Article

Answering the call to accessible quality health care for all using a new model of local community not-for-profit charity clinics: A return to Christ-centered care of the past

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This article uses studies and organizational trends to understand available solutions to the lack of quality health care access, especially for the poor and needy of local U.S. communities. The U.S. healthcare system seems to be moving toward the World Health Organization's recommendation for universal health coverage for healthcare sustainability. Healthcare trends and offered solutions are varied. Christian healthcare traditionally implements works of mercy guided by a Christian ethos embracing the teachings of human dignity, solidarity, the common good, and subsidiarity. Culture of Life Ministries is one of many new sustainable U.S. healthcare models which implements Christ-centered health care to meet the need of quality and accessible health care for the local community. Culture of Life Ministries employs a model of charity care through volunteerism. Volunteer workers not only improve but also transform the local healthcare system into a personal healing ministry of the highest quality for every person.

Summary: The lack of access to quality health care is a common problem in the U.S. despite various solutions offered through legislative and socioeconomic works: universal healthcare models, insurance models, and other business models. U.S. health care would be best transformed by returning to the implementation of a traditional system founded on the Christian principles of human dignity, solidarity, subsidiarity, and the common good. Culture of Life Ministries is an example of such a local ministry in Texas, which has found success in practically applying these Christ-centered, healthcare principles into an emerging not-for-profit, economically sustainable, healthcare model.

Keywords: Christian ethics, Health care access, Volunteering, Community, Poverty, Household impact, Cultural stigma, Right to health, Solidarity, Morality, Christianity

INTRODUCTION

The lack of access to quality health care is a common problem among low-income social groups in the United States (Richman and Lattanner 2014). As a result, low socioeconomic status is associated with poor

healthcare outcomes, including higher rates of obesity, diabetes, and chronic musculoskeletal pain (Pampel et al. 2010), (McIntyre et al. 2006). The resulting health disparity is predicted to worsen as fewer citizens display Christian solidarity in the practice of works of mercy in health care (Bărbat 2015).

Furthermore, the lack of access to primary healthcare services burdens emergency departments and urgent care centers. Non-emergent medical conditions are treated in emergency rooms because a local doctor's office or outpatient facility is not open or accessible (Gindi et al. 2016). The increased expense of health care, resulting in typical outpatient procedures, screenings and workups being done in the hospital, continues to plague a failing system (Louhiala 2013).

In order to improve health outcomes and access to healthcare services, the WHO encourages the implementation of universal health coverage (UHC) (WHO 2016a). The WHO recognizes that establishing UHC is a complex process that is challenged by financial constraints and political obstacles. Despite those challenges, Lê et al. (2016) found that healthcare outcomes improved in the forty countries that initiated UHC with integrated health services.

The current discussion of health care in U.S. political and social circles, however, is not as much about how health care can be improved but about a call to transform the whole system. These discussions speak of the need to scrap the broken systems of government-run, socialized medicine, and insurance-controlled healthcare bureaucracies and come up with a more personal caring way of treating all members of the community with dignity and respect. Is transformation possible? Is there a sustainable model available?

HEALTHCARE QUALITY AND ACCESS IN RELATION TO UNIVERSAL HEALTHCARE EQUALITY

One of the most influential healthcare organizations in the world, the World Health Organization (WHO), encourages stepwise goals toward universal health coverage, as is reflected in their 2030 agenda

for sustainable healthcare development (WHO 2016a). Sustainability is planned partially through partial or full subsidization of health service costs for those who are unable to pay. Out of forty countries who are attempting to make progress on healthcare sustainability, the WHO reports that the United Kingdom, Canada, and Australia are implementing UHC goals most visibly (Lê et al. 2016). These countries are implementing UHC through government-run (and government-financed) programs. While many propose that the U.S. needs to attain UHC through a central or state government program, there are other ways to reach this goal. In fact, one could say that the U.S. could reach UHC by looking to its past of privately financed health care. The U.S. government certainly made some recent attempts toward increasing the affordability, availability, and quality of health care when the Affordable Care Act (ACA) was signed into law in 2010. (Obamacare 2016) Instead of trying to overhaul the entire healthcare system, the U.S. government chose a piecemeal approach with the goals of expanding access to health insurance, protecting patients against arbitrary actions by insurance companies, and reducing overall healthcare costs. Although proponents attest to the fact that ACA is working by citing an overall decrease in the number of uninsured in the U.S., critics comment on the fact that healthcare costs and quality have not improved but have left only a complex and cumbersome law to be sorted out (IAFF 2016). Its makers claim that all will see the full, promised effects of the ACA by the year 2020. Until then (or possibly longer), we all await eagerly a universally accessible and sustainable system of quality health care.

Before speaking of the sustainability of healthcare quality and access, one must remember that there will always be the issue of unequal access of healthcare

resources. Whether it is due to inequality from socioeconomic differences in families or due to the limited access resulting from geographic differences, there will always be a struggle to raise standards and increase resource access for those who are considered impoverished or needy. Inequality in healthcare access and resources is almost certain to reflect an inequality in the quality of health care. The moral duty of a follower of Christ in the care of one's neighbor should always be congruous with our right understanding and belief of our duty to display a merciful and compassionate love for our neighbor as we strive in solidarity for attaining the common good for all those in our community. The Lancet Commission on Investing in Health (CIH) has introduced their vision of healthcare coverage and sustainability which can be found in their published "Global Health Report for 2035" (Jamison et al. 2013). The report describes and promotes faith-based goals and maintenance of healthy lifestyle as being vital to implementing universal health coverage through improving equality, health outcomes, and financial well-being, particularly for the poor and needy. "Many countries remain challenged by financial constraint, increasing citizen demands, political obstacles and by the [overall shear] complexity of moving toward UHC" (Lê et al. 2016).

The interpretation of U.S. research conducted in 1996 pointed to a decrease in public support of health care for low-income families and individuals as a direct cause of decreasing access of quality health care for the poorest U.S. citizens. Now government-funded, social-service bureaucracies scramble for new ways to provide support as the prevalence of certain illnesses increases, such as chronic pain, obesity, musculoskeletal disorders, and mood disorders (as reflected by the recent 400% increase in antidepressant prescriptions). These same studies imply that some are

desperately trying to receive help for a social problem (the inadequate access to quality health care) but instead are given a pill to take as a treatment for a medical problem, i.e., mood disorder (Hansen et al. 2014).

The growing need for health care for worsening chronic diseases and their co-morbidities forces many in the U.S. to go to the emergency room for care. The trend of a healthcare system increasing its struggle to care for the increasing prevalence of the same health problems is a recognizable, consistently losing battle. Over the last several years, the system's struggles are still the same: serious underlying chronic medical diseases, no available doctor's office appointments, shortened clinic visits as a way to improve efficiency, and lack of access to specialty providers (Gindi et al. 2016). Healthcare screening for many diseases proves to be ineffective in the community as many such common diseases are diagnosed as a result of an expensive hospital workup for an acute and urgent symptomatic presentation. It is even questionable as to whether such hospitalizations, which result in numerous diagnostic and therapeutic workups and prolonged hospital stays, are even ethical (Louhiala 2013). The other side of the argument, of course, invites the question of whether the discharge of such a patient into an outpatient world that is unable to continue the needed workup and adequately care for such patients is morally palatable.

POVERTY AND ITS CONSEQUENCES

Poverty exerts negative influences on human development and health (WHO 2016b). Such effects in disparity of health care is especially seen in low- to middle-income families. Some studies show evidence of a direct relationship between illness and poverty: the illness of a family member has a

greater negative economic consequence for impoverished individuals and members of their household. For families in poverty, the economic cost of a family member's illness is usually greater than 10 percent of the entire household income; consequently, illness plays a detrimental role in worsening poverty on a familial level (McIntyre et al. 2006).

A meta-analysis shows that poverty and its structural, cultural stigma worsen behavioral health outcomes, thus they have downstream effects on overall health outcomes (Richman and Lattanner 2014). So, impoverished families and members of communities with a lack of access to quality health care will be more likely to remain in a circle of poverty and its intrinsic consequences, becoming more vulnerable to further disease and exploitation.

GENERAL APPROACH OF CHRISTIANITY TO HEALTH CARE

Christian charity historically has been promulgated as a special mission commanded by Jesus to all who follow him, as we remember His words:

“For I was hungry and you gave me food, I was thirsty and you gave me drink, a stranger and you welcomed me, naked and you clothed me, ill and you cared for me, in prison and you visited me.” Then the righteous will answer him and say, “Lord, when did we see you hungry and feed you, or thirsty and give you drink? When did we see you a stranger and welcome you, or naked and clothe you? When did we see you ill or in prison, and visit you?” And the king will say to them in reply, “Amen, I say to you, whatever you did for one of these least brothers of mine, you did for me.” (Matt 25:35–40)

We also recall the earlier context and command of our Heavenly Father to the nation of Israel: “The land will never lack

for needy persons; that is why I command you: ‘Open your hand freely to your poor and to your needy kin in your land’” (Deut 15:11) (Bykov 2015). Voluntary service, specifically in the work of healing, has been a characteristic sincere and zealous work of Christians throughout the centuries. The continual establishment of Christ-centered healthcare ministries and institutions throughout the world reflects the deep intentionality of Christians to change the pagan world through the proclamation of the Gospel of Christ and through acts of healing. As the power of the Gospel has transformed lives, particularly through the healing touch of the risen Lord Jesus, Christian communities and their culture of life grew; and the pagan culture waned as new converts continued to spread the Gospel which had made them a new creation. This power of transforming lives is witnessed more so in the Christian's love overflowing from personal relationships than in a movement characterized by a fervor of compulsion from commanding strength or entrepreneurial ingenuity. The world became truly blessed as these Christ-centered, healthcare workers came along and brought not only health care for their own community but also for the outcast, the widow, the orphan, and the foreigner (Bykov 2015).

Much has been written in the current age about the importance of collective welfare which displays itself in multiple factors, such as economics, culture, education, religion, social work, healthcare political policies, and socioeconomic and governmental welfare programs. As many industrialized societies and governments leave the Christ-centered culture of life and Christian virtue, a tendency toward unintended discrimination, prejudice, superficiality, and dehumanizing abuse is growing in modern health care. There is an immediate need to recover a health care emanating from personal knowledge of the patient and to implement the

fundamental Christian ethos exemplified in teachings, such as subsidiarity, human dignity, solidarity, and the common good (Bärbat 2015).

THE IMPORTANCE OF HUMAN DIGNITY, SOLIDARITY, SUBSIDIARITY, AND THE COMMON GOOD

The ability to provide universal access to quality health care is not an impossible task and is not a special socioeconomic plan that needs a large-scale corporation or government to implement. The prior experience of Christendom shows that quality accessible health care has been a treasured part of Western communities but has all but disappeared in our modern, mechanistic, materialistic world. If we as a society are to 'recreate the past' in the sense of bringing back the 'old fashioned' quality nursing and doctoring that was available to all, the key fundamental building blocks must return to their foundation, who is Christ.

Human dignity

Christ-centered care is by nature a personal work of loving a neighbor as oneself. As a healthcare worker enters deeper into the care of another person, the attitude naturally tends more toward being a steward of respecting the sanctity of life and less of an objective duty out of compulsion to keep a human machine alive and healthy. Health care becomes more of personally entering into the knowledge of oneself and one's neighbor through sacrificial care and less of doing a job merely as a societal dictate or role. Healthcare workers share in the divinity and humanity of Christ as they become Christ to the patient and treat Christ who is the patient. As a healthcare community

implements this type of subjective personal care, the degrees of technologically advanced tests and treatments which are available (and the arguably high healthcare costs associated with them) take a secondary role in the healthcare system. On a practical level, personalized care can reduce the need of over testing (lessening a tendency to perform defensive medicine) and can better tailor patient testing and treatment as the patient's story of his illness is better understood. On a metaphysical level, technology and all forms of medical care can serve to raise the patient's dignity to that of Jesus Christ, as the patient imitates him who lived, suffered, and died. Medical care then becomes a means to meticulously care for each patient by recognizing his dignity as a mortal who bears the image of the immortal God. Such a healthcare system always acts with a goal of caring for those who are on a temporary earthly pilgrimage rather than acting with a goal of merely prolonging longevity and/or quality of a patient's mortal life.

The use of life-sustaining technology is judged in light of the Christian meaning of life, suffering, and death. In this way two extremes are avoided: on the one hand, an insistence on useless or burdensome technology even when a patient may legitimately wish to forgo it and, on the other hand, the withdrawal of technology with the intention of causing death. (USCCB 2009, 30; see also CDF 1980)

Solidarity

While it is important to recognize each human as having the dignity of being made in God's image, it is just as important to realize that we as parts of the community share a connection with one another that is deeper and stronger than merely sharing the same neighborhood, culture, or traditions. We care for our

neighbor's health not only because our neighbor is seen as having dignity worthy of such, but just as much because our lives are linked in such a way that our very own lives depend on one another. This concept of solidarity was a common mindset in the health care of centuries past; it is not just a view of treating populations versus individual patients. To be in solidarity meant to live and die in a community which understood the value that each individual contributes to society. The justice and peace of communities depend intimately on the strength of the social bonds of community members in solidarity. The do-it-yourself attitude which morphed into a caricature of rugged American individualism was a completely foreign idea. This attitude even among contemporary healthcare workers has been frowned on as unacceptable and harmful as a team approach to patient care; a way of working in solidarity has become a standard.

The common good

As members of a community acknowledge the sanctity of life (human dignity) and begin to strengthen their bonds of living in harmony with one another (solidarity), the sacrificial step of working for the common good of all members in the community becomes natural. Providing health care for the common good goes against the tendency to be caught up in one's own interests and concerns. It opposes the idea of making sure that the healthcare system first provides well for those who support and run it and then may accommodate those who choose not to or are unable to directly contribute. "The common good is the sum of those conditions of social life which allow social groups and their individual members relatively thorough and ready access to their own fulfillment"

([Vatican Council II 1965](#), no. 26). Therefore, access to quality health care by all, which includes those who cannot afford it or who consume the most healthcare resources, is strongly tied to the common good.

Subsidiarity

There can be a tendency for the society itself to employ its members in servitude for the community. While it is true that each person finds identity and value in a life of communal solidarity, the human person is and ought to be the principle, the subject, and the end of all social institutions. ([Vatican Council II 1965](#), no. 25 § 1) There is great value in the collaboration and unifying of many local communities and governing bodies to accomplish large goals which can be attained only through large social efforts. Such large-scale efforts can be fraught with inefficiency, misappropriations of resources, ineffectiveness, and even outright danger to personal freedom and health to all who are involved. The teaching of the Church has elaborated the principle of subsidiarity, according to which

a community of a higher order should not interfere in the internal life of a community of a lower order, depriving the latter of its functions, but rather should support it in case of need and help to co-ordinate its activity with the activities of the rest of society, always with a view to the common good. ([John Paul II 1991](#), no. 48 § 4; see [Pius XI 1931](#), 184–186)

The local efforts of U.S. communities to provide health care for their neighbors has been rendered ineffective in many ways by the interference of larger, nationwide insurance companies as well as state- and federal government-controlled health plans. Instead of trying to change the way the "community of a higher order"

interferes in the health care of many local communities, history has shown that health care functions more effectively when controlled at the local level and only aided in its activity by higher order governments and companies.

Culture of life ministries: A practical implementation of Christ-centered health care

As a result, in part, of the problem of access to quality health care affecting a local South Texas community, Culture of Life Ministries (COLM) was started in 2012. Its purpose being twofold: to provide dignified quality health care to all in need regardless of their socioeconomic status; to provide a means for all those in the local community to work together in a volunteer capacity in solidarity for the common good. It is interesting to note that COLM is not a unique response to the desperate and failing U.S. healthcare system as many other organizations and local clinics have popped up throughout the country to aid those in need by combining the strong tradition of quality diagnostic and treating acumen to the Christian heart of serving as Jesus would, with a heart of mercy. This Christ-centered way of serving and treating all as if they are Jesus seems to always embody a notion of working in solidarity and treating all with human dignity, a work of service characterized as social justice and a human right (Tiedje and Plevak 2014). Despite the gravity of our national healthcare problems, there is a movement underway in the U.S. to provide a solution. The solution is growing in the form of grass roots organizations and ministries (such as COLM) whose mission and impetus is to go back to the model of health care whose source is Christian charity (Bykov 2015).

Culture of Life Ministries was started by one physician to answer the call of the people needing health care in Harlingen, Texas, and the surrounding community of the Rio Grande Valley. As the news of this ministry spread by word of mouth, many of those considered vulnerable and with special needs were able to receive desperately needed care. COLM was incorporated as a 501c3 organization with a board of three directors in 2013. The organization is financially sustained entirely through donations of individuals, foundations, and churches. Although classified as a hospital by the IRS, COLM is currently a rapidly growing outpatient clinic which sees patients by home visit or appointment or as a walk-in three days a week. We operate out of donated space in local churches (Protestant and Catholic) and the local homeless shelter. Services provided include counseling, fertility awareness training, laboratory/bloodwork testing, women's health (pap smears, IUD removals, endometrial biopsies), EKGs, stress echos, endoscopies, sleep study testing, ultrasounds, and spirometry. We also are continuing to expand our program of praying for patients on an individual level (for those who desire it) and bringing to avail the sacraments of healing, such as reconciliation and anointing of the sick (we have begun to coordinate this through the Diocese of Brownsville). Our hope is to fully integrate these sacramental ministries of healing and prayer with the medical care, not just provide them in parallel. From time to time, we receive grants to help patients with certain services we do not provide (such as pharmaceuticals, eye exams, and x-rays). These funds we use to fill in the price gaps when the patient cannot afford the whole payment (for example, when a patient is able to pay only \$20 of the \$65 eye exam, we will cover the rest). Although many would say that the stereotypical needy individual is a homeless patient struggling with addiction or chronic

disease, the typical needy individual of the over two thousand patients who, to date, have come to COLM still continues to be someone of low middle class income who works full time but is unable, for many different reasons, to access quality care from the traditional established healthcare system. The number of volunteers drawn to help in this work of mercy has also increased in parallel to its demand to the point where there are over seventy volunteers to date (including those from non-medical backgrounds as well as primary care physicians, specialists, midlevel providers, residents, medical students, nurses, and therapists) who provide encouragement, counseling, medical consultation, prayer, diagnostic testing, and material aid to patients. We turn away no one regardless of financial, ethnic, religious, or social status (the needy sometimes comes in the form of an immigrant or a well-to-do professional). Although our current budget of around \$60,000 per year does not cover sufficient funds for staff salary, COLM started this year to collaborate with Agape Missionaries for Life (a charitable organization) whose goal is to credential and provide monthly stipends for prolife medical missionaries who might otherwise not be able to volunteer without financial sustenance.

INSIDE FINDINGS OF HEALTHCARE VOLUNTEERING

Volunteering at COLM

Many would say that in more than one way our volunteers are the key to the functioning of this small but effective healthcare organization. COLM functions as a group of many different kinds of volunteers integrated into one organism in Christian solidarity. Volunteers tend to join after hearing of the exciting and life-giving opportunity from their friends or family

members. Retired professionals come with stories of struggling with depression after they stopped working and found themselves sitting at home in front of the TV, living a life with seemingly little purpose. Young adults and college students join as an opportunity to learn about health care and use their energies and free time in a positive healthy way. As the old and the young, the rich and the poor, those of different religious and cultural traditions join as a volunteer force, they realize how strong and effective they are in providing quality health care with a personal touch for each patient. This force of volunteers features many who have no traditional link to the field of health care. In its brief history, COLM bears witness to the proclamation of a common gospel in the life of an ordinary volunteer: there is a joy that springs from serving others for the common good. As the number of beautiful experiences of meeting Christ in the face of the sick and suffering grows, many volunteers share similar feelings of connectedness to Jesus Christ and one another, and with the patients themselves. Here are some examples of some shared feelings that volunteers (physicians, nurses, retired teachers, retired secretaries, college students, retired business professionals) wrote down when asked about their service in COLM:

“I feel this volunteering is something that I have always wanted to do. When I started I had no idea what a need there was for this ministry in this community. I realize that as much as I am giving, I am also getting back. I just feel such a blessing to see all the volunteers that come out and give their time! I wish blessings on all.”

“It is a great experience. It is always good to help to put smiles on people’s faces. When the patients are happy, you are happy.”

“I love working here. There is a lot of respect among the volunteers. We are

here for the purpose of helping people in need that otherwise have no medical help. We have very competent people helping that give of their time to help others. The doctors perform all kinds of special tests to better help the patients. I like that the doctors pray with the patients and with those helping.”

“It has been a blessing to give of oneself out of pure sacrifice from the heart. It also has been a great challenge to bury the selfish desires and to suffer for service through and with and in Christ.”

“My community has a need, and I’m here to help. This gives me a purpose, to enrich those lives. I enjoy it, and I like serving. The rewards cannot be measured.”

“[COLM] is the best thing that happened to this community. Without it, a lot of people would never be able to get to the doctor as they can’t afford it. I started volunteering about 2 years ago. I wasn’t sure I would like it, but I really enjoy helping all the people and meeting them. Thanks to the doctors who volunteer their services. I’ve been told by many patients that it is a godsend and they really appreciate it.”

“This [service] is a helpful activity to give back to our community: to use my skills and talents since I have the time now that I am retired... and I feel better that I do not waste my time watching TV or just sitting at home. I enjoy the time I spend with clients and their families. I am able to teach and give the clients the knowledge they need to make their life better and healthier.”

Volunteering and its effect on health

Some observational and experimental studies show that compared to their peers, individuals who volunteer have better mental and physical health, and a more healthy lifestyle. For example, compared with no volunteering at all, studies show

volunteers are at low risk for smoking, alcohol abuse, and sedentary lifestyle. Volunteering has been associated with increasing a person’s purpose in life, augmenting physical activity, enhancing social integration and community participation, lowering blood pressure and cortisol, and giving an improvement in overall health (Kim and Konrath 2015). In essence, volunteering appears to be a means of fortifying solidarity and strengthening the common good in communities.

Many organizations exist today which help by offering medical humanitarian aid as well as alternative health care. Some provide primary care without proof of insurance or legal documentation, in many states. They exemplify how faith-based health care combines its traditional notions of compassionate, Christian care and political works of mercy in solidarity as social justice and advocacy for human rights in the rural U.S. They show that some volunteer organizations are helping health professionals return to their professional vocation (Kim and Konrath 2015).

CONCLUSION

To believe and to act in accordance with Christian charity is a demonstrable way of helping our brothers and sisters in our community. This help is not only beneficial for the people who receive health services, but also provides a tremendous benefit to the volunteer staff as well, not to mention its impact on solidarity and the common good of the local community. Health care that is Christ-centered and flows from a heart of mercy and charity strengthens solidarity in the community and works for the common good. Christ-centered health care improves the physical, emotional, and spiritual health of all, including those individuals and families

who serve and those community members who are most vulnerable and needy.

As those who participate in shaping health care look to the future, there are certain prominent obstacles which prevent current improvement in healthcare access and quality. Many do not see a way to leave the current mainstream healthcare system which is based on either an insurance-mediated model or a socialized, centralized, governmental healthcare system. Many rely on a fundamental idea that health care is intrinsically expensive: the more money an individual or society invests, the better it becomes. In such a paradigm, one is led to think that health care that could be detached from a payment system is not only unsustainable but of the poorest quality. As the growth of a new variety of local charitable healthcare organizations continues, members of communities will inevitably struggle with the idea of providing a valuable healthcare service in a spirit of mercy and charity to members of society who may never contribute to its sustainability. There is a difficult truth which is revealed at some level to all involved: many who benefit the most from such services (and use the most resources) tend to contribute the least to its sustainability (or will never contribute at all). It is when one acknowledges this time-proven mysterious truth that one can clearly identify with the compassion of our Lord and Savior Jesus Christ, who gave his life for all knowing that those who benefit from his work of love and mercy will never be able to adequately repay him. As we serve those who have no way of adequately repaying us (or who decide not to give back for whatever reason), we learn a valuable lesson as we grow in virtue and in the likeness of Jesus our Lord.

There are many things that healthcare service will never change regardless of improvements in accessibility, quality, or compassion. Our master's saying that we will always have the poor with us has

always proved to be true. Although making a difference one life at a time is very beautiful, good and true, the greatest difference is sometimes the transformation that takes place in the heart and character of the servants. It is through the true sacrifice of picking up and carrying one's cross that eternity is changed from the inside out. Such goals and desires are embodied in the work and mission of COLM.

It is due to such local Christ-centered organizations that a simple ministry of health care is raised to a greater cause: to care for all members of the community, even those who are not labeled as having a healthcare need. Volunteers, therefore, are composed of an eclectic gathering of individuals from various fields of labor, who have various talents (even to the point of having no healthcare experience or notable relation thereto). At first glance, it would seem that such a group of volunteers with little or no training in health care would be a detraction at least or a liability at most. On the contrary, since its inception, COLM has demonstrated that such a team of volunteers creates a much stronger force of health care for the community than one could dream of having. Volunteers with no healthcare experience learn quickly how to help in simple or even more profound ways as they integrate into the healthcare team. Many such volunteers would argue, however, that the ministry serves the volunteer much more than the patient.

SUGGESTIONS

As the healthcare field grows in a modern world of efficient transportation, high speed telecommunications, and increasing diagnostic and therapeutic advances, there is great potential for the local charitable healthcare ministry to reach many in their community as they integrate many of these

advancements into their daily service. It has been discovered that many of these advances which at first glance may seem cost prohibitive are actually realizable and cost effective when the community begins to seriously and prayerfully examine possibilities and work with respective companies. Many companies have been excited at the opportunity to contribute their services to COLM in a charitable way.

In recent years, communities have been blessed by increasing collaborative efforts of local charitable organizations working together on specific projects and the creation of effective pathways for getting those with a need to the right organization which provides the respective service. COLM has found a great benefit in working with local foundations, service groups, churches, and local charitable organizations (including other charitable clinics). Collaboration with other organizations (even those that may not be completely congruent in mission and morals) has been a way for opening opportunities for service and even a way of spreading the culture of life and living the New Evangelization.

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CULTURE OF LIFE MINISTRIES MISSION STATEMENT

We serve all people in the Harlingen community and its surroundings through a

healing ministry. We strive to restore physical, mental, and spiritual health. We agree to work together in solidarity to welcome all who seek to serve or be served. The services of this ministry are a gift to all, therefore no fee or charge or payment is requested or desired. We strive as servants to treat all as if they are our lord and savior Jesus Christ.

We embrace the culture of life and strive to reflect this culture in living out the morals and teachings of Jesus Christ in our interactions with others. We embrace health in all its forms from pregnancy/conception to birth to natural human development and even to natural death. Therefore we do not promote or offer anything which opposes the culture of life such as contraceptives, abortions, sterilizations, physician assisted suicide, etc.

DEFINITIONS

Health Services: “The most visible function of any health system, both to users and the general public.” Those services include “all service dealing with the diagnosis and treatment of disease, or the promotion, maintenance and restoration of health. They include personal and non-personal health services” (Kim and Konrath 2015).

Human dignity: “The ethical, legal, and political discourse as a foundational commitment to human value or human status,” “It is a potential to bridge different fields of regulation—human rights, bioethics, humanitarian law, equality law and others—that we might take to be the most important function of human dignity in international law” (Stephen Riley 2016), (United Nations 1948).

Solidarity: “Unity or agreement of feeling or action, especially among individuals with a common interest,” “mutual support within a group” (Riley 2016).

Subsidiarity: “(In politics) the principle that a central authority should have a subsidiary function, performing only those tasks with cannot be performed at a more local level” (Riley 2016).

Common good: “The benefit or interest of all” (Oxford University 2016b).

Poverty: “Often defined in absolute terms of low income—Less than US \$2 a day,” “Poverty is associated with the undermining of a range of key human attributes, including health” (Oxford University 2016b).

Christianity: “The religion based on the person and teachings of Jesus Christ, or its beliefs and practices” (Oxford University 2016a).

Volunteer: “A person who freely offers to take part in an enterprise or undertake a task” (Oxford University 2016c).

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