Frequent nurse contact with homeless people was inversely related to having a positive attitude. With a few exceptions, nurses and members of the lay public had similar views about homelessness.       |
| Zrinyi M and Balogh Z (2004) Student nurse attitudes towards homeless clients: a challenge for education and practice. <i>Nursing Ethics</i> 11:334–48. | To describe the attitudes of nursing students towards homeless clients. To explore the extent to which student nurses may obstruct homeless clients when they seek access to and use healthcare.                             | A Hungarian study. 250 second-, third- and fourth-year nursing students. 50 paramedics training in the same faculty. | A cross-sectional descriptive research design. Convenience sampling.                                   | 68% of the sample had a neutral or almost neutral attitude to homeless clients. Some negative attitudes prevailed. 63% approved of the unconditional use of force against homeless people. Only 9% of participants felt that physical abuse of homeless people was entirely against their beliefs/values. |

Table 1 Continued

|   |   |   |  |  |
|---|---|---|--|--|
| <p>Dela Cruz FA <i>et al</i> (2004)<br/>Transformation in family nurse practitioner students' attitudes toward homeless individuals after participation in a homeless outreach clinic. <i>Journal of the American Academy of Nurse Practitioners</i> 16:547–54.</p> | <p>To determine the attitudes of nursing students towards homeless people before and after participation in a homeless outreach clinic.</p>                                   | <p>A US-based study. 15 students divided into two focus groups.</p>                     | <p>Mixed method study using focus groups and tape transcripts.</p>   | <p>Students' attitudes towards homeless people were significantly more positive after they had interacted with them in the homeless outreach centre.</p>                                       |
| <p>DeLashmutt MB and Rankin EA (2005) A different kind of clinical experience: poverty up close and personal. <i>Nurse Educator</i> 30:143–9.</p>   | <p>To identify changes in nursing students' attitudes, before and after clinical placement at a day shelter and multi-resource advocacy centre for the poor and homeless.</p> | <p>A US-based study. 51 pre-registration nursing students, from one university.</p>     | <p>Qualitative research involving questionnaires to assess students' attitude prior to attending a homelessness day shelter and seminars at the shelter. A post clinical experience questionnaire, to assess changes in students' attitudes.</p> | <p>Clinical experience of working with homeless people resulted in students' attitudes towards them becoming more positive.</p>  |
| <p>Chung-Park M <i>et al</i> (2006) RN-to-MSN students' attitudes toward women experiencing homelessness: a focus group study. <i>Journal of Nursing Education</i> 45:317–22.</p>   | <p>To examine the attitudes of nursing students towards mothers and their children living in a transitional shelter.</p>  | <p>A US-based study. 10 nursing students from one university. A convenience sample.</p> | <p>Focus group method. Two focus groups, one conducted before a 15-week clinical placement at the shelter and one conducted after the clinical placement.</p>  | <p>Students' attitudes changed during the course of the 15-week placement. They reported heightened awareness of homelessness issues and a more positive attitude towards homeless people.</p> |

Table 1 Continued

| Authors   | Aim   | Participants  | Method  | Findings   |
|---|---|---|---|--|
| Wen CK <i>et al</i> (2007) Homeless people's perceptions of welcomeness and unwelcomeness in healthcare encounters. <i>Journal of General Internal Medicine</i> 22:1011–17. | To examine homeless people's past experiences of encounters with healthcare providers and characterise their perceptions of these interactions. | A Canadian-based study. 17 homeless men and women aged 29–62 years, residing in five different shelters in Toronto, Canada. | Qualitative content analysis of 17 in-depth interviews.                               | Most of the participants had experienced an unwelcoming attitude and had perceived this as an act of discrimination. The negative attitudes of healthcare staff made the homeless participants feel dehumanised and less likely to seek healthcare. When the healthcare staff had a welcoming attitude, this made the participants feel empowered and valued as individuals. |
| Hunt R (2007) Service learning: an eye-opening experience that provokes emotion and challenges stereotypes. <i>Journal of Nursing Education</i> 46:277–81.                  | To investigate the lived experiences of nursing students who were participating in clinical work with homeless families.                        | A US-based study. 14 nursing students who were working with families in one homeless shelter.                               | Descriptive phenomenology following audio-taped interviews that lasted for 1–2 hours. | The participants found the experience eye opening and emotional. Assumptions and stereotypes were challenged. Reflection on the similarities and differences between the students and their homeless patients were explored.   |



