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ARRIVING AT A PREFERRED DOCTORS REFERRAL LIST
FOR USE IN PASTORAL COUNSELING

Daniel P. Kriefall

Spring 1993

Concordia Seminary
Saint Louis, Missouri

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CONCORDIA SEMINARY

ARRIVING AT A PREFERRED DOCTORS REFERRAL LIST
FOR USE IN PASTORAL COUNSELING

THE MAJOR APPLIED PROJECT SUBMITTED TO
THE FACULTY OF DEPARTMENT OF PRACTICAL THEOLOGY
IN PARTIAL FULFILLMENT OF THE DEGREE OF
DOCTOR OF MINISTRY

BY

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ABSTRACT

This Major Applied Project consists of a series of steps carried out by the candidate in order to arrive at a Preferred Doctors Referral List. The list consists of the names and locations of a select group of health care professionals in the St. Louis/West County area. The complete list (along with explanatory information) is included in the final section of the report.

The candidate selected this area for growth and development out of a heartfelt need for such a record of professional persons in his everyday work and ministry. As Director of Family Care and Counseling at St. John's Lutheran Church and School, a large and rapidly growing suburban congregation in Ellisville, Missouri, the candidate is frequently asked for such a name or recommendation within the context of his role as pastoral counselor on staff.

The goal of the Applied Project, stated in expanded form, then, is this: The candidate attempted to arrive at a list of preferred doctors in the geographical area of his congregation, focusing especially upon medical doctors and dentists, psychiatrists and family counselors, and to have a personal sense of confidence in making referrals from that list, having researched the subject, conducted private interviews, and enlisted the aid and opinion of the Christian community in arriving at a final selection.

INTRODUCTION

EMPHASIZING THE “APPLIED” IN A MAJOR APPLIED PROJECT

The real value of a Major Applied Project in a Doctor of Ministry program may be ascertained with a simple and direct question: Does the Project have at its heart and core a hands-on-usability for Christian ministry, or does the Project have to it the feel of one designed primarily to fulfill an academic requirement? Between the lines of this rhetorical question lies a strong personal opinion, to be sure; but it is an opinion worth mentioning in that it sets the stage for the content of the pages that follow.

The following pages represent a report and not a research paper in the usual sense of the word. As a report, it is designed to trace the steps of a Major Applied Project, one whose dominant objective is to present a simple, usable tool for parish ministry, and to supply samples and examples of that original idea placed into action. The report is not designed, therefore, to carry the weight of the Project. The real work of the Project was carried out in the field, was conducted ‘on assignment’, so to speak, and took the form of personal readings and research, interviews and consultations, and, most importantly, enlisted the aid of the membership of six large, suburban congregations. The objective of the Applied Project, then, was largely carried out among the people and by the people for whom the Project was designed.

Although the issue of referral in pastoral counseling is critical to the focus of the paper, no attempt will be made to produce a definitive work on the subject. Such

efforts are best reserved for those who are writing doctoral dissertations with that focus in mind. Key issues regarding pastoral counseling and the role of referral will be reviewed, however, and various sources will be cited, but only in a number and to a degree as to illuminate the significance and value of the Project's main objective: To develop a practical and useful instrument for parish ministry.

The Major Applied Project consists of a series of steps carried out by the candidate in order to arrive at a Preferred Doctors Referral List. This list consists of the names and locations of a select group of health care professionals in the St. Louis/West County, Missouri area. The complete list (along with explanatory information) is included in a later section of the report.

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The Word of God frequently refers to two realms that exist side by side in the world, namely, the realm of "this world" (1 Cor. 1:28, 2:12) and the realm of those

who belong to the family of God (Mt. 5:14, Jas. 2:5). As Christians, we are strictly cautioned against mingling our values and principles with those of the world (1 Jn. 2:15, Rom. 12:2, Jas. 4:4). In the first mid-week sermon on Matthew 18-24 in July, 1537, Martin Luther summed up the issue like this: “The devil always wants to cook and brew these two kingdoms into one mess.”¹ At the same time, whole sections of the New Testament are devoted to the work of the Holy Spirit (Romans 8, et al), sections which explain how the Spirit of Christ guides, directs, and nurtures His people in their everyday walks through life. How does the Spirit of God touch and move His people in appropriate directions? Very often through the words and examples of those people with whom the Spirit of Christ dwells (1 Cor. 12:4-11).

In order to apply this Scripture truth to the Major Applied Project at hand, one can begin by asking a series of important questions. For example: When it comes to selecting a health care professional, how should the Christian proceed? Considering the complex nature of the moral and ethical issues at large, are degrees attained, or popular status acquired, a truly sound measure for selecting such a professional person, one whose decisions may impact the life of the Christian immeasurably? Does one accept the word of mouth of the general public when it comes to such a recommendation? And, if not, how then might the Christian arrive at a list of good doctors for use by his family? Stated more appropriately, how might he arrive at a list of doctors who are good for his family as Christian people?

The answer to these questions sets the stage for the overriding theme of the Applied Project: The goal of the Project was to allow the Spirit of God to speak as directly through His people as possible in arriving at a Preferred Doctors Referral List, a list based, in large part, upon the prayerful discernment of the Christian community itself.

CHAPTER 1
THE BASIC ELEMENTS OF REFERRAL
Theological Dimensions

The theological dimensions of referral in pastoral counseling begin and end with the pastor's heartfelt desire to accomplish what is best for the counselee. Quoting from Charles Kemp's A Pastoral Counseling Guidebook:

The welfare of the individual or family is the primary consideration. The pastor should never attempt to do what someone else can do better.²

A theology of referral, therefore, if called upon to define it in the least possible words, might read: Since God wants what is best for His people, so, too, should the pastor, even when it means sending them to someone else for help.

One must be careful at this point not to be drawn into the huge, encompassing topic of the role of God in pastoral counseling as a whole. Books on the subject literally line the shelves of seminary libraries. A look at the titles gives one an indication of the flavor and popularity of the theme: Counseling and Theology³ Physicians of the Soul,⁴ Atonement and Psychotherapy,⁵ The Use of Scripture in Counseling,⁶ Pastoral Care and Families: Its Theology and Practice,⁷ When Religion Gets Sick,⁸ Theology and Pastoral Counseling,⁹ A Theology of Pastoral Care.¹⁰

The list is seemingly endless. Where it does wind down, there begins the list of book chapters and magazine articles on the subject. In keeping with the theme of offering suggestions that are likely to be used by the busy parish pastor, the candidate

would recommend two volumes for their brief yet meaningful contributions to the topic: Wayne Oates', The Presence of God in Pastoral Counseling,¹¹ and John B. Cobb's, Theology and Pastoral Care.¹²

At the same time it must be said that it is not possible to avoid the subject of the theology of pastoral counseling, pastoral care, and pastoral healing, in general, when the subject of pastoral referral is being considered. How, then, does one focus on the one and not the other? In the opinion of the candidate, the answer is that you don't; you simply limit the discussion of the theology of pastoral care to a select few sources that you found most enlightening and interesting before moving on to a discussion that directs itself exclusively to the matter of referral.

In Protestant Pastoral Counseling, Wayne Oates describes pastoral counseling as "an adventure in pastoral theology," and then goes on to say that James Smart has accurately defined pastoral theology as bringing "the whole of theology to a focus upon the point in the church's life where it attempts to deal with human beings not in the mass but as individuals or in intimate groups, family or otherwise."¹³ Oates arrives at this descriptive assessment based on a paragraph that he wrote prior to it:

We need now to examine critically the pastoral task of the minister in the light of the internal Protestant principles which have given dynamic and direction, warmth and compassion, to Christian pastors in every age who have taken these principles seriously and sought to focus them upon their encounters with people in need. Our purpose now is to focus four salient Protestant principles upon the meaning, purpose, and function of the Protestant pastoral counselor.¹⁴

The principles that Oates lays out deserve mention, along with a word or two of explication regarding each:

(1) The Sovereign Lordship of Christ.

This is the first principle that defines and illustrates the practice of pastoral care. In this sense, pastoral counseling in all its forms should provocatively challenge all idolatry and distractions. A distinctly pastoral counseling does not begin with the nature of man. Rather, it begins with the truth about God and His relationship to man. Oates drives home this point with a wonderful quote from John Calvin in Institute of the Christian Religion, Volume I:

The human mind is, so to speak, a perpetual forge of idols . . . stuffed as it is with presumptuous rashness, [the human mind] dares to imagine a god suited to its own capacity . . . it substitutes an empty phantom in the place of God. The god whom man has thus conceived inwardly he attempts to embody outwardly. The mind, in this way, conceives the idol, the hand gives it birth.¹⁵

The point that the author wishes to make is that as pastoral counselors we are challenged to a twofold prophetic role by the Lordship of Jesus Christ: (a) To cast down every high thing that exalts itself against the knowledge of God in Christ, including non-Christocentric therapies and counseling procedures and (b) To speak words of comfort and forgiveness to the penitent counselee. We are often called, as Isaiah was, to pick up the pieces, “to bind up the broken-hearted,” as he put it (Is. 61:1). A good pastoral counselor actively does these two things. In this way Oates clearly divides the role of the pastoral counselor from that of the secular counselor. At the same time the question “Is counseling a science, or an art/theology?” is addressed. For Oates it is clearly the latter as far as pastoral counselors are concerned.

(2) The Dialogue Between Creator and Creature.

Oates sets this over against the philosophical debate between the natural and supernatural causes of healing. He insists that we see the doctor [or counselor], the

praying Christian [or counselee], and various forms of medicine [or therapies], as parts of the total creation and God as Creator mobilizing both the hidden and revealed resources of His creation to bring about the healing process.

(3) The Consecration of Life and the Priesthood of All Believers.

This principle focuses upon the practice of pastoral counseling in at least three important ways. First, it underscores the mutual burden-bearing character of the Christian community, a fact which illustrates again the importance of a major theme in the Applied Project, namely, that the Christian community, as a whole, should be involved in the process of finding and recommending doctors for referral. Every man is responsible for his brother. No one is sufficient unto himself. For the pastor to publicize the need for counseling referrals sources is no evidence of a lack of confidence, or of competence, or of resources, but is rather the activation of a livelier faith-response in which God leads the Christian community to measures of mutual assistance with the fellowship.

In the second place, the priesthood of all believers is relevant to pastoral care and counseling in that it affirms the duty of all Christians to serve one another in love in all stations in life. The psychologist, the psychiatrist, the social worker, the orthodontist, the chiropractor, the internal medicine expert, all can from their stations in life sustain a Christian in his distress whether they are themselves Christian or not. If they are not Christians, and yet the Christian community, by way of a survey, confirms them as being a "preferred" professional, then the Christian community has a ministry to render to them in turn. They too have a need of a friend, a confidant, a pastor, a Savior. They are not sufficient unto themselves either. They receive the ministry of Christ also. If, by the grace of Christ, they should become Christians, they

would still function as always in their stations in life.

Martin Luther, in his Christmas book, says of the shepherds who went to see the Christ child:

The Scripture plainly says that they returned and did exactly the same work as before. They did not despise their service, but took it up again where they left off with all fidelity, and I tell you that no bishop on earth ever had so fine a crook as those shepherds.¹⁶

The third way in which the priesthood of all believers challenges our thinking with reference to pastoral care is at the point of the pastoral counselor as an independent entity. From a clinical point of view, counseling is by nature a shared responsibility, whether we think of it as such or not. The medical psychotherapist, for instance, shares his responsibility with the rest of the medical profession. Medical doctors as a whole might be said to share the Hippocratic Oath as a “Creed.” The pastor by the nature of his cliental shares his ministry as a counselor with “the Church,” (which will be discussed). This is why the caring concerns of the pastor should be taught to laypersons by the pastor, something the candidate has attempted to accomplish at St. John’s by means of the Stephen Ministry program. This is also why the pastor should be quick to ask for help from the laity when Arriving At A Preferred Doctors Referral List for Use in Pastoral Counseling.

(4) The Bondage of Self-justification and the Freedom of Justification by Faith.

Justification begins with the disclosure of God in Christ, who, “without asking a sign of worth, extended his forgiveness to those who trusted him rather than themselves and their activities.”¹⁷ When Luther grasped the truth that the justice of God had decreed in Christ that “through grace and sheer mercy, God justifies us through faith,” he said, “Thereupon I felt myself reborn and to have gone through open

doors into Paradise.”¹⁸

Wayne Oates continues this line of thought by clarifying that: “God has broken the vicious circle of rejection whereby a person moves from one idolatrously human relationship to another, hoping to find complete acceptance . . . by the transforming good news of the Kingdom that God is not man, that he, in Christ, is eternally different from man. Yet He has taken His stand with man in the event of the incarnation, the Person of Christ, and the indwelling Holy Spirit in the community of faith.”¹⁹

Hidden away in a book by a lesser known author, William Backus, in Telling the Truth to Troubled People, is a section titled “Christian Counseling Is Different.”²⁰ On first perusal of the title and the content of the section, one receives the impression that you are about to encounter another haranguing of the secular psychologist/psychiatrist. As you look more closely, however, what you find is a clear and wonderfully concise handling of the age-old debate. What you also find is a theology of pastoral care and counseling that is equally terse and thereby equally satisfying.

“Christian counseling is not just ordinary talk therapy done by someone who goes to church on Sunday.” Backus begins in an off-the-cuff style. “It trains in different values and grows out of different premises.”²¹ He continues by pointing out that without exception secular counseling systems assume that God is irrelevant to human well-being, emotional or physical. Problems confronted in psychotherapy or counseling have to be solved using the resources of human beings themselves. There is no help from the “transcendent” God. Such systems must lack ultimate values and deny fixed truths. “What is good for you and what is true are treated as relative, rather than fixed and absolute.”²² Then Backus supplies the polished nugget of a

paragraph that contains his particular theme or slant:

The major premise of Christian counseling is that truth makes people free when they believe and obey it (John 8:31,32). Here, the task in counseling is to replace misbeliefs with truth. Truth is firm and fixed because it is grounded in God who does not lie. The person who, through counseling, becomes better able to know, think, and do the truth will attain real and lasting freedom from the results of misbelief, from neurosis and uncontrolled harmful behavior.²³

Perhaps it is no accident that another such “nugget” comes from a pastor/counselor who is also Lutheran, Ken Haugk, known for his contributions toward Christian lay caregiving. In the short volume that serves to introduce his larger system of lay ministry, Christian Caregiving: A Way of Life, Haugk reflects on the fact that “We Are All Members of the Body of Christ” in such a way as to produce an abbreviated theology of the church and pastoral care all within the space of a few short paragraphs, and each with a direct application for a theology of counseling referral.²⁴

Take the following paragraph for example:

The Scriptures describe the Christian family in a variety of ways. One of the most powerful metaphors for this is used by the apostle Paul, who states that every Christian is a part of the body of Christ (1 Cor. 12:27). Just as the human body has many parts, so it is with the body of Christ (12:12). It encompasses people of vastly different ethnic groups, cultures, ages, abilities, and interests. Yet this heterogeneous body is a unity (12:13). Jesus has connected every believer with himself in such an intimate way that he lives in us and we in him. In a burst of creative love God has suddenly laced us fragmented, lonely humans to himself and to each other with threads of gold.²⁵

How could a group of people so defined and described not wish to be a part of a whole effort to find for one another the very best health care professionals available in their community?

However, it is Luther himself and not these Lutheran writers who speaks most powerfully when it comes to the doctrine of the Church. Often these discussions were designed to clarify the role of the Church and to distinguish that role from the one

being propagated by the existing Roman Catholic Church. In the process, and much like that of the four Wayne Oates principles we explored from Protestant Pastoral Counseling, there evolved a theology of parish care, as opposed to one that is uniquely pastoral; it is Christian love that “covers a multitude of sins” and not the priest or the pastor himself. Notice the all important presence of the pronoun “we” as Luther speaks on the subject of forgiveness:

The kingdom of Christ is so constituted that at the same time it has those who either for a while or always are either weak or strong. But those who are always strong are rare. And we should not harshly deal with the members of who are weaker than these; for the kingdom of Christ is the kingdom of consolation, a kingdom of the needy and afflicted. It is not established in order to force and frighten people unless they are proud and stubborn. Therefore we should impart consolation to those who are frightened and should tell them . . . Christ is the King of the needy.²⁶

In The Heart of Pastoral Counseling: Healing Through Relationship, Richard Dayringer presents perhaps the finest book chapter encountered on the theology of pastoral counseling. In Chapter Ten, “The Use of Christian Resources,” Dayringer breaks the “Resources” into three distinct categories and introduces them by saying that “Using these resources is [or should be] as normal to a minister as breathing: (1) Confession and Forgiveness, (2) Prayer, and (3) Scripture.”²⁷

Attempting to do justice to even one of Dayringer’s categories would take us farther from the focus of the report than it is wise to go. We must assume that most counseling pastors realize the profound theological, spiritual, and practical implications that each “Christian Resource” has to offer for their everyday ministries. It is, after all, just such a ministry of confession and forgiveness, prayer, Scripture, and, finally, healing, that the whole Church is about, and it is the individual pastor as shepherd of an individual flock who sets the wheels in motion. By his example and leadership he

becomes the prime agent or mover of his church in that direction. Referral counseling has in it the potential to become a valuable tool for carrying out this very task. Marie Cunningham says it well in “Consultation, Collaboration and Referral,” her single contribution to the volume, Clinical Handbook of Pastoral Counseling:

Pastoral counseling, psychological counseling and psychotherapy are by their very nature vital parts of the healing ministry of the Church. A concerned Christian companion who refers a hurting person to a pastoral counselor shares in the ministry of healing to which all Christians are called. A pastoral counselor who refers a counselee to a spiritual director, psychologist or medical doctor for more specialized care extends the effectiveness of his or her own ministry of healing. The process of referral, therefore, is an important part of the healing experience of the individual seeking wholeness and is important to the effectiveness of the pastoral counselor.²⁸

Several pages later she speaks more directly to this “healing ministry of Christ” as it relates to the pastor himself:

In order for the referral process to be truly an extension of the healing ministry of Christ, the pastoral counselor must make sound professional judgments regarding the nature of the needs of the counselee, the counselor’s own limitations in diagnoses and counseling, and identification of the professional who can best serve the counselee.²⁹

Again in the same book, there is a single, paragraph that summarizes the goals and objectives for the Applied Project as thoroughly as any:

A competent pastoral counselor builds a referral system branching through the surrounding geographic area. The system includes community mental health agencies, psychologists, psychiatrists, social workers, spiritual directors, physicians and clinics. Once the referral network is identified, the counselor should meet with the various mental health specialists. The purpose of these meetings is threefold: to insure the professionalism of the other specialists, especially concerning religious issues of the counselees to be referred; to establish good working relationships with the various specialists in the area; to develop a mutually acceptable manner of handling referrals. Once the referral network is in place, the pastoral counselor will discover that his or her own effectiveness has been enhanced significantly.³⁰

When a theology of care and of healing is being considered, it is finally imperative that we look at what might be the most critical element of all as it relates

to referral, namely, the role of the pastoral counselor after the referral is made. As Richard Vaughan says in Basic Skills for Christian Counselors, “After you have made a successful referral, your obligation to the counselee does not end.”³¹

He goes on to explain that counselees remain people of faith during the process of psychiatric, psychological, or any other kind of treatment and that they still need their relationship with God and with the church. Then, he makes the point a very personal and challenging one:

You, as a pastoral counselor, should try to help the individual . . . [to] derive the greatest possible benefit from his or her religious commitment. This may mean occasional visits with you during the course of therapy to strengthen the religious commitment. At this time questions and doubts about religion can be discussed as well as any conflicts between religion and psychiatry that may arise. The continuing relationship with you can have great significance to the former counselee and hasten the time when he or she no longer needs psychiatric or psychological care.³²

David Switzer recognizes referral follow-up as an even more important element in pastoral counseling by placing it in a list of five necessities that must accompany referral:

Fifth, the minister should reassure the person in crisis of his deep concern and verify the fact that the referral . . . does not mean that the minister will step out of his life.³³

Although theological implications were implied in each of the sources that dealt with referral follow-up, none succeeded in offering a Scriptural reference in order to illustrate what that theology can or should be at its most primary level. When our Lord Jesus assures us, “I will never desert you , nor will I ever forsake you,” he is presenting to the pastoral counselor both an example and a mandate (Heb. 13:5). As shepherds who follow in the footsteps of the great Good Shepherd, we must take his example, and the advice that it offers, very seriously.

We are not being challenged never to leave the counselee in body, which is why we will need to examine the whys, whens and hows of that process as it relates to the well-being of the counselee. However, we are certainly being told by the Lord's words and example that we are never to leave a suffering parishioner in spirit, just as He has never withheld His Holy Spirit from us. The plaintive voice of the Psalmist says it well: "Cast me not away from Thy presence, and take not Thy Holy Spirit from me." (Psalm 51:11)

In the absence of our consistent physical presence as primary counselor to the needy parishioner, we continue to function as his or her spiritual leader, advisor, shepherd; we continue to speak words of hope and of comfort and, above all else, of forgiveness. The words, "As a called and ordained servant of the Word, I announce the grace of God unto you. And in the stead, and by the command, of my Lord Jesus Christ, I forgive you all of your sins,"³⁴ must pour continually from out lips, in the congregational setting as well as in the company of the individual counselee who has been referred. To the pastoral counselor who fully understands the depth of his divine calling, no words will have a more profound significance upon his life and upon his work.

What Is Meant By Referral

Having explored the theological dimensions of referral in pastoral counseling, it is important to further define what is being meant by the term. Brian Childs, in Short-Term Pastoral Counseling: A Guide, offers this neatly polished version of a definition:

A referral is the directing of a counselee to another professional for further evaluation and treatment. By referring a counselee the pastor gives up only his or her counseling relationship with the person. Other forms of ministry, including pastoral care, visitation, and teaching are not to be terminated. Only the

formalized and limited counseling relationship is discontinued.³⁵

Indeed, the pastor is in a strategic position to assist people in finding competent and specialized help when they need it because many of them, his own parishioners in particular, trust a pastor's judgement and turn to him spontaneously when trouble strikes. This is more than a sweeping generalization or an opinion based on personal experience. Significant research on counseling by clergy confirms the truth of the statement, as pointed out by J. David Arnold and Connie Schick in their article, "Counseling by Clergy: A Review of Empirical Research," in the Journal of Pastoral Counseling:

Clergy bridge the gap between informal social support systems and more specialized formal helping professionals. Clergy have day to day contact with their parishioners and are highly visible in their communities when compared to agencies or private therapists.³⁶

The point, quite simply, is this: that a wise and studied referral is one of the most meaningful services that a pastor can offer a struggling parishioner. When a family or an individual in the midst of difficulty is prayerfully guided to effective help, this is a credit to the pastor, and not a detriment. In turn, the pastor is able to multiply his availability to troubled people many times over.

Unfortunately, many pastors feel that to refer is to admit that they are weak or inadequate in a crucial area of their ministry. This fact accounts for the troubling results of a nationwide study designed to determine where it is that people take their troubles when they surface in their lives. Gerald Grob sums up the sad news in his book, Action for Mental Health: "The helping process seems to stop with the minister and physician in the majority of cases, and far more so with the minister than with the physician."³⁷ Again it is Klink who, citing the same study, points out the fact that

physicians referred eight times as many persons to mental health facilities and practitioners as did ministers. It is clear that pastors have much to learn about the importance of what Klink calls "Pastoral care by referral."³⁸

At this point it should be said that there is limited justification for the reluctance many pastors seem to feel in making referrals in counseling. The vindication comes in viewing their counterpart in the extreme, that is, those few pastors for whom referral is so automatic and so mechanical as to appear insensitive or indifferent. Because of their too-spontaneous manner of referral, their potential as helping caregivers is greatly diminished and they miss out on some of the deepest and most meaningful experiences in the pastoral ministry. By not attempting to establish healing relationships with those individuals who may need precisely what they have to offer, namely, confession, absolution, the very Gospel itself, troubled parishioners often get the feeling that they are being passed off to persons less qualified to offer the healing that they seek. And, sometimes they are right.

Properly understood and carried out, referral counseling stands as a means of utilizing God's complete "team" of caregivers in an effort to help a troubled individual, couple, or family. It is a "broadening and sharing," to use the most frequently encountered quote on the subject, "and not a total transfer of responsibility."³⁹ Only by drawing on the specialized helping skills of others can pastors and ministers have time and energy to fulfill their unique Christian function as spiritual heads of a congregation.

