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Introduction

Hospitality and health care are clearly connected, both etymologically and practically. Health care has traditionally been delivered in hospitals. In fact, the word hospital is derived from the Latin hospes, meaning guest, visitor, or stranger (Simpson, 2003). Similarly, hospitality, the relationship between guest and host, is also derived from hospes. In the practice of hospitality, the guest is generally welcomed, respected, and treated as an equal by the host, while also provided with necessary and/or requested services. As such, hospitality is, or should be, an integral part of health care, in which patients (i.e. guests/strangers) who seek medical services are welcomed with compassion, respect, and dignity, and provided appropriate high-quality medical treatment by health care providers and staff (i.e. hosts). This focus on caring for the individual patient is captured in the oaths/pledges taken in most, if not all, health professions. In contemporary health care, this hospitality has extended beyond the walls of the hospital and expanded into the community in the forms of hospice, medical offices, clinics, pharmacies, and other ambulatory care settings.

Hospitality is rooted in approachability and the concept that we are all God's people, one people, and thus should remain open to receiving and serving all people. Personally, this concept of hospitality recalls a theme of my parish men's Cornerstone Retreat, which I participated in several years ago. At the retreat, we studied and greeted each other with the following: "The God in me salutes the God in you," similar to the Indian expression and symbolic gesture, "*Namaste*." In recognizing the divinity in each of us, we may more readily practice and foster unconditional love, compassion, respect, equality, and service of and for our neighbors.

Utilizing the work and teachings of Saints Vincent de Paul and Louise de Marillac, we may apply the Vincentian charism to this concept of hospitality. It is a charism rooted in God and in service to others, with a preferential option for the poor. It is focused on a shared vision of integral human development and the creation of sustainable solutions to issues of social justice. It is important that those who work in healthcare understand and remain committed to Vincentian and hospitality-based health care, particularly for the indigent and marginalized. This population is an overlooked, under-served and vulnerable patient population. It is well-documented that disparities of care exist when comparing the indigent to those who are financially stable and sufficient, with the indigent often receiving less than optimal care. Furthermore, it is critical that we engage our current and future health care students in caring for the indigent/underserved in their educational experiences, so that they may identify and understand this as a

professional responsibility and can, in turn, teach successive generations of health care professionals.

Vincentian Health Care History and Principles

Louise Sullivan, D.C., noted Vincentian scholar and an expert on seventeenth-century France, has written a comprehensive and instructive work on Vincentian health care entitled: Vincentian Mission in Health Care (1997). This work provides a detailed historical overview of the formation and operationalization of Vincentian health care and identifies essential attributes. The foundation of Vincentian health care largely stems from the Daughters of Charity, founded by Vincent de Paul and Louise de Marillac in 1633. While not limited to health care, service of the "sick poor" was central to the Daughters of Charity vocation from the very beginning. Both Vincent and Louise had significant personal experiences both in being sick and in working with the sick poor, which appears very likely to have inspired their dedication to this patient population, along with their abundant faith. It is important to note that from the very beginning Vincentian health care was intentionally holistic, meaning that it was to serve the sick poor "corporally and spiritually," to minister to the body with physical care, the mind with psychological care, and the spirit with spiritual care.

A full historical review of Vincentian health care is beyond the scope of this article and expertise of its author. Briefly summarized, though, Vincentian health care in the seventeenth century was largely the work of the Daughters of Charity and involved a variety of health care services, including nursing care and pharmacy-related services at hospitals. Responsibilities in hospitals included nursing and pharmacy services management, and a variety of direct patient care measures such as proper nutrition, medication distribution and administration, bloodletting and purging, dressing of wounds, hygiene initiatives, psychological interventions, and others. Aside from the hospital setting, the Daughters were involved in home health care; care of the mentally ill; care of the elderly; and crisis intervention (e.g., care of the wounded on battlefields). Vincentian health care, therefore, demonstrated a wide scope of health care services and settings but always remained highly focused on the poor and indigent as its core and unwavering mission.

In addition to the diverse array of health care services provided by the Daughters of Charity to the poor and marginalized, Vincentian health care distinguished itself for its innovative structure and methodology. Vincent and Louise recognized early that organization and continuous evaluation was a necessity to ensure a successful and sustained service to the sick poor. They provided explicit structure and guidance in their rules and roles so as to make sure they were focused and clear. Vincentian health care was conceived, and remains, as an integrated service that is patient-centered. The efforts and responsibilities of all involved in health care (e.g., administrators, health care providers, staff, chaplains, etc.) are directed to high-quality patient care. This focus on patient-centered care and continuous quality improvement remain critical areas of focus in modern health care, almost four centuries after the development of Vincentian health care.

In her article, Sr. Sullivan was able to adeptly identify eight essential attributes of Vincentian health care. These attributes remain as relevant today as they were in seventeenth-century France and provide us with guidance for continued Vincentian health care. The attributes are clearly aligned with a hospitality-based practice of health care. In her words, the attributes are as follows:

1. *Spiritually rooted*: Vincentian health care recognizes the patient as a privileged place of encounter with God. Those involved in it form a "family of faith" which strives to serve the sick wih cordial respect, compassion, and gentleness.
2. *Holistic*: From its origin Vincentian health care has sought to serve the sick "corporally and spiritually" that is to minister to body, mind, and spirit.
3. *Integrated*: Vincentian health care is patient focused, integrating all services, regardless of level, to provide comprehensive care

and blending the humanistic with technical competence.

4. *Excellent*: Vincentian health care places quality at the center of its mission. The health care providers must not only be competent but efficient and dedicated.
5. *Collaborative*: By the gratuitousness of their patient centered service, those involved in Vincentian health care strive to be a bridge for unity in the multiple partnerships formed to insure better care for the sick. Vincentian health care seeks by such alliances to collaborate rather than to merely compete with other health care facilities.
6. *Flexible*: Vincentian health care is ever ready to reach out beyond institutional walls to serve the sick where needed and to intervene in crises when necessary.
7. *Creative*: Vincentian health care is ever seeking new or renewed ways to meet the changing needs of the sick while maintaining a clear "sense of the possible."
8. *Focused:* From its origin for the service of the "sick poor," Vincentian health care has viewed a preferential option for the poor as central to its mission. It thus strives to integrate this vision into all aspects of its service and to keep the primacy of it alive among all those who share in their ministry of care of the sick. (Sullivan, 1997)

Health Care and Health Inequities

Worldwide, incredible advances in health care have been made since the seventeenth century and the conceptualization of Vincentian health care. These improvements in overall health care are a consequence of a multitude of factors and events, including, significant advances in scientific research, education, and technology. This increased knowledge has led to numerous paradigm shifts in health care over time, with a central goal of improved health for people. Similarly, health care professional education has also experienced significant paradigm shifts resulting in new and expanded health care professional/support staff roles and responsibilities, with a goal of developing highly-qualified and dedicated professionals and staff to meet the health care needs of the public. While health care continues to encompass the provision of medical care for people who are acutely ill, there has been increased recognition, responsibility, and resource allocation for supportive care, chronic disease state management, health promotion, and disease prevention initiatives. Consequently, people living in the United States and many other countries have experienced an overall improved quality and duration of life. As an example of this emphasis on population health and the related continuous evaluation, since 1979 the United States (U.S.) Department of Health and Human Services has developed a detailed national 10-year plan for improving and measuring the health of all Americans. The most current iteration, Healthy People 2020, has identified more than 1,200 distinct objectives to achieve its goal, and provides interventions and resources to assist in attaining these objectives (HealthyPeople.gov, n.d.). Some of the topics focused on in Healthy People 2020 are disease-specific such as diabetes mellitus, cancer, and HIV infection, while others are focused on broader areas such as access to health services and public health infrastructure.

In addition to the tremendous scientific advancements and achievements made in health care, there has also been an increased emphasis on hospitality in modern health care. Health care buildings such as hospitals, clinics, physician offices, and pharmacies, are commonly designed to be aesthetically pleasing and welcoming to patients and families. A "home-like" experience is pursued for the patients. In fact, some hospitals have focused on providing hospitality services for their patients and family/visitors that can, at times, rival hotels. Health care providers, administrators, and staff are keenly aware of the importance of providing hospitality-based service/practice to their patients/clients.