However, other studies found conflicting results. Delashmutt and Rankin (2005), Kee *et al* (1999) and Jezewski (1995) all reported neutral or positive attitudes towards homeless people. Although negative attitudes appeared to be absent from the results, several authors recognised more subtle forms of negativity. In the USA, Minick *et al* (1998) used a phenomenological approach to study 15 nurses. They found that even when the participants reported altruistic feelings towards homeless people, negative feelings could emerge, for example, if the homeless person complained, or forgot to say 'thank you.' The nurses explained that homeless people were still seen as having no right to make a complaint. Nurses were also reported as referring to homeless people as 'this woman' or 'those people', rather than by name (Minick *et al*, 1998, p. 365). Although this study was small in size and from two geographically similar locations, an effort was made by the researchers to include participants with both positive and negative attitudes in the study. Equally, an attempt was made to obtain diversity with regard to gender and race. Therefore it can be argued that even where studies show positive attitudes of nurses towards people who are homeless, some nurses still demonstrate some degree of negativity or prejudice.

### People who are homeless being regarded as objects and dehumanised

Only one study examined the point of view of people who are homeless (Wen *et al*, 2007). Semi-structured interviews were conducted with 17 homeless people to establish how they experienced 'welcomeness' and 'unwelcomeness' in past encounters with healthcare providers. The results suggested that negative attitudes were those that made them feel 'disempowered' and 'not listened to' (Wen *et al*, 2007, p. 1011). One of the key factors in this study was that it analysed the interview transcripts using Buber's philosophical ideas of how people relate to objects (I–It) and how people relate to dynamic beings (I–you) (Buber, 2004). Writing in 1923, Buber suggested that by relating to people as (I–it) rather than as (I–you), people are treating others in the same way as they would treat an object. The homeless participants in the study by Wen *et al* (2007) confirmed that such dehumanising attitudes were frequent in encounters with healthcare providers. To what extent this dehumanising behaviour is unique to the homeless population compared with the general patient population would require additional, comparative research. However, although the authors acknowledged such limitations and recognised that the use of such a tool may be challenged, other studies also referred to dehumanising behaviour by nurses and other healthcare professionals. Minick *et al* (1998,

p. 365) found that some nurses refer to people who are homeless as 'this' and 'those.' A mixed method study of 15 nurse practitioner students (Dela Cruz, 2004) illustrated participants' surprise when homeless people were given responsibility and trust by other people in a similar position. The results suggested that, prior to working with homeless people, the students would not have considered them capable of being responsible or trusted.

### How nurse attitudes predict behaviour

Having established that negative attitudes exist among nurses, it was interesting to find that there were conflicting views within the literature as to whether there was a positive relationship between nurses' attitudes and their behaviour. Some studies made the assumption that prejudicial attitudes towards homeless people equated to delivery of poorer-quality care, without questioning whether or not there was a positive correlation between the two. One study stated that 'negative attitudes and feelings held by health providers are likely to adversely affect healthcare' (Kee *et al*, 1999, p. 3), but the authors did not indicate how they had reached this conclusion. Dela Cruz *et al* (2004) suggested the same relationship, but used the attitude–behaviour theories of Ajzen and Fishbein (2000) to endorse their assumption. Zrinyi and Balogh (2004, pp. 347–8) also drew a parallel between attitude and behaviour, but did include the two factors in their study questionnaire. They reported a positive correlation between the results of two statements: 'people who are homeless don't deserve health/social services' and 'it is useless to invest in the health of people who are homeless.' Thus the less nurses believed that patients who were homeless deserved care, the less they tended to invest in the health of those individuals. This was the only study that attempted to make a link between attitude and behaviour, but this was not the main aim of the investigation, which limits the extent to which the findings can be generalised. In addition, Price *et al* (1989) suggest that nurse professionalism may override prejudicial attitudes towards the homeless. This area requires more investigation before a link between nurses' negative attitudes and nurse behaviour is assumed.