At this point it is important to move away for a time from the arena of the writers on the subject to that of the actual parish, for it is here that the rubber meets the road, and it is here that the definition of referral in pastoral counseling moves from

generalities and theory to that actual needs and applications. The switch might be accomplished by raising a question that is central to the thesis of the report: What was it, exactly, that compelled the candidate to pursue the subject of referral in pastoral counseling to the extent and to the degree as to result in an investigation of the options and possibilities connected with the subject?

The answer to this question can be seen through the use of three examples, each recalling a visit and each occurring during the same week in which the candidate was arriving at a decision regarding a project that would be pertinent to his everyday ministry.

Example #1

A young woman, a new Christian and recent member to the congregation makes an appointment to see the candidate in his capacity as pastoral counselor. She arrives at the appointment and announces that she is pregnant and that she has recently been to see her doctor. He informed her that her baby “may be in some kind of trouble.” The doctor suggests that since it is early in the pregnancy she might wish to consider termination. The woman is shaken. She would like the opinion of a second doctor, perhaps a Christian doctor, “or at least someone who wouldn’t be so cold and matter of fact about the abortion.” Could the pastor recommend someone to her?

Example #2

The congregation receives into membership a new family that is transferring from a Lutheran parish in a northern state. Several weeks later the candidate receives a telephone call from the mother of the family. She has noticed his title in the worship bulletins. She is seeking a really good orthodontist, because their child had a truly bad experience with the previous orthodontist and the family doesn’t want to go through

that again. The candidate suggests his own dentist and a second doctor who is a member of the parish. Deep inside he wishes that he had more data and a longer list from which the new member might make her own selection.

Example #3

A middle-aged businessman and lifetime member of the congregation is being treated for chronic depression. He has seen the same psychiatrist for two years and receives medication for his condition. Intermittently, he comes to the candidate for pastoral counsel as well. He claims that his psychiatrist seems uneasy whenever the subject of God comes up. Finally, during his last session, the psychiatrist makes the statement, "Why don't you try leaving God out of this?" The remark is upsetting to the businessman. Can the pastor suggest a doctor "who better understands my faith and how important it is to me?"

Examples such as these are common occurrence in the candidate's office. In the case of the young mother, the child in question was a teenage daughter who felt that her orthodontist was touching her inappropriately. It was a matter of his arms and forearms being placed against her upper body. In the estimation of the parents, it may have been carelessness on the part of the doctor, or it could be the results of an overactive imagination on the part of their daughter. But how could they be sure? They did not wish to make an embarrassing and unfair accusation, nor did they want to discontinue their daughter's dental program in mid-treatment. But neither did they wish to appear insensitive to their daughter's opinion and concern. The mother asked, "How can one hope to confirm the moral character of such professional persons?" They were relieved when a job transfer brought them to St. Louis and the issue was avoided.

Long after the conversation had occurred, a great many questions remained in the mind of the candidate, questions that hung in the air long with the mother's plaintive tone. How, indeed, can one hope to confirm the moral character of such professionals? Other questions of a similar nature followed: What if the candidate had been the one to recommend that particular doctor? Is there any way to attempt a reasonable screening of the field? Might there not be a way to arrive at a list of recommended doctors, a list from which the family might make their own selection based on the input of other Christian families who themselves have a teenage daughter who has been fitted for braces?

These and other questions haunted the mind, sparked entirely by an incident that might have been innocent. What of the dozens of other situations that were in no way questionable? What about a doctor who recommends an abortion too quickly? What about a businessman who is asked to leave God out of his healing process? What about the woman who comes to the candidate's office twice monthly, burdened with guilt from an adulterous affair that she had with her psychiatrist?

Each time that such a situation presented itself, and each time that there was a request for such a referral, the candidate felt uncomfortable with the feeble list of doctors he had at his disposal. What did he really know about the ones that he did recommend? He often wished that there was a more responsible and trustworthy means of making such referrals. Or should he decline to make such suggestions at all, turning the counselee to a generic referral service such as those available through the hospitals and health care facilities, or from the social welfare systems? Should a Christian congregation be involved at all in a dental, non-emergency referral? Or, if so, how are such referrals different from psychological referral and should they be handled

differently?

The question of why to pursue a list of preferred health care professionals began to share a place of importance with the already existent questions of when, to whom, and for whom such referrals should be made. In the process, a new, more accurate definition of referral began to take shape. It was a personal definition that took an alternate path from those encountered in the readings. Certainly, referral in pastoral counseling is a “broadening and sharing, and not a total transfer of responsibility,” as has been quoted from Clinebell. It is also H. Norman Wright’s “best counsel you can give,”⁴⁰ Ronald Lee’s, “skilled work in action,”⁴¹ Harold Haas’, “two-way exchange,”⁴² Brian Child’s, “time-limited response,”⁴³ Richard Parson’s, “Acting Together,”⁴⁴ as well as being part of David Switzer’s, “total therapeutic plan.”⁴⁵ Yet, none of the sources on the subject seemed to capture the essence of what referral most commonly is in the pastoral office. They approached the matter from the backdoor in, walking on tip-toe, as it were, with shoes in hand, ever cautious not to offend the sensitivities of the counselee. What they failed to recognize in doing so is an important and noteworthy fact: That it is usually the counselee who is seeking to be referred.

Such was the lesson presented in the three preceding examples. There was a pattern to the visits, a pattern that revealed itself in the presentation problems on the part of the counselees. Each came to the pastor in search of a referral, not cringing in fear of one. Each came to the pastor with full knowledge of the fact that the pastor had little to offer by way of the help that they were seeking . . . except that he represented someone they could trust, someone whose opinion they valued, someone who might know about such things. In a practical sense, then, the best working definition of what

referral most commonly is might be this: It is getting the right person to the right place because he or she requested it. The troublesome question of who that right professional is becomes the significant one, while the time-worn questions of when and to whom to refer take on a more realistic perspective. Howard Clinebell, considered by many to be the father of pastoral counseling in the modern era, begins a chapter in his classic work, Basic Types of Pastoral Care and Counseling,⁴⁶ with the following quote from Thomas W. Klink:

Referral is not a pastoral failure. It is a subtle and important helping art . . . I purpose that we think about it as illustrative of the more generally useful skill of helping people to focus their needs and clarify their feelings.⁴⁷

Clinebell goes on to explain that, although it is seldom viewed as such, a basic skill in the art of referral is indispensable to a pastor's ministry of care and counseling. It is Wayne Oates who says it even more directly:

One of the reasons that pastors do not have time to do their pastoral ministry is that they insist on doing it all themselves . . . They have failed to build a detailed knowledge of the community as to the agencies, professional and private practitioners, etc., who could help them in their task.⁴⁸

Oates is far from alone in his description of the malady. In his own way, Clinebell is even more cutting when he describes the ultimate "victim" of the oversight: "By default, the 'lone ranger' pastor often deprives troubled people of needed specialized help that is readily available in the community."⁴⁹ C. W. Brister hits the heart of the matter as well with a more positive assessment: "The minister calls upon community resources, not in order to pass the buck, but because he wished the best for all persons concerned."⁵⁰

It is a goal of this Applied Project to do better, that is, to build a more "detailed knowledge of the community" as prescribed by Oates, and to put that knowledge into

practical use in the area of pastoral care and counseling within the parish setting. The details of that process will become evident in Chapters 2 and 3 of this report.

Guidelines For Referral

The question “Whom To Refer,” that is, which persons should a pastor send to someone else, becomes an important and provocative one. Many writers on the subject begin their list of potential candidates with a similar thrust: (1) Those who can be helped more effectively by someone else. Using this thought as a framework upon which to hang further considerations, they proceed along the lines of Howard Clinebell who, in addition to the guideline above, offers the following suggestions as well:

- (2) Those with problems for which effective specialized agencies are available in the community.
- (3) Those who do not begin to use pastoral help in four or five sessions.
- (4) Those whose needs obviously surpass the minister’s time and/or training.
- (5) Those with severe chronic financial needs. Public welfare agencies with trained social workers are appropriate referrals.
- (6) Those who need medical care and/or institutionalization.
- (7) Those who need intensive psychotherapy.
- (8) Those about the nature whose problem one is in doubt.
- (9) Those who are severely depressed and/or suicidal.
- (10) Those toward whom the minister has a strong negative reaction or intense sexual attraction.⁵¹

Clinebell explains that it is also important for pastors to build working relationships with one or more medical doctors in their community. His rationale is that a counselee who has not had a physical check-up recently should be strongly encouraged to do so if the pastor has any suspicion that the person may need physical

as well as emotional attention. If there is the slightest suspicion that,

neurological, endocrine, or other medical problems may be lurking behind or complicating psychological or interpersonal conflicts, the pastor should insist that the person consult a doctor. A close collaborative relationship with a physician is also vital in counseling with those who have psychosomatic problems, severe depression, suicidal tendencies, alcoholism, other addictions, menopausal problems, physical handicaps, chronic or terminal illness, severe sexual problems, geriatric problems, pronounced mood swings, or severe anxiety.⁵²

David K. Switzer explores an additional dimension to the question of whom to refer when he raises the issue of “Referral or Transferral?”⁵³ He, along with others who use the term, similarly define it as:

The term “transferral” is used to refer to occasions of severe crisis when a person is seen to be a danger to himself or someone else or is on the verge of a psychotic reaction. Not only is seeing someone else recommended, but the counselor takes whatever steps are necessary to get him there and does not relinquish his primary responsibility with the person until the other professional or agency clearly assumes it.⁵⁴

Another interesting slant to the question of whom to refer appears when William Oglesby approaches it entirely from the perspective of the unique position of the pastor and not the counselee. He explains:

One possible reason for this lack of clarity [regarding whom to refer] stems from the fact that in most attempts to define the point of referral the emphasis is on the condition of the parishioner . . . While there is definite logic in such a formula . . . the difficulty comes in that the situation of the minister is presumed constant throughout.⁵⁵

Then in keeping with his thesis, Oglesby offers three conditions (or “Limitations”) on the part of the pastor that should result in referral:

- (1) Limitations of time
- (2) Limitations of skill or experience
- (3) Limitation of emotional security⁵⁶

The first two “Limitations” from Oglesby generally speak for themselves. It is

the third that requires additional explanation:

To begin with, it is likely that this is not the best term to employ [Limitation of emotional security]; yet, to date, no other has appeared which gives promise of being any better . . . What is meant is the minister's freedom from emotional tensions such as threat, anxiety, fear, insecurity, loneliness, and the like. It is, of course, obvious that any such notion is always relative. Inevitably, it changes from time to time and from situation to situation.⁵⁷

Oglesby supplies several good examples where "limitations of security" tends to become critical, one being when the parishioner presents a problem or describes an experience which the minister has never resolved in his own life, say in the case of the minister who has never been able to work through feelings of resentment toward what seemed to him to be tyrannical or authoritarian attitudes of his father who felt guilty by reason of his resentment. This pastor as counselor would be hard pressed to help a parishioner whose presenting problem was hostility toward his parents. A second example that the author supplied was that of the minister whose understanding of sex was a mixture of puritanical prudery and morbid fascination; he would find it difficult to listen to the tangled struggle of a teenager or the agonizing confession of an unfaithful wife.

Following several more examples, author Oglesby was quick to point out that it is neither possible nor necessary for the minister to attain a perfection in all areas of his life. Indeed, it is his very participation in the varied struggles of human existence that enable him to identify with those who find themselves overwhelmed by this or that distress. The point, however, is that until the pastor has effected some kind of "general resolution" of any particular aspect of his life, he will find himself drawn to dealing with his own feelings rather than those of his parishioner.⁵⁸ It is this point by Oglesby that is worth mentioning because he is right, and he is right when he

concludes that in such a situation the only promising procedure is referral.

Earlier in the report, it was argued by the candidate that the question “To Whom To Refer” is the primary one since more people came to him seeking referral than those who came to him fearing one. Nonetheless, it must be acknowledged that there are indeed those who come to the pastor because they want to see their pastor and no one else. There are those who are convinced that he alone has the answers. There are those who fear the cost of outside counseling. There are those who believe a psychiatrist is called a “shrink” for a very real reason and they want no part of it. Reasons do abound for the frequent resistance to outside help. Therefore, an assessment of the steps that might be taken in order to alleviate apprehension on the part of the counselee is important.

Of all the sources, it was Clinebell once again (maybe his reputation is not overstated) who offered the finest set of “How To” guidelines for effective referral. This judgment is based not so much upon the length or completeness of the list as it is upon the degree of sensitivity that it reflects in regard to the counselee’s apprehension. Notice how delicately the author addresses each proposal. Also, following each listing the candidate will offer additional information that clarifies the author’s thinking, where needed, along with practical guidelines and suggestions for putting the proposal into action:

- (1) Create the expectation that referral may occur.

The function of assisting members in finding specialized help can be mentioned when the pastor’s availability for counseling is described in printed material. At St. John’s, we periodically publish fliers and informational packets for our new members. We include a description of the role each pastor plays and an overview of the functions

of the boards that he directs. In the candidate's description as Director of Family Care and Counseling are included the words, "Specializes in short-term and crisis intervention counseling." The candidate also mentions this phrase repeatedly in the church bulletin and occasionally in the question-and-answer type article, "The Counselor's Corner," that is published as a part of our monthly newsletter.

- (2) Mention the possibility of referral early in counseling relationships where it is likely to occur, explaining why specialized help may be needed.

Members who have mustered their courage to come to their pastor for help may feel some degree of rejection if it becomes necessary to refer them. This is true even if they understand why the referral is necessary. The longer the pastor waits to plant the seed of the possibility of referral and the greater the dependence that has developed, the more likely it is that referral will arouse feelings of rejection. Usually the candidate covers the prospect of referral during his initial visit.

- (3) Start where persons are in their perceptions of their problems and the kind of help needed.

Until the pastor understands these perceptions and expectations, he is in a poor position to make a referral. Counselee's inner pictures of their problems and their solutions is often very different from the counselor's perceptions of the nature of the problems and the help that is needed. The candidate continues to see one counselee in particular because she requires medication for severe depression. Long after he referred her she insisted that the medication was not necessary. They have an agreement that he will continue to see her so long as she continues to take her medication, and the arrangement has worked out nicely.

- (4) Work to bring counselee's perceptions of their problems and their solutions close enough to the counselor's perception to permit referrals to take.

This may require several sessions of counseling. Referral efforts often fail because counselee's perceptions of their situation is fundamentally different from that of the referring pastor. Such persons naturally resist referral by not going to the helping resource or by not continuing long enough to receive benefits. The example supplied in #3 applies equally well here. A reverse example also helps to make the point: The candidate sees a mildly schizophrenic woman who desperately needs psychiatric help but he has not succeeded in moving her to accept it. She finds constant excuses for not going to each doctor or for not returning once an initial visit has been made. Once, following an outbreak of physical violence, a transferral was accomplished but it did not last. She soon refused to take her medication or to return to the doctor to refill her prescription. The candidate continues to see the woman and continues to encourage her to refill the prescription. He has informed the doctor of the situation and together they hope to move her into accepting the form of treatment that she needs.

- (5) Help counselees resolve their emotional resistance to the particular helping person or agency recommended.

Thomas Klink emphasizes the linking of two vital helping processes-- acceptance of feelings and support of reality testing--in enabling persons to accept referral.⁵⁹ The pastor should ask about persons' feelings about a particular referral while helping them move forward toward accepting the reality of the need for specialized help. Attempts to refer persons without clarifying and accepting their feelings and enabling them to become more realistic about their need for other help usually fail.

For example, the candidate sponsored and promoted the formulation of an Al-

Anon/Adult Children of Alcoholics group on the campus of St. John's. The decision was based on his desire for a support group for his many counselees who were struggling with alcohol abuse related issues in the present or from the past. The group began to thrive, in large part, only after discovering and alleviating the fears, misinformation, and emotional resistance that had initially caused the group to flounder for lack of attendance. Dealing with these inner blocks often takes time and repetition, but it is an essential part of motivating a person to accept the help that is recommended.

- (6) Interpret the general nature of the help that persons may expect to receive, relating it to their own sense of need.

One must do this without making the mistake of overselling the potential help, a mistake that makes the therapist's or agency's work more difficult, or committing the agency or therapist to a specific treatment approach. Sometimes there is a thin line between selling and overselling a product when the need to sell is so crucial. However, an open and honest assessment of the recommended doctor or counselor is the best policy in the long run.

- (7) Establish strong enough rapport with persons to develop a bridge over which they may walk into another helping relationship.

The use of this trust bridge is facilitated if counselees know that their pastor is personally acquainted with the persons or agency to whom they are being referred. This truth affirms the importance and relevance of the interviews conducted by the candidate as a part of the Applied Project. It is always a great comfort to be able to say to the counselee, "I know this counselor personally. We went to school together," or "I've known so-and-so for ten years and he's always been a big help when I need to refer someone. I'd like for you to see him." It has even been helpful to

be able to say, “This counselor is affiliated with the seminary that I attended. I know that he counsels the seminarians and their families.” Any such personal connection and endorsement is worth more to the counselee than academic credentials.

- (8) Encourage referred persons to really try a given therapist or agency, even if they are only mildly willing.

You might call it the “Give it a try. What can you lose?” approach, without ever saying it, of course, in those exact words. A skilled therapist given only one session may not be able to knock down the barriers that he could easily topple in two or three visits. With those who are suffering from the effects of alcohol abuse in their homes, the candidate does all that he can to reduce their resistance to his on-campus Al-Anon/Adult Children of Alcoholics group by urging their continued attendance whether or not they cared for their first visits. In many cases this exposure allows the warmth and the informal group therapy to make an “end run around their defenses.” Their resistances gradually dissolve as they experience the acceptance and support of the group. The same procedure works equally well with other problems and other support groups in the area.

- (9) A final guideline is to let persons know that one’s pastoral care and concern will continue after the referral.⁶⁰

One cannot overstate this final point by Clinebell. The unique strength of referral by a pastor is that a pastoral care relationship can and should continue following a referral. This helps to lessen the sense of rejection. A “Pastor’s Guide to Community Services” makes this meaningful recommendation:

After you refer continue to show Christian concern and friendliness. Keep in touch with the agency . . . so that you can work together effectively to help the client. No community agency can take the place of a pastor or the fellowship of the church. In a healthy, collaborative working relationship, both the agency and the church should feel free to express any question or criticism of the other so that

there can be better mutual understanding and appreciation.⁶¹

In Basic Types of Pastoral Care and Counseling, Clinebell has more to say on the subject:

A collaborative interprofessional relationship may not be easy to maintain, but such a relationship often is in the best interest of the person being helped. In making referrals for psychotherapy, it often is necessary for the pastor to gradually diminish her/his supportive counseling in order to motivate the persons to move into another relationship.⁶²

The author goes on to spell out that a person who is in psychotherapy should not be allowed to “drain off” problems by continuing to counsel with the pastor. The relationship should be one of pastoral care, not pastoral counseling. Otherwise the person may attempt to use one parent figure against the other in a self-defeating manner. He suggests that it is usually appropriate for the pastor to ask “occasionally” how things are going in therapy. “If that relationship is unproductive, another therapist can be recommended.”⁶³

Perhaps the guideline was too delicate, in Clinebell’s estimation, to be included in his list in a general way, or perhaps he and the other writers on the subject of “How To Refer” have committed a regrettable oversight, for there remains an additional way to alleviate counselee resistance to referral that was not explored in the encountered readings. When appropriately applied, it has the potential to outshine all other suggestions in its overall effectiveness.

The candidate offers this personal suggestion with a note of caution and reservation:

Within the boundaries of good sense and reason, the pastor should supply examples from his own life and experience where a counselor or an agency served to benefit his family or himself.

Whenever such personal disclosures are made, the pastor must proceed with

care; he must never stray too far from his professional posture, nor must he in any way diminish the sense of confidence that the counselee holds for him. There is a large body of literature on the use of “self” in therapy, and within this literature both spectrums of boundry issues are explored. However, for now suffice it to say that the delicacy of the suggestion is outweighed by the profound impact that it can have on the counselee, not to mention the counselor.

In openly sharing his personal experiences in this way, the pastor increases the level of trust between the counselee and the counselor immeasurably. Also, he places the counselee in a position to understand that there is no shame or embarrassment in reaching out for help when it is needed.

For example, the pastor might say: “When my wife and I became concerned about our oldest daughter, we were quick to seek out the advice of a counselor who specializes in working with adolescents. Or, to bring the suggestion to its most personal level, the candidate has made the following disclosure more often than he can remember: “For a number of years I wrestled with the question of alcoholism in my family background and in my own life as well. My favorite uncle died from the disease when I was ten. He was only fifty-one at the time. It was something the family all knew about but never discussed. When early warning signs began to show in my own life, and my wife became concerned, it was time to do something.”

“I’d already had a number of conversations with friends an my co-pastors about her concerns and my own. They encouraged and supported me in seeking out a professional opinion. It was easy for me in a way. Maybe easier than it would be for you because I’d dealt with alcoholism so much. It didn’t frighten me and I didn’t view it as a moral failure. It became a matter of practicing what I’d preached in counseling

and I knew that I must do that. With as much openness as possible, I accepted a formal evaluation and treatment.”

“That was five years ago. Now I’ve accepted the fact that I am one of the ten persons or so who can never use alcoholic beverages of any kind and that makes it simple. It has been easy for me and yet I might never have arrived at the decision on my own. The decision came with the help of friends whom I love and who love me. It came with the help of a God-sent counselor who understood me. I want to be that kind of person to you, John, if you’ll accept it. And I want you to see my good friend, Marie Glenn, for the same kind of evaluation that I had. Once you’ve done that, the decision is your’s. But please tell me that you’ll do that much. I’ll call her and set things up if you like.”

It is not possible to relay the full effect that this approach has had on bringing people with alcoholism to a level of acceptance of their need for help. Once past the stage of denial, much can be done for the counselee and his family that would otherwise have been impossible, and the percentage of incidents in family counseling that relate directly or indirectly to drug or alcohol abuse is inestimably high.

The point is, what might have become a serious threat to the candidate’s personal and professional life has been used by God to become one of his most effective and well-polished tools for ministry. The writer to the Romans says it well: “All things work together for good to those who love [and who trust] in God.” (Rom. 8:28) But this scriptural truth was rendered possible only through an attitude of openness and trust toward his friends and co-workers. And that same spirit of trust must be extended to the counselees as well.

CHAPTER 2

COMMUNITY RESOURCES

Finding “Good Professionals”

Time has been spent describing the importance of finding the right professionals for referral. Now it is equally important to explore the avenues that lead to such an end. “What makes a professional a good professional?” is the question in a nutshell. It is here that the sources provide a variety of information that is both stimulating and helpful.

Since the matter of the pastoral counselor referring to another counselor or agency is often the most delicate one (as opposed to the pastor referring to another form of health care professional, say, to a medical doctor or to a dentist) it is best to begin with an examination of that scenario. In An Introduction to Pastoral Counseling, edited by Wayne Oates, A. Donald Bell offers a valuable section called, “How To Measure a Counselor’s Worth.” Here the subject is explored from a philosophical/sociological angle:

In counseling, as in every area of human relations, it is difficult to make accurate evaluations. Many people who have a good technical background in the field of counseling are unable, because of personality difficulties, to do a good job. Other people with a minimum of formal training seem to be made up that people will come to them. Certainly the ideal in measuring the worth of a counselor is to consider both aspects of the role--training and personality.⁶⁴

What A. Donald Bell is saying, of course, is that there is more to being a good counselor than having good credentials. Perhaps in the field of counseling more than in

any other, academic credentials are a mere starting point. Other elements of interpersonal skills come into play most profoundly, that is, a genuine heart, a listening ear, a good and honest spirit, and so forth. Without these, a counselor may cover his walls with diplomas and yet fail miserably. Some facet of his personality or of his basic nature block his efforts at effective communication, and without that communication very little is accomplished by way of helping and healing people. On the other hand, another counselor might succeed on the basis of his people skills primarily. It seems that somehow he demonstrates a willingness to reach out and touch the lives of those in need.

Other writers on the subject are more clinical in their approach. For example, the seven tests presented by Wayne Oates in his own book, Where To Go For Help, are more specific and precise:

- (1) Who sponsors your counselor?
- (2) Has the person been in the community very long?
- (3) Has the person been adequately trained for his task?
- (4) Is the counselor a person of basic spiritual integrity?
- (5) Has the counselor been reasonably successful in dealing with other people's problems?
- (6) Does the person promise much and do little, or does he promise little and do much?
- (7) Can you trust this person basically?⁶⁵

With this list, Wayne Oates is offering an alternative approach to determining the qualifications of a counselor than to rely too heavily on either personality or academic degrees. With whom is the counselor affiliated, Wayne Oates wants to know, and how is it working out? What are the counselor's clients saying about him

and how much faith do they reflect in his abilities? These are the questions that must be addressed, according to Oates. Track record and working situation determine a counselor's worth.