Health care establishments routinely survey patients regarding quality of care and hospitality

measures following their experiences, and they evaluate these surveys to assess and improve the patient experience. In addition to the concern for their patients, the hospitality focus is emphasized due to the competitive nature of the business of modern day health care (wherein, often, numerous health care establishments offering similar services vie for the same patients). It is important to note that while advances in medical and overall health care have largely been fruitful in the promotion of health, care does not come inexpensively. In 2011, U.S. health care expenditures were estimated at $2.7 trillion, essentially doubling, since 1980, the percentage of U.S. gross domestic product to 17.9% (Moses et al., 2013). Health care in the U.S. has become an increasingly complex system and continues to draw attention and concern from those who receive, provide, and finance it.

Despite significant advances in modern health care, health inequities clearly exist on both a national and global scale. High-quality and hospitality-based health care is available for some, but certainly not all. The World Health Organization (WHO) defines health inequity as "systematic differences in the health status of different population groups" (World Health Organization, 2011). The WHO cites numerous examples, generally intertwined with poverty, and I have included some examples below for consideration. Everyday more than 21,000 children die before their fifth birthday, many from conditions easily treatable with modern medicine. Children from the poorest 20% of households are almost twice as likely to die before their fifth birthday as children from the richest 20%. Approximately 99% of maternal deaths and 95% of tuberculosis disease deaths occur in developing countries; these are deaths and disease largely preventable with modern medicine/health care. Providing further evidence of the impact of poverty on health inequity, the average life expectancy in low-income countries is fifty-seven, while in high-income countries it stands at eighty.

This health inequity has not gone unnoticed. At the United Nations Millennium Summit in the year 2000, leaders from 189 countries signed the Millennium Development Goals (MDGs) declaration (United Nations Millenium Declaration, n.d.). The MDGs provided eight detailed goals with measurable targets and explicit timelines for improving the lives of the world's poor. Three of the eight MDG goals are health-related and have specific targets for the year 2015: reduce child mortality, improve maternal health, and combat HIV/AIDS, malaria, and other diseases. Although lauded as perhaps the most successful global anti-poverty initiative in history, the likelihood of meeting their health-related goals is threatened by poor health service delivery to hard-to-reach populations. I am continuously inspired by the great global health work of the WHO and non-governmental organizations such as Catholic Relief Services, Médecins Sans Frontières/Doctors Without Borders, and Partners In Health. They each strive to eradicate health inequity by providing care directly to those in need, continuously exploring and evaluating new models of care to help the underserved and demonstrating to the world that it can and must be done.

Although frequently associated with the poorest developing countries, problems of health inequity and poverty also exist within the U.S. Despite its position as a globally powerful and wealthy country which offers the opportunity for state-of-the-art high-quality and hospitality-based health care, the fact is that many people within the U.S. do not have access to or cannot afford health/medical care and/or treatment, let alone hospitality-based care. The Commonwealth Fund estimated that in 2012, there were 47.3 million people uninsured and an additional 31.7 million people who were underinsured within the U.S. (Schoen, Hayes, Collins, Lippa, & Radley, 2014). These access barriers have led the country into a continuous national debate on how best to provide health care to its residents. Recently, the U.S. has seen the passage and early implementation of the Affordable Care Act (ACA), which is intended to provide Americans with improved access to affordable, quality health insurance while reducing the growth in health care spending. It is the most significant health insurance expansion and market reform since 1965, when Medicare and Medicaid

were enacted. The success of the ACA is a matter of fierce debate within the county, and its assessment at this time appears to be largely based on political affiliation. In reality, we will likely need further experience with and analysis of the ACA outcomes before it can be determined if it has been successful at achieving its intended goals.

Reflections from the Road: Health Care for the Homeless/Indigent and Incorporation into Pharmacy Education

A 2013 U.S. Department of Housing and Urban Development (HUD) study, using data from a count conducted by homeless shelters within the U.S. on a single night, found that 610,042 persons were homeless, 65% of whom were sheltered and 35% of whom were unsheltered (Henry, Cortes, & Morris, 2013). Recognizing the cyclical nature of homelessness, the total number of people who experience homelessness during the course of a year is likely significantly higher, with some estimates ranging as high as 3.5 million people. Homelessness is clearly pervasive in the U.S. and has multiple root causes. It threatens the welfare and dignity for those whom it affects and is a detriment to society at large. I have spent much of my professional career as a pharmacist and an educator working closely with the adult homeless and indigent population of New York City, mainly in relationship to health care. The remainder of this paper is largely based on my experiences with this vulnerable and special population.

A subset of the indigent, the homeless are an especially marginalized population and face significant obstacles to seeking and obtaining health care. The lack of financial and housing stability and sufficiency force those who are homeless to focus on responding to immediate needs such as shelter, food, and safety. Health becomes a secondary priority despite the fact that time and again there are significant medical needs. When the homeless consider seeking health care, it is regularly based on an acute pressing medical need rather than the management of chronic medical conditions or preventative care needs. Complicating this situation further is the potential lack of health care insurance or an ability to pay for medical care. For those homeless who are fortunate enough to be eligible for Medicaid or alternative health insurance, and have successfully navigated the fairly complicated application requirements and received coverage, they may still find it challenging to find a primary care provider and to see them regularly. There is a national shortage of such providers in health care today. Thus, many homeless have limited options to access care and therefore seek care in the emergency departments (ED) of hospitals. This additional patient volume for typically busy ED's can be overwhelming, chiefly because many times the care requested does not require specialized urgent and emergency care and further strains the limited resources of the hospital. After being treated in the ED, patients may, if needed, be discharged with a small supply of medications and/or prescriptions for medications. When homeless patients are prescribed medications they can be challenged by the cost of them at the pharmacy and therefore may be unable to have the prescription filled. This lack of treatment can then potentially exacerbate their medical problems and cause them to return to the ED, where the cycle begins all over again. It is evident that health care of the homeless can be very challenging, particularly considering that some patients may also suffer from psychiatric and/or addiction illnesses.

Fortunately, a variety of governmental and non-governmental organizations have focused on assisting and providing care and health care for the homeless. These organizations generally are focused on preventing or managing the problems previously identified for homeless populations. For the past twelve years, I have had the privilege of working closely with one such organization, Project Renewal. I serve as their Clinical Coordinator of Pharmaceutical Care Services, in conjunction with my full-time academic appointment in the College of Pharmacy and Health Sciences at St. John's University. Although Project Renewal is a secular organization, I do believe it is an excellent example of an organization that effectively provides high-quality hospitality-based health care directly to the

urban homeless/indigent population. I also believe the organization encompasses the vast majority of the previously identified attributes of Vincentian health care.

Project Renewal has a forty-seven-year history of providing care directly to the homeless of New York City. Its mission is to end the life cycle of homelessness by empowering men, women, and children to renew their lives through health, homes, and jobs (Project Renewal, n.d.). This is a challenging mission considering that there are more than 50,000 homeless people estimated to be living in the city (Coalition for the Homeless, n.d.). The organization offers a wide array of successfully integrated programs and services to achieve its goal. One of the hallmarks of Project Renewal is that it is focused on meeting the homeless where they are, bringing their services directly to people in need. It operates a variety of shelters, transitional housing, and permanent housing for its clients throughout New York.

Project Renewal also offers a variety of health services to the homeless and indigent population, for which it has rightfully received numerous awards and national recognition. In 2013, more than 11,000 people received health care at Project Renewal. It operates health clinics within its shelters which provide primary care services, psychiatric care, dental care, eye care, HIV care, and other services. Project Renewal further fulfills its mission by innovatively bringing health care directly to the homeless where they live, on the streets and in shelters. In 1986, Project Renewal launched the "MedVan," a state-of-the-art mobile medical clinic staffed by a team of medical providers and staff. The MedVan became a national model for health care delivery to the homeless. Today, Project Renewal operates a fleet of five such mobile medical vans that maintain a specific schedule throughout the week (Monday-Saturday), providing medical care at soup kitchens and shelters throughout New York. The vans consist of private exam rooms, medical equipment for patient examination, and a confidential and secure electronic medical records system. Many health services are offered in the vans, including: primary care, urgent care, HIV-screening, immunizations, health screenings and other preventative care measures, and a network of referral-based care, within and outside of Project Renewal. Additionally, the vans have staff who assist patients in attaining health insurance when eligible.

As the pharmacist at Project Renewal, I help to oversee medication-related issues on the vans and within the HIV-clinic. My work includes assisting providers in determining the most appropriate treatment for patients, answering drug information questions, educating patients on their medications, monitoring medication storage and inventory, clinical research, and other duties. I have the privilege of welcoming to Project Renewal, teaching, and supervising doctor of pharmacy students from St. John's University studying in their ambulatory care experiential course. This is a 4-week, full-time, course for senior pharmacy students who are immersed into the care provided at Project Renewal, mostly on the vans and in the HIV-clinic. The pharmacy students are active and integrated members of the health care team throughout their experience. The students and I assist medical providers by collecting medical and medication histories prior to the patient's being seen by them. When ready to see the patient, we accompany the provider into the examination room and actively participate in the assessment and development of a plan for the patient. If that patient's plan includes medications and the patient has no insurance, the health care team has a limited stock of medications available on the van from which we can provide (at no cost to the patient) the most appropriate treatment. If the patient has insurance, they are provided with an appropriate prescription. The students and I provide detailed medication counseling to all patients receiving medicine or prescriptions from the medical providers.

As a proud member of the Project Renewal health care team, I can attest to the dedication of its medical providers, its staff, and the *excellent* high-level health care the patients receive. It is to me the definition of hospitality-based Vincentian

health care, aside from the spiritual care aspect. From its onset, Project Renewal has been focused on providing care to the homeless poor. It delivers care in creative ways that maximize outreach, such as the use of medical vans that reach out directly to the poor. Patients are welcomed onto the van by friendly and competent staff and providers. The consistency of the van schedule and providers assigned to them and to clinics allows for an appropriate continuity of care, with patients frequently being seen by the same medical provider(s) each time they receive care. Patients are treated with respect by the health care team and are not judged on their appearances, behaviors, or medical problems. Patients are provided ample time when being interviewed, evaluated, and cared for by the health care team and are encouraged to ask questions and be engaged. Guided by the highly qualified medical providers and staff, the patients play a central role and participate in all treatment decisions. Project Renewal truly provides patient-centered care and patients typically form a strong bond with the health care team, as relationships are cultivated over time and experience with each other. The health care team works in a flexible, integrated, and collaborative way with each other and any other outside providers, as needed for the patient. Although not providing spiritual care, Project Renewal does aim to provide *holistic* care in the sense of caring for both mind and body, especially critical for this patient population.

For pharmacy students at St. John's, the ambulatory care experiential course at Project Renewal is an academic service-learning course. It is an opportunity for students to apply the learning objectives and competencies learned in the didactic instruction of their pharmacy program. Academic service-learning at the university is a classroom/experiential site-based program that involves students in some form of required community service that benefits the common (public) good and uses service as a means of understanding course concepts. The service activity meets course objectives, and through reflection students examine issues pertaining to social justice and responsibility (St. John's University, 2014). Pharmacy students are provided with the opportunity to be an integral part of an inter-professional team of health care providers providing competent, dedicated care for the underserved that includes physicians, physician assistants, nurse practitioners, and staff. Curricular inclusion of caring for the underserved, and guidance for it, has long been called for in academic pharmacy studies and other educational fields of health care (Zweber et al., 2008). Through engagement with and service to the poor, I hope that pharmacy students participating in this course will better realize the Vincentian mission of our university, and also develop a fervor for applying their unique pharmacy knowledge and skills to the underserved.

Reflection is an important component of academic service-learning. I have my students write several guided reflection papers prior to, during, and at the completion of their course at Project Renewal. With the permission of a former student, I will share a final reflection paper below. I have chosen this paper as it is provides a glimpse of the Project Renewal experience and its impact on pharmacy students, and it is fairly representative of the themes included in all the reflections I have received from students while teaching at St. John's:

> A strange thing happened to me on the A train ride downtown Friday afternoon. A man walked into the middle of the train with a paper cup in his hand, announcing to commuters that he was homeless and hungry. He looked unkempt, but not dirty. He wore a slightly tattered coat, blue jeans, and a baseball cap. Standing by his pole, he began to sing the 1970s Bill Withers classic, "Lean on Me." He sounded great.
>
> For a while, I did what I (and most others) usually do in these kinds of situations. I sat tightly in my seat with a lowered gaze, and continued to read my book and browse through my iPod, patiently waiting for him to exit into the next car or onto the platform at the next stop. But my old routine had failed me; I couldn't concentrate on the

passages, and couldn't hear the music through my headphones. I could only ask myself, "How much longer will I ignore the needs of the indigent, and the harsh reality they face on a daily basis?" I knew sitting quietly wouldn't change anything, and giving money wouldn't necessarily help him either (depending on where it was going). Finally, I spoke up and said, "Excuse me, sir."