### Nurses' prejudice as a barrier to homeless people accessing healthcare

A recurrent theme in the literature was how nurses' prejudice acted as a barrier to homeless people accessing healthcare. This theme had two main elements. First, a perceived barrier to the initial process of accessing care was presented in the literature (Jezewski, 1995;

Zrinyi and Balogh, 2004; Wen *et al*, 2007). Secondly, the literature suggested that once a homeless person had accessed care, the continuity, follow-up and quality of care given was shown to be less than that for the general population (Price *et al*, 1989; Zrinyi and Balogh, 2004; Wen *et al*, 2007). However, the literature did not clarify whether the lack of continuity and quality of care was due to the attitudes of nurses or to the behaviour of homeless people. The strongest evidence that nurses' attitudes affect access to healthcare came from the study of 17 people in shelters in Toronto. Although this study did not use 'barrier to healthcare' as one of its coding categories, it did use examples from transcripts that showed a clear reluctance on the part of homeless people to access healthcare, following negative attitudes from health professionals. For example, one homeless client said that he 'would rather sit here and die on a bench than go over there' (to access healthcare) (Wen *et al*, 2007, p. 1013). Frequent distrust of healthcare workers was reported, and sometimes their negative attitudes appeared to have a negative effect on the homeless person's desire to look after their own health. Although these are specific examples from a small study of healthcare workers rather than nurses, it was the only study that represented the homeless person's viewpoint. However, it also raises the question of why homeless people are participating in research if they claim to be reluctant to access healthcare services, which thus casts doubt on the representativeness of the sample. Nevertheless, when the researchers were coding the data they had attempted to ensure that data saturation was achieved (Aveyard, 2007). They also acknowledged the lack of triangulation within the study. It was therefore felt that this study helped to build an overall picture of barriers to healthcare from the homeless person's perspective.

Jezewski (1995) suggested that barriers were formed as a result of breakdown in communication between healthcare professionals and homeless people. They examined many different aspects of communication and highlighted episodes where nurses within the homeless clinic had to intervene during interactions between homeless people and other healthcare providers, because of cultural and social prejudice towards the former. One of the key topics within Jezewski's research was that of 'staying connected', facilitating the link between homeless people and healthcare providers (Jezewski, 1995, p. 205). Jezewski's work identified three more key themes, namely 'lack of health insurance', 'insensitivity of healthcare providers towards people who are homeless' and 'stigma and cultural barriers', as the most frequently discussed barriers to accessing healthcare (Jezewski, 1995, p. 207). The most commonly cited barrier was 'lack of health insurance', which would not apply in the UK, thus making 'insensitivity of healthcare providers toward

people who are homeless' and 'stigma and cultural barriers' the two most relevant themes. This was a small study with a single investigator, and therefore the findings cannot be generalised. However, its results are consistent with those from the other studies.

One way of examining whether nurses' negative attitudes are truly a factor in reducing access to healthcare is to examine whether positive attitudes make any difference. Jezewski (1995) maintained that a positive attitude towards homeless clients increased their ability to access healthcare, although it was recognised that other factors, such as itinerant lifestyle and priorities with regard to survival, also affected access to healthcare. Wen *et al* (2007) also suggested that increased access to healthcare was achieved when nurses had a positive attitude. Attitude is not the only factor responsible for creating or removing barriers to accessing healthcare, but the literature suggests that it is an important factor for people who are homeless.

Following initial access to healthcare, two studies identified further problems caused by nurses' negative attitudes. Zrinyi and Balogh (2004) showed that 72% ( $n = 157$ ) of nurses did not strongly agree that homeless people received comparable attention to other clients during healthcare interactions. Similarly, Price *et al* (1989, p. 1047) found that 36% ( $n = 69$ ) of nurses 'did not believe that the quality of care the poor received was equivalent to the care all others received.' The literature implies that not only does nurses' prejudice cause barriers to accessing healthcare, but also it may have an impact on the quality of care that is received.

## How to change nurses' negative attitudes

Since prejudice and negative attitudes among nurses have been shown to exist, it is important to examine how the literature suggests bringing about change. Four of the studies examined the attitudes of student nurses before and after working (for varying lengths of time) with people who are homeless. All of the studies showed a positive change in attitude towards homeless people following the experience. Personal exposure changed the students' views about the causes of homelessness, and helped them to identify personally with clients who were homeless. Exposure also contributed to their personal growth, increased their sense of social responsibility and increased their political awareness (Dela Cruz, 2004; DeLashmutt and Rankin, 2005; Chung-Park *et al*, 2006; Hunt, 2007).