In a chapter titled, "Referral Counseling," in Basic Types of Pastoral Care & Counseling, however, Howard Clinebell calls attention to the fact that "Accurate evaluations of the competence of the various counselors, psychotherapists, and agencies in one's community are difficult to acquire." He continues:

The reputation that therapists or agencies have among physicians, counselors, and ministers provides a reasonably reliable guide. Beyond this it is helpful for ministers to become personally acquainted with as many possible of their community's therapists and social agency personnel. In my experience, the most trustworthy evaluations of therapists' personal authenticity and professional competency come from direct contact with them and from observing the outcome of referrals to them. By having coffee or lunch with such persons, visiting the local child guidance or mental health clinic, and attending open meetings of AA and Al-Anon, pastors build relationship bridges that can prove immensely useful when they need to make a referral.⁶⁶

For reasons that become clear in a follow-up explanation, a second paragraph of equal length should also be included from Clinebell's book:

A cooperative team spirit among the helping professions of a community does not happen by accident. Someone must take the initiative. In order to do pastoral work optimally, ministers need such a team. What is more, pastors are in an ideal position to take the initiative in this, perhaps starting with a monthly breakfast meeting of a small group of helping professionals in one's congregation and community. Such meetings enhance communication of mutual concern and build working relationships. Participants may begin to ask the pastor for assistance in helping their clients or patients deal with value and meaning problems, as well as overtly religious issues. Thus, collaboration between clergy and other professionals becomes a two-way street as it should be. To work effectively with physicians and mental health professionals, pastors may need to resolve self-esteem and authority problems that cause them to give their power away to these professionals.⁶⁷

There is so much of value being said in these two paragraphs that they deserve inclusion in spite of their length, and the content deserves further analysis. Indeed,

the majority of the suggestions that Clinebell describes had been undertaken by the candidate in an effort to arrive at a Preferred Doctors Referral List before he was aware that such a program had been prescribed by the venerable author. The book had been first read by the candidate during his years at Concordia Seminary, and many of the particulars had been forgotten. Or, perhaps, those details had been placed away in a subconscious portion of his memory, waiting to be exhumed when the time was right and the need presented itself. In any event, it was a serendipitous experience when the re-exposure occurred, given the set of circumstances.

When Clinebell says, “It is helpful for ministers to become personally acquainted with as many as possible of their community’s therapists and social agency personnel,”⁶⁸ it is advice that is worth its weight in gold. In fact, in the opinion of the candidate, based on his own experiences, it is the best single piece of advice that he encountered in the readings.

At the same time that such lavish praise is being directed toward the writer, it is necessary to use him as representative of a failure that appears in the thinking of the authors as a whole on the subject of referral in pastoral counseling. What Clinebell fails to point out or suggest in his recommendation of face-to-face visits is the extremely limiting nature of this approach to finding competent health care providers. The first problem is the most obvious, namely, the time element involved, or the lack of it, in most cases, on the part of the average parish pastor. Would the pastors really take the time to do it? This factor in itself narrows the value of the suggestion in terms of raw practicality.

It is a second, less obvious problem, however, that merits the greatest attention. By pursuing this course as a primary means of screening the field of

counselors and doctors, the pastor is placing himself in a position to be the single determining factor, either from the standpoint of his first hand visits with the health care professional or from the data received from the limited number of referrals that he has made to any one individual or individuals. The following remark, "In my opinion, the most trustworthy evaluations of therapist's personal authenticity and professional competency come from direct contact with them," is indicative of the error. To be fair to the author, the statement was first quoted in context; but that does little to eliminate the glaring flaw in the thinking.

It is this flaw that brings us directly in line with the dominant theme of the Applied Project at hand: Why just the pastor? When it comes to discerning the competency of doctors and health care providers, why not begin with the attitudes and opinions of the Christian community itself, or of as much of that community as you are able realistically to survey? These are the men and women who are in the best position to know who truly are the finest professionals. These are the men, women, and children whose bones have been set, whose babies have been delivered, whose teeth have been straightened, whose cares have been heard, whose physical and emotional wounds have been tended. Many of these laypersons have gone through the gut-wrenching process of trial and error in an effort to eliminate the charlatans, the careless, the inattentive, and ineffective doctors from the past, to replace them with a 'just-right' doctor or counselor whose healing ways they have come to know and appreciate. Why not ask them? Why should a counseling pastor in need of referral resources rely so heavily upon his own powers of observation and discernment?

The only question that remains to be asked is the simple one of how: How might the pastor arrive at what has just been termed "a realistic survey" of the

Christian community? The answer appears in the question itself: You ask them, with a realistic survey, literally.

Types of Referral

Having concerned ourselves with the quality or competency of the individual counselor when seeking to answer the question, “To Whom To Refer?” we still need to consider the matter of which type or specialty of counselor we are talking about. This depends, of course, upon the needs of the client.

Often emotional difficulties have a physical as well as a psychological cause as any counselor knows. According to Theodore Millon, this is especially true of severe mental illnesses.⁶⁹ Consequently, Richard Vaughan argues:

. . . those who are severely disturbed generally should be referred to a psychiatrist, who is a medical doctor and can prescribe medication as well as offer psychotherapy.⁷⁰

Vaughan goes on to explain that the psychiatrist’s skill in handling both chemical therapy and psychotherapy is a good measure of his or her competence. A critical part of a psychiatrist’s practice is diagnosis and the choice of the most suitable therapy for the particular person. Therefore, when the individual seems to the pastor to be “quite disturbed” and the pastor is uncertain as to the diagnosis, the counselee should be referred to a psychiatrist.⁷¹

It is this foggy area of the “quite disturbed,” to use Vaughan’s own words, that sets the stage for the largest controversy regarding pastoral referral among the writers on the subject. To refer to a psychiatrist, or not to refer? That is the question. One author in particular owes his claim to fame, to a resounding, “NO!” to the question.

Pastoral counselors with formal training will recognize the name, Jay Adams.

Quoting from the back cover of his most well-known work:

Seldom has a book written for pastors, Christian workers, and lay persons received such widespread attention and such avid readership as has Competent to Counsel. First published in 1971, the book has been reprinted more than thirty times! It has assumed the role of a classic in the field of Christian counseling.⁷²

The unnamed writer of the piece goes on to say that “the refreshing new approach to counseling advocated in Competent to Counsel, now firmly established as nouthetic counseling (from the Greek word ‘noutheteo’, to admonish, warn, instruct), obviously was a method of counseling sought by any who may have suspected that secular counseling techniques were not only antithetical to biblical truth but also amazingly barren and ineffective, and that Adam’s thoroughly scriptural approach offered a welcome escape from the deeply worn ruts of secular psychiatry.”⁷³

But it is the content of the volume that speaks most strongly for itself:

The real issue for the minister is referral. At this point he cannot dodge the question. He must ask himself, shall I refer my parishioner to a psychiatrist or a mental institutions, or can I do something for him?⁷⁴

Then, in a footnote to his own question, Jay Adams adds:

Referral of any sort ought to be considered by a minister only as a last resort. The fact that a counselee has sought out a Christian counselor should itself be considered of some significance. He may have selected him as a counselor precisely because he is aware of his sin and need for forgiveness.⁷⁵

Again in the original paragraph, he concludes:

. . . it is necessary for him [the pastor] to come to some conclusions about the true nature of the problems of the so-called “mentally ill.” The question must be considered from a biblical perspective, beginning with scriptural presuppositions, refusing to baptize Freud. Such a consideration reveals that the central issue boils down to a discussion of the question: Is the fundamental problem of persons who come for personal counseling sickness or sin?⁷⁶

Within the scope of this report it is not reasonable to attempt a meaningful

exposition of Jay Adams' stance regarding the "mentally ill," or that which he has termed the "issue of sickness or sin." In his book he devotes a full chapter to the subject.⁷⁷ For now suffice it so say that many writers on the subject of referral share the same perspective as Adams, although to a lesser degree.

Kenneth Haugk is one such writer who represents the more common, middle-of-the-road stance. An advocate of "holistic" congregational caregiving and founder of the Stephens Ministries program of lay involvement, Haugk is much more a counselor and director than he is a writer on pastoral counseling. Yet he begins one chapter in his book, Christian Caregiving: A Way of Life, in this noteworthy and catchy way:

Sometimes I think of sending this letter to Sigmund Freud, the founder of the modern mental health movement:

Dear Sigmund,

I admit that the techniques and insights you and your followers have developed are vital to the treatment of troubled people. But there are questions of life, death, meaning, and spirituality that you never touch.

Sincerely, Ken⁷⁸

Haugk is not completely accurate when he describes Freud as the founder of the "modern" mental health movement, or when he claims that the venerable psychiatrist never touched upon spiritual matters. Freud had a lot to say about the place of God in the human psyche, all of it bad, which accounts for the walls of defense that are often erected against him.

As early as 1958, Jay Adams points out, in a paper read at Harvard University, Leo Steiner made this statement:

The ministry makes a tremendous mistake when it swaps what it has for psychoanalytic dressing . . . Where will psychoanalysis be even twenty five years from now? . . . I predict it will take its place with phrenology and mesmerism.⁷⁹

The paper was titled, “Are Psychoanalysis and Religious Counseling Compatible?” and time and the theme of the paper have demonstrated the danger of taking the extreme position on the age-old debate. In the opinion of the candidate, the better posture is to allow each to do what each does best, without insisting on a high degree of compatibility, and to utilize psychiatric services in conjunction with pastoral counseling, especially in those cases where there is a clear diagnosis of the need for medication.

In a lesser known of his works, Mental Health Ministry of the Local Church, Howard Clinebell supplies a list of signs the pastoral counselor should look for in confirming a decision to call upon the aid of a psychiatrist:

- (a) Persons believe (without any basis in reality) that others are attempting to harm them, assault them sexually, or influence them in strange ways.
- (b) They have delusions of grandeur about themselves [the Napoleon complex].
- (c) They show abrupt changes in their typical patterns of behavior.
- (d) They hallucinate, hearing nonexistent sounds or voices, or seeing nonexistent persons or things.
- (e) They have rigid, bizarre ideas and fears, which cannot be influenced by logic.
- (f) They engage in . . . repetitious patterns of compulsive actions or obsessive thoughts.
- (g) They are disoriented (unaware of time, place, or personal identity),
- (h) They are depressed to the point of near-stupor or are strangely elated and/or aggressive.
- (i) They withdraw into the inner world, losing interest in normal activities.⁸⁰

This is not the time nor the place to lapse into a diagnostic discussion about what each of Clinebell’s signs might indicate, except to say that an alert pastoral

counselor will recognize them as signs of severe mental disturbances. When such signs appear, it becomes the duty of the pastoral counselor to help such persons and their families to find specialized mental health treatment as soon as possible. The recovery rate from severe mental disturbances is higher if intensive treatment is begun at an early stage.⁸¹ Well-chosen doctors are the pastor's and the family's logical allies in such situations.

Charles Kemp supplies an even more extensive list of factors that "may indicate that such a referral is advisable." These appear in Section 27 of A Pastoral Counseling Guidebook under the heading, "Psychiatric Referral."⁸²

Finally, Harold Haas offers a complete chapter that speaks to the important and delicate issue, Chapter 7, "Signs of Severe Disorder and Referral," in Pastoral Counseling with People in Distress.⁸³ It is a chapter as good as any on the subject and should be read by every pastoral counselor who takes his or her duties in this area seriously. One can go on and on citing sources and recording the opinions of various writers on the subject of pastoral referral to psychiatrists. The candidate was overwhelmed by the number (virtually hundreds) of articles that have addressed the issue. But to pursue the matter further would detract from the focus of the report rather than illuminate it. Before moving on, however, he would recommend one better, full-book overview of the subject, namely Allison Stokes', Ministry After Freud, which tells the fascinating story of the impact of Freud's depth psychological discoveries on the practice of American Protestant ministry.⁸⁴ Another work, Josef Rudin's Psychotherapy and Religion, which is directed, in the words of the author, "to the wider circle of those who are alarmed by the real or apparent opposition between the new insights of depth psychology . . . and the basic convictions of theology,"⁸⁵ is also

worth reading.

Two of the most current articles available, can supply the reader with an updated assessment of the very old issue of debate. The first is Joseph Driskill's, "Pastoral Counseling and Spiritual Direction: Enrichment Where the Twain Meet." Written in regard to "Protestant pastoral care, which turned increasingly away from its own historical and theological traditions to embrace findings in social sciences, and has become interested again in the unique gifts that religious counselors bring to the counseling context."⁸⁶ it explores these issues in full. Another by H. Newton Malony, "Making a Religious Diagnosis: The Use of Religious Assessment in Pastoral Care and Counseling," shows the author assuring "a unique role for pastoral counselors in the helping process and providing a model that avoids over-dependence on psychology and psychiatry."⁸⁷ Both articles appeared in Pastoral Psychology in the new year (1993).

The subject of the exact type of mental health care professional to whom to refer, and when, remains a matter that needs to be explored, and a number of insightful articles have been written on the subject as well. Among these are Minnie L. Waterman's "Pastoral Decision: To Counsel or Refer," which appeared in the Journal of Pastoral Care.⁸⁸ In the article, Minnie Waterman takes the position that the question of "ego strength" has an important bearing on the decision. According to Watermann, persons with weak egos generally respond best to help that is primarily supportive [active listening-based] rather than uncovering [psychoanalytical]. The goals of such therapy, in her opinion, are to help persons gain strength by blocking regression, limiting their impulsive "acting out," and helping them handle their adult responsibilities and use their personality strengths (rather than trying to erase their

liabilities). Waterman contends that “social casework agencies” are often able to provide this form of “ego-adaptive” therapy, while persons with psychoneurotic problems and a reasonable degree of ego strength often are able to utilize the various forms of uncovering psychotherapy in growthful ways.⁸⁹

Although there is value to what is being said by Waterman in regard to finding the right ‘type’ of counselor for the right counselee when the decision to refer has been made, the article is included in this report not for its strengths but for an inherent weakness, and in this way it serves to demonstrate a problem in the thinking of a great many writers on the subject.

The problem reveals itself when Waterman automatically resorts to a language of “ego strength” and “social case work agencies” as the logical alternative to the pastor as counselor or the psychiatrist or psychoanalyst. Between these two alternatives lies a body of people, a group of trained professionals, that the candidate believes to be the most useful and appropriate extension of his own ministry of care, namely, the clinical psychologist with a background and expertise in pastoral or in Christ-centered counseling.

Although such Christian clinical psychologists cannot prescribe medications because they do not have a medical degree, this fact often proves to be an advantage to their overall program of health care providing for they are called upon to “counsel” and to “care” their way toward healing rather than to resort too spontaneously to a system of drug applications. This is in no way intended to imply that there are not cases, and many of them, where the needs of the counselee demand the use of medication. A classic case, of course, would be that of the chronically depressed individual with a chemical imbalance. However, far too often the role of the

psychiatrist as a ‘counselor’ has been abandoned altogether, which lends immeasurable support to the recommendation of a good and competent psychologist, especially if that psychologist is a woman or a man with a heart for Christian caregiving.

The candidate has discovered that such clinical psychologists usually have a doctorate degree (and virtually always a master’s) in the areas of psychology or counseling or both and have been licensed (or are moving in that direction) by the state in which they work. Their training generally consists of an intensive academic program over a period of four to five years and an internship in a hospital or agency. Many professional Christian psychologists continue to take courses in graduate classes where their work has demonstrated a need for specialized development. Clinical psychologists are often equipped to help people with neurotic and adjustment problems and some of the more experienced psychologists care for psychotic clients as well, usually in conjunction with a psychiatrist who prescribes the necessary medication.

In the opinion of the candidate it is these men women and who are the most valuable resources for the counseling pastor in need of making referrals. Consequently, it is these individuals whom the pastor should make a special effort to get to know personally, to meet and to interview. Often this is most realistically accomplished by setting up an interview with the director of the agency as representative of the individual counselors on staff. This was the direction most vigorously pursued by the candidate in partial fulfillment of the goals of the Applied Project. More will be said regarding the scope and nature of those interviews in the methodology section of this report.

Counselors who specialize in marriage and family problems are another source for referrals that should be mentioned under referral types. Richard Vaughan offers the following description by way of categorizing their particular vocational training and expertise:

Marriage and family counselors usually have a master's degree in marriage and family or counseling psychology and at least a year, usually three years, of supervised experience. In many states, marriage and family counselors need certification before they can practice. They are trained to handle marriage counseling and problems related to family life.⁹⁰

Not a great deal more needs to be said about marriage and family counselors since the agencies that have been discussed previously usually have counselors on staff who specialize in this area as well.

The matter of making good referrals to social and welfare agencies is a far more complex one. John L. Mixon, best known for his work in social ministry, suggests these principles to the parish for making such referrals:

- (a) Secure basic information regarding the agency. This should include an understanding of the purpose, functions, and intake policy. To guess at possible services to be rendered by an agency resulting in indiscriminative referrals is a waste of everybody's time and frustrating to the person to be served.
- (b) Do not commit an agency to a specific service or solution. The agency must be free to assist within the limits of its resources and in relation to the real needs of the applicant.
- (c) Provide such information as you may have to the agency called upon, either by letter or by phone.
- (d) Follow up all referrals. This will enable you to evaluate the services for the future. Your understanding of what took place will assist you in the further consultation if the person returns to you.⁹¹

Howard Clinebell also offers some suggestions in regard to making referrals to social agencies, beginning with a very general one, namely, that pastors should begin

to prepare themselves for an effective ministry soon after arriving in a new parish.

According to Clinebell this includes doing two things:

- (1) Assembling a growing referral file of community resources.
- (2) Building relationships with the social agencies and helping professionals.

“An organized file,” the author contends, “becomes increasingly useful as the minister accumulates information about social agencies; directories, marriage counselors, and AA groups, etc.; phone numbers of pastoral counseling centers, emergency psychiatric facilities, mental health clinics, suicide prevention centers, etc.”⁹²

What are the major problem areas where the pastor needs to draw on community resources in counseling? One referral manual by Marcus Bryant and Charles Kemp, The Church and Community Resources, includes helping resources in these categories:

Adoption and child placement, alcoholism, financial assistance, business problems, child guidance, child welfare, child abuse, crisis intervention, day care, correctional institutions, deafness, crime and delinquency, dental services, disaster relief, drugs, older persons, planned parenthood, problem pregnancies, retirement, retardation, veterans, vocational guidance, youth services.⁹³

Published here in St. Louis, this manual by Bryant and Kemp also includes a directory of national resources, church related, governmental, and voluntary, as well as a section where pastors may enter their own working list of local phone numbers and addresses. Filling in this section would be a good starting point for following Clinebell’s suggestion that a pastor begin “assembling a growing referral file of community resources.”

However, at this point the candidate would like to offer an alternative suggestion that is in keeping with his goal to keep the Project as practical and as

usable as possible. With the exception of his suggestion that a congregational survey be conducted in order to arrive at a list of preferred doctors, this suggestion is offered to the parish pastor with his strongest possible recommendation: Dispense with all the idealistic notions that given enough time you will come up with your own list of community resources; dispense with the idea that sooner or later you will arrive at a suitable collection or file of social service directories, referral manuals, and informational guides; dispense with all such well-meaning but unrealistic ambitions and simply do this--place into your hands a single copy of the Community Service Directory of the United Way from your area and introduce it to every member on your staff. In the opinion of the candidate, this is the best way to begin the process of putting information into the hands of the members of your congregation. Following that the pastor may further research the subject as his time allows, carefully including in a separate list those highly trained and highly skilled care providers that may have been excluded from the United Way directory.

Such United Way directories are available for all the larger metropolitan area throughout the United States and they cover extensive portions of the geographic area surrounding each city. The candidate repeats: They are one of the best community and social service resources available.

In order to supply a detailed description of the Directory, and to give the parish pastor a flavor for the vast number of resources that are listed, the candidate will discuss the 1989-90 Edition of the Community Service Directory of the United Way of Greater St. Louis. But remember, the St. Louis/Bi-state area is not one of the larger metropolitan areas in the country. Published annually or bi-annually, the current listings for your particular locale may well be even more extensive.

We begin with a definition of the goal of the Directory as it appears on page ii in the forepart of the volume under “User’s Guide”:

The goal of the 1989-90 edition of the Community Service Directory is to provide a comprehensive listing of direct service programs provided by health and social service organizations in the greater St. Louis area. With the exception of selected state governmental agencies, the organizations listed are located within the United Way’s ten-county service area . . .⁹⁴

The information on community resources is presented in an easy to read format developed with the assistance of community professionals. The page size is a full 8 1/2” by 11” and there are a total of 514 pages. Cross references and indexes of two types (Popular Name and Programmatic) aid the reader in locating resources. Descriptions of the function and purpose of the individual agency/program/organization accompany each listing. All information is computerized in the Service Agency Inventory System (SAIS) database which contains over 1,200 health and human service organizations. The system is in daily use at First Call For Help, the United Way’s telephone information and referral program. They have commissioned a computer program to organize and print each page of the Directory in a fraction of the time required for manual editing. This means that the information is extremely accurate and up-to-date.

The Community Service Directory is part of the continuing commitment of the United Way of Greater St. Louis to enhance the availability of information on human services in the area. The book contains detailed information on over 900 organizations small and large, private and governmental, at over 3,000 service sites offering more than 6,000 programs. This includes not only the entire bi-state area but also some “outstate” (mostly governmental) organizations.

All information presented in the Community Service Directory has been

compiled and updated with the help of agency representatives. Agencies which are listed are included primarily because they provide an established and continuing program of services with a regular contact person. The candidate has found the information to be extremely accurate and up-to-date.

The Directory may be purchased by check or money order made out to The United Way for \$20.00 plus \$2.50 shipping, or may be picked up at the United Way office. However, if your church has an operating food pantry, you are eligible to receive a complimentary copy upon request. A National Directory of Information and Referral Services is also available for \$25.00, plus \$2.50 shipping. This book contains a state-by-state listing of all available services and the same basic information as contained in the local directories.

Contacts may be made by way of the following:

Community Services Department
United Way of Greater St. Louis
1111 Olive Street
St. Louis, MO 63101-1951
(314)421-0700 or (618)398-1951.

The preceding information has been collected from the Forward of the described edition, and from telephone conversations with Kaye Archer-Newberry, Senior Associate, Information and Referral Services, the United Way, St. Louis, Missouri. Mrs. Archer's private line is (314) 539-4035 and she encourages calls from pastors when special help or information is needed.

Finally, because it is not possible to describe fully the Agency Profiles, the Indexes, and the Guide to Programs contained in the Community Service Directory of the United Way in the body of this report, the complete User's Guide, along with sample pages from the Directory itself, have been duplicated and appear in the

Appendix to the report. (see Appendix 1)

Letter's That Speak

We began this chapter of the report with the question, "What makes a professional a good professional?" We analyzed the difficulty one encounters in making such a judgement, reviewed some suggestions on the part of the 'experts' for arriving at a decision when it is needed in referral counseling, studied the issue of referral 'types' to be made, and the candidate shared his opinion that the sources he had reviewed overlooked an obvious fact, namely, that it is frequently the counselees who are desirous of referral.

Which brings us back to the original question. What makes a professional a good professional? A number of the notes and letters that accompanied the returned survey forms speak to the question (and to the theme of the project) far better than the candidate could hope to accomplish in another way:

Dear Pastor Kriefall,

As a member of Lord of Life and also a registered nurse, I feel you are addressing the need for a long overdue resource.

Enclosed is my form and one from a friend of mine.

Kind regards,
Carol K.

Dear Pastor Kriefall,

I recommend Dr. John Mantovani to your Preferred Doctors List. He is a Pediatric Neurologist. Dr. Mantovani was very helpful and totally encouraging to us.

When you (as a parent) are told your child has a medical condition which cannot be "fixed," it is good to have someone by your side that can be optimistic about the future. This man was fantastic. Besides, he is also accurate and

knowledgeable.

Linda S.

Dear Pastor Kriefall,

I recommend Dr. Robert Cralle to be added to your list of excellent Christian doctors. Dr. Cralle served as my father's vascular surgeon. He is very caring, patient, and willing to talk to his patients and their loved ones. Dr. Cralle provided my father excellent medical service along with a sincere and caring attitude.

Sincerely,
Bill S.