He leaned towards me, and under the bill of his cap I saw a pair of kind eyes. I paused for a moment, and then told him that for the past month I had been working with an organization called Project Renewal. I spoke about the MedVan, and the medical services it provides to the homeless and uninsured. He had heard about the organization before, and told me he stayed mostly uptown, in Harlem. I gave him the address to our [Harlem] site, and encouraged him to visit the MedVan on Monday afternoons and Friday mornings for free medical care. "I can help you this way," I said. He thanked me, said, "God bless you," and walked away.

It was at that moment I realized just how much I had matured, both morally and professionally, over the past month. I felt as if it was my duty, as a moral individual and as a provider of health, to reach out to that man, and I thank Project Renewal for instilling that belief within me. The organization has given me the opportunity to view the indigent people of New York City through an honest and intimate lens without which I would have remained ignorant to their humanity, their needs, and the unfortunate injustices they face in our society.

I was most moved by the case of MC, a 54 year-old African-American female who presented to the MedVan with an ulcerative wound covering the entire lower left leg. Since the infection started last August, she had gone to several private hospitals where she had received care for a few days, but was ultimately sent away because she did not have health insurance. Unable to pay for services, MC took it upon herself to care for her wound; however, she fell short. Upon examination, the infection was so extensive that we were unable to provide adequate on-site care, and called EMS [Emergency Medical Service] to send her to the ER at […] Hospital. Because of her past experiences, she initially refused to be taken to the hospital, not believing us as we informed her of [the hospital's] mission, as a public institution, to serve the uninsured and that she would not be denied care. As I watched [the] Dr. re-dress her wound before the EMS arrived, I noticed that MC began to weep. To this day, I am incapable of accurately describing the painful, hopeless look in her eyes. She seemed disillusioned by the healthcare system, betrayed by her society. It was an unfortunate incident, a heartbreaking sight. I kept thinking how preventable this was, had her circumstances been different, had she been insured. On the subject of healthcare and human rights, Paul Farmer once said, "The thing about rights is that in the end you can't prove what should be considered a right." For the cynics of a universal healthcare system, this is proof.

I leave Project Renewal with a heightened sense of awareness of what is being done to cope with the inadequacies of today's healthcare system. I am comforted by having met providers like those aboard the MedVan and throughout the organization's various clinics; they

serve their patients with incredible skill, passion, and compassion. It is also encouraging to know that Project Renewal's office administrators practice their profession in the same way, giving hope to the future of this organization and the people they serve. With shared values and common beliefs, I now feel a moral and professional responsibility to carry on their ideals in my own practice of pharmacy, and to fight against the injustices I have seen to provide a better standard of care for the indigent population of New York City.

Conclusion

Vincent de Paul and Louise de Marillac developed the concept and practice of Vincentian health care, demonstrating a preferential option for the poor. The practice of hospitality was an essential part, wherein the poor were welcomed and respected while receiving high-quality health care. The need for Vincentian and hospitality-based health care remains relevant and necessary in contemporary society, as there remains health inequity, particularly for the poor. It will require hard work and dedication to ensure that the indigent receive appropriate health care. However, as Vincent taught us, "Let us love God, brothers, let us love God, but let it be with the strength of our arms and the sweat of our brows; for very often many acts of love of God, of devotion, and of other similar affections and interior practices of a tender heart, although very good and desirable, are, nevertheless, very suspect if they don't translate into the practice of effective love" (Vincent de Paul, n.d., 11:32).

In reflecting on this paper, I have continued to ask myself the Vincentian question: "What must be done?". With regards to the focus of this paper, I believe that we must provide Vincentian- and hospitality-based health care to the poor and underserved. With regards to "How must this be done?", we are fortunate to have numerous models of Vincentian health care in existence today from which we can learn, improve and expand care. Additionally, this is a time of dynamic health care reform, which may provide greater health care access to the poor. It is imperative that we expose and immerse students of the health professions into this charism of caring for the poor to inculcate a professional responsibility. I believe these experiences provide the opportunity for students to be sensitized to, inspired by and better able to care for the poor and to teach future generations of health care professionals. *Namaste*

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Notes

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