In all of these studies the students reported that they were closer to homelessness than they had previously realised. They showed surprise that there were people who were homeless despite having jobs and qualifications, who were well dressed and who were not

substance abusers. They also reported a change in attitude to government policy, which suggests that the students had become more aware of the broader environmental impact on people who are homeless. Hunt (2007) suggests that nurses widen their view of what constitutes professional responsibility after working with homeless people, looking beyond individuals towards the well-being of groups and communities.

These studies were unanimous in suggesting that experience of working with people who are homeless has a beneficial effect in changing attitudes. Specifically, the study by Zrinyi and Balogh (2004) found a positive correlation between personal experience of working with people who are homeless and reduced fear of them (Zrinyi and Balogh, 2004). This reduction in anxiety after spending time with homeless people was also observed in the research by Hunt (2007). Several articles made links between the importance of education and a positive attitude (Minick *et al*, 1998; Zrinyi and Balogh, 2004; Chung-Park *et al*, 2006; Hunt, 2007). In addition, Jezewski (1995) argued that the role of the nurse as collaborator with other healthcare professionals was fundamental to reducing negative attitudes towards homeless people.

However, one of the studies showed conflicting results. Kee *et al* (1999) studied 377 students and found that nurses' positive attitudes decreased with increasing level of experience of working with homeless people. The authors of that study suggest that the role of idealism in attitude formation requires further study, as idealism can quickly turn to cynicism in the face of reality. Although it is possible to recognise the role that experience plays in attitude formation, it seems that more research is needed to establish a firm link between the two.

## Discussion and limitations of the review

This literature review had several limitations. First, the method of coding and analysing the data meant that choices and judgements had to be made about the inclusion and exclusion of relevant data. There was no consensus of opinion available. Therefore this method may have been open to subjectivity when considering which data were most relevant. Secondly, the method of coding the data meant that there was a risk that subtle variations in the themes may have been missed. Similarly, any bias in the study may have been replicated within the themes.

Another major limitation was the lack of research that focused specifically on the attitudes of nurses towards people who are homeless. Equally, only one study examined this issue from the homeless person's

perspective. The majority of the research examined overall barriers to healthcare or looked at attitudes towards homeless people from the perspective of healthcare providers in general. As there were 676 547 nurses listed on the Nursing and Midwifery Council register for the year ending 31 March 2008 (Nursing and Midwifery Council, 2008b), there is a need for additional research into this important area in the UK.

Although it can be argued that at some point in a nurse's career they are likely to encounter and treat a patient who is homeless, the amount of exposure to this client group will inevitably vary. Some of the research suggested an association between the amount of time spent with people who are homeless and a more positive attitude among nurses.

Only the studies by Price *et al* (1989) and Jezewski (1995) sought the views of registered nurses alone. The other studies either used a sample consisting of registered and student nurses, or focused exclusively on the views of students. No potential differences between trainee and registered nurses views were explored. Equally, the range of settings on which the research focused was either not stated or limited to homeless shelters, with the exception of research by Price *et al* (1989), who examined the views of registered hospital staff nurses only. However, none of the research compared and contrasted nurses' attitudes in different settings (e.g. community, acute and primary care settings). This may have had significant ramifications for nurses who work in areas that are rarely accessed by homeless patients. Both the implied correlation between nurses' attitudes and their previous experience of working with homeless people and the differences in nurses' attitudes within different healthcare settings need to be explored in greater depth. There was also no attempt in the literature to examine whether the length of time for which a person had been homeless affected the results of the studies.

No research studies were found on this topic from the UK. All of the studies were based in the USA, Canada or Eastern Europe. Although many of the issues may have been similar, there are significant differences in the health systems and in nurses' education in these countries, leading to potential differences in research outcomes and applicability of the data to the UK. Geographical bias was further demonstrated when examining the demographic data for the participants. Only one of the studies actively attempted to seek diversity in terms of gender and race (Minick *et al*, 1998). Jezewski (1995) acknowledged that all of their participants were female, and Price *et al* (1989) deliberately excluded the five male participants, examining the views of female nurses only. The other studies did not present extensive demographic data for the participants. However, among the studies that were examined there appears to be a bias towards white female nurses. Despite these limitations, the

concurrency of the themes led to several recommendations for nursing practitioners, which are outlined below.

## Recommendations

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Clinical governance places responsibilities on nurses, holding them 'accountable for continuously improving the quality of services and safeguarding high standards of care' (Scally and Donaldson, 1998, p. 62). Thus all nurses are required to ensure that discrimination does not occur in their area of work. According to the literature, there are three principal ways for nurses to facilitate healthcare for people who are homeless, namely by *changing nursing practice*, and by *education* and *research*.

### Changing nursing practice

First, nurses must examine their own attitudes and practice. Although it is difficult to admit that members of a caring profession should hold negative attitudes towards people who are homeless and thus create barriers to care, the evidence suggests that this is a reality. In order to acknowledge patients as individuals and create an environment that is intolerant of stereotypes and inequality, it is essential that nurses understand their own value systems and biases (Martino-Maze, 2005). For the individual, this can be a difficult process. Nurses are expected to behave professionally, although they are not immune to feeling vulnerable and uncertain (Jack and Smith, 2007). However, awareness of these limitations is necessary in order to improve personal practice. Understanding ourselves can make us take action to become less anxious and more resourceful (Jack and Smith, 2007). Self-awareness can act as a catalyst for providing effective interventions (Dela Cruz *et al*, 2004). Taking into consideration the fact that it is not always easy to recognise a person who is homeless (DeLashmutt and Rankin, 2005; Chung-Park *et al*, 2006), increased awareness of the complex health problems of people in this situation can lead to a more in-depth assessment of their health needs on admission.

Secondly, nurses should be aware of the importance of collaboration with other health and social care providers, aware of the available local resources, and able to facilitate links between healthcare providers and other services for people who are homeless (Jezewski, 1995; Wen *et al*, 2007). This means that nurses should both find out about other care providers and form networks with them, in order to be effective advocates for homeless people (Chung-Park *et al*, 2006). This

could be as simple as displaying lists of useful organisations and contacts at their place of work.

Thirdly, in most situations, nurses work as part of a team. Therefore they are ideally placed to influence the practice of other people, providing effective role models for colleagues and more junior staff (Zrinyi and Balogh, 2004). As managers, they may be in a position to reward nurses who display positive attitudes and behaviours towards homeless people. This may be done informally, or through performance assessment structures such as appraisals, thereby reinforcing positive behaviour (Price *et al*, 1999; Kerr *et al*, 2005). In addition, by acknowledging the existence of an inverse care law, nurse managers who have strategic influence are well placed to initiate or support broader interventions and to help to develop anticipatory care models.

### Education

The literature suggested that education and experience of working with homeless people was an important factor in changing nurses' attitudes. As a result, it seems logical that nurses should attempt to gain as much experience as possible with this client group, and try to create placement opportunities for more junior staff and students. This may include allocating student nurses to caseloads that involve homeless patients. Formal education and seminars may be appropriate (Chung-Park *et al*, 2006), as well as the inclusion of equality and diversity training within nursing and social work curricula.

### Research

Finally, there is an apparent lack of research in this area. For nurses considering research opportunities, there are gaps in research from the perspective of homeless people, only limited research based in the UK, and a lack of research focusing on specific nursing settings.

## Conclusion

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In view of the current numbers of people who are homeless in Scotland, it is likely that nurses will encounter people who are homeless in the course of their work. Research shows that the causes of homelessness are complex, and that people who are homeless have higher rates of certain diseases, higher mortality rates and higher rates of mental illness compared with the housed population. Therefore the relationship between homelessness and health should be of concern to nurses. Following a literature search, it was

established that despite government legislation and initiatives to increase access to healthcare for homeless people, as well as nursing codes of ethics and professional codes of conduct, pervasive negative and dehumanising attitudes exist among some nurses. Consequently, barriers to homeless people accessing healthcare may be created, and poorer-quality care may be given. Research suggests that changing nurses' negative attitudes is an essential element of increasing access to healthcare and improving the health of people who are homeless.

The literature shows that if nurses are self-aware, increase collaboration with other health and social care providers, and act as positive role models for more junior staff, nursing practice can be changed. In addition, it suggests that experience and education are important factors in improving nurses' attitudes towards people who are homeless. Finally, further research is needed to examine the negative attitudes and prejudice that homeless people may encounter, so that the equity of care that professional nurses should be providing becomes a reality.

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#### CONFLICTS OF INTEREST

None.

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