Although unsolicited, such notes came in with regularity and they were always a great joy to receive. It was this last letter, however, that truly captured the spirit and attitude that the candidate hoped to uncover through the use of the survey:

Dear Pastor Kriefall,

Dr. Robert Blaskiewicz is a very caring and understanding doctor. He always took the time to make sure everything was explained to my satisfaction. He considered every concern of mine as being important. On the day my baby was delivered he called the hospital constantly and carefully monitored my progress. He was very dedicated and goes beyond the call of duty. I felt he honestly cared about me as a person and my baby.

When we were having difficulty conceiving, Dr. Blaskiewicz did everything possible and encouraged us to try. He is very pro-life and children are important to him. If it were not for his persistence and gentle caring ways we may not have our wonderful 20 month-old daughter today.

When I was in the hospital I had some trouble late at night with medication. My husband called the doctor and he immediately called the hospital and the nurses really moved then. Before they weren't going to do anything for my problem. This was about 2:00 a.m.

Recently I was in the hospital for a kidney stone. I was under the care of two

doctors. I quickly learned neither one of them cared about me at all. The appreciation for Dr. Blaskiewicz really surfaced at this time. I wished I could go to him for my kidney stone!

This doctor truly deserves to be listed among the best!!!

Sincerely,
Susan M.

In an interesting and short book, Basic Skills for Christian Counselors: An Introduction for Pastoral Ministers, Richard Vaughan makes the following observation:

It can be said that there is no substitute for knowing the professional personally, which means that you would do well to meet with a couple of psychiatrists, psychologists, and marriage and family counselors in your locale and discuss religious and other issues with them.⁹⁵

The author is making the remark in regard to the method for discerning the competency and trustworthiness of the professionals that he names. It is hoped that the reader will share to some degree the candidate's opinion that there is, indeed a "substitute for knowing the professionals personally." There are, indeed, a great many substitute opinions available after all.

CHAPTER 3

METHODOLOGY

The remaining pages of the report explain the methodology that was pursued in arriving at a Preferred Doctor's Referral List. That methodology followed a three-part program: 1) Interviewing significant health care personnel associated with the two major hospitals in the area. 2) Visiting and interviewing key health care professionals (doctors and counseling agency directors in particular). 3) Designing, conducting and implementing congregational surveys.

Hospital Personnel

Beginning in the same week that permission was received from Concordia Seminary to pursue this proposed Major Applied Project, the candidate embarked on a series of personal interviews with key health care professionals in the two major hospitals in the geographical area of his congregation. The first interviews took place on a one to one basis with Dr. Thomas Hooymann, Director of Institutional Ethics at St. John's Medical Center. The interviews consisted of two separate visits of one hour each. The second interviews were conducted in a group setting and at a meeting arranged by Mr. Paul Wunderlich, President of the St. Luke's Hospital System. Present at this meeting were Mrs. Christine Scanlon, Director of Marketing and Public Relations, Dr. John Schaeffly, Chairman of the Ethics Committee, Mr. Gary Olson, Director of Administrative Offices, and Rev. Edward Heathcock, Chaplain and Head of Pastoral Services. The purpose of the interviews was fourfold:

- (1) To grow in a personal understanding of the ethical issues being addressed in modern medicine.
- (2) To be better equipped to answer hard questions being raised by the candidate's counselees regarding issues in particular, namely, abortion and life support.
- (3) To arrive at a clear understanding of the hospitals' formal positions on these issues and how those positions affect the personal positions of the doctors on staff.
- (4) To be better equipped to refer, or not to refer, to the various staff doctors.

The weight and depth of the knowledge that was gleaned from these interviews cannot be presented in a cursory way. The value of the experience as an informational tool, and the example it provides as a model for screening, would be

understated and minimized. Therefore, and since tape recordings were made, those recordings have been transcribed and the transcripts are included as an Appendix to this report. (see Appendices 2-3) The transcripts are included for those pastors who may be wrestling with some of the same questions regarding referral and medical ethics issues.

Doctors and Agencies

In addition to the interviews just described, numerous other contacts have been made of a less formal and structured nature. These include meetings and consultations with the following health care professionals:

- (1) Dr. Kevin Baum, Chiropractor, Ballwin, Missouri
- (2) Dr. Neil Pape, Director of Public Relations, Lutheran Family and Children Services, St. Louis, Missouri
- (3) Dr. Mark Ortinau, Family Dentist, Ellisville, Missouri
- (4) Dr. Jerry Marks, Certified Social Worker, Counselor, and Adolescent Psychologist, Chesterfield, Missouri
- (5) Dr. Bruce Stolle, Orthodontist, Ellisville, Missouri
- (6) Dr. Robert Cralle, Heart Surgeon, Chesterfield, Missouri
- (7) Dr. Gary Meyerrose, General Practitioner, Ballwin, Missouri
- (8) Mrs. Marie Glenn, Substance Abuse Counselor, The Hyland Center, St. Louis, Missouri
- (9) Dr. John Livingston, General Practitioner, Ellisville, Missouri
- (10) The Reverend James Rodgers, Parish Pastor, Chesterfield, Missouri
- (11) Dr. William North, Administrative Director, Care & Counseling, American Association of Pastoral Counselors, St. Louis, Missouri
- (12) Dr. Robert Taylor, Head of Intensive Care, St. John's Mercy Medical Center, St. Louis, Missouri

- (13) The Reverend Gary Behm, Personnel Director, Lutheran Family and Children Services, St. Louis, Missouri
- (14) Mrs Donna Steiner, Associated Counselors of West County, St. Louis, Missouri

Although the settings for these interviews may have been as informal as “having coffee or lunch with such persons,” the matter of referral was the consistent topic of conversation. Other related issues were credentials, costs, and waiting periods.

In certain cases, however, there were matters of a deeper concern and nature. For example, in the case of the last two persons on the list (Numbers 13 and 14), the first gentleman, Rev. Behm, represented the counseling agency that the candidate had used as a primary source of referral throughout ten years of pastoral ministry. However, in the most recent years, the candidate had developed a growing concern regarding the competency of the agency’s counselors, based on the feedback that he was receiving from those individuals that he had referred as well as on the general complexion of the make-up of the counselors on staff. Two items in particular were a source of concern to the candidate and he addressed them very candidly to Rev. Behm in a luncheon date and in a follow-up visit to the Director’s office: Item 1 -- That an agency that focuses its attention on family problems has no one on staff who specializes in the evaluation, care and treatment of alcoholism when the disease is the most consistent cause of dysfunctional families in the nation. Item 2 -- That in terms of years of experience and training, new additions to the staff of LFCS generally look to be low-bid counselors; perhaps budget restraints are becoming a detriment to the quality of the organization.

At the same time that the candidate's concerns were mounting, a new counseling agency appeared on the scene, an agency directed, in part, by Dr. Joseph Barbour, a counselor and seminary professor who the candidate knew personally and whose qualifications and expertise were well established in the Lutheran community. The candidate began referring counselees to the new agency, Associated Counselors of West County, and the feedback that he received was highly positive. It became important to meet with a second key figure from the new counseling agency in order to reaffirm his decision to change agencies as a primary source for referral. Mrs. Donna Steiner represented the new agency. The candidate met with Mrs. Steiner as one of his last formal visits. The meeting occurred in her office and transcripts of the meeting are included in the Appendix of the report for the value that they hold in terms of content and example. (see Appendix 4)

In A Pastoral Counseling Guidebook, a notebook-style work that is the most practical and usable book of its kind encountered by the candidate, Charles F. Kemp prescribes a list of guidelines that may be followed in order to make the most of such interviews. "While one may not need to know all the answers to all the following questions in order to suggest an agency," the author points out, "these are the questions one should have in mind in considering any agency."⁹⁶

Using Kemp's guidelines as a format, the candidate recalls the details of a meeting that was held with Dr. William North, the Director of Care and Counseling, an agency of the American Association of Pastoral Counselors. By combining the guidelines with the information that was collected from the interview, the importance of an agenda for such visits will become apparent.

(1) What is its background?

Dr. North's Response: Care & Counseling goes back twenty-five years. It began as the dreamchild of Edward Stevens, who realized the need for such a service for the Christian community. This need was felt on the part of a number of key individuals as well, doctors, pastors, seminary professors. We began to hold counseling sessions on the campus of Concordia Seminary in the early 1970's.

(2) Who sponsors the agency?

It is sponsored by an inter-denominational effort, with the aid, in large part, of the Presbyterian and Episcopal churches in the area.

(3) How is the agency supported?

We are more or less self-supporting, although we do receive gifts and grants from outside sources along the way. We are a not-for-profit organization which has distinct advantages.

(4) Who does it serve, or who can it accept for service?

The agency is designed to serve anyone who finds a need for care and counsel. Obviously there are no age or race or membership prerequisites. We are especially there to serve those who wish to have a spiritual dimension to the care that they receive. We are a Christian organization with a Christ-centered philosophy but that does not mean that we would exclude a non-Christian from receiving care.

(5) What are the expenses involved?

We practice a policy that is popularly called a sliding scale, but that is a limiting description. Many different arrangements for payment can be made. The costs per session run from \$5 to \$80, depending upon the situation and the resources that are available to the counselee. Frankly, very few sessions are conducted in the \$5 range. It would be deceptive to pretend that they were. We would never cover our expenses if they were.

(6) How soon are the services available?

We have a very short waiting period under normal circumstances. One week to two weeks might be considered average. If there is an emergency of sorts we will make arrangements accordingly.

(7) Where is the location?

We do all our counseling here at this campus (Ladue Road at 270 in West County, St. Louis). Under unique circumstances a counselor may meet with a client elsewhere, say in the hospital, for instance.

- (8) Does a person have to make his own appointments?

There is no set policy in regard to who makes the appointment. Naturally it is the client on most occasions.

- (9) What are the attitudes of the staff?

(This question was not used during the interview.)

- (10) What is the opinion of professional people about the agency?

We have had a very rewarding history in that regard. It is rare that we do not receive the highest degree of support and encouragement from the professions that we rub shoulders with. You must remember that we are not in the position to be compared to a lot of other agencies. We have a somewhat unique service to offer and it is valued by the community professionals in general.

- (11) What is the training of the personnel?

Most of our counselors come to us with a Master of Divinity degree with a specialization in pastoral counseling and several years of experience. Almost all of them went through some form of practical experience during or after their seminary years. These internships go by several names, depending on the denomination. We have a lot of counselors with doctor degrees in counseling, psychology, social work and the like. Then there are all the requirements of the AAPC, stiff certification requirements, and the state licensing requirements. Our counselors are highly trained and highly certified, believe me. This is all very important for insurance coverage and liabilities and the like.

- (12) What are the affiliations of the agency?

As I've said, our primary affiliation is with that of the AAPC, that is the American Association of Pastoral Counselors. That is the agency that controls certification.

- (13) What do former clients say about the agency?

(This is a very critical question, but it was not asked during the interview with the director. The question is best reserved for the clients themselves).

- (14) What has been the effectiveness of the agency over the years?

Our track record pretty much speaks for itself. Other than our general reputation, our effectiveness is not a highly measurable item. We continue

to receive a lot of referrals from these pastors who have sent clients to us, which might represent the highest praise an agency such as our's can receive. Also, the fact that word-of-mouth referrals keep our agency alive might speak to the question.

This is where the list of suggested questions ends in the Charles Kemp guidebook. One additional question that the candidate felt was extremely important but was not included in the list was answered in part by the last question. However, the question should stand by itself and should always be included in the course of such an interviewing process: Who sends you the most referrals? Dr. North answered the question by saying that each year it is a toss-up between clergy persons in the area and those persons who have received, or are presently receiving, counseling services from the agency. In the calendar year 1991, more new clients came to them as a result of clergy referral; in 1992 the reverse was true, with more new clients having been referred by counselees. In each year the variance was a matter of two or three percent. This has been fairly standard throughout their years of operation.

Congregational Surveys

The idea of a congregational survey evolved as an original thought, based on a consistent need on the part of the candidate in his role as pastoral counselor, and did not come as the result of a suggestion in any of the readings.

It was decided that the survey would be conducted on a circuit-wide level in order to expand the range of participation. The pastors of the five largest parishes of the Ellisville Circuit of the Missouri District of The Lutheran Church--Missouri Synod were contacted and their cooperation was procured.

Telephone calls were made to the secretaries of the congregations, inquiring as to the number of worship bulletins that are produced each week. Survey forms were

then duplicated and delivered in appropriate numbers to the outside congregations. (see Appendix 5) The largest number of forms were duplicated for use in the candidate's own parish.

It was requested that the pastors include the survey forms as an insert to their worship bulletins. Five of the six pastors agreed to do so. The sixth pastor preferred to conduct the survey by way of his Board and Council meetings, having had better results with this procedure on his own surveys in the past.

A letter of introduction and explanation was written and printed on the backside of each survey form. (see Appendix 6) Also, the pastors agreed to add their own words of support during the announcement times following each worship service. Each pastor was asked to explain to his parishioners how the survey forms might be returned. The majority decided to request that the survey forms be returned the following Sunday and deposited in a designated box.

The return results from the survey were about as could be expected from the outside congregations, averaging from seven to twelve percent. If these figures appear low to the inexperienced eye, one must take into account the dynamics of all such survey efforts. The number one and two factors that affect a high or low return percentage are: 1) The time space between distribution and collection and 2) The convenience of the return procedure. These factors were taken into account by the candidate. By not insisting that the forms be filled out and returned immediately, he automatically raised the conviction level that was required in order for the forms to be returned. In short, the quality of the returns, and not the quantity, became the objective. Also, in this way he did not compromise the purpose of the worship setting in which the forms were distributed.

The return results from the candidate's home congregation exceeded expectation. To date, approximately sixty percent of the families who received a form have returned them and more continue to come in daily. Since it is not possible to know the exact number of families that were represented at the worship services in which the forms were distributed, all such statistics from the six participating congregations are approximate figures.

The data that is obtained from the survey will be duplicated and shared with the administrative offices of each participating congregations when it is reasonably certain that all the forms that can be expected are returned. The staff members from the various congregations have expressed a deep interest in the results and hope to make use of the Preferred Doctors Referral List in their own ministerial settings. The candidate suggests that the List be placed into the hands of a key office person such as the church secretary rather than be retained by pastor or pastors since the office personnel are more consistently on campus and can disperse the information to any member who calls during the business hours of the day. However, the List should be filed or stored in such a way as to make it readily accessible to any one of the staff members. Also, along with a note of thanks to all those persons who participated, the candidate intends to run an announcement in the church bulletins and monthly newsletters informing the memberships that the information is now available. It is suggested that a similar announcement be made periodically throughout the year, informing the newer members regarding the nature of the survey and of the fact that such a Preferred Doctors Referral List is available through the church office to anyone who asks. The data is presently being computerized and placed into a databank at St. John's in order that it may be updated as needed. The exact procedure for updating

the information will be decided along the way; but it is intended by the candidate that the List remain current and changing as doctors move from the area or retire, or as the names of different doctors are added by those members who have been moved by the doctors' level of expertise and caring ways.

A sample of the cover letter to the survey form, and the survey form itself, appear in the Appendix to this report. (see Appendix 7) Also included in the Appendix is a complete and updated version of the Preferred Doctors Referral List itself. (see Appendix 6) It is important to note that the names of the persons who are making the recommendation, along with their telephone numbers, are also included on the List next to the names of the doctors that they are suggesting. This has been done in order that they may be contacted by those who are considering the referral, in the event that information of a more specific nature regarding the doctor is required or desired.

CHAPTER 4

CONCLUSION

What Was Done

The Major Applied Project consisted of a series of steps carried out by the candidate in order to arrive at a Preferred Doctors Referral List. The list is made up of names and locations of a select group of health care professionals in the St. Louis/West County area of Missouri.

The candidate selected this area for growth and development out of a heartfelt need for such a record of professional persons in his everyday work and ministry. As Director of Family Care and Counseling in a large and rapidly growing suburban congregation, he is frequently asked for such a name or recommendation within the context of his role as pastoral counselor on staff.

The series of steps carried out by the candidate followed a three-part program. First, the element of referral in pastoral counseling was researched on the basis of written materials on the subject. Numerous books, book chapters, and magazine articles were read and examined with special attention being given to the theological dimensions involved in referral. The issues of where, when, how, and to whom to refer were explored along with the issues of community resources and social welfare agencies.

The second step of the study consisted of personal interviews and

consultations with significant health care professionals. The first of these interviews took place on a one-to-one basis with the Director of Institutional Ethics at a major medical center. The second interviews were conducted in a group setting at a meeting arranged by the president of a large hospital system. The purpose of the interviews was to grow in a personal understanding of the ethical issues being addressed in modern medicine. Only through an increased awareness did the candidate feel qualified to refer, or to decline to refer, to the various doctors and institutions with a degree of confidence, objectivity, and accuracy. In addition to these interviews, numerous contacts of a less formal nature were made with practicing health care providers. The subject of referral in pastoral counseling was the consistent focus of attention in all of the interviews.

The final step of the program involved the use of a congregational survey. The idea of a survey evolved as an original thought, based on the need on the part of the candidate for a list of preferred doctors. The survey form was designed, and the survey was carried out, among the membership of five large Lutheran churches in the West St. Louis County area of Missouri. The purpose of the survey was to enlist the aid and opinion of the Christian community in arriving at a final selection of preferred health care professionals.

What Was Learned

The Major Applied Project proved to be an exercise in discovery for the candidate. The key lessons that were learned corresponded directly to the nature of each step in the three-step program.

Although few books were uncovered that focused exclusively on the topic of

referral in pastoral counseling, the candidate was surprised to learn of the large number of book chapters, subtitles, and magazine articles that were available on the subject. The variety of opinions and attitudes of the various authors provided a wealth of information. It became evident quite early that it was not necessary to reinvent the wheel; it was only necessary to sort and to shift the existing positions into such a form as to arrive at one that was compatible with the candidate's own feelings and opinions. To say it another way, the various writers on the subject of pastoral referral put into words, and into useable formats, those thoughts and ideas that had yet to be defined in the candidate's own mind. Furthermore, the raw abundance of the resources that are available for referral became increasingly evident as the research progressed.

The interviews that were conducted were as rewarding and as stimulating as the research that preceded them. The professionals in the various health care facilities proved more than willing to share of their time and expertise. Delicate issues were explored with complete candor. Formal positions once thought to be classified information by the candidate were discussed with honesty and openness. Christian verses non-Christian postures were debated and defined. The final results of the visits was an increased awareness and clarity on the part of the candidate regarding the issues of abortion and life-support, especially as viewed through the eyes of professional health care providers.

From an emotional or non-intellectual standpoint, the congregational survey proved to be the most rewarding of all the experiences. The response on the part of the candidate's own members was especially satisfying, both in terms of their willingness to participate in the survey as well as in their eagerness to make use of

the collected data once it was printed, publicized, and made available to them. Originally, twenty copies of the Preferred Doctors Referral List were printed for distribution upon request by the membership. That number was quickly doubled to forty as the supply became depleted in the church office. To date, forty copies continue to circulate in and out of the church office and from the office of the candidate. The icing on the cake came in the form of additional notes and comments of appreciation from the members for an instrument that they described as “much needed but seldom seen” within the congregational setting.

In his book, Referral in Pastoral Counseling, William Oglesby makes the following, sensitive observation:

There is a loneliness in the ministry. It is the kind of loneliness which is shared by everyone in professional life who daily finds himself confronted with issues and problems for which there is no “blueprint”. It is a loneliness which wells up whenever decisions must be made that effect the lives of others, and for which there can be no definite assurance as to the final outcome. It is a loneliness which becomes increasingly poignant for the minister who realizes that he deals with time and eternity--that the questions put to him have to do with life and death and life again. It is a loneliness which tends to overwhelm when it emerges in a realistic consciousness of personal inadequacy.⁹⁷

No other paragraph in the researched materials better captures the feelings that led to this major applied project. The pastoral ministry *can be* a very lonely business. There are elements to it, however, that remain only as lonely as the pastor permits. The issue of referral in pastoral counseling certainly falls into this category. It is hoped that this Project calls attention to a number of options that are available to the pastoral counselor for sharing that burden of responsibility. The fact that these options exist in such measure might be the foremost lesson that was learned by the candidate.

APPENDIX 1:
COMMUNITY SERVICE DIRECTORY
OF
THE UNITED WAY OF GREATER ST LOUIS
(USER'S GUIDE AND SAMPLE PAGES)

(73)
Twenty-first Edition, 1989-90

COMMUNITY SERVICE DIRECTORY

*The most comprehensive
human resource referral
guide available in the
St. Louis/Bi-state area.*

*Published by the
United Way
of Greater St. Louis.*



United Way
of Greater St. Louis

1717 N. Illinois
Belleville, IL 62221-3828
Phone: (618) 398-1715

1111 Olive
St. Louis, MO 63101-1951
Phone (314) 421-0700

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This publication of the 1989-90 Community Service Directory marks the 21st edition of this valued community resource.

This book continues the past tradition of publications dating back to 1911, when our first directory of human care services was issued as the St. Louis Directory of Charities & Philanthropies.

This new edition is marked by many "firsts." The information on community resources is presented in an entirely new and easier to read format developed with the assistance of numerous community professionals. We have expanded the page size to a full 8 1/2" x 11". Cross references and indexes have been substantially increased to aid the reader in locating resources. All information is now computerized in the Service Agency Inventory System (SAIS) database which contains over 1,200 health and human service organizations. This system is now in daily use at First Call For Help, the United Way's telephone information and referral program. We have commissioned a computer program to organize and print each page of this new Directory in a fraction of the time required for manual editing. This means that the information is far more accurate and up-to-date prior to publication than ever before. The frequency of future editions will be greatly enhanced as a result.

This new edition of the Community Service Directory is part of the continuing commitment of the United Way of Greater St. Louis to enhance the availability of information on human services in our area. The book contains detailed information on over 900 organizations at over 3,000 service sites offering more than 6,000 programs. This includes not only the entire bi-state area but also some "outstate" (mostly governmental) organizations.

All information presented in the Community Service Directory has been compiled and updated with the help of agency representatives. Agencies which are listed are included primarily because they provide an established and continuing program of services with a regular contact person. Every effort has been made to be accurate in the information provided. Inclusion in the Directory does not imply endorsement by the United Way of Greater St. Louis, nor does exclusion imply disapproval.

The Community Service Directory is not intended to be used to solicit the sale of products or services to the agencies listed. The possession of a copy of this Directory does not authorize its use for any other purpose than to assist individuals and groups to find and make effective use of the community resources contained herein.

If users of this Directory know of other organizations which should be considered for inclusion for future editions, please contact:

Community Services Department
United Way of Greater St. Louis
1111 Olive Street
St. Louis, MO 63101-1951
(314) 421-0700

If you want assistance on how to use the Directory or have additional questions about any organizations listed therein, feel free to call the United Way at (314) 421-0700 or (618) 398-1715.

USER'S GUIDE

USER'S GUIDE

The goal of the 1989-90 edition of the Community Service Directory is to provide a comprehensive listing of direct service programs provided by health and social service organizations in the greater St. Louis area. With the exception of selected state governmental agencies, the organizations listed are located within the United Way's ten-county service area, including the Missouri counties of Lincoln, Warren, Franklin, St. Charles, St. Louis, and Jefferson and the Illinois counties of Monroe, St. Clair, Clinton, and Randolph. (77)

The Community Service Directory is arranged as follows:

- ♦ **SECTION ONE: ILLINOIS**
 - Agency Profiles
 - Agency Official/Popular Name Index
- ♦ **SECTION TWO: MISSOURI**
 - Agency Profiles
 - Agency Official/Popular Name Index
- ♦ **SECTION THREE: ILLINOIS and MISSOURI (combined)**
 - Program Index

I. AGENCY PROFILES

The Agency Profiles Sections are a compilation of information about agency central (or main) offices, their service sites, and their programs. The profiles are listed alphabetically by the official name of the organization. Agencies whose central offices are located in Illinois appear in the first Profiles Section; organizations whose central offices are located in Missouri are presented in the second Profiles Section.

Agency Central Office

Information about the central (or main) office for each agency is presented as follows:

- ♦ Official name of agency: (UW) indicates United Way member agency; (UWP) indicates partner with the United Way in fundraising; (#) indicates agency receives United Way funds through the Combined Health Appeal of Greater St. Louis.
- ♦ Central office address
- ♦ Central office phone number
- ♦ Executive Director or Chief Operating Officer for the agency followed by their official title

The format for this information is illustrated in the following sample entry:

PROVIDENT COUNSELING, INC. (UW)
(FORMERLY-FAMILY & PERSONAL
SUPPORT CENTERS)
2650 OLIVE STREET
ST. LOUIS, MO 63103
(314) 371-6500
Kathleen Buescher, President

Service Site Information

A service site is an established location where an agency provides services and to which a client may be referred. For agencies with one location, the service site will be the same as the central office. For agencies that deliver services in more than one site, each site location will be listed, numbered in ascending order.

The Service Site description contains:

- ♦ The Service Site Number which is used to identify a site as the location where a program is offered (as listed in the Program Section).
- ♦ The Service Site name, address, and phone number.
- ♦ The Service Site Director (no listing denotes this information was not provided by the agency).
- ♦ The Service Site's intake worker who can be called directly for referral and/or service information. (No listing denotes this information was not provided by the agency.)

The format for this information is illustrated in the following sample entry:

2 Provident Counseling, Inc.
 4232 Forest Park Blvd.
 St. Louis, MO 63108
 (314) 533-8230
 Site Director: Elmer Otey
 Intake Worker: Call (314) 533-8200 for
 Central Intake

Program Information

A specific service of an agency, usually identifiable by discrete supervision, staffing, and budget, is considered a program. Agency programs are classified according to a system that groups together related services within broad categories. Examples of programs/categories are: Crisis Intervention, Food Provision in Emergencies, and After School Care.

For a listing of all program categories used in this book, see the section titled "Program Classifications."

An agency's programs do not appear in order of importance; programs are presented in an order which is determined by a 5-digit classification number within the SAIS program coding system. The Program Section includes:

- ♦ Program title according to the classification system
- ♦ A short description of the program, including special features, as provided by the agency
- ♦ The site number(s) indicating the service site(s) of the agency where the program is available; this number refers the user to the numbered list of service sites in the section immediately preceding the program information. To determine where a program is available, match the numbers listed in the program section to the corresponding service site number(s).

The format for this information is illustrated in the following sample entry:

Programs

CASE MANAGEMENT/SOCIAL CASEWORK SERVICES

Services include assessment of the clients' needs and initiation and monitoring of the appropriate services.

Service Site(s): 2,3,4,5,6,7

II. INDEXES

The Community Service Directory has two indexes that provide access to information on agencies and programs:

- ♦ Agency Official/Popular Name Index
- ♦ Program Index

Agency Official/Popular Name Index

The Agency Official/Popular Name Indexes, one for Illinois and one for Missouri, list all agencies in the 1989-90 Community Service Directory and the page number on which they can be found in the Agency Profiles Sections. The alphabetical indexes list an agency by its official and familiar name, acronym or abbreviation. In addition, any service site of an agency whose name is considered well-known is listed in the index. When popular names, abbreviations, or service sites are listed individually, reference to their official agency of affiliation is in parentheses.

An agency that has recently changed its name is listed by its new and former name; former names are designated as such in parentheses. The agency's new official name is followed by a reference to the former name in parentheses; exceptions to this format may occur due to line space limitations.

The Index examples below show the sample agency listed by its new and former name:

AGENCY NAME

FAMILY & PERSONAL SUPPORT CENTERS (FORMER NAME)
 FAMILY ADOPTION & COUNSELING SERVICES, INC.
 FAMILY CARE CENTER OF CARONDELET
 FAMILY CENTER, THE
 FAMILY HEALTH COUNCIL, MISSOURI
 FAMILY PLANNING CLINIC OF FRANKLIN COUNTY
 FAMILY RESOURCE CENTER

PROVIDENT COUNSELING, INC. (UW)(FORMERLY FAMILY & PERSONAL SUPPORT
 CENTERS)
 PSYCHIATRIC SERVICES COUNCIL
 PSYSHIATRY, MISSOURI INSTITUTE OF
 PSYCHOANALYTIC INSTITUTE

Program Index

The Program Index lists all service sites of agencies in the Directory categorized by program area or type of service. The term "program area" represents broad service categories, e.g., Day Care; Pre-School; Self-Help Groups; Food Provision in Emergencies. Following the program area is a short, generic definition to assist the user in choosing the appropriate program. In many instances, program area definitions are cross-referenced with related service categories that will further aid the user in locating appropriate programs. Service sites of agencies offering a program categorized under the program area are then listed in zip code order; this arrangement enables the user to quickly find programs located in a specific geographic area. The Program Index lists five columns across the page:

- ♦ Zip code of the Service Site
- ♦ The official name of the agency
- ♦ The number of the agency's site that provides the program as listed in the agency's profile
- ♦ The Service Site's telephone number
- ♦ The page on which the complete agency profile can be found

The format for this information is illustrated in the following sample entry:

CASE MANAGEMENT/SOCIAL CASEWORK SERVICES

Assessment of client need; initiation and monitoring of appropriate services. Episodic or ongoing. Casemanager usually assigned. See also: ENTITLEMENT COUNSELING, INCL. ADVOCACY; HOSPITAL SOCIAL WORK SERVICES.

ZIP	AGENCY NAME	SITE	PHONE	PAGE
63050	MISSOURI STATE: DIVISION OF FAMILY SERVICES	3	(314)789-3322	207
63084	MISSOURI STATE: DIVISION OF FAMILY SERVICES	2	(314)583-2571	207
63101	MISSOURI STATE: DIVISION OF FAMILY SERVICES	7	(314)444-6800	208
63103	MISSOURI STATE: DIVISION OF FAMILY SERVICES	6	(314)658-8000	208
63104	ST. LOUIS CITY PUBLIC SCHOOLS	5	(314)865-4550	281
63105	MISSOURI STATE: CIRCUIT COURT, ST. LOUIS COUNTY	1	(314)889-3028	201
63105	PROVIDENT COUNSELING, INC. (UW) (FORMERLY-FAMILY & PERSONAL SUPPORT CENTERS)	4	(314)727-3235	246
63106	HUMAN DEVELOPMENT CORPORATION OF METROPOLITAN ST. LOUIS	4	(314)421-5885	144

III. GUIDE TO PROGRAMS

Below is an alphabetical listing of all program areas used in the Community Service Directory. This list will aid the user in the search for specific programs.

ADOLESCENT HEALTH SVCS, COMPREHENSIVE, OUTPATIENT	CASE MANAGEMENT/SOCIAL CASEWORK SERVICES
ADOPTION INFORMATION AND COUNSELING	CHEMICAL DEPENDENCY TREATMENT SERVICES
ADOPTION SERVICES	CLOTHING PROVISION IN EMERGENCIES
ADULT BASIC EDUCATION (ABE)	COLLEGE EDUCATION, SPECIALIZED PROGRAMS
ADULT DAY CARE	COLLEGE PREPARATION
ADVOCACY FOR AN INDIVIDUAL OR ORGANIZATION	COMMUNICABLE DISEASE TREATMENT
ADVOCACY FOR GROUPS, SPECIALIZED	COMMUNICATIONS NETWORK/LIAISON SERVICES
AFTER SCHOOL CARE	COMMUNITY DEVELOPMENT
AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)	COMPANIONSHIP SERVICES
ALCOHOL ABUSE TREATMENT SERVICES	COMPREHENSIVE COMMUNITY HEALTH CENTER
ALTERNATIVE EDUCATION	COMPREHENSIVE FAMILY SUPPORT SERVICES
AMBULANCE, MEDICAL TRANSPOR- TATION, RESCUE	CONGREGATE MEALS
AMBULATORY SURGERY	CONSOLIDATED YOUTH EMPLOYMENT PROGRAM
ANIMAL SERVICES	CONSUMER PROTECTION SERVICES
ART AND MUSIC SCHOOLS	CONSUMER SAFETY
ARTISTIC PARTICIPATION ACTIVITIES	CONTINUING EDUCATION
BABYSITTING SERVICES	CORRECTIONS
BILINGUAL EDUCATION	COUNSELING (GENERAL AND SPECIALTY)
BLOOD, ORGAN, TISSUE BANKS	COUNSELING FOR ABUSED ADULTS AND CHILDREN
BUDGET COUNSELING/CREDIT MANAGEMENT	COUNSELING FOR THE DISABLED
BUILDING MANAGEMENT	
CAMPING, OVERNIGHT	

COURTS
 CRIME PREVENTION PROGRAMS AND/OR
 INFORMATION
 CRIME VICTIM SERVICES
 CRISIS INTERVENTION
 CRISIS NURSERY
 CULTURAL ACTIVITIES
 DAY CAMPING
 DAY CARE FOR INFANTS AND/OR
 TODDLERS
 DAY CARE, PRESCHOOL
 DEATH, DYING, BURIAL INFORMATION
 AND COUNSELING
 DEFENDANT SERVICES (PRE-TRIAL)
 DENTAL CARE, OUTPATIENT
 DETOXIFICATION SERVICES
 DEVELOPMENTAL DISABILITY
 COMMUNITY SERVICES
 DEVELOPMENTAL DISABILITY
 COUNSELING
 DEVELOPMENTAL DISABILITY DAY
 TREATMENT
 DEVELOPMENTAL DISABILITY DIAGNOSIS
 AND EVALUATION
 DISASTER RELIEF SERVICES
 DISPLACED HOMEMAKER SERVICE
 DRIVER IMPROVEMENT PROGRAMS
 EARLY CHILDHOOD EDUCATION
 INFORMATION
 ECONOMIC DEVELOPMENT
 EDUCATION COUNSELING AND
 INFORMATION
 EDUCATIONAL DIAGNOSIS AND
 EVALUATION
 EDUCATIONAL MATERIALS OR SERVICES
 FOR THE DISABLED
 EMERGENCY MEDICAL CARE
 EMERGENCY RESPONSE SYSTEM
 EMPLOYMENT SERVICES
 ENGLISH AS A SECOND LANGUAGE (ESL)
 ENRICHED HOUSING
 ENTITLEMENT COUNSELING, INCLUDING
 ADVOCACY
 ENVIRONMENTAL PROTECTION AND
 PREVENTION
 EQUAL OPPORTUNITY PROTECTION
 ESCORT, ERRAND RUNNING, AND
 SHOPPING SERVICES
 FAMILY DAY CARE
 FAMILY PLANNING MEDICAL SERVICES
 (CONTRACEPTION)
 FAMILY PLANNING/PREGNANCY INFO
 AND COUNSELING

FINANCIAL AID IN EMERGENCIES
 FINANCIAL AID, SPECIAL TYPES
 FINANCIAL ASSISTANCE FOR HOME
 REPAIR
 FINANCIAL RESOURCES ADVOCACY
 FOOD PROVISION IN EMERGENCIES
 FOOD STAMPS
 FOSTER CARE IN EMERGENCIES
 FOSTER CARE SERVICES FOR ADULTS
 FOSTER FAMILY CARE FOR CHILDREN
 GED (HIGH SCHOOL EQUIVALENCY)
 INSTRUCTION/EXAM
 GERIATRIC CARE, OUTPATIENT
 GLASSES, VISUAL AND HEARING AIDS
 GROUP HOMES
 HALFWAY HOUSES (TRANSITIONAL
 CENTERS)
 HEADSTART EDUCATION
 HEALTH COUNSELING & INFORMATION
 HEALTH RELATED FACILITY (HRF)
 HEALTH SCREENING
 HEARING TESTING AND EVALUATION
 HEMODIALYSIS CARE UNIT, OUTPATIENT
 HIGH SCHOOL EDUCATION, SPECIALIZED
 AREAS OF STUDY
 HOME ATTENDANT SERVICES
 HOME HEALTH CARE
 HOME MANAGEMENT SERVICES
 HOME RELIEF (HR)
 HOME-SHARING PROGRAM
 HOMEMAKER SERVICES
 HOSPICE CARE
 HOSPITAL CARE INPATIENT SERVICES
 HOSPITAL SOCIAL WORK SERVICES
 HOUSEKEEPER/CHORE SERVICES
 HOUSING COMPLAINTS (AND ADVOCACY)
 HOUSING COUNSELING AND
 INFORMATION
 HOUSING REHABILITATION
 HOUSING SERVICES, SPECIAL
 IMMIGRANT SERVICES
 IMMUNIZATION
 INFANT STIMULATION
 INFERTILITY SERVICES
 INFORMATION AND REFERRAL
 INFORMATION FOR THE COMMUNITY
 JOB TRAINING
 KINDERGARTEN
 LANGUAGE TRANSLATION AND
 INTERPRETATION
 LEGAL SERVICES
 LIBRARY SERVICES

LIFESAVING EDUCATION AND INFORMATION
 LITERACY INSTRUCTION
 MANAGEMENT IMPROVEMENT AND TECHNICAL ASSISTANCE
 MEALS HOME DELIVERED
 MEDIATION, ARBITRATION
 MEDICAID
 MEDICAL CARE, OUTPATIENT
 MEDICAL CARE, SPECIALIZATIONS, OUTPATIENT
 MEDICAL SUPPLIES AND EQUIPMENT
 MEDICAL TESTING AND DIAGNOSIS OF OTHER TYPES
 MEDICARE
 MENTAL HEALTH DAY TREATMENT
 MENTAL HEALTH DIAGNOSIS AND EVALUATION
 MENTAL HEALTH SERVICES
 METHADONE SERVICES
 MISSING PERSONS SERVICE
 NURSING HOME INFORMATION, PLACEMENT ADVOCACY
 NUTRITIONAL TRAINING
 OBSTETRICS AND GYNECOLOGY (OB-GYN)
 OFFENDER/EX-OFFENDER SERVICES
 ON-THE-JOB TRAINING
 PARENTING EDUCATION
 PEDIATRIC CARE, OUTPATIENT
 PLANNING, COORDINATING, RESEARCH SERVICES
 POLICE SERVICES
 PREGNANCY COUNSELING/INFORMATION
 PREGNANCY TESTING AND EVALUATION
 PRENATAL CARE, OUTPATIENT
 PREPAID HEALTH CARE
 PREVENTIVE SERVICES FOR CHILDREN
 PROBATION SERVICES FOR ADULTS
 PROBATION SERVICES FOR JUVENILES
 PROFESSIONAL ASSOCIATION
 PROFESSIONAL GROWTH OR TRAINING OPPORTUNITIES
 PROTECTIVE SERVICES FOR ADULTS
 PROTECTIVE SERVICES FOR CHILDREN
 PSYCHIATRIC EMERGENCY ROOM SERVICES
 PSYCHIATRIC SERVICES, INPATIENT
 PSYCHIATRIC SERVICES, OUTPATIENT
 PSYCHOLOGICAL TESTING
 PUBLIC DEFENDER/COURT APPOINTED LAWYER
 PUBLIC HEALTH SAFETY AND INFORMATION
 PUBLIC HOUSING
 PURCHASING COOPERATIVES
 RAPE COUNSELING, INFORMATION AND ASSISTANCE
 RECREATION FOR ADULTS/FAMILIES
 RECREATION FOR CHILDREN OR YOUTH
 RECREATION FOR SENIOR CITIZENS
 RECREATION FOR THE DISABLED
 REHABILITATION SERVICES, INPATIENT
 REHABILITATION SERVICES, OUTPATIENT
 RELOCATION ASSISTANCE
 RENTAL COUNSELING & REFERRAL
 RESIDENTIAL FACILITIES, SHORT OR LONG TERM
 RESIDENTIAL SERVICES FOR DEVELOPMENTALLY DISABLED
 RESIDENTIAL TREATMENT AND CARE OF CHILDREN
 RESIDENTIAL TREATMENT AND CARE OF SUBSTANCE ABUSER
 RESPITE CARE
 RETREATS
 SCHOLARSHIPS
 SELF-HELP GROUPS (GENERAL AND SPECIALTY)
 SELF-HELP GROUPS FOR SUBSTANCE ABUSE PROBLEMS
 SELF-HELP GROUPS, HEALTH RELATED
 SENIOR AIDES PROGRAM
 SENIOR CENTER ACTIVITIES
 SEXUAL FUNCTIONING INFORMATION AND COUNSELING
 SHELTER FOR ABUSED ADULTS AND CHILDREN
 SHELTER, SHORT TERM (EMERGENCY)
 SHELTERED EMPLOYMENT
 SKILLED NURSING CARE FACILITY (SNF)
 SOCIAL SECURITY
 SPECIAL EARLY CHILDHOOD EDUCATION
 SPECIAL EDUCATION
 SPEECH: TESTING, EVALUATION AND THERAPY
 STERILIZATION SERVICES OUTPATIENT
 SUBSIDIZED HOUSING
 SUBSTANCE ABUSE EMERGENCY SERVICES
 SUMMER LUNCH PROGRAM
 SUMMER YOUTH EMPLOYMENT PROGRAM
 TAP CENTER (TESTING, ASSESSMENT AND PLACEMENT)
 TAX PREPARATION AND INFORMATION
 TELEPHONE REASSURANCE SERVICES

THERAPY, SPECIAL TYPES
TRANSITIONAL SVCS (INDEPENDENT/
SUPPORTIVE LIVING)
TRANSPORTATION FOR THE DISABLED
OR ELDERLY
TUTORING, REMEDIAL EDUCATION
VENEREAL DISEASE TREATMENT
SERVICES
VETERAN'S BENEFITS
VOCATIONAL AND CAREER COUNSELING
VOCATIONAL EVALUATION, TESTING
AND ASSESSMENT
VOCATIONAL REHABILITATION
VOCATIONAL SCHOOLS
VOLUNTEER PLACEMENT SERVICES
WEATHERIZATION AND WINTERIZATION
WOMEN, INFANTS, AND CHILDREN
PROGRAM (WIC)
WORK EXPERIENCE PROGRAM

If you want assistance on how to use the Directory or have additional questions about any organizations listed therein, feel free to call the United Way at (314) 421-0700 or (618) 398-1715.

Community Services Department
United Way of Greater St. Louis
1111 Olive Street
St. Louis, MO 63101-1951

8 Union Electric Customer Assistance Program (PC)
7645 Delmar Blvd. (North & South)
St. Louis, MO 63130
(314) 863-1504
Site Director: Carol McMahan

Programs

BUDGET COUNSELING/CREDIT MANAGEMENT

Works with individuals & families who are in danger of losing their electric power due to default on bills; most have had good credit with UE over past year.

Service Site(s): 8

PSYCHOLOGICAL TESTING

Provides psychological testing for children, adolescents and adults.

Service Site(s): 2,3,4,5,6,7

MENTAL HEALTH DIAGNOSIS AND EVALUATION

Provides mental health assessment, evaluation and diagnosis for children, adolescents and adults.

Service Site(s): 2,3,4,5,6,7

CASE MANAGEMENT/SOCIAL CASEWORK SERVICES

Services include assessment of the clients' needs, and initiation and monitoring of the appropriate services.

Service Site(s): 2,3,4,5,6,7

PSYCHIATRIC SERVICES, OUTPATIENT

Offers psychiatric assessment, evaluations, treatment and referrals for persons of all ages.

Service Site(s): 2,3,4,5,6,7

MENTAL HEALTH SERVICES

Provides outpatient family mental health services for adults and children. Social workers & psychologists provide assessment, treatment and referral.

Service Site(s): 2,3,4,5,6,7

CHEMICAL DEPENDENCY TREATMENT SERVICES

Certified substance abuse treatment program for individuals and families.

Service Site(s): 2,3,4,5,6,7

COUNSELING (GENERAL AND SPECIALTY) (84)

Outpatient family mental health services, assessment, treatment & referrals to community resources for employees of business and industry (by contract).

Service Site(s): 1

COUNSELING FOR ABUSED ADULTS AND CHILDREN

Provides individual, group and psycho-educational counseling for women who have been sexually abused as adults or as children.

Service Site(s): 2,3,4,5,6,7

PSYCHOLOGISTS AND EDUCATORS, INC.

1023 EXECUTIVE PARKWAY, SUITE 12

CREVE COEUR, MO 63141

(314) 576-9127

Alan J. Politte, Ed.D., President

1 Psychologists And Educators, Inc.

1023 Executive Parkway, Suite 12

Creve Coeur, MO 63141

(314) 576-9127

Site Director: Alan J. Politte, Ed.D.

Intake Worker: Cheryl D. Pinkston

Programs

PROFESSIONAL GROWTH OR TRAINING OPPORTUNITIES

Speakers available for presentations to teachers and professionals on topics such as learning disabilities, attention deficit disorder, etc.

Service Site(s): 1

TUTORING, REMEDIAL EDUCATION

Tutoring provided primarily for those with learning disabilities.

Service Site(s): 1

PARENTING EDUCATION

Speaker's Bureau available to make presentations on topics such as learning disabilities, attention deficit disorder, etc.

Service Site(s): 1

**SPEECH/LANGUAGE: TESTING,
EVALUATION & THERAPY**

Provides diagnosis and speech therapy for all ages.

Service Site(s): 1

PSYCHOLOGICAL TESTING

Provides a variety of tests including personality, intelligence and academic achievement tests.

Service Site(s): 1

**COUNSELING (GENERAL AND
SPECIALTY)**

Provides individual, group & marriage counseling and psychotherapy for children and families conducted by a professional staff of psychologists and educators.

Service Site(s): 1

QUEEN OF PEACE CENTER

325 NORTH NEWSTEAD AVENUE
ST. LOUIS, MO 63108
(314) 531-0511
Jane Lee, Administrator

- 1 Queen of Peace Center/Cathedral Tower
325 North Newstead (Maryland)
St. Louis, MO 63108
(314) 531-0511
Site Director: Jane Lee

Programs

**HALFWAY HOUSES (TRANSITIONAL
CENTERS)**

Extended care facility for adult women recovering from substance abuse. Residents obtain jobs 2 weeks after entering the program. Average stay is 3-6 months.

Service Site(s): 1

**TRANSITIONAL SVCS
(INDEPENDENT/SUPPORTIVE LIVING)**

Extended care for adolescent girls referred from primary treatment for an average stay of 6 months. Individ., family & group counseling with an educational focus.

Service Site(s): 1

**R.P. FOUNDATION FIGHTING (85)
BLINDNESS (RETINITIS PIGMENTOSA)**

C/O 79 TOWER VALLEY
HILLSBORO, MO 63050
(314) 942-2149
Marcie Frey, President

1 Retinitis Pigmentosa Foundation

C/O 79 Tower Valley Drive
Hillsboro, MO 63050
(314) 942-2149
Site Director: Marcie Frey

Programs

SELF-HELP GROUPS, HEALTH RELATED

Support for persons with Retinitis Pigmentosa and their families. Provides I&R regarding R.P., Macular Degeneration and Ushers's Syndrome.

Service Site(s): 1

RAINBOW ACTIVITY CENTER, INC.

219 N. CHRISTINA
UNION, MO 63084
(314) 583-4235
Sue Jones, Administrative Director

1 Rainbow Activity Center, Inc.

219 N. Christina
Union, MO 63084
(314) 583-4235
Site Director: Sue Jones

Programs

**DEVELOPMENTAL DISABILITY DAY
TREATMENT**

Habilitative training for mentally handicapped adults, including daily living skills, pre-vocational training and community integration.

Service Site(s): 1

CHEMICAL DEPENDENCY TREATMENT SERVICES

For persons with chemical dependency problems, both in- or out-patient. Certified program. See also: (86)
ALCOHOL ABUSE TREATMENT SERVICES; SUBSTANCE ABUSE EMERGENCY SERVICES; METHADONE SERVICES; RESIDENTIAL TREATMENT AND CARE OF THE SUBSTANCE ABUSER; DETOXIFICATION SERVICES; SELF-HELP GROUPS FOR SUBSTANCE ABUSE RELATED PROBLEMS; HALFWAY HOUSES (TRANSITIONAL CENTERS).

ZIP	AGENCY NAME	SITE	PHONE	PAGE
62205	COMPREHENSIVE MENTAL HEALTH CENTER	1	(618) 482-7330	13
62220	BELLEVILLE MENTAL HEALTH OUT-PATIENT CENTER	2	(618) 235-0330	6
62220	GATEWAY FOUNDATION (UW)	1	(618) 234-9002	19
62221	PROVIDENT COUNSELING, INC., ILLINOIS CENTER (UW)	1	(618) 235-5656	30
62278	HUMAN SERVICES CENTER	1	(618) 282-6233	20
62298	HUMAN SUPPORT SERVICES (UW)	1	(618) 939-8644	20
63010	COMMUNITY TREATMENT, INC.	2	(314) 296-6206	104
63028	COMMUNITY TREATMENT, INC.	1	(314) 937-3300	104
63049	COMMUNITY TREATMENT, INC.	3	(314) 376-5604	104
63090	ST. JOHN'S MERCY HOSPITAL (WASHINGTON, MO)	1	(314) 239-8000	272
63104	CAREUNIT HOSPITAL OF ST. LOUIS	1	(314) 771-0500	85
63105	PROVIDENT COUNSELING, INC. (UW) (FORMERLY-FAMILY & PERSONAL SUPPORT CENTERS)	4	(314) 727-3235	246
63106	BLACK ALCOHOL/DRUG SERVICE INFORMATION CENTER, INC. (UW)	2	(314) 621-1283	74
63106	ST. PATRICK'S CENTER	1	(314) 621-1283	317
63108	BLACK ALCOHOL/DRUG SERVICE INFORMATION CENTER, INC. (UW)	1	(314) 367-8200	74
63108	MAGDALA FOUNDATION	1	(314) 652-6004	179
63108	PROVIDENT COUNSELING, INC. (UW) (FORMERLY-FAMILY & PERSONAL SUPPORT CENTERS)	2	(314) 533-8230	246
63110	JEWISH HOSPITAL OF ST. LOUIS, THE	7	(314) 454-8587	159
63112	ARCHWAY COMMUNITIES, INC.	1	(314) 361-1630	64
63117	NARCOTICS SERVICE COUNCIL, INC.	2	(314) 647-5444	223
63117	ST. MARY'S HEALTH CENTER	1	(314) 768-8000	315
63122	DRUG & ALCOHOL REHABILITATION & TREATMENT (UW)	2	(314) 822-2256	117
63122	ST. JOSEPH HOSPITAL OF KIRKWOOD	3	(314) 966-1633	275
63126	PROVIDENT COUNSELING, INC. (UW) (FORMERLY-FAMILY & PERSONAL SUPPORT CENTERS)	6	(314) 968-2870	246
63128	ST. ANTHONY'S MEDICAL CENTER	2	(314) 525-7200	266
63131	METROPOLITAN MEDICAL CENTER (FORMERLY-NORMANDY OSTEOPATHIC HOSPITAL)	2	(314) 821-5850	187
63132	CHRISTIAN PSYCHOLOGICAL & FAMILY SERVICES	1	(314) 423-6552	97
63132	DRUG & ALCOHOL REHABILITATION & TREATMENT (UW)	1	(314) 569-3105	117
63133	METROPLEX, INC.	1	(314) 863-0015	184
63134	PARKSIDE LODGE OF ST. LOUIS, INC.	1	(314) 428-4201	239
63136	PROVIDENT COUNSELING, INC. (UW) (FORMERLY-FAMILY & PERSONAL SUPPORT CENTERS)	5	(314) 521-6464	246
63139	MISSOURI STATE: DEPARTMENT OF HEALTH, EASTERN DISTRICT	1	(314) 781-7825	204

ZIP	AGENCY NAME	SITE	PHONE	PAGE	(87)
63141	PROVIDENT COUNSELING, INC. (UW) (FORMERLY-FAMILY & PERSONAL SUPPORT CENTERS)	3	(314) 432-3305	246	
63144	NATIONAL COUNCIL ON ALCOHOLISM & DRUG ABUSE - ST. LOUIS AREA (UW)	1	(314) 962-3456	228	
63301	BRIDGEWAY COUNSELING SERVICES, INC. (UW)	1	(314) 723-3666	80	
63303	PROVIDENT COUNSELING, INC. (UW) (FORMERLY-FAMILY & PERSONAL SUPPORT CENTERS)	7	(314) 946-6636	246	
63376	BARNES HEALTH CARE SYSTEM/BARNES ST. PETERS HOSPITAL	1	(314) 447-6600	68	
63379	BRIDGEWAY COUNSELING SERVICES, INC. (UW)	3	(314) 528-7611	80	
63385	BRIDGEWAY COUNSELING SERVICES, INC. (UW)	5	(314) 327-7785	80	

CLOTHING PROVISION IN EMERGENCIES

New or used clothing to needy consumers in emergency situations. See also: DISCOUNT AND FREE ITEMS OR SERVICES; DISASTER SERVICES.

ZIP	AGENCY NAME	SITE	PHONE	PAGE
62201	URBAN LEAGUE, ST. CLAIR COUNTY OPERATIONS (UW)	1	(618) 274-1150	43
62205	LESSIE BATES DAVIS NEIGHBORHOOD HOUSE (UW)	1	(618) 874-0777	26
62205	SALVATION ARMY, ILLINOIS OFFICE (UW)	2	(618) 874-3136	31
62225	U.S. GOVERNMENT: USAF FAMILY SUPPORT CENTER	1	(618) 256-8670	40
63010	FISH VOLUNTEERS, INC. OF ARNOLD	1	(314) 894-6363	128
63011	CIRCLE OF CONCERN	1	(314) 394-0104	100
63026	FEED MY PEOPLE	2	(314) 349-0944	127
63033	NORTH COUNTY WOMEN'S ASSOCIATION	1	(314) 994-7388	231
63101	BOARD FOR INNER CITY MISSIONS-THE UNITED CHURCH OF CHRIST, METRO ST. LOUIS (UW)	4	(314) 231-0273	75
63103	AMERICAN LEGION	1	(314) 231-1759	57
63103	NEW LIFE EVANGELISTIC CENTER	1	(314) 421-3020	230
63104	KINGDOM HOUSE (UW)	1	(314) 421-0400	165
63104	SOUTHSIDE SENIOR CITIZENS CENTER	1	(314) 664-5024	263
63106	BEREAN CHRISTIAN CARE CENTER	1	(314) 421-2487	72
63106	CHRISTIAN SERVICE CENTER OF ST. LOUIS, INC.	1	(314) 241-8803	98
63106	HUMAN DEVELOPMENT CORPORATION OF METROPOLITAN ST. LOUIS	4	(314) 421-5885	145
63106	ST. PATRICK'S CENTER	1	(314) 621-1283	317
63107	NORTH SIDE TEAM MINISTRY, INC.	1	(314) 534-5656	233
63108	HUMAN DEVELOPMENT CORPORATION OF METROPOLITAN ST. LOUIS	1	(314) 652-5100	144
63108	HUMAN DEVELOPMENT CORPORATION OF METROPOLITAN ST. LOUIS	10	(314) 533-7128	145
63108	URBAN LEAGUE OF METROPOLITAN ST. LOUIS, INC. (UW)	1	(314) 371-0040	334
63109	ST. LOUIS METRO BAPTIST ASSOCIATION	2	(314) 353-1005	304
63110	CATHOLIC COMMUNITY SERVICES	1	(314) 534-1180	89
63110	FIVE CHURCH ASSOCIATION	2	(314) 776-1410	129
63110	INTERNATIONAL INSTITUTE OF METROPOLITAN ST. LOUIS (UW)	1	(314) 773-9090	151
63110	ST. CRONAN SOCIAL SERVICES	1	(314) 531-7021	271
63110	UNITED METHODIST METRO MINISTRY	1	(314) 534-1010	330

APPENDIX 2:

INTERVIEW WITH DR. TOM HOOYMANN,
DIRECTOR OF INSTITUTIONAL ETHICS
AT
ST. JOHN'S MERCY MEDICAL CENTER

Interview with Daniel Kriefall, Director of Family Care and Counseling at St. John's Lutheran Church and Dr. Tom Hooymann, Director of Institutional Ethics at St. John's Mercy Medical Center

I understand from our first meeting that your position is somewhat unique, especially here in St. Louis. Tell me a little more about that - what it means to be the Director of Institutional Ethics. Am I correct to say that you are the only one in the area?

"That would be true. St. John's Mercy is owned by the Sister's of Mercy, which has a larger health system that covers the central region of the United States. And this particular system moved towards an institutionally based model of ethics. So within our system there are three of us and a fourth one coming. I serve here in St. Louis, Tobias Meeker serves St. John's Regional in Springfield, Missouri, Sister Rose Marie Trus serves the hospitals in Arkansas and then another Mercy nun, who is in training now, will be serving in New Orleans in about a year from now. So the other systems across the country basically have adopted system based ethicists. For instance, St. Mary's Hospital in Clayton is owned by the Sister's of St. Mary Health Care System and Dennis Brodeur, who is their system ethicist, works out of the system headquarters. He covers all of the hospitals for that particular system. So within the St. Louis area, as far as I know, I am the only full-time ethicist in a community based hospital like St. John's. Kevin O'Rourke, who is another ethicist, and Jean DuBois, are both at St. Louis University. That model is a university based emphasis where they are affiliated with the medical school and will consult with various ethics committees that are usually affiliated with the university. So they work with Cardinal Glennon and the University Hospital."

As I recall it is a relatively new position here too?

"I began in 1990. The Ethics Committee at the hospital has been in existence since 1987. Prior to that it was in existence for two years in 1981 and 1982."

Which demonstrates how complex the ethical issues are becoming in medicine.

"The complexity of the issues is driven by the advance in technology. Over the past 30-40 years the technology has so rapidly increased that it has caused the relationship between patients and physicians and hospitals in general to change. Even the idea of something as simple as antibiotics is a phenomenon of roughly 40-50 years. The dialysis machine has really only been around for about 30 years. What you see now in the papers as far as transplantation technology is not only artificial organs but transplanting animal organs into humans. This would be a further issue in the future. But much of that is in the experimental stage."

Yes but the bioethics that are involved are incredible. Before we move on to some of that, to some of the particulars, you could give me a history of ethics committees in general throughout the United States. We had mentioned in our

first visit that before the 60's there really wasn't such a thing. Maybe some dates, if you could supply any of those.

"The first ethics committees that came on the scene, so-to-speak, began in the 60's with the advent of the dialysis machine. The first committees were looking at the question of who should be dialyzed and who should not when you have limited resources such as a dialysis machine. Prior to that there was discussion, and a few reports that came out of the Nuremberg War Trials based upon experimentation that was done in Nazi Germany, and a code of human experimentation guidelines came out of the Nuremberg War Trials."

As to what was ethical and unethical about their experimental procedures.

"Right. So at the same time those experiments were going on in Germany there were a variety of experiments going on here in the States that had no type of ethical review by any type of committee for protecting the human subjects that were involved. The more significant research projects that were the Tuskegee Syphilitic Research Project in Alabama, where they followed 1,000 African-Americans in Alabama who tested positive for syphilis. They followed the disease process from 1930 to 1972. They wanted to see what this particular disease did to a population. Penicillin was discovered in the middle of the project and they didn't tell the research subjects that they now had a cure for this particular disease and continued the research. That was up until 1972. There was this study and a couple of other research projects in upstate New York. One was at a chronic home for the elderly where they injected relatively healthy elderly people with liver cancer cells, wanting to see that particular disease develop in a chronically debilitated old person. There was another similar experiment with meningitis, I believe, with mentally retarded children in a state institution in New York. Some of those research projects came to the forefront - those experiments were occurring in the 40's and 50's - those research projects came about and people began to ask if there should be an ethical component in research. So what really brought this to some fruition was the National Institute of Health in the early 60's, when it established an ethical review for research. That was really the beginning of formal ethics - bioethics. Then it moved from the research setting into the clinical setting with the dialysis machine and a variety of other issues. There is another case in the early mid-60's at John's Hopkins University dealing with a baby that was born with Down's syndrome and a tracheoesophageal fistula, an opening between the trachea and the esophagus which could be surgically corrected. The parents decided not to correct that particular hole because the baby had Down's. Of course, the understanding of Down's syndrome in the 60's was Mongoloidism, which is a devastating disease and genetic disorder. There was a famous case at Hopkins where the Kennedy Institute was formed in 1967 and was looking at the ethical questions involved with actual clinical settings such as those issues. In the mentioned case, the baby died after a couple of weeks in the nursery. They couldn't feed it because every time it would feed it would vomit and asphyxiate itself. So that was a rather traumatic case."

Do you remember if any of those had any legal ramifications involved in them?

I'm sure that becomes a question now too. How the legality and the liability of a hospital relates to these ethical issues.

"Right. a lot of the legal questions were a few steps behind the ethical questions. Now it has taken a turn. A crucial legal question or case was the Karen Ann Quinlan case in 1976. The family wanted to remove her from the ventilator after she had suffered irreversible brain damage. She was at a party drinking and someone put drugs in her drink and caused her unconsciousness and seizures. It wasn't a car accident - a crude practical joke or whatever the motive was. But in the New Jersey Supreme Court Decision, the courts said it was permissible for the family to remove the ventilator support from her and allow her to die from the underlying pathologic condition. But in that court decision they also suggested that hospitals should have ethics committees in order to review these cases and keep them out of the courts; they are better decided at the bedside than with the judge who is far removed from the actual case. So the ethics committee suggestion from the Quinlan case sort of set in motion a force to begin to develop ethics committees at hospitals. Here in St. Louis the ethics committees that are presently are rather new. Ours here is probably one of the older ones in the area. There are other hospitals who have just begun forming ethics committees over the past one to two years."

Let's move right into that - through the historical part - and tell me a little bit about how the ethics committee functions here. What did they do, when did they become involved in these issues, what role did they play?

"Most ethics committees not only here at St. John's but across the country have primarily three functions. 1) Education of the hospital staff, everyone - patient's families, the community. Education regarding ethical issues. 2) Policy review and development. So looking at particular cases, particular issues, such as something along the line of when to resuscitate or not to resuscitate a terminally ill patient or any patient for that matter which people would refer to as DNR (Do Not Resuscitate). So it would be a physicians order to not use cardiopulmonary resuscitation, not to use CPR. It is an example of policy. 3) Ethical Consultation."

That's with not only the patient, because they are often incapacitated or comatose, but with the family at arriving at a decision about life support.

"Right. Sort of with the history of the bioethics movement or bioethics committees, all of the other things that were going on in the United States in the 60's and 70's, two significant events, probably the patient's rights movement and the civil rights movement, where prior to 1960 there wasn't much of a notion of individual civil rights per se in the idea that there is an emphasis upon autonomy, upon individual freedom in that whatever I want to do I can do and no one can tell me not to do what I want to do."

Remember we talked about this in our first visit. I thought this was a key element involved here.

"Whoever understands what happened in the 60's and 70's would probably get a Nobel Prize. There was definitely an occurrence of several things coming together. For instance, if you think of how medicine was practiced prior to 1960, just in general, it was more along the lines of a Marcus Welby, M.D. T.V. show. This was the idea that people had. A doctor was very patronly towards the patient, knew what was best for the patient, and made all of the decisions for the patient. The patient's family said `doc, whatever you think is best for the patient will do'".

Almost a God-like figure in terms of his decision making.

"Exactly. Now in the context of the 60's and 70's, with the human rights history, the patient's rights movement began where people were coming out saying that just because I am going into a hospital doesn't mean I am no longer a citizen. If you think of it, hospitals are a very controlling environment. We tell people what to wear, what to eat, who they can see, who they can't see, when they should go to bed, when they should go to the bathroom."

In care giving ministry, there is a real focus on trying to emphasize that. Also, provocative films have come out where interns are exposed to the very elements that their patient's are. In the movie, Doctors, the hero decides that the primary lesson for the residents was to take off your clothes and become a patient and see what this was like. But in any event, this truth that a patient does not necessarily relinquish his human rights when he enters a hospital became a critical element.

"Or making those decisions. Then the notion of informed consent came into existence in the early 60's, where you were to explain to the patient what you were going to do and what risks and benefits were involved with this particular procedure. They could either accept or refuse. They were the principle decision maker of that particular care plan. Now, if you push informed consent or autonomy to its limits, then the physician or the hospital merely becomes a vendor of health care and you, the patient, become the primary decision maker and the physician will do whatever you decide you want the physician to do. Now that removes some of the moral authority of the physician, and the moral expertise of the physician, in regards to weighing the benefits and the burdens. So we are sort of in a shift; it's possibly a pendulum. But with the committee here, it reviews some of that history and tries to come away with educational programs that reflect that history and understand it. Not only the general history of the country but the history of the institution and the Catholicity that goes along with the values of this institution. And some of that has to do with the ethics consultation. That is what most committees will deal with."

How many men and women sit on this committee and how are they appointed or elected to do so? Are they heads of departments often?

"Most committees are multidisciplinary in nature. That would involve nursing, physicians, administrators, social workers, chaplains, attorneys, ethicists, other employees of the hospital that are not directly involved with patient care issues."

So these are not just doctors.

"Also, generally most committees will have an external community member, a person who is not salaried by the hospital, but is, if there could be such a person, kind of the typical patient you would deal with. They bring a perspective from the community to the committee that hopefully reflects the community whom you're serving."

Are priests and clergymen often invited?

"The chaplain we have is Sister Gil Marie Moody, who is the Director of Pastoral Services for the hospital. Some committees that I am aware of could have a priest; if it is a non-Catholic affiliated institution they generally will have a minister, a pastor, or rabbi that is associated with that particular denomination."

I am thinking particularly of non-staffed people that you mentioned. People from the community.

"That would be a possibility. The structure, the dynamics of the committee would allow it. Our committee has 16 people on it, so there are a variety of individuals, not only disciplines but they also represent various areas of the hospital. For instance, from a pediatric perspective to a geriatric perspective. So they will wear two or three hats as they sit around a table."

Do they meet regularly and review issues that came up in the past month?

"We meet on a monthly basis. Part of that meeting is involved in review of cases that have occurred in the past month. If it is a very complex case, we will draw an ad hoc group of the committee to review it and offer consultation as quickly as we can. Generally within the clinical setting, and if you have an ethical dilemma that needs immediate review, you can't wait two or three weeks or a month from now because if you just missed a meeting you will have to wait until next month. Well, the patient is here right now and can't wait. So there are a variety of models across the country of ethics consultation. We've chosen sort of a mixture of those models where I coordinate the ethics consultation service and most of the consultations I will do individually. It will be up to me to make an assessment of the particular situation and decide if it requires additional members of the committee for a multidisciplinary perspective."

You are Director of Institutional Ethics and also chairman of that committee. Or is there another person who serves as chairman?

"I serve on the committee. The committee elects its own chair and presently the chair for this year is a nurse. In past years it has been a physician, an administrator, and the director of respiratory therapy."

Because they are so often involved in those decisions.

"Some of that. More or less it's whoever wants the job. It's an additional duty that people have besides their regular job. There isn't extra pay or there isn't any remuneration. It's kind of like working within a parish where you serve on this council and that council. It is sort of all part of being here."

Let me get into some of the real practical issues involved. Is there a particular issue that comes up most often? The life support issue I'm guessing - when to withhold resuscitation or when to withhold or include inhalation.

"Yes. For the past two years since I have been coordinating the consultation service. And I should say most committees don't jump right into consultation. This committee for its first year and a half just studied bioethics. It didn't write any policies; it more or less educated itself. And there is a natural development that most committees go through where they first must educate themselves and then, after a couple of years, move into consultation. So over the past two years I have been involved with about 150 formal consultations. Besides a kind of stop you in the hall or call you on the phone and say, 'can I run this particular issue past you, what do you think,' a kind of informal review. Of those I would say, probably 55-60% are involved with withdrawal or withholding treatment. Generally it involves the patient that has lost the capacity for decision making and the family or guardian is left with decisions of how far should we continue to treat."

Now that is important to me because often as a pastor I'm thinking of emergency room situations where someone is rushed in from an automobile accident - the pastor is often the first one to be called. Often I feel unable to direct that family with a sense of confidence or competence and I would like to defer that and often do. I will say to the family, "we need to defer this decision to the doctor." Do clergymen sometimes consult you, asking how they might best put this family at ease? Could they use you, or people on this committee, as a resource to that decision?

"A simple answer would be yes, that does happen, where I am available. There is no charge for my services for ethics consultation or any type of support that can be provided to a patient family and the team that is involved in caring for this particular patient and their family. I think that in the situation you are describing people can feel that they are in a bind, that once they start a treatment they can never stop it. So you have this decision right now and once we go down that road we can never turn around. We put a perspective on that, that there is no ethical difference between withholding or withdrawing any medical treatment, including ventilator support, artificial nutrition, hydration, tube feedings, dialysis, surgery, chemotherapy, whatever. If you think of it, it makes common sense. For instance, if you break your arm and a cast was put on and you turn up six or seven weeks later and it is time for the cast to come off and the surgeon says, 'I'm sorry, we can never stop a medical treatment - the cast has to stay on forever.' But your arm is fine, the cast has served its purpose. Or perhaps the cast needs to be taken off to have the arm rebroken or reset or something else, whatever. So how we look at any medical treatment is, if it is serving its present purpose as far as a care plan goes, if there is a goal established of where we are going with this

particular patient, then the treatment can be continued. Those goals may change. For instance, in an automobile accident you can have a person unconscious with a closed head injury, a young person, and have no idea how extensive that brain damage may or may not be. so we will error on the side of treatment, thinking that we can always withdraw any treatment once we assess where things really are, once you are out of an emergency situation. It could be a couple of weeks. I have dealt with families who have refused to have feeding tubes placed in young people, closed head injury, motor vehicle accident situations, because they are afraid of starting tube feedings because of the Nancy Cruzan case. Nancy was a young woman involved in a single car accident in the southwestern part of the state, who suffered severe brain damage and anoxia when she was without oxygen to her brain for at least 10 minutes or more. She was resuscitated at the scene and brought to the hospital and then placed on a ventilator to aid her in her breathing. So when they initially treated her in the emergency room - a young woman, 24-25 years old - full steam ahead - which is appropriate. You don't know how severe that particular brain damage would be. She wasn't dead but she did have extensive brain damage. Later the diagnosis became more clear as to the extent of her brain damage, what her recovery might be. And, in that case, they expected her to be in a persistent noncognitive state, never to regain consciousness, never to have higher brain function, but merely brainstem activity. And that may take a couple of weeks or a couple of months. It all depends on the clinical skills of the physicians, the diagnostic equipment they have available, depending on where you live in the country, whether you have a catscan or MRI, that type of imaging equipment available, and also the extent of the injury, the individual themselves. A young person does better than an old person, in general, because of other diseases that could be present, the frailty of the individual. So a lot of those things are unknown."

In that case, it was particularly exemplary of those unknowns.

"Right. They really didn't know for about 3 or 4 months to what extent she would recover. They tried extensive rehab and nothing worked. She plateaued at a very minimal noncognitive level. So then the question was raised, 'Is this a quality of life that this individual would want to live?' We can keep them alive, we can sustain them through tube feedings through good basic nursing care, but would they want it. What Missouri came down to in that case is when an adult loses the capacity for decision making such as Nancy Cruzan. At one point she had it. She was 18, she was making her health care decisions but she lost it at that car accident. She lost her capacity for making decisions. So the Missouri Supreme Court, reviewed by the US Supreme Court, back to the Missouri Supreme Court, said, basically, 'A competent adult can refuse any medical treatment including nutrition and hydration.' Once you have lost capacity there has to be clear and convincing evidence of what you would want prior to losing capacity. So what they have to do is go back and find out if she ever talked about this, did she ever write anything down. So they went back and talked to friends and family and this is what Nancy said."

They are pursuing the autonomy issue. They are doing everything they can to predict the will of the patient.

"Right, it all rests on autonomy, upon self-determination. So did you talk about this beforehand? Now, in Missouri, if you haven't enough clear and convincing evidence, and that particular trauma happens to that person, legally, the hospital is bound to continue treatment. No one has defined clear and convincing evidence. Judge Teal, when he reviewed the case, looked at her, listened to what she said, - this is what she talked about, she never wrote anything down, - but, yes, this sounds like what she really meant and in my mind, as a judge, my review of this, I think it meets the standards for clear and convincing. It doesn't say that you must write something down, that you must repeat it to your spouse every day when you wake up, or if you say it once or one-hundred times. Or the one time I say it I say it so forcefully that I am never going to say it again, don't bring it up, this is it. Is that clear and convincing? Historically, that is how medicine is practiced - the physician, trying to figure out the values of the person, turning to the family saying, 'Here is my best guess for the prognosis. We can go that route, we can go sever routes. Here is my recommendation. I know the patient, you know the patient.'"

And the family then seeks to make that decision. Do they become the primary decision maker? Obviously they have the input, the opinion, of the doctors but we are still at that place where we want the recipient of the health care, or their family, to decide. Is that to protect the hospital legally?

"The legal climate is such that it pushes autonomy. You will hear people - and you may have had this experience or you will come upon a particular case - and you'll think that this is really not in their best interest, especially if you look at it within a faith context."

That is when I become involved. The question is, "What is God's will in this?" They have heard the doctors opinion. They call me and say, "Do you concur with this? Do you think this is God's will that we do this?" Now this is the doctors impressions, opinion, his will so to speak, is this in keeping with God's will? And that is a troublesome spiritual question.

"To discern that in the same way that you try to discern any other time you ask that questions 'what is God's will?' When you are choosing career, a place to live, when you chose a family, whether or not to have children or not, all of those. People say, 'Well how do you make that discernment?' Sometimes you look for signs. Well a lot of times there aren't any signs."

I'll tell you what my position has been. I advise them that God has placed these people in a position of authority by virtue of their training and education and exploration of the issues and I ask them to defer that decision back to the doctor. The doctor then handles the actual decision.

"But see, for the physician making that decision, there are two ways they can make it. One is referred to as "Substituted Judgement." Where the physician or the family, whoever it might be, is substituting themselves into the patients shoes and trying to decide, as if they were the patient, putting on the values of that patient. So that

pushes autonomy. The second way to decide is "Best Interest." This is more or less how a parent decides for a child. The parent doesn't get into the values of a four year old, say something like a vaccination or to go to the dentist or to have the cut stitched up. I am saying you are going to have this because it is in your best interest."

Your decision is not necessarily what is preferred by him, in the case of a child, whose deathly afraid of getting sewn up.

"From the child's perspective. So, when you move into "Best Interest," that brings up questions of quality of life and benefit and burden. So if you look at something like vaccination, you say well, what are the benefits of vaccination? Well, they are tremendous, eliminating all of these very life-threatening childhood diseases. What is the burden associated with it? Well, it's a stick in the arm. You would say the benefits outweigh the burdens, in this case. And that is reflected in what is the overall goal of life. Of preserving life, of an understanding of the relationship between the creation and the creator, and we would continue to move in this direction because you can continue to glorify God's name. You can continue to expand yourself spiritually, mentally and physically in that dimension. If you move that to a person who has had a severe stroke, an elderly person, who has lost the capacity for decision making, who is aphasic, has lost all expression, does not recognize family, is not expected to recover and, let's say, has been like that, and you ask the physicians, 'how long do they think it will be before they see some recovery,' and they say, 'if we don't see some within a month it's not going to happen.' Or they may say, 'depending on the brain injury if we don't see recovery within a week it's not going to happen.' That's when you defer for the medical opinion of when you expect to see improvement and to what extent will that improvement be. Then, when you get that picture, you can say how does level of functioning fit into this person's overall goal of life? And, in their faith context, how they relate to God and the community and to their family, and is keeping them alive more burdensome to them than what they are benefiting from it in their overall perspective."

In regard to these faith issues, what really becomes complex is the Christian believes that death is not the ultimate enemy any longer. That the ultimate enemy has been defeated for them in their life by Christ, and to prolong this physical dimension at all cost is no longer the ultimate goal, but rather to receive or achieve eternal life becomes an important issue in a Christian's life. I've often made the statement that playing God is not just making the decision to withhold life support - often playing God is making the decision to maintain or preserve life when God seems to wish to end it in this dimension.

"And you will have people who will say, and it is a difficult thing to argue with, if God wants to take them God will take them no matter what we do. You say, 'well - that may be true, but'...that moves into theological issues - can you ever live with the power of God - well - you can't. There is also the question of free-will. And I don't understand - that has been a long debate over God's will and free will. That goes back to the 300's with Augustine and that is a mystery - that has never been solved. But that question - that perspective of it is stewardship of life and its gift. We are

supposed to take care of it to the best that we can, but it is never life in the Christian tradition, or the Catholic tradition which I am more familiar with, has never absolutized life as the ultimate good or the ultimate goal."

Medicine generally has.

"You think that is where you'd want medicine to be and needs to be. You'd want physicians at the bedside, you'd want them to say, 'I will give it my best shot.'"

To keep the person alive - or to save the life. Then you end up defining what you mean.

"Right. The goal of medicine is not to keep people alive no matter what. The goal of medicine is to care always, to cure sometimes, in general. But they are also looking to restore it to some function of health. Some function, to prevent disease. If a person is disabled, to get them back to some level of functioning. But I've yet to meet a physician who finds it of value, or fits their understanding of medicine, to keep somebody alive no matter what."

If you don't mind, let's change years just a little and continue our discussion in regard to quality of life and sustaining life. By an large the bylaws of this hospital as a Catholic hospital were formed by the stance of the Roman Catholic church in terms of official policy. That gives a lot of direction to the ethics committee, not so much in terms of their individual understanding but as to the general posture of the hospital. The "official position" often becomes your official position within the hospital?

"Exactly. The Mercy hospitals throughout the country. If you put Mercy hospitals together, it is the second largest system of hospitals behind the Veterans Administration. So it is a large health care provider throughout the United States and that is just one particular religious order. I don't know how many Catholic hospitals there are. But within any of those hospitals, generally, and St. John's in particular, there would be within the bylaws of that institution a statement that they will abide by the ethical and religious directives of the National Conference of Catholic Bishops. The hospital as a whole is making this statement. For a hospital in the Catholic tradition to enter into a diocese, even for this hospital to be here, historically, the bishop approached the order of nuns and invited them into the diocese to open a hospital. We are only here by invitation of the bishop. And at any time that invitation can be withdrawn. It is sort of like having theological faculties, or priestly faculties, that if you moved outside the tradition you're no longer a Catholic priest, for instance, on an individual basis. So the question would be, if you have a Catholic university, Catholic school or whatever it might be, a Catholic hospital, if your actions, your beliefs, move outside of that tradition then those who are the keepers of that tradition, which is the church as whole, not just the bishop, but the church as a whole, the bishop officially acting in that capacity would have to say in truth that you are no longer part of this tradition, you have moved outside of our understanding of the tradition. So that's where the ethical and religious directives would come into play."

Very often, then, that is your source for guidelines or directives. You find yourself in a minority position on issues that are less controversial but still crucial, let's say the abortion issues. Certainly your stance is a minority view, considering the posture of the country and the population as a whole. Sterilization, especially, must be a real minority issue. But you do take a clear stand on those issues, and that is of interest to me as a member of The Lutheran Church--Missouri Synod because our particular, very conservative stance on those issues often concurs with that of the Roman Catholic church, unlike even some of our other more liberal Lutheran denominations. That is a valuable element in my decision making when people come to me and ask me to recommend a hospital, when these issues are involved.

"I should say, with those directives from the National Conference of Catholic Bishops, that they are to be interpreted by the local bishop. As with any document, it may vary in how it is interpreted from diocese to diocese, state to state, depending on who your local bishop is. There are conservative bishops, some are moderate, some are liberal, and they all take different perspectives."

Just like in individual parishes. Very often the parish has a different stance, at least subtly, depending on the liberalism or the conservatism of the particular priest in the parish. How he chooses to interpret and apply the formal position.

"Right. So a lot of that is within interpretation of the document itself, and the institution reflecting upon its own understanding of the tradition and trying to maintain a truthfulness, a fidelity to that tradition."

Now each individual doctor, however, and I thought this was a noteworthy point in our first visit, is not asked to adhere to these particular beliefs as an individual but by and large in practice, that which is conducted within, let's say, the confines of this medical institution. He is bound to those procedures that the Roman Catholic church encourages and condones and blesses. But in their individual practices they may have a differing posture and practice completely.

"When a physician joins the staff, and there are 900 on staff, and they could be on staff at a variety of other places too, most physicians will do that, they will be given a copy of the ethical and religious directives. Stated with the bylaws it is said that, if you intend to practice medicine here, this is what you will follow. If a physician rents space in the doctors office building, now that's a separate owner lessee relationship. We own the building but they are renting space from the hospital; they are in private practice. In the lease agreement it states that they will abide by the ethical and religious directives in their private practice."

Let's use an easy one, vasectomy. They are directed not to perform sterilization techniques within that office space as well as within this hospital building?

"Right. If it is for the principle purpose of contraception. Where there would be

incidences of a diseased organ, then interpretations come into play. These are the guidelines of the institution and the physician would be expected to hold. Now we don't police or monitor a physicians practice. Hopefully, you attract physicians to a hospital that share your values and there is a certain trust level and a level of integrity that the institution must have of the practicing physician."

Even if you did police, I don't know how you would enforce it. You would open yourself to such tremendous legal disputes that no medicine would proceed.

"Some of it could depend upon the extent of the scandal I suppose."

Well, this is where my list of issues ends. I can't tell you how much I've enjoyed our visits together. It's been very enlightening. I thank you.

"Anytime. Really."

APPENDIX 3:
INTERVIEW WITH KEY HOSPITAL PERSONNEL
ST. LUKE'S HOSPITAL

**Interview with Daniel Kriefall, Director of Family Care and Counseling at St. John's Lutheran Church and Mr. Paul Wunderlich, President, St. Luke's Hospital
Cristi Scanlon, Director of Marketing and Public Relations
Dr. John Schae-fly, Chairman of the Ethics Committee
Gary Olson, with the Administrative Offices
Ed Heathcock, Chaplain and Head of Pastoral Services**

To begin, I'd like to personally thank you for giving me this time. I know you're all very busy people, so let me jump right in. Mrs. Scanlon, as I understand it, some of your duties for the hospital include relationships in the community and to the community, publicity and that sort of thing.

Cristi Scanlon: In regards to the Ethics Committee, one of my responsibilities is to make sure that patients and family members are aware that the hospital does have an ethics committee and that it is in our printed literature so that they can review that information. There is also a speakers bureau of the hospital that will go out to different organizations, companies, churches, schools and do programs about advanced directives which ties in with the ethics committee.

Advanced directives in regards to especially to life support procedures should they need them and so forth. Making sure that people know they can ask these questions and maybe who they talk to, maybe the chaplain or a doctor.

Cristi Scanlon: That's really how I tie in with the ethics committee, even though I really don't sit on the committee. We try and disseminate the information and make it available to all patients and the community in general. You don't have to be an inpatient to become knowledgeable about what an ethics committee is and what are advanced directives and living wills.

Gary Olson: The hospital is about 125 years old. It has made many changes, physical changes. We have moved to several different locations. And with physical changes have come technological changes and medical enhancements. Over the years we have learned, and perhaps a little bit through the push of state and federal directives as well, that ethical issues have to be dealt with. I think that Dr. Schae-fly would agree that prior to the ethics committee, and still subsequent to that, the ethical questions are individually handled by the patient, the patient's family and the doctor or a close friend or a relative or someone from the church or whatever combination is appropriate and is brought into the decision making process. But with that, and not having an organized manner to deal with that and maybe not having an outlet for someone to search and get additional input on whatever the ethical question might be. There was a discussion by the medical staff several years ago as to whether or not we should be forming an ethical committee. It was concluded that we should. Dr. Schae-fly at the beginning was involved with the formation, who should be a part of it, what representation should be on the committee, how large it should be, and then graciously accepted, was "appointed" the chairman of that committee and has done that since its inception. The committee is fairly large and is represented by members of the medical staff, members of the committee, board members, employees from departments within

the hospital, and a number of nurses and physicians as well. So we have the medical versed people and those who are not really familiar at all with hospitals. We feel that it is very important to get that outside input.

So the year of inception was 1988? Did they meet then regularly to review specific cases?

Gary Olson: Yes, 1988. Let me just make one comment and then I'll let Dr. Schaeffly answer that. Cristi mentioned advanced directives, status of legal guardian, those types of things. The state of Missouri requires that as you are admitted to this hospital, as well as any other hospital in the state of Missouri, that you are presented information regarding Missouri state law on those issues. So St. Luke's, through Cristi and her people, and with nursing and with physician input, have produced, in printed format, those pieces of information that are given out to each patient as they are admitted into the institution. In the admitting department they will be given a sheet that describes what an advanced directive is. They will be given a brochure on the ethics committee, a definition of legal guardian, and are asked whether that should be something they should consider. As I understand it, those are all individual choices by the patient as to whether or not to act on them. But we are required by law to that and then of course we want to because that gives us the opportunity to do more than just hand them the paper. By giving it to them in an organized fashion and allowing some discussion back and forth, and maybe some guidance from them to talk to whomever, that's a much better way than being up in their room deciding that they better talk to their lawyer, or I better do this or that, and not knowing which way to go. So we face it right at the beginning during admission.

Schaeffly, you mentioned an ad hoc committee. Does it still function in much that same way?

Dr. Schaeffly: The ad hoc committee was formed to decide whether or not we wanted an ethics committee. It was decided in June 1988. And as Gary has mentioned, the committee is a fairly large one and includes a diversity of individuals and interests. We meet once a month except for July and August. In addition, we also meet, at any time an ethical problem comes up, if it is indicated. If it is a problem a patient or physician wants to bring before the ethics committee, a meeting of this committee, or some of the members of the committee, would be held at the request of the patient or physician. We have three objectives, with our main one being education. Earlier on it was self-education. Not many of us knew too much about medical ethics. We have also sponsored 5 or 6 seminars, the next one being the 1st of April, for people in this committee who are interested in medical ethics. The speakers have been people who are well known in the ethical community. Another objective of the committee is to establish policy if we are asked to. This hasn't been asked very often. We were asked by the hospital about a year ago to implement the Danforth Self-termination Act. That really wasn't a policy but we had to be sure it got done the way the law said it had to be done.

Is there a standard at this hospital like that which exists within the Roman

Catholic hospitals, St. John's in particular, a standard that is established by the Episcopal Church in regard to certain issues. At St. John's, of course, the Roman Catholic church has a tremendous amount of say in regard to matters such as sterilization and other delicate ethical issues. Does the Episcopal Church play a role in that way? In other words, does the ethics committee find itself in a position to review the official position of this church body prior to reaching a position?

Dr. Schaeffly: Actually there hasn't been too much connection there. And there hasn't been any real problems that have come up involving church policy and even hospital policy for that matter. At least as of now. One can go forward down the road a bit and there are going to be some ethical problems that are going to become more and more frequent. I presume, during the 90's, with regard to the rationing of medical care and a number of other things, all of this genetic experimentation is going to pose problems for the ethics committee.

So to date, the physicians of the hospital and the positions of the Episcopal Church, have been fairly consistent. In the Roman Catholic traditions, some of their positions are extreme and conservative, and they would have had problems. For example, if someone sought to have a vasectomy at St. John's Mercy, they could not have done that. I am sure that your hospital is much more free to do those sorts of things. So you haven't had the run-ins with the ultraconservative position of your church body.

Dr. Schaeffly: It certainly hasn't come up, as far as the ethics committee is concerned. There may be policies in departments of the hospital, OB/GYN for example, that I don't know of. And there are some questions as to what is medically to be decided and what is ethically to be decided. And what you have just chatted about - obviously St. John's is Roman Catholic. We are many things. We have in our name Episcopal Presbyterian and by far that is the strongest influence. But as Ed will attest to, we have Catholics, we have Jews, we have every denomination of Protestants. We try to be very flexible. But there are certain things that all hospitals will or will not do. You mentioned sterilizations. That is something that St. John's won't do but that is something a hospital like St. Luke's will do. And the majority non-Catholic hospitals in town will do.

Tell me just a little bit, Ed, about the pastoral department. I know Paul says that it is probably as well staffed as any in town.

Chaplain Ed Heathcock: Well I think it is but of course I've got my bias'. We have two chaplains here full-time. Gary mentioned that we are both Episcopal and Presbyterian. I have a colleague who happens to be Presbyterian so he deals with the Presbyterian side and I take care of the Episcopal side. There are the two of us and then we run an education program with 4-7 residents, candidates for supervisory pastoral education. I have been with Dr. Schaeffly and the ethics committee from the early beginnings. It is interesting that you raised the issue of religious influence. As I look back, I think it was Dorothy Bernard who was on the initial steering group. She

was a board member, at that point, but was also one of the leaders of the Presbyterian church. I guess the thing that surprised me most about that is that I don't normally think of religious denominations first. When I look around at the committee, there are a number of people. Some I know their religious affiliation and some I don't. I do know we have some Catholics, some Episcopalians, some others. We don't even list them by religious faith groups. But the influence is there, by virtue of being part of the committee, and those viewpoints get expressed. Church bodies have particular postures about certain moral issues.

Abortion for example.

Chaplain Ed Heathcock: But I do not think you will find either the Presbyterians or the Episcopalians seeking to impose those "church positions" to regulate the behavior of a parishioner or anybody else. It is not that we don't have these positions, but trying to modify someone else's behavior against them - I don't think you'll find these two church bodies involved in that.

And the way that the Mercy hospitals do that is quite simply that they do forbid certain procedures, abortions, sterilizations, and so forth.

Chaplain Ed Heathcock: We prohibit abortions too unless it is life threatening to the mother at that instant - otherwise we won't do an abortion. Those types of things are, as you have eluded to, hospital policies. So we have made those decisions. Those types of things don't need to come to the ethics committee. It's the unusual, the non-everyday type thing.

For example, what to do in life support situations?

Chaplain Ed Heathcock: It could be, and I am not the expert, but it could be something that might deal with a family decision. You have one family member saying that this is what we should do for dad, and another family member saying that this is what we should do, and they are not agreeing. So the doctor might say, "Does anyone want to give me a thought on how to approach this differently?" Here is where I come in with the family. . . .

Let me ask Dr. Schaeffly, then, regarding a working definition of "death." Over the last 20 years this has gone through some development and I don't know that pastors like myself have kept current. What is the present definition of death? When is somebody considered dead?

Dr. Schaeffly: This has gone through a certain amount of evolution over the years. As of now, a patient is considered dead when they are "brain dead" and that means a flat EEG including the brainstem. Now there is a difference between the brain and the brainstem. The brainstem has to do with breathing and automatic functions and the rest of the brain has to do with cognizance, thinking. But brain dead means both the cerebrum and the brainstem have a flat EEG.

Meaning the electrical energy is nonexistent.

Dr. Schaeffly: Right. It brings up some problems because there are certain instances, as you have been reading in the paper, Nancy Cruzan, Christine Busalacchi, and a number of others, where they are not brain dead but they are in a permanent vegetative state. In other words, they can breathe and eat, things that are automatic, but they have no cognizance, absolutely none. This has been a complicated situation. It is becoming more and more accepted now that people who are in a permanent vegetative state, if they had made a commitment earlier that they don't want anything done as far as life support is concerned, then nothing is done - if it has been preordained by that individual.

And the ethics committee would come into play only if there was a family disagreement?

Dr. Schaeffly: The function of the committee is to hear case presentations. We are trying to develop this, to get more of these, because I have the feeling that there are problems that the ethics committee could help solve that are not being presented to the ethics committee. But we have had a number of instances when a physician has brought to the committee's attention an ethical problem. We don't try always to seek a consensus - it is simply a discussion. and most of the problems that come up with regards to life support, nutrition and hydration, if they are discussed, if there is communication, goes on between the physician, patient and the family. This doesn't come up very often. But it did happen at our last ethics committee meeting where a case was presented. As I recall the patient said she didn't want anything done, and then the family, the kids, were adamant that she have intubation. They ended up intubating her because the family was so adamant - even though the patient had said definitely that she did not want to be intubated. These are the kinds of questions that come up and they are not always solvable and the committee does not tell them what to do. The committee is an advisory body.

That is what I wasn't sure about. They may advise the doctor or the family, but who has the power to make the final decision? Will the hospital, or the ethics committee, or both in combination say, 'yes, we will do this?' when do you decide 'no we won't do this.'

Dr. Schaeffly: According to the law, correct me if I'm wrong, [speaking to the others at the table] the hospital, the intensive care units, are legally bound to carry out the advance directive of a given patient. Now this can and has been altered in some instances.

Now that's radically different, historically, isn't it? The hospital used to have sole power in those issues. This is one thing (I've learned most dramatically) in these visits - this growth in autonomy on the part of the patient and the family. The power to make those decisions used to be in the hands of the hospital. Now it is almost exclusively in the hands of the patient or the family. The rights of the individual and the autonomy of the ethical decision are the standard.

Dr. Schaeffly: It is because medical technology has outstripped social development in these ethical areas. You can keep somebody alive now indefinitely even though they are brain dead.

But if a person were brain dead in the sense that you describe, say absolutely no EEG, will the hospital, at the wishes of the family, continue to keep that patient alive?

Dr. Schaeffly: We have never had that happen here. But it has happened elsewhere in the country.

A person who is unstable might say 'do not take this machine off.' Is the hospital liable?

Chaplain Ed Heathcock: On our ethics committee sits a legal council. The law is a different issue than morality. Dr. Schaeffly made a point earlier - and Gary said something about it - the multidisciplinary sitting on this committee. In reference to the case we just listened to: the patient did not want to be tubed and the rest of the family on site was o.k. with that. So there wasn't any problem. But then in flew a son from California, and it was the son who insisted that she be tubed. One of the things that shook out of that conference was that it became apparent that this particular son had some psychological stuff that he was working out that was getting in the way of this family's ability to come to a decision. This case was presented postfacto but in the process I think some people walked away with a better understanding of how the ethics issue works its way out in a system on interdisciplinary people. Even though the physician is there, and is responsible for any kind of decision that is made, it is still done so on a shared base. There are lots of different ways to look at it, lots of different people involved, nurses, respiratory therapists, chaplains, and so forth.

Coincidentally, I was a part of the case that you are referring to and I know the background. I go back 10 years with this particular family. The psychological baggage behind the scenes was incredible. Unless the doctor knew some of those details - he wouldn't know that the son's decision not to withhold life support had little to do with the definition of death involved here.

Chaplain Ed Heathcock: And it's these kinds of cases that make it difficult to have decisions made ahead of time that are going to apply to all of these contexts because they don't. They push and shove from a variety of different places and none of it was related, as I recall. What was going on between the patient and the physician was very clear. The ethics committee, provides a place within the system as a forum to kind of look at those things and get a variety of people involved.

Mrs. Scanlon, you mentioned before that informing and educating people is an important part of your function. I was surprised just now to find out that the hospital does not perform abortions except under life threatening situations. I don't know that the general public knows that, certainly not just about this hospital but about hospitals in general. Are you in a position, then, to share

hospital policies? In other words, someone calls in and wants to explore the possibility of artificial insemination, do you say, 'I'll get back to you.

Cristi Scanlon: We have pretty clear communication between the medical staff, especially the physician referral nurse who works in my area too.

What as to your hospital will or will not do procedurally.

Cristi Scanlon: That or if it is a case where the procedure is unclear we refer to several physicians and we ask the ethics committee to discuss that particular issue with the physician.

Gary Olson: That is really the key to this, those are medical questions as well as ethical questions, so that if we would simply say over the phone that we don't do those, we might not be doing the best service to that patient. We could say that, and when we get asked we do, but the best approach that Cristi's office does is we give them referral names so that physician gets in touch with that patient and can ask the patient what he really wants. Sometimes the patient is very educated in what they do want and, as they talk it out, the physician might come back with 'well this is really unnecessary or maybe inappropriate. What you need to do is come in and talk to me or an OB doctor if your dead set on this or that. We don't do abortions but if you have been given some medical information that maybe isn't clear, let's come in and talk and maybe there is another alternative to what that person might be thinking.' We try to the best of our ability to give to the patient a physician when they call in with a medical question. But, if point blank asked, obviously it's very easy to say we don't do this or we do that. But generally there is more to their questions than just what they are asking so we try to get them to a physician who can answer those questions you've talked about it. There may be callers who want to have children.

I noticed that on your brochure that was one of the areas of medicine. Let me change the subject just slightly. I learned that at St. John's, even though they have the Arch Diocese setting policy for the hospital, and they know what that policy is, there is no way that they attempt to police their doctors. I'm sure that is the case here too. In other words, just because St. Luke's doesn't do abortions on demand doesn't mean that your doctors necessarily hold that to be their personal policy as well. Is that true? In other words, someone on the staff at St. Luke's doesn't necessarily have the same position regarding the abortion issue. So referring to a doctor who is affiliated with St. Luke's would not necessarily mean, on the part of a pastor, that he is referring to a doctor who is very much against abortion. Let me give you some background on why I ask. Someone just came from their family doctor and were a little surprised how he quickly recommended abortion, in the case of a questionably healthy fetus, and they asked me if I could recommend a doctor or a hospital for a second opinion. I didn't have an answer for that person. I told them I'd have to make some phone calls. That visit, in fact, is what prompted me to do this as my project or dissertation. I hadn't done any homework on that sort of thing and thought I had better do it now. If I would call the physician referral service at St. Luke's would

they be able to recommend a doctor who is less eager to do abortions?

Gary Olson: If someone would call and ask to talk to a physician about the abortion issue - I'm sure the comment would be made that we will refer you to several doctors on our staff - and you are absolutely right, each doctor has his own opinion about a lot of issues. Then he would talk with that person if he or she so elected and work from there. But the doctor is clear that this procedure, as with St. John's, would not be done here. Would we refer them to somebody who is willing to do them [abortions] somewhere else? That we would never do or be a part of. What we would do is try to categorize the patient's inquiry to the appropriate medical service, whether it be OB, surgery, or medicine. And then, as the time evolves with that person discussing it with that doctor, they would work out, whatever appropriate care was in her mind and his.

Cristi Scanlon: And there is, to a certain degree . . . we don't call it policing by any means . . . there is a quality assurance committee. If abortion is the diagnosis for a patient, it is going to be reviewed. And it should relate back to the medical condition of the mother and if it was a life threatening situation.

The hospital, though, must be very careful, I'm sure about recommending particular doctors. If someone calls in, for example, and says I want a Christian doctor, that's certainly not a medical issue or an area of expertise. Do you know how that question is answered?

Dr. Schaeffly: What do you mean a Christian doctor?

A practicing Christian as opposed to, let's say, someone who is Hindu. There are a lot of Indian doctors in the United States and I'm not sure what their position would be on some of these delicate Christian issues. Are you able to share with the caller the religious affiliation of the doctor, if they ask?

Cristi Scanlon: We know everything there is to know about the physician. We know entrances they take, we know their age, we know where they went to school, we know if they are board certified. We do not list religion on our computer system. I guess the question has never really come up.

Dr. Schaeffly: I can dig this up for you but I think somewhere there is a statue that says that cannot be done because of the discrimination that goes on. Honestly I don't know the answer.

Cristi Scanlon: And the other thing we do is try and give them more than one name and then that question can be asked of the physician by the patient as opposed to us trying to determine what the physician is on that particular position. So if a patient calls up and says 'I'm new in the community and I want a Christian physician,' whatever, you decipher what they are asking for from a medical standpoint and then you give them three names to pick from. We try and do it somewhat geographically. We then rotate that. We let some of those questions go on between the physician

and the patient

Some of the questions that I have remaining are pretty general. I think I have asked most of them. Are there any particular items that you would like to share with a pastor. We pastors would like to know when we are getting in the way in the hospital or where we are infringing upon what the hospital is trying to do?

Gary Olson: Patients coming in express different desires all the time. Some will come in and ask that we don't tell anyone that they are here. Others will ask that we get their pastors over here as soon as possible. What we try to do is establish a channel of communication so that if any of their requests are presented we can get the right resource to that patient. And we do have those who come in and ask for a minister and they don't have a minister. We then send Ed down, or his associate, and they take it from there.

Something you do that is highly appreciated is the little clergy book. The first thing I do when I enter the hospital is flip to "L" for Lutheran, look down that list, and I know what particular room my parishioner is in. Also I will see names of people who are too shy to inform their congregation. I'm amazed that other hospitals do not do the same. In terms of PR, that is a tremendous oversight on their part.

Chaplain Ed Heathcock: We have a hospice here which is modeled to take care of the terminally ill and their families. Each week we meet with the nurses involved who take care of the patients who are near terminal and, terminally ill at home. We always discuss each patient with the chaplain at the time. We discuss the goal of the clergy in the care and the care of that patient's family. Our clergyman get in touch with whoever the proper person is at the church they belong to be sure that there is a connection. This is an active program as part of the hospice.

St. Luke's does a fine job of making that connection. We will get calls informing us of that.

Chaplain Ed Heathcock: We focus specifically on some of the moral worries that patients have. It is not out of the ordinary for a patient to be in conversation with their doctor while they are here and the doctor says some things to them that doesn't stick, or they misunderstood, or they haven't heard, or whatever. Talking about pastoral care, that is one of the places where we have been able to support the facilitation of the intervention, whatever the ethical decision might be. It provides an opportunity for people to talk about what they have been told. I encourage them to enter into the dialogue. Sometimes they don't want to hear it again. There are other times when it comes to options, when a physician may say something about 'well we could do this or we could do this,' and there is a decision to make. We provide an opportunity to think out loud about those alternatives. Some family members, for example, might not permit mother to even think about death but mother may need to think about it. We do not prejudge the situation. So I think pastoral care has a real opportunity at that point, whether you come from the outside or whether you are in on the inside. In fact, as I

was suggesting earlier, we are able to facilitate the decision that needs to be made rather than to come in and pronounce it, or get into a conflict with the family.

Pastor Dan Kriefall and Chaplain Heathcock discuss pastoral care and worship services.

Are there general Protestant services offered and does a Roman Catholic priest come in? Is there a variety offered? How does that work?

Chaplain Ed Heathcock: First of all, the department is ecumenical. I mentioned earlier that my permanent staff is Presbyterian and Episcopalian. The resident group changes. Every time we get a new resident group we may get a Missouri Synod Lutheran in the group this time but he may move on and may be replaced by American Baptist. So the mix of everybody on the staff is always different. We carry either 5 or 6. Right now we have 5. We have one Roman Catholic sister, an Episcopal priest, and an American Baptist female minister, a Southern Baptist male and a ELCA male. They are here full-time for a year or two years training. They are not permanent staff. So that what happens is, basically we do an Episcopal prayer service every morning here at St. Luke's and then we do an Episcopal evening prayer service over at Surry Place nursing home. Then on Wednesday at 1 p.m. - the first thing we do is have the auxiliary go through the hospital and announce that we are going to have a communion service or Eucharist in the chapel at 1 p.m. And anyone who wants communion brought to their room, we will do that immediately after the service.

To any one who desires. The Lutheran Church--Missouri Synod is more conservative in that position.

Chaplain Ed Heathcock: My colleague and I alternate on that service. This week it is Episcopal and next week it will be Presbyterian. But after the service the whole department goes out throughout the hospital. What we try to do is to match. If we have an Episcopalian who wants communion, we try to send a priest up, if you follow me. Obviously we don't have enough bodies but believe it or not it really doesn't matter. The only people that it really matters to are the Catholics, but believe it or not they are mellowing some. That's basically the service. Now another service we have is on Sunday and I do the Episcopal Eucharist both places, both the hospital and nursing home on Sunday morning. In the afternoon we have a general Protestant service, general ecumenical service that is televised here in the chapel and then we do one on site in the chapel at Surry Place. Now what happens is that when the Catholic sister does it, it is a Catholic prayer service. If a Lutheran does it then it is a Lutheran service. Follow me? So that we don't reduce anything. Then if it is an American Baptist, the afternoon service will be a American Baptist service. We try to maintain publicity so that the people coming in don't get caught by surprise. We publish a bulletin or pew sheet that goes out on the breakfast trays in the morning and the sheet will say right on it that the service this afternoon will be done by Chaplain so and so who is a Baptist, etc., so there won't be any surprises.

Are these worship services a lot different?

Chaplain Ed Heathcock: Well, yes they are. Some of them are similar, the Lutheran and the Catholics and the Episcopalians are quite similar but the Baptist is quite different. The Baptist liturgy is quite different. Then what we will do is bedside communion. Then we have a Catholic priest who is really not on our staff but has worked at St. Luke's, he comes out of St. John's. I think he may be paid out of the Arch Dioceses - I'm not sure. He covers St. John's, their nursing homes, Missouri Baptist and us. He has some Lay Eucharistic ministers who come in, I think every Thursday, and distribute Catholic communion. Of course, we keep the sacrament here as well. We have our resident Sister.

The Roman Catholic has gone to lay ministers?

Chaplain Ed Heathcock: They can distribute communion.

We are moving toward that as well. In fact, our parish has asked our Elders to assist with our shut-in visits. That was a bit radical. That was not done in the LCMS in years past except in extreme situations. Anyway, I'm glad to hear that these services are made available. Such things are important.

Chaplain Ed Heathcock: We are busy. It is impossible for us to see ever every patient as you may imagine. Of course nowadays there are outpatients. There are outpatients that we can't get to. We do our best. I imagine we probably make around 2,000 to 2,500 contacts a month.

Do you keep a record of those?

Chaplain Ed Heathcock: We keep all of those statistics out of the department in terms of the activities and even breakdown some of the kinds of ministry, whether it was a visit at the time of death, or an emergency room call, or whether they were called back in the evening or on a weekend - we don't live in the building - for an emergency of some kind. We also keep a Liturgical Record of every liturgical act that we do. All of the services, the attendance, the communions, the baptisms, the funerals, the weddings - we don't get too many weddings particularly.

Sick bed weddings?

Chaplain Ed Heathcock: It was interesting. Not too long ago, we had a couple who were in their 80's and had lived together all their life but had never formally or religiously been married, kind of common law. He was dying and they felt the need to put that together. They had the kids come in.

I'm surprised that it doesn't happen more often for either tax or legal purposes.

Chaplain Ed Heathcock: I'm glad we're here to do that. You're living in a parish community where all the people belong to that community. We have people here who

have no religious community anywhere. If it weren't for us they wouldn't have any religious ministry at all.

Or they are torn from theirs by distance. People from out of state.

Chaplain Ed Heathcock: We may even get a call from somebody in Chicago who has a parishioner here who is visiting a son or a daughter and they will call us knowing they are in the hospital asking us to be their pastor.

Are area clergyman invited to be on the ethics committee? Are they included or must you purposely exclude them so as not to be partial?

Chaplain Ed Heathcock: No, we don't exclude. To my knowledge, other than myself, I guess I am the only cleric representative on the committee. It depends on how you mean clergy. Dorothy Bernard, who you heard me mention - Dorothy, Dr. Schaeffly and I formed that initial ad hoc steering committee - Dorothy is an elder and former moderator of the Presbyterian Church U.S.A. She is ordained. To answer more in the way you have asked your question, no we have not had any clergy on, though we do have representatives from the community.

I thought you might not be in the position to invite clergy for fear of showing a partiality to a particular denomination. If you invited a Roman Catholic to be on the committee another denomination might say 'wait a minute,' say a faith that has really opposing views to the Roman Catholic position on key ethical issues.

Chaplain Ed Heathcock: I haven't thought about that. That does raise a point in terms of how we provide the ministry here. I was talking about being a mixed faith group. We will provide the pastoral ministry to anybody who wants it, without violating their own religious faith group or integrity, but in terms of any direct proselytizing or overt hustling or evangelizing, we don't do it and we won't permit you to do it. If you were going from room to room trying to get converts I would intercept you. We can't do this. Which is also to say that we will on occasion find proselytizing information left in waiting rooms. Without being specific, I think you know what I am talking about. We gather it up because it looks like we endorse it.

Do you ever find an irate clergy? Let's say you offer the sacrament to a Roman Catholic and they accept it - the priest finds out.

Chaplain Ed Heathcock: I have been here 7 years and to my knowledge I have not had one complaint. I know there have been periodic complaints from the Catholic side that they sometimes don't get responded to quickly enough. They want communion before they go to surgery or they want communion today and the priest is not going to be here until tomorrow.

This is a question that maybe varies with the priest. Will a priest request that this pastoral department administer the sacrament if he can't be here?

Chaplain Ed Heathcock: I don't know what they might do but they have not to my knowledge asked us to do that. What they have said, if it happens to be someone calling a local pastor, like down the street from where you are, for example, that priest may say 'Father Sullivan is there to cover the pastoral needs of those patients' and thereby not come in. Then we have gone to visit when they were asking for a Roman Catholic priest. One incident I recall was a lady who wanted to see a priest before she went into surgery and she would not go into the OR until she had seen one. They had been trying to find one and were having difficulty so I went down. She wasn't needing the sacraments, just someone to talk to. So I talked with her a bit. I did not pawn myself off as a Catholic priest. I told her the father was not going to be in until later. Lots of times, the pastoral needs we do provide for the Catholics. We don't exclude them when we go to visit. When I walk into a room I don't have any idea if it is Lutheran or Catholic or whatever. Lots of times our pastoral ministry is all that is desired. When it comes to needing a sacramental ministry, even LCMS, we've got a LCMS contact person. We have other contact persons, Jewish and some of the other faith groups to call.

That wraps up our time, Ed. You've been very generous to help me with this. Thank the others again for me as well.

Chaplain Ed Heathcock: Certainly. I've enjoyed the time together.

APPENDIX 4:

**INTERVIEW WITH DONNA STEINER
ASSOCIATE DIRECTOR, ASSOCIATED COUNSELORS OF WEST COUNTY**

Interview with Donna Steiner

I'll give you a copy of the transcripts to look at before I publish it in any way even in terms of just picking out details. What I have done with most of these people is just gone through a very simple list of almost informational things. Again the thesis that I was just talking about - it looks at the general idea that in pastoral counseling they tend not to make referrals as often as they should and sometimes it's not just a matter of reluctance, it is simply a matter of lack of research and really looking and studying the options. I had always referred almost automatically to the folks at Lutheran and Family Services just out of loyalty to them. But I have had a growing concern based on some interviews with some of their people but more than that was the feedback I was getting from counselees and some calls I had made or had others made whom I had referred for marriage counseling in particular about the time of wait and so forth. And then in interviewing with them it seemed they were often hiring the least expensive person they could get and I don't blame them if they have a budgeting problem but that is certainly not the best way to go. But I blame some of that on the feedback I was getting so began referring elsewhere. I knew Joe and that is how I began referring people over here. I have been getting real good feedback and I wanted to interview you and use that as an example of things that need to be done especially with people who specialize in pastoral counseling - so thanks for this visit Donna Steiner. A good Jewish girl.

My daughter came home from Lutheran South a couple weeks ago and said "mom, one of the kids asked me if Steiner was Jewish." Well it is German in origin and I am sure there are a lot of Jewish families out there with that last name as there are many other names.

What about your own particular relationship with Joe Barbour? How did you get to know him.

That is kind of an interesting story. He and I were taking a class together at SLU maybe 8 years when we both had just moved here. He had moved here from Bolivar and I had moved here from Kansas City. I was getting my masters and he was getting his PhD and we were in a class together. You know how you go around a room and introduce yourself and he said he was a pastor and I thought that was interesting. So after we introduced ourselves I went up to him and we found out, we both went to the same church and our kids went to the same school but we met each other in this class at SLU.

Did he then begin referring to you as I understand it based on his need at the seminary for a kind of a specialty.

Yes, I think that we both talked at length - we both kind of saw a need in the Lutheran community for some additional counseling services. At that time he was seeing folks at St. Paul's.

So then, when he was looking to form an association the two of you talked about that or did you approach him? Not that it matters.

It evolved over time. He and Randy Winkle really got together first and started talking. He is a pastor. He took a call and is now in Florida. He is still technically one of our partners. But he felt like the call he received from Florida was what he wanted to do.

It would have been like mine at the doctoral level. He was one of the regular counselors. He didn't have experience from the AAPC but did have experience. Did that affect you insurance wise? That question comes up? I remember talking to Gary B. at Lutheran Family and Children Services. They had talked about bringing me on board there and that was a problem doctorate or no. Without that certification - it was something I would have to work toward. You were able to work still with him on staff. With your own situation - are you running into the same problems? Do you have a masters degree?

I have a masters degree but I am also a licensed clinical social worker and since the state passed the licensure about 3 years ago I think there is a pretty strong lobby in the National Association of Social Workers. It has been very successful in getting us coverage on quite a few insurance programs. I would say we do run into from time to time with some individuals who carry insurance where it has to be a psychiatrist or a licensed clinical psychologist. We have no one with those credentials on staff here.

What does that mean? How does one receive a license as a clinical psychologist?

First of all you have to get a PhD in the school of psychology and then pursue your license.

So it is strictly PhD stuff?

We work with families. We try to get the insurance information all cleared up by what's covered and what's not before they come in. It's primarily their responsibility to do that.

The reason I ask that is I like to be able use people that are both degreed and also tested by people. In other words when someone comes back to me, someone I have referred, and says I made more progress with this person than with two psychiatrist, it's an irritation not to be able to recommend that person because they cannot finance that- that cannot afford to have that person because of lack of certain certifications.

I am very pleased with the insurance response that we have had as a group. Joe and I are the only two who are currently on several plans like Preferred Health Care. I have been very pleased with the insurance reimbursement we have received.

And Pastor Winkler when he was here had none of that. So that was a greater problem. Of the people that you mentioned how many people do you have on staff? That changes I imagine. There is kind of a turnover I suppose. They use this space and they kind of use this space and work for you. How does that work?

Primarily they rent office space from us. They are not employees of ours. We have been introduced to them from a variety of different ways and have discussed their perspectives on how they do counseling and it fits with ours. We do make referrals to them.

Someone calls with a particular need as I have and I described or tried to make a diagnosis of my concerns or limitations and I say you have an expertise, I am thinking of a particular situation, and I say you have an expertise in this area and try to match that need with someone on staff. So again numbers wise?

It is growing all of the time. We have 6 other people besides Joe and myself. All part-time. Two people almost finished with their PhD's who have experience even with their masters. Ellen Ranney very talented. She is just about to receive her PhD.

This concept is about two years old then? Let's talk the referrals you receive. You said largely from the Lutheran community - a lot of pastors referring?

It is interesting that you brought up the referral. I did a talk in our Thursday morning seminars about referrals. So we had an opportunity to talk to quite a few pastors about what are some of the barriers or obstacles to referring. It was interesting to hear them tell us about it.

If you ever need a presenter I am going to be a prime candidate. If Joe will pass my paper. He sent me back to the drawing board.

Do the people who seek you out in large part come with an agenda in their mind of wanting or needing spiritual or pastoral guidance as well as a secular or psychiatric approach? In other words do you notice that they are avoiding in any way going to the secular setting or is it that their pastor has said that this is the best person?

I would say from my own personal point of view that most people feel very connected that I am a Lutheran and that I am a Christian. It gives us a lot of common ground on which to build. It connects us in a way that you don't get connected if you go to someone in the secular community. It is difficult to make that phone call for anyone. And to make that initial appointment - to walk in these doors - and to tell a complete stranger some of the most personal things that have ever happened to you. It seems to provide a framework that people are really drawn to.

But not necessarily expecting. In other words, do you have any ideas of what the percentage is that come from pastors? Or who are members?

It is a large amount.

So we are looking at 80% or 90%.

It is very important to the pastors.

It is important to the client. Because you get into that whole thing of when to refer and whom to refer that I am logging down right now. The question "is this a Christian counselor" comes up all of the time.

The pastors want to know from us - if I send you a couple that is struggling - are you going to tell them to get a divorce or

The basic framework theologically speaking.

I think that they know it guides and directs our lives and we see it as a source of strength. And we bring that into the treatment. In terms of your question about pastoral. I don't consider myself a pastoral counselor. I don't get into scripture. I learn so much from my clients. They will use scripture all of the time. Sometimes it does seem appropriate to bring up something like that but generally speaking it is not part of the treatment plan.

Behind that question there is another question. Have you noticed any pattern why pastors feel a need to refer? Do some of them refer out of habit or do they run into a particular type of problem that they feel ill equipped to handle? In other words, if you move into a neuroses, do they suddenly say this is out of my league. Any patterns that you have noticed? Schizophrenia and that whole phobic area sort of thing?

Because it is going to be a tough problem or he wouldn't refer?

Yes. We have heard in some of the seminars we have done that they don't have time, they don't feel that they have the expertise. A few pastors have told us they will tell people up front, 4 visits for marriage counseling or something and then if things don't seem to move in a direction that feels comfortable for everyone that's when. So it seems that pastors have developed their own agenda as to when to refer.

Time limited response as one expert calls it. They establish an almost a crisis intervention philosophy of counseling and after that it is referral.

I'd say generally speaking we are handed a population that others have found to be challenging. That is pastors in particular.

That is certainly true in my case - some of my referrals. Others have been - I think that sometimes a female client or counselee really needs to be with a female counselor. That may sound sexist but I don't mean it that way. I just

think there are disclosures and areas that a female would do a better job. That is finally my criteria for referral is when I am convinced for whatever reason that someone else would be able to do a better job for this person. Today I referred someone here. And I have been seeing this person for a year. And I have had the same basic diagnosis of the needs and the problem and she wants to move on that but I asked her not to until she consults someone else and gets a feeling or confirmation of what we have already arrived at as a course. But for her confidence sake I have asked her to do that and she has agreed.

If insurance is not able to cover this or if a person has no insurance are there means by which you can adjust the fee to match to available funds or income of that person? Some people call it adjustable scale or sliding scale.

We would like to stay away from those terms. And what we tell pastors is that we will try and work it out on an individual basis. We would like the responsibility of discussing the finances to be between us and the client. We just tell pastors to send the people to us and we will work with them. We have to set our fees and then we work with people.

That has to be cumbersome for you too, to have to go through the financial end of things.

I think you develop your own style. I do it on the first phone call directly with them. We talk about it, we get everything before they come in so that everyone is comfortable before they come in. Every therapist handles that individually on their own.

Is there any particular time that most people are asked to wait in terms of waiting period? Do you try to get everyone in the week that they call or is there any policy about that I can tell people?

I think that generally speaking if someone calls and say they need to see someone ASAP we will find someone to work with them. The problem we run into is Joe probably gets most of the referrals. His name is very well known and respected in the community. I really work hard at seeing people who are experiencing a crisis. I run about a 10 day wait if people feel they can wait.

So there you have the assessment of the crisis.

If someone says they need to be seen they will be seen by someone in our group. Someone will have time for them - it could be the next day.

Often that is when the pastor gets the first call. They get a lot of crisis intervention. This call I received right now is classic of that. I need to rush over to the emergency room. The person who is there is a goner - they don't need the care - it is going to be the survivors and they may need in the future some ongoing therapy as they get caught in the grief process. That is how I view an

agency as a resource to me. I'll answer the beeper and I'll get things under control but for long term counseling - even though my title is Director of Family Care and Counseling I want to more in more see myself in the capacity as the expert in referring. And I think that more pastors and the thesis of my paper is what pastors need to pursue not only that but a gleaning of the Christian community. How do you find out where the good counselors are? That is my thesis. You ask the people who are seeing the counselors. And the more you can ask the better. Not just the ones you have been referring, ask the people who have been referred by friends. So I did a survey. In fact on the tape that I lost I asked Bill North if he has run into that on any of the sources that talk about referral - Suggesting to the pastoral counselor that he surveys the Christian community who they think are really good doctors and counselors right down to chiropractors not just relying on his own perceptions discernment and these sorts of visits - ask his people. He said he has never run into to that in approximately 50-100 books that have chapters or suggestions. Have you?

No. I think it is a wonderful idea.

I passed out 3,000 surveys and got from my own congregation nearly 35-40% back. I have a list now of about 20 pages of highly recommended doctors. Some of these people have been through half dozen doctors to find this particular doctor. So they are on that list. I will certainly include you folks on that list. My name will be behind that you. So that is why I am not putting anyone on that - it's called My Preferred Doctors Referral List - without having visited with them.

So thank you for your time.

APPENDIX 5:
PREFERRED DOCTORS REFERRAL LIST SURVEY

PREFERRED DOCTORS REFERRAL LIST SURVEY **

(123)

** Please fill in the following information to the best of your ability.
The correct spelling of the doctor's last name is the only information
that is critical.

* * * *

We have found the following doctor(s) to be a particular blessing to
our family (or to me).

Doctor's Name _____
Office Address _____ (Number and Street)
_____ (Town, State, Zip)
Hospital Staff _____
Specialization _____ (*Cite letter from list below, when possible)

Doctor's Name _____
Office Address _____ (Number and Street)
_____ (Town, State, Zip)
Hospital Staff _____
Specialization _____ (*Cite letter from list below, when possible)

- | | | |
|-------------------------|-----------------------|-------------------------|
| * A. Family Medicine | G. Psychiatry | M. Ob/Gyn |
| B. Allergy-Asthma | H. Counseling | N. Pediatrics (Child) |
| C. Cardiology (Heart) | I. Chiropractic | O. Plastic Surgery |
| D. Dentistry (General) | J. Ear-Nose-Throat | P. Dermatology (Skin) |
| E. Orthodontic (Braces) | K. Neurology (NerSys) | Q. Geriatrics (Elderly) |
| F. Internal Medicine | L. Cancer Treatment | R. Any Other (List) |

* * * *

Your Name _____
Address _____ (Street) _____ (Town)
Telephone # (Home) _____ (Work) _____
Husband/Wife's Name _____ Number of Children _____
Church Membership _____

APPENDIX 6:
LETTER OF INTRODUCTION
TO
PREFERRED DOCTORS REFERRAL LIST SURVEY

February 10, 1993
(125)

Dear Christian Friends:

Greetings in the name of our Lord and Savior.

For those of you who don't know me, let me begin by introducing myself. I am Pastor Daniel Kriefall of St. John's Lutheran Church and School in Ellisville, Missouri. I have been on the staff at St. John's since 1979, where I currently share pastoral duties with Dr. Stuart Brassