Abstract: Poor and marginalized individuals have greater difficulty accessing health care compared to more privileged members of society. Classic theories on poverty help to explain the relationship between poverty and health. In an attempt to understand the experiences and perceived needs of the poor as well as their interactions with health care providers, a participant-observation study was conducted. The investigator spent time on the streets of New York City among the poor and homeless and attempted to access various health care services specifically set up for this population. The purpose of this article is to describe what it was like to be "down and out" and in need of basic health care.

Key Words: Homelessness, Marginalization, Poverty

DOWN AND OUT IN NEW YORK CITY:
A PARTICIPANT-OBSERVATION STUDY OF THE POOR AND MARGINALIZED

Approximately one in every seven American citizens lives at or below the federal poverty level, and one in every five American households has difficulty meeting basic needs including buying food and paying utility bills (U.S. Census Bureau, 2000). More than 44 million Americans, including nine million children, have no health insurance, and every month more than 100,000 people lose their health insurance (National Coalition for the Homeless, 2005a). In New York City during the winter of 2004-2005, more than 36,000 homeless men, women, and children slept each night in shelters, and thousands more slept on the sidewalks, in the parks, or over subway vents (Coalition for the Homeless, 2005).

When estimates of poverty and homelessness are compared across subgroups of the population, it is clear that the chances of living in poverty are not randomly distributed in society. Minorities, children, the elderly, and female-headed households have a greater chance of being poor than other segments of the population (National Coalition for the Homeless, 2005b). Such a non-random distribution of poverty raises questions about the nature of poverty. What characteristics increase a person's risk of living in poverty? What is it about the nature of American society that promotes higher rates of poverty among some groups than others? Most importantly, what is it about American society that allows such staggering rates of poverty to exist?

THEORIES OF POVERTY
The Culture of Poverty Theory
There are four basic theories of poverty in the classic social science literature. The culture of poverty theory, having the longest history in anthropology and sociology, suggests that the characteristics of the poor help to cause and perpetuate poverty (Banfield, 1970; Galbraith, 1979; Lewis, 1966a, 1966b, 1998). Originally intended as a "liberal, innovative perspective since the 'poor' had previously been constructed as lacking culture" (Solinger, n.d., ¶1), this theory has now been largely rejected by social scientists. Even so, the theory continues to be popular
among conservative politicians and policymakers as well as the general public.

Analysts and proponents of the culture of poverty theory argue that poverty produces people with unique personal characteristics (e.g., present-oriented outlook, hopelessness, sense of fatalism, lack of work ethic, "disorganized hedonism," "irresponsible self-indulgence") that in turn help ensure that the poor and their children remain in poverty (Samuelson, 1997; Solinger, n.d., ¶1). Social scientists have paid considerable attention to the trait of present-time orientation. This trait is hypothesized to be important in perpetuating poverty and preventing upward mobility out of poverty because the poor learn not to delay gratification or plan for the future, and they are not psychologically prepared to take advantage of new opportunities. Alternately, this trait is thought to be a coping mechanism since it would be psychologically damaging to continually worry about or plan for a future that holds no promise of improved life circumstances or a better life (Lewis, 1966b). In short, the poor must learn to live for today.

On an individual level, the poor are believed to have strong feelings of helplessness, dependence, inferiority, and marginality (Lewis, 1998). On a family level, there is the absence of a long childhood, early initiation into sex, free unions or consensual marriages, a relatively high incidence of the abandonment of wives and children, and female-centered families. On a community level, there is said to be a lack of participation by the poor in the institutions of the wider society with the exception of contact with the criminal justice and welfare systems (Niskanen, 1996). The goal of this theory, then, is to change the poor rather than to change society. One of the strongest criticisms of this theory is that the poor do not constitute a homogeneous group, and there is actually considerable movement out of poverty (Young, 2005).

The Situational Theory of Poverty

The second category of explanatory models is situational theories, which place emphasis on micro-level social conditions as causes of poverty. According to the situational view, the poor behave differently than members of more privileged groups because they lack basic resources and secure jobs or simply lack opportunities to live up to values held by mainstream society. In other words, they may be reacting realistically to their situation (Beeghley, 2000; Della Fave, 1974; Rodman, 1963). Many of the actions of low income people can be seen as pragmatic responses to the stresses and deprivations of life (Gans, 1972; Lewis, 1966b). It is not that low income persons have failed to learn middle class values but rather that certain attitudes and behaviors are inappropriate when living in poverty. Rodman (1963) wrote of a "lower class value stretch," which allows lower class persons to develop alternative sets of values without rejecting the general cultural norms of society. Socialization of the poor, according to this view, is not substantially different; the problem is that the conditions of life in poverty are basically inconsistent with the realization of middle class aspirations and goals.

Poor individuals share many values with the dominant strata, but they must accept alternative arrangements when contradictions between cultural ideals and situational conditions are too sharp. For instance, the middle class ideal of a traditional family structure (i.e., two parents and children) is still the dominant type among poor families, but it is more difficult to maintain this configuration when the husband is unable to earn enough to support a family or is frequently unemployed. Although the conventional two-parent family is preferred, broken families or alternative family structures may be more adaptive at certain stages in the family lifespan. As noted by Valentine (1968):

"Consensual unions provide a flexible adaptation that is functional under conditions in which fluctuation in economic circumstances, actual or threatened incarceration, and other external conditions often make it advisable for cohabiting pairs to separate either temporarily or permanently and contract alternative union, again either temporary or lasting. (p. 80)"

Many of the distinctive aspects of the low income lifestyles are accommodations when money and other resources are scarce. The poor cannot save money because there is little money to save. They buy more expensive goods at neighborhood stores because transportation to distant shopping centers is too costly or unavailable. They get hooked into high interest rates by loan sharks because banks will not offer them low interest loans. They have a strong present orientation because they realistically surmise that the opportunities for substantial improvement of their socioeconomic status are not great or because they lack the resources to take needed actions to bring about change and improvement.

Proponents of the situational theory of poverty maintain that inequities in the opportunity structure constrain the behavior of the poor and that opening up the opportunity structure would allow the expression of underlying middle class motivational and behavioral patterns (Davidson & Krackhardt, 1977). Although not focusing on the overall system of inequality, situational theories remove blame from poor persons and place it on restrictions of opportunities. What is overlooked by situational theories, however, is that improved schools and job training programs oriented toward unskilled individuals would help only a small percentage of the poor. Such remedial measures would not benefit subgroups of persons liv-
ing in poverty such as elderly individuals, illegal immigrants, persons with mental illness, or mothers with limited childcare options (Young, 2005).

The Conflict Theory of Poverty
A third theory is the structural, or conflict, view of poverty. Based on Marxism, this theory stresses that political and economic forces in society produce and maintain poverty (Beeghley, 2000; Collins, 1974; Dahrendorf, 1959; Mills, 1956; Schellenberg, 1996). In contrast to micro-level situational theories, structuralists maintain that the macro structure of society produces inequality and, consequently, poverty (Islam, 2005).

Consider the position of the poor in the occupational structure of society. The occupational structure is a situation of conflict and competition in the marketplace. Individuals with advanced skills (i.e., skills that are in high demand and are relatively scarce) can demand and receive higher wages for their labor and can maintain more secure jobs than less skilled persons. The poor, of course, are at the bottom of the occupational structure. They have few skills or only skills that can be easily obtained (e.g., picking grapes or assembling parts or gadgets moving along on an assembly line), and technological advances have minimized the need for unskilled labor, particularly in industrialized sectors. Islam (2005) has argued that global capitalism and industrialization are responsible for large-scale poverty all over the world.

The Functionalist Theory of Poverty
In a nation as wealthy as the U.S., the obvious question is “Why does pervasive poverty continue?” Functional theorists would argue that segments of our society benefit from the existence of the poor (Beeghley, 2000; Davis & Moore, 1945). There are a number of political, social, and economic functions that the poor perform for society. First, the presence of the poor means that society’s dirty work—physically dirty, dangerous, dead end, underpaid, undignified, and menial jobs—will be performed at low cost. Second, poverty creates jobs for occupations and professions that service the poor. It creates both legal employment (e.g., community health nurses, public health experts, social workers) and illegal jobs (e.g., drug dealers, prostitutes). Third, the identification and punishment of the poor as deviants upholds the legitimacy of conventional social norms and mainstream values regarding hard work, thrift, and honesty (Samuelson, 1997; Solinger, n.d.). Fourth, in hierarchical societies, the existence of poor people guarantees the higher status of members of more affluent groups. Finally, the existence of the poor provides opportunities for more fortunate members of society to meet philanthropic needs (Gans, 1972).

The working poor represent a relatively new class in the literature on poverty (Broyles, Narine, & Brandt, 2002; Shipler, 2004; U.S. Census Bureau, 2000). These are persons who work in unskilled, low-paying, temporary, and/or seasonal jobs. Many are functionally illiterate and find it difficult to read help wanted advertisements, fill out job applications, and decipher their pay stubs. Many are high school dropouts. They are not likely to vote. About six million of the working poor actually work full time but still must depend on public assistance such as food stamps.

Class hierarchies lead to inequalities in power relationships and political interests, as well as economic policies that can interfere with health. A person’s chances of significantly affecting change in society increases proportionately to the resources he or she can command. Social structures, such as class and status, define how privilege, exploitation, and powerlessness are distributed among persons and groups in society (Beeghley, 2005). In this line of thought, oppression is a term used to indicate unequal power relations embedded in society (Freire, 1971; Roberts, 2006). Oppressed persons are therefore constrained in their quest for human potential.

In addition to the various social classes, there exists at the very bottom of the underclass a group of people called the marginals. These people live on the margins, or the edges, of society rather than in the mainstream (Hall, Stevens, & Meleis, 1994). They are the people the system of labor cannot or will not use. Marginalization is perhaps the most dangerous form of oppression, since a whole category of people is expelled from useful participation in social life and, thus, subjected to severe material deprivation and even extermination. This group is often referred to as being disenfranchised, meaning they do not have all of the privileges and rights as citizens in higher social classes. Persons who live in extreme poverty are often isolated in inner cities and rural areas in which persons of middle or higher class rarely travel. The marginalized include large numbers of homeless persons, persons with mental illness, disabled individuals, and the elderly and very young. These persons are often invisible in society. They have little voice and almost no power. They are unaware of the alternatives to their current life and are unable to make life changes. They are the most vulnerable to “health risks resulting from discrimination, environmental dangers, unmet subsistence needs, severe illness, trauma, and restricted access to health care” (Hall, 1999, p. 88).

Poverty and Health
The number of persons living in extreme poverty in the U.S. has been increasing over the past decade. Almost 45% of all poor persons in the U.S. have incomes that are less than half of the poverty line (Na-
Persons living in poverty have higher rates of chronic illness, higher infant morbidity and mortality, shorter life expectancy, more complex health problems, and more significant complications resulting from chronic disease (Broyles, McAuley, & Baird-Holmes, 1999; Hoffman, Schoen, Rowland, & Davis, 2001; Mouton, Beaudouin, Troutman, & Johnson, 2001; Rathore et al., 2000; Reilly, 2003; Schulman, Berlin, & Harless, 1999). Hospitalization rates for poor persons are more than three times greater than the rates for more affluent individuals.

Poor outcomes are very often the direct result of barriers to health care access (Andrulis, Duchon, Pryor, & Goodman, 2003; Reilly, 2003). Barriers may be physical, such as the lack of a health care facility in a geographic area, or a lack of transportation. Barriers may be temporal, such as inconvenient clinic hours. Barriers may also result from a lack of health insurance or inadequate income to pay for health care. Additionally, barriers may be more subtle, such as negative attitudes on the part of health care workers, language difficulties, and low self-esteem among poor and marginalized individuals (Furlong, 2005; Van Court, 2005). Poor health results in reduced productivity in daily roles and tasks as well as in school or at work. Hence, poverty is associated with poor health, and this, in turn, contributes significantly to the cycle of poverty.

DOWN AND OUT IN NEW YORK CITY: A PARTICIPANT-OBSERVATION STUDY

As a nurse practitioner with a practice mainly consisting of very poor and marginalized clients, I have long been concerned about inequities in the allocation and distribution of health care resources. After reading extensive literature and collecting data on the health and healthcare of the poor from the perspective of a care provider, I began to wonder what it was like from the other vantage point: the recipient of care. I pondered over the many times I tried to assist my patients navigate the complex health care system. I recalled the difficulties I faced even with my advanced professional education and insider's knowledge of the system. In an attempt to understand the experiences and needs of this population as well as their interactions with health care providers, I decided to spend time in New York City among the poor and homeless and join them in accessing various health care services specifically set up for this population.

Methodology

The study used a participant-observation methodology in which the investigator becomes a member of the group being observed (DeWalt & DeWalt, 2002; Gold, 1958; Spradley, 1980). In participant-observation research, data are collected from the perspective of group membership rather than as an outsider. With this strategy, the actions and interactions of group members and other actors are less likely to change or reflect social desirability bias due to the presence of the outsider. While an outsider's ability to actually become a member of a group in thought and observable actions can be questioned, this method does allow for experiences, observations, interactions, and reactions that enrich the investigator's understanding of the phenomenon and population under study (Wing, 1989).

As a participant-observer, I walked among the group, presented myself as sharing the characteristics of the group, and recorded my observations regarding daily occurrences as well as my personal reactions. Observations and informal interviews were conducted in public settings during the normal course of events. No attempts were made to interfere with group interactions. Group members and actors were free to voluntarily communicate or not with the investigator/participant. No personal or identifying data were collected or requested. Study methods were reviewed by a university's Institutional Review Board for the Protection of Human Subjects (IRB), and exempt status was granted.

Much has been written about free and low cost clinics and programs for the poor, but little is written about the experiences of the poor in actually accessing services. In my attempt to gain this information on a first-hand basis, I went to New York City and posed as a person in extreme poverty. I interacted with poor and marginalized persons on the streets and in public settings. I also presented with new onset headache and diplopia ("my head hurts real bad and I see sort of fuzzy...") at nine clinics specifically set up to care for the indigent. I chose a relatively benign complaint so that scarce resources (e.g., laboratory work, radiology) would not be unnecessarily used.

To provide a case control of sorts, I visited my own personal physician before the onset of data collection and presented with the same health complaint. I documented the reception I received (very prompt and respectful), the history and physical examination conducted (lasting about 40 minutes, including fundoscopic examination), the diagnostic questions asked (related to diabetes, head trauma, coordination, medication usage, recreational drug use, alcohol consumption, and caffeine intake), treatment options offered (together, my physician and I agreed upon Excedrin®), and the education and instructions provided, including plans for follow-up care (I was asked to evaluate the outcome for five to seven days and then call with an update; if specific signs and symptoms arose, I was to call back immediately).

Participation-observation research took place in New York City during four- to 10-day stays during the winter months over a five-year period (i.e., one data collection session per year).
Findings: Excerpt Experiences and Observations

The month was February, the weather conditions were harsh, and the temperature was sub-zero. Ten minutes into my first participant-observation session, I wished for my warm winter jacket, boots, and gloves, as well as many other things I had taken for granted. Dressed in thick socks and worn shoes, an old and very tattered jacket, and a torn scarf, I went to the first clinic I identified for uninsured and underinsured persons. Not wanting to carry a purse, I put a few single dollars in a jacket pocket along with a handful of change. In my sock, I put a $20 bill, my hotel room key card, and my faculty identification (ID) card.

The first clinic I chose to visit was more than 30 blocks away from the midtown hotel in which I was based, so I thought I could take a taxicab to within a few blocks of its location. However, no cab driver would stop for me. Initially, I could not understand why, then I looked at my reflection in a store window. I certainly did not look as if I could afford a bus, much less a taxicab. By the time I had walked the 30 blocks to the clinic, I was hot and sweaty and really did have the headache with which I was going to present, as well as a blister on my foot from the ID card rubbing against my skin.

I walked in the building and noticed a drab atmosphere that seemed to echo the hopelessness one might feel when poor, homeless, and sick. In the reception area and waiting room, there were cracked plastic chairs against walls that were the color of two day old oatmeal and an overflowing trash can in one corner. I could almost hear Dante saying quietly, “Abandon hope, all ye who enter here...” (Alighieri, n.d., ¶2). There were posters in day-glow colors on the walls that screamed out, “You too can get AIDS! Use condoms.”

As I walked to the reception counter, I noticed a few other patients in the uncomfortable chairs: a grizzled old man with a scraggly grey beard and no socks and a woman with a large bruise above her left eye that blossomed into color as it spread over the left side of her face. Two young women were behind the reception counter talking audibly about someone named Pete. Apparently, Pete was a loser, although an incredibly good-looking one, who did not like to take his girlfriends out to dinner, but expected them to hop into bed with him at the snap of his fingers. The first girl advised the second girl to dump him before he dumped her. The second girl spoke at length about whether she should stay with this handsome but cheap demi-god or go through the trouble of finding another boyfriend.

As fascinating as this conversation was, I thought that listening for over five minutes to Pete’s virtues and vices was enough, and I attempted to break into the conversation. The two girls looked at me in sur-
prise, and then Pete’s girlfriend said, “We’ll get to you in a minute.”

They then returned to their conversation, which lasted another several minutes. When they finished, Girl One sat down at the cluttered desk behind the reception counter and said, “Well?”

After I told her about my new headache, Girl One asked how I was going to pay. I replied, “Pay? I don’t have any money.”

Girl One turned to Girl Two, rolled her eyes, and said, “Another one of those.” She then handed me some papers and told me to fill them out, ending with astringent, “…and don’t steal my pen.”

When I handed back the papers, Girl One glanced at them briefly and said, “Headache, huh?” As I nodded, she turned back to Girl Two and said, “Probably fell down when she was drunk and can’t remember.”

They both laughed as I stood there with my face flaming red, trying not to slap my hands down on the counter and shout, “Stop treating me as if I can’t hear you. I’m a nurse and a professor. But most importantly, I’m a human being!” However, I just bit my tongue and allowed them to humiliate me in front of the staff and the other patients in the waiting room. The unfortunate thing was that I had not been singled out by them; the two receptionists treated the other patients the same way. And like me, the others just stood there and accepted the inhumane and embarrassing treatment without saying a word.

As bad as this experience was, however, the worst was yet to come, at least from my perspective. I walked back to the hotel, lost in thought about what I had seen and how I had been treated. As I got closer to Broadway and the better tourist parts of town, I began to notice well-dressed people giving me a wide berth. No one seemed to want to get too close to me. This avoidance depressed me even more. I tried smiling at several people, all of whom averted their eyes and walked by. I tried to ask one or two individuals for directions, but no one would answer my questions.

When I finally arrived at my hotel, I was cold, tired, and confused from what I had experienced. I went to the main door and attempted to walk inside. A burly doorman dressed in a pseudo-military type uniform blocked my way. I said, “Excuse me” and tried to pass by him. He stepped directly in front of me again. I asked if there was a problem. He told me to move along and not block the way for guests. I informed him that I was a guest, and as his eyes raked over my person, I felt embarrassed and humiliated again. In a more authoritative tone, I requested that he step aside and let me in so that I could go to my room. He snidely told me that the Sheraton Hotel “frowned upon deadbeats in the doorway.”

I drew myself up to my full height, looked him directly in the eye, and said, “My name is Dr.
Romeo, and I am a research scientist. Now please let me by.” He laughed and replied, “Yeah, and I’m a brain surgeon.”

He then threatened to call the police if I did not leave the hotel premises. I suggested that it was unnecessary to involve the police, while I pulled out my ID card and room key. Despite the evidence I produced, the doorman called the manager who listened to my story and examined my room key. I invited the manager to go up to my room and look in the top right hand drawer of the dresser where he would find my red shirt and a novel, which would prove that I really was staying in that room. The manager then, albeit grudgingly, allowed me to enter the hotel. He and the doorman then exchanged comments about the clientele at the Sheraton Hotel not “being what they used to be.”

Wearily, I made my way to my room. As I walked down the hall, one of the maids passed by, looked at me, and asked in heavily accented English, “Are you all right? Do you need help?” I told her a little about the work I was doing. She just smiled, and then said quietly, “What did you expect?”

On my visit to a third clinic, I waited more than two hours to be seen. I sat next to an African American man who looked to be in his late forties or early fifties. He had the gray sheen on his skin that comes with being on the streets for a prolonged period of time. His hair was dirty and unruly, and he had the beginnings of a beard. His coat was frayed and torn and much too thin for a bitter February day. I noticed that the upper part of his shoes had come apart from the soles at the toes and that he was not wearing socks. Part of his left foot was visible: his great toe was black, and the two adjacent toes were darkened.

Most of my prior attempts at conversing with fellow patients in clinic waiting rooms had not gone very well. Most of the indigent men and women waited quietly and did not respond to my conversational comments or questions. However, this man told me his name was Samuel and that he had been without socks for a few months. In fact, he shared the story of how the last night he spent at a shelter, some younger men held him down while one stripped him of his sweater, his shirt, his socks, and his shoes. He related this experience without rancor, as if it were a normal and expected part of life. I told him that I had an extra pair of socks stashed away and offered him the pair I was wearing. He eagerly took off his shoes while I peeled off my socks and helped him put them on. Not only were his toes black, but yellow streaks (i.e., signs of gangrene) went up his feet and ankles. I asked him if his feet hurt. Samuel smiled and responded that he had not been able to feel anything in his feet for quite some time. My nurse’s brain was horrified at his lack of sensation and the obvious evidence of gangrene. I asked him if he had told a doctor about the signs and symptoms in his feet and legs. He indicated that he had and that several doctors had told him that he should have his feet “cut off” or he would die of “sopitis” (sic) (i.e., sepsis). When I asked him what he planned to do, he replied, “What do you mean? How could I walk without feet?”

All the way back to my hotel, I thought about Samuel, and, indeed, I still think about him today and wonder what finally became of him. What choice does one really have in situations such as Samuel’s? Prostheses and rehabilitation are not typically available for poor, uninsured persons. How can a person survive on the streets while on crutches? These thoughts and questions went through my mind as I walked along the icy New York City streets in the February cold without my own socks, feeling my own feet becoming numb.

Then there was Margie. I found this African American woman sitting on the sidewalk next to a small store near Lincoln Center. I noticed Margie because she had a black and white cat in her lap. I sat down next to her and noticed her lack of teeth when she smiled at me. I stroked the cat, and we talked a little about the recent sunny weather. She finally asked me where I was from and commented that I did not look as if I were from around here. I responded that I recently came from elsewhere and needed some medical help. Margie emphatically advised me to go to a certain clinic where “the nurses were nice.” She told me they were always trying to encourage her to start taking insulin for her diabetes. When I asked why she didn’t want to go on insulin, she looked surprised and asked how long I thought she would last if she carried needles around with her. She had a point. She would quickly become a target if it were known on the streets that she had access to syringes.

Many of the poor and homeless people I met in public places and clinics had major medical problems. Some of these individuals had found health clinics where honest attempts were made to help them. Yet too many presented at the clinics where I experienced humiliating interactions and inadequate care. I thought of my own patients at the major urban medical center where I practiced and at the several free clinics where I regularly volunteered. I remembered how pessimistic and sad I felt when I had to discharge someone who I knew would spend the night under a bridge. I recalled discussions with my colleagues about the concept of “poverty medicine,” a phrase first coined by Dr. David Hilfiker in Washington, DC (Hilfiker, 1994). I can understand the frustration and weariness that many caregivers for the poor and underserved must feel, as well as their sense of helplessness and hopelessness.

In seven of the nine clinics I visited posing as an extremely poor woman in New York City, I was treated with a lack of respect. My questions on length
of wait time went unanswered. In these seven clinics, the history and physical examinations that were conducted were cursory at best, with few questions about my past medical history or current medication/drug usage. No diagnostic tests were ordered. Treatment was only offered at two of the nine clinics and consisted of two Tylenol® tablets. The clinic staff provided no information on signs or symptoms or reasons to return for follow-up care.

In two of the clinics, one of which was a mobile van, I was treated with respect despite my appearance, reported undomiciled status, and lack of insurance or money. In these two clinics, the nurses actually introduced themselves, sat down to elicit and record my history, and looked at me while I answered their questions. Unlike staff or providers at other facilities, the nurses at these two clinics also asked if I felt that I was safe. They offered resources which could be accessed either at the time of my clinic visit or in the future if I should feel unsafe or worried that someone might hurt me.

Findings at these nine clinics were consistent during my return participant-observation visits over the five year period. Overall, with the exceptions of these two clinics, I was humiliated, laughed at, and made to feel ignorant and incompetent throughout the course of my participant-observation experience. I also felt as if I were invisible, a nuisance, or in the way. Providers at most of the clinics I visited assumed that I did not have any knowledge of my previous health or medical history. I felt as if I were treated as if I were a non-person. I can only imagine how much worse my experiences would have been if I were non-White, non-English speaking, or physically or mentally challenged.

Is it that so many of us have simply become inured to the poverty we confront on a daily basis? Has it become so commonplace to us that we just ignore the poor and their needs? On one of my evenings in New York City, I was walking down Broadway as myself (i.e., not a homeless person) at about 10:30 p.m. I saw a man lying on the sidewalk near one of the theatres. I approached him to see if he was breathing. People walked around and past him. He was so dirty that I could not tell the color of his skin. I bent forward to try to take his carotid pulse but quickly pulled my hand back as a large insect crawled out of the collar of his coat. As I was trying to decide what to do, I noticed a young girl coming toward us, clasping the hand of the young man next to her. He bent down and whispered something to her, and she threw her head back and laughed. I particularly noticed her because she was wearing a beautiful full-length red satin gown. As the couple came close to the man on the sidewalk, they did not even look down. The girl just leaped over his arm and shoulder and continued laughing while facing the young man. At first I was angered, thinking to myself, "How could they just ignore this man?" Then I realized they were not ignoring the comatose man. They didn't even see him. What I observed was a bigger problem: the poor and homeless have become so commonplace in our lives that they have become largely invisible.

I called an ambulance and waited until it arrived. The paramedics were very condescending and irritable; they said they knew this man to be an alcoholic but agreed to transport him to the nearest hospital. The next day during daylight hours, I saw the man again, sitting against the building in the same spot. He seemed a bit slow but did respond to my questions. He wouldn't give any information about his emergency room experience the night before but said that he was "o.k." He refused my offer to help find him a shelter. He chose to remain down and out, a way of life to which he apparently had become accustomed.

DISCUSSION AND CONCLUSIONS
Experiences and observations from this participant-observation study provided evidence of the suboptimal healthcare that is available to the poor and marginalized. From study findings, it can be concluded that healthcare for poor and marginalized individuals is often based on the assumption that these individuals bring on their own health problems due to their behavior, which is consistent with the culture of poverty theory. Furthermore, consistent with the concept of present-time orientation as well as the situational theory of poverty, poor and marginalized individuals are often treated as if they do not mind waiting indefinitely to be seen by providers and do not need to be told what the wait time will be, unlike middle and upper class patients with appointments at private offices. Consistent with social hierarchies in the conflict and functionalist theories of poverty, poor and marginalized individuals are often treated as if they do not have feelings and cannot hear rude remarks. Also from a functionalist perspective, findings showed that while poverty creates healthcare jobs that service the poor, the negative views that some staff and providers have of the poor and marginalized are sometimes used to service their own needs rather than the needs of clients.

Attempting to access health care as a member of a marginalized group can be a very difficult experience. However, in spite of the barriers, the hopelessness, and the lack of resources, there are some very dedicated healthcare workers, nurses, and primary care providers who demonstrate concern for poor and marginalized individuals and treat them as fellow human beings.

Caregivers for the poor and marginalized are obliged to demonstrate professionalism and empathy in carrying out their work. Caring for these populations would afford caregivers with opportunities
to creatively translate knowledge into practice in the trenches, often using limited resources. When educating a homeless patient about wound care, a diabetic diet, or behaviors that minimize peripheral vascular disease, one must do so knowing that the patient probably has no access to running water to wash his hands prior to changing a dressing, may eat out of garbage cans or at a sporadic soup kitchen, and cannot sit with his feet elevated if he lives under a bridge. Caring for these populations offers great professional challenges and occasional rewards, but not everyone can thrive in this type of work. Therefore, being aware of one’s biases, knowing one’s limitations, and recognizing burn-out is crucial for caregivers to the indigent and poor.

Remember, the next time you find yourself at five o’clock in the evening at the end of a long and frustrating week and see only one last scruffy patient sitting in the waiting room, look closely. It may be me.

REFERENCES


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