POPULATIONS AT RISK

Homeless People's Perceptions of Welcomeness and Unwelcomeness in Healthcare Encounters

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BACKGROUND: Homeless people face many barriers to obtaining health care, and their attitudes toward seeking health care services may be shaped in part by previous encounters with health care providers.

OBJECTIVE: To examine how homeless persons experienced "welcomeness" and "unwelcomeness" in past encounters with health care providers and to characterize their perceptions of these interactions.

DESIGN: Qualitative content analysis of 17 in-depth interviews.

PARTICIPANTS: Seventeen homeless men and women, aged 29–62 years, residing at 5 shelters in Toronto, Canada.

APPROACH: Interpretive content analysis was performed using iterative stages of inductive coding. Interview transcripts were analyzed using Buber's philosophical conceptualization of ways of relating as "I–It" (the way persons relate to objects) and "I–You" (the way persons relate to dynamic beings).

RESULTS: Most participants perceived their experiences of unwelcomeness as acts of discrimination. Homelessness and low social class were most commonly cited as the perceived basis for discriminatory treatment. Many participants reported intense emotional responses to unwelcoming experiences, which negatively influenced their desire to seek health care in the future. Participants' descriptions of unwelcoming health care encounters were consistent with "I–It" ways of relating in that they felt dehumanized, not listened to, or disempowered. Welcoming experiences were consistent with "I–You" ways of relating, in that patients felt valued as a person, truly listened to, or empowered.

CONCLUSIONS: Homeless people's perceptions of welcomeness and unwelcomeness are an important aspect of their encounters with health care providers. Buber's "I–It" and "I–You" concepts are potentially useful aids to health care providers who wish to understand how welcoming and unwelcoming interactions are fostered.

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INTRODUCTION

Meeting the health care needs of homeless persons is a daunting challenge. An estimated 800,000 Americans are currently homeless, and in Toronto, Canada, more than 5,000 people are homeless on any given night.[1–4] Homeless individuals have a high burden of illness and are at increased risk for premature death,[5–9] but factors such as the daily struggle to meet basic needs, lack of health insurance, mental illness, and addictions can limit homeless people's ability to access health care services appropriately.[1,10,11]

Homeless people's attitudes toward health care services, shaped in part by previous health care encounters, may also affect their propensity to seek care.[12] In this qualitative study, we examine how homeless persons experience interactions with health care providers and specifically explore what it means to these individuals to feel "welcomed" or "unwelcomed" during these encounters. We believed that these concepts might be particularly meaningful to homeless people because of their everyday experiences as a marginalized group.

METHODS

Participants

This study was conducted in Toronto at a convenience sample of 3 men's shelters, 1 women's shelter, and 1 mixed-sex shelter. Potential participants were identified by random selection of bed numbers. Eligibility criteria were age ≥16 years, ability to communicate in English and give written informed consent, and lifetime duration of homelessness ≥1 month. Participants received a payment of $15. The study was approved by the St. Michael's Hospital Research Ethics Board (IRB).

Of 22 individuals approached, 17 consented to participate. Five individuals declined, citing illness (n=2), fatigue (n=2), or dislike of research studies (n=1). Sampling was discontinued after 17 interviews when there were sufficient similarities in the data to identify a common understanding of welcomeness

and unwelcomeness (i.e., theoretical saturation was achieved). Participants included 4 women and 13 men who ranged in age from 29 to 62 years (median 40 years). Lifetime duration of homelessness ranged from 8 months to 14 years (median 3 years).

Data Collection

Each participant completed an audio-taped in-depth semi-structured interview conducted by a single investigator (CKW). An interview guide (available on request) was formulated after literature review and discussion among the research team and revised based on pilot interviews. The interview explored the nature and meaning of welcomeness and unwelcomeness in health care settings. We prompted participants to recount at least 1 health care experience in detail. When needed, probes were used to focus their narratives (e.g., "How did that experience make you feel unwelcome?"). Direct questions concerning the concept of interest were also utilized (e.g., "What does 'welcomeness' mean to you?"). Interviews lasted approximately 1 hour. Audiotapes were transcribed verbatim. To ensure confidentiality, no personal identifiers were recorded. Fictitious names are associated with all quotations in this paper.

Coding and Analysis

We performed interpretative content analysis, which involves identifying, coding, and categorizing patterns in textual data.[13] Codes, which are abbreviated phrases representing underlying concepts or themes, were generated from and applied to the data. Coding began inductively and was iterative (i.e., codes were tested and refined as each transcript was successively analyzed). Line-by-line coding of each transcript was performed by the lead author (CKW) with ongoing input from the other researchers. Discrepancies in interpretation were discussed and resolved during consensus meetings.

During coding, we noted that some participants characterized unwelcoming health care experiences as dehumanizing, using words such as "subhuman" or "dehumanized." For example, 1 participant stated:

> "…she just didn't care. It was like you were a piece of meat."
>
> (Timothy)

These observations led us to consider the philosophical writings of Martin Buber as a potentially relevant framework for understanding these emerging themes. In his seminal work *I and Thou* (1923), Buber described "I–It" as the way a person relates to a thing or object that does not have the power to define its own essence and function.[14] Buber contrasted this with "I–You," the way in which a person relates to a dynamic being who has a say in defining his or her own essence and who should be approached with a degree of openness and receptivity. Buber suggested that rather than relating to others as "I–You," people sometimes relate to other persons in an "I–It" manner, that is, in the same way that they relate to objects.

The language of dehumanization in participants' accounts suggested that "unwelcoming" encounters between participants and health care professionals could be conceptualized as "I–It" relationships, whereas "welcoming" encounters could be conceptualized as "I–You" relationships. To systematically explore this possibility, we generated codes consistent with Buber's definitions of "I–It" and "I–You" relationships and applied them to all transcripts to test their robustness and appropriateness (Table 1). Support for these interpretations is provided using segments of data that most clearly illustrate each analytic point and are representative of the entire dataset.

RESULTS

Experiences of Unwelcomeness

Participants described health care encounters that made them feel unwelcome in a variety of ways. During these episodes, participants often felt that they were being ignored, rushed, brushed aside, or treated rudely. Moreover, 13 of 17 participants perceived their experiences of unwelcomeness as acts of discrimination. Some participants spontaneously and explicitly mentioned a connection between unwelcomeness and discrimination during the course of their interview. For example, when asked to describe any health care experience that stood out for him, 1 participant responded:

> "…on two occasions I had reason to believe that because I'm in a shelter, it's like secondary treatment, not as how we envisage it should be when you go to accident and emergency [an emergency department]."
>
> (Hernando)

For other participants, the connection between unwelcomeness and discrimination was implicit. A participant reported waiting in an emergency department and seeing other patients arrive after him but receive care first. He stated:

> "You know, I mean that's not fair. I mean, I work myself, I pay my taxes and stuff like that. I don't work full time, but I work part time, as a longshoreman. Just like everybody else, I pull my own weight. You know, I just live here [in a shelter] because rent's so high and stuff like that—maybe I can come here and save some money."
>
> (Michael)

This participant felt that he was treated differently because he was homeless, and implicitly attributed this treatment to the stereotyping of homeless people as "freeloaders." Participants identified various characteristics that accounted for what they believed to be discriminatory treatment, most commonly homelessness (n=9) and low social class (n=9). Additional reasons, each mentioned once, were drug addiction, mental illness, race, and age.

For many, perceived discrimination in health care settings was understood as part of a widespread societal pattern of discrimination against homeless persons. Six participants spontaneously related discrimination in health care settings to their general life experiences. For example, 1 participant explained poor treatment in a health care encounter in these terms:

"We are always discriminated against because we are homeless... Walking down the street, people laugh at us. They know you're homeless... wearing not so normal clothes, dirty clothes or something like that."

(Matt)

Another individual explained his experience of unwelcomeness in this way:

"[homeless people] are less welcome in the majority of places...You go to any mall, you dressed the way you are and me, and we sat down on a bench in a mall and was having coffee, within thirty-five minutes a security guard would come over and tell me that I had to leave. They wouldn't say nothing to you."

(Luke)

Many participants reported intense emotional responses when they felt unwelcomed, which frequently led to a strong distrust of health care workers and a desire to avoid health care institutions at almost any cost. As 1 individual stated:

"I get to the point where I don't really, I don't know, trust or like physicians. More and more I see it as almost they would sooner deal with rich people, people with good insurance, and everything else."

(Luke)

Another participant reported:

"I got treated like that the first time over there, and I'm not going to get treated like that, I'm not going through that again. I'd rather sit here and f____n' die on a bench than go over there."

(Michael)

This latter statement was a response to a short interaction with an attendant at a hospital information desk who redirected the individual to the Emergency Department. The participant stated that he perceived unwelcomeness through the attendant's "attitude" and not because of anything the attendant said. Thus, some homeless individuals may impute a great deal of meaning to brief contacts that do not involve any overt verbal discourtesy. A number of participants reported similarly strong negative reactions to subtle experiences of unwelcomeness. Feeling unwelcomed could even affect the desire to care for one's own health:

"If you were welcome, you would feel better, it makes you feel better, it makes you want to get better. If you are not welcome, you don't want to get better. What the f__k, you don't care. I shouldn't get better so I don't care if I get better or not"

(Matt)

Unwelcomeness and Welcomeness as "I–It" and "I–You" Relationships

Participants' descriptions of unwelcoming experiences were often consistent with Buber's characterization of an "I–It" way of relating, in which the patient felt that the health care provider reduced them to an object, was unwilling to know and empathize with them, ignored or failed to listed to them, was preoccupied with their own agenda, and made them feel disempowered (Table 1). In contrast, welcoming experiences were more consistent with an "I–You" way of relating, in which the patient felt that the health care provider valued them as a person, was willing to know and empathize with them, truly listened, acknowledged their needs, and minimized power imbalances (Table 1).

Feelings of dehumanization were frequently evoked by unwelcoming health care encounters, suggesting that participants felt treated as an object and in a manner not recognizing their worth and personhood:

"it makes me subhuman, like that I don't really belong in society,"

(Luke)

In contrast, welcoming health care encounters were often associated with feelings of humanization:

"they made me feel like I was a person, not just some derelict that, you know, shouldn't be breathing."

(Luke)

Accounts of unwelcoming experiences often included descriptions of a closed disposition, also associated with the "I–It" way of relating:

"You [the health care provider] withdraw. You don't really want to know who I am or what I am all about."

(Timothy)

Participants also perceived that health care providers in unwelcoming encounters lacked a desire or ability to empathize:

"like they heard you, but they weren't really concerned as much"

(Irene)

When participants described welcoming experiences, they often perceived the health care provider to have an open intellectual and emotional disposition toward them:

"they're open and receptive and they don't stereotype me..."

(Lisa)

Welcoming experiences enabled genuine sharing and communication. An individual described a welcoming encounter in which he felt invited to disclose his feelings:

"they ask you how you are feeling and you talk about what is wrong with you. Some places are better at doing that."

(Matt)

Unwelcoming experiences with health care providers often involved poor or absent communication, which is characteris-

Table 1. Coding Categories Consistent with "I–It" and "I–You" Encounters, with Specific Examples from Interview Transcripts

"I–It" Encounters			"I–You" Encounters		
Coding category	**Description**	**Examples from transcripts**	**Coding category**	**Description**	**Examples from transcripts**
Identity as object	When an individual feels as though he or she has been reduced to a thing or object	"it makes me subhuman almost, like that I don't really belong in society" (Luke) "…she just didn't care. It was like you were a piece of meat." (Timothy)	Identity as person.	When an individual feels as though he or she has been acknowledged or valued as a person.	"It makes you feel happier inside. It makes you feel wanted." (Matt)
Closed intellect	A closed way of knowing the other. An unwillingness to know the other and/or the use of restrictive concepts to define the other (e.g., stereotypes)	"most of them automatically judge you and stereotype you" (Luke) "…it just seemed like she just wanted to be just, just sit down and wait. Like it seemed to me that she didn't even believe me." (Joe) "they didn't even want to know who in the hell I was." (Timothy)	Open intellect	An open way of knowing the other. A willingness to know the other and the absence of restrictive concepts that define the other (e.g., stereotypes)	"They don't really judge people. They just take all walks of life, whether you're working or not working or where you live." (Irene) "the person likes to get to know you or wants to know about you." (Timothy)
Closed emotions	A closed way of relating to the other. An unwillingness or inability to empathize with the other.	"A lot of the problem is that doctors don't have or won't take the time to actually find out where you are or how things are affecting your life and why." (Luke) "she made me feel like she was sympathetic…but I don't think she was…i don't know, it's just the way I felt" (Matt) "like they heard you, but they weren't really concerned as much" (Irene)	Open emotions	An open way of relating to the other. A willingness and ability to empathize and be receptive toward the emotions of the other.	"To say, you know, I see where you're coming from…" (Irene) [welcomeness is]: "Hi, how are you? How do you feel? Where have you been?" you know? That instead of just "where is the form I sign? Okay, here you go, go". (Pierre)
Closed communi-cation	When an individual feels as if he or she is ignored or not listened to.	"That's it, I don't want to talk to you,' that's the impression I got." (Andre) "They ignore me completely. People only talk to me bad." (Hernando) "They were a bunch of jerks…just because they are running a big hospital they should just take time to personally interact with the individual…you feel like they are snobs and they just don't want to get to know you." (Timothy)	Open communi-cation	When an individual feels as if he or she is truly listened to.	"uh, they ask you how you're doing, sort of thing and if you need any help … What am I looking for, what type of help or?" (Irene) "…with just the tone and the expression of how they talk to you. You know, a lot of times you get them asking how are you doing? Have a bit of a conversation," (Luke)

(*continued on next page*)

Table 1. (continued)

"I–It" Encounters			"I–You" Encounters		
Coding category	**Description**	**Examples from transcripts**	**Coding category**	**Description**	**Examples from transcripts**
Closed agenda	An unwillingness or inability to acknowledge the needs of the other, and preoccupation with one's own agenda (e.g., functional or mechanical relationships)	"...they just gave me like that whole facial look, like, like I'm too busy and all this stuff, like...but that's just how it is though right." (Joe) "they're very business-like I dunno...they want to get on with the next patient... their work day...basically" (Raj) "You serve the customer, get them out of the way, and go to the next one. That's all it basically seemed like, was just an assembly line." (Luke)	Open agenda	A willingness and ability to acknowledge the needs of the other, even at the expense of one's own agenda. (e.g., caring relationships that are not purely functional or mechanical)	"they show that they care, its not just a job... they want to know you as well as a person, if you're okay in general and any other treatments you might need." (Irene) "We see you, you ask for help. We will get you the help you need. And basically didn't abandon me." (Luke)
Power imbalance	When an individual feels disempowered by the other	"...like you're less than the working population." (Christopher) "...like I had no sense of worth." (Matt)	Power equity	When there is a balance of power between individuals encountering one another	"[the doctor] didn't talk down to me like some doctors do...they sometimes have a tendency to do that...I think, maybe doctors just think they're smarter than the public on average" (Christopher) "He knows me, I know him... giving one another pointers, helping, I mean like working together right and not sort of just, just, just dividing ourselves." (Joe)

tic of the "I–It" way of relating. One participant described his frustration when he tried to ask a nurse at an Emergency Department about his expected wait time:

> "She snubbed me when I went up to ask her, you know, how long it's going to be? It will be as long as it takes, was her reply. It's just the way she moved her body, you know. I was sitting there and she was sitting here, and she sort of turned her back on me, and I said, excuse me, and she just looked over and kept pointing over there and kept turning away, so I finally gave up on this one and went back inside and waited."
>
> (Timothy)

Unwelcoming encounters had a purely mechanical, functional, and unidirectional character, another feature of "I–It" relating:

> "Yep, I felt like she was processing a piece of meat…Let's just do this guy out and get him into the waiting room."
>
> (Timothy)

In contrast, participants felt their own agendas were heard and taken seriously during welcoming experiences. This participant described an encounter in which she received assistance with an application for disability benefits:

> "…someone spent an hour on the phone trying to help me get a package together…and that amount of work on, on a case to improve my life circumstances and make an adjustment in me is really commendable."
>
> (Lisa)

Finally, unwelcoming experiences were characterized by power imbalances, consistent with the "I–It" way of relating to persons like things or objects; for example:

> "right then, I felt about that big [gestures to indicate small size]… you feel demeaned…you feel lower class"
>
> (Timothy)

In contrast, a welcoming experience was described in terms of perceived power equity:

> "He makes me feel great. He talks one on one to you, you know, at your level. It doesn't matter whether you are above him or below him. He talks to you at the same level. A lot of people don't do that."
>
> (Timothy)

DISCUSSION

Our findings indicate that perceptions of welcomeness and unwelcomeness are a potentially critical dimension of the homeless people interviewed for this study. Respondents often reported that unwelcoming experiences elicited strong emotional responses and decreased the likelihood they would seek health care in the future. These preliminary findings suggest that the provision of effective care for homeless people may be tied to the ability to create a welcoming environment. Further, many unwelcoming experiences involved nonclinical staff such as receptionists, suggesting that *all* workers who come into contact with patients should be included in future research studies.

Trust has been defined as an "acceptance of a vulnerable situation in which the truster believes that the trustee will act in the truster's best interests."[15] Patient trust is engendered by a health care provider's technical competence, interpersonal interactions, and fiduciary role.[15] Although the experience of feeling welcomed, which arises through interpersonal interactions, likely contributes to the creation of trust,[16] we postulate that welcomeness is not merely a component of trust, but a unique and salient concept in its own right. In this work, we have seen how welcomeness and unwelcomeness are important because they are closely linked to patient perceptions of interactions as humanizing or dehumanizing. Buber's concepts of "I–You" and "I–It" ways of relating provides a useful theoretical framework for examining homeless people's narratives of welcoming and unwelcoming experiences, and offers a new and previously unexplored way of thinking about patient–health professional interactions. Future work exploring the interrelationship between trust, patient satisfaction, and Buber's concepts would be valuable.

Study participants often linked unwelcoming experiences with discrimination, suggesting that stigma is an additional dimension of these interactions. Stigma is "a special kind of relationship between attribute and stereotype" in which an objective attribute (e.g., "homelessness") is linked to a stereotype that is often of a discrediting nature (e.g., "lazy").[17] In social encounters between a nonstigmatized and a stigmatized person, there is a strong tendency for the former to relate to the latter on the basis of these stereotypes. This mode of relating maps clearly onto Buber's "I–It" concept because the stigmatized individual is approached within the preconceived constraints of a stereotype rather than with openness. Prevailing stereotypes of homeless people and homeless individuals' past experiences of discrimination heighten the risk that a homeless patient will feel unwelcome and dehumanized during an encounter.

This study has several limitations. First, our sample of 17 participants, although consistent with qualitative research methods, limits the generalizability of our findings in a statistical sense. Nonetheless, all descriptions of welcoming and unwelcoming experiences included at least some elements of "I–You/I–It" ways of relating, suggesting that our results are likely to be applicable to similar patients in other locations. Second, the rationale for our choice of Buber's "I–You/I–It" conceptualization as an analytic tool may be challenged. Although other theoretical frameworks could have been used, we selected Buber's because it coherently captured important and varied aspects of the nature of patient–physician interactions, which figured prominently in participants' accounts, and because it offered a new and potentially useful understanding of patient–provider interactions. Third, we focused on identifying shared themes in this exploratory study and did not attempt to determine the differential effects of characteristics such as sex, race, or duration of homelessness on experiences of unwelcomeness. Studies of this nature could be the focus of future work. Fourth, study participants often linked their

experiences of unwelcomeness to their homeless state, but such experiences may be shared in common by individuals belonging to a wide range of stigmatized groups or those who frequently use emergency departments as their main source of health care.[18] This is an empirical question that would benefit from additional study. Finally, we sought to understand health care encounters from the perspective of homeless persons and did not aim to critique the objectivity or factual accuracy of their accounts. We worked from the position that participants' accounts accurately described their own honest perceptions and understandings of these interactions. However, homeless people do have a high prevalence of mental illness, substance abuse, and previous traumatic experiences,[19] which may increase their risk of misinterpreting health care providers' verbal and nonverbal cues. Homeless people may also display difficult behaviors that might encourage negative responses from providers. Future studies triangulating the perceptions of both homeless patients and health care providers would address this problem.

In summary, our results indicate that conveying welcomeness was an important aspect of health care for the homeless persons we studied. Whereas this concept is less tangible than other factors that contribute to the accessibility of health care for homeless people, it is no less important. Healthcare providers may find that Buber's "I–You" way of relating provides an easily remembered outline of the characteristics of a welcoming interaction; it encourages health care providers to approach each patient with openness, humility, and receptivity befitting his or her dignity and fullness as a sacred person. Clearly, this goal can only be achieved by recognizing the unique circumstances of each patient rather than through a mechanically applied formula. Such an approach may prove useful in guarding against the tendency to stereotype patients who are members of a stigmatized group.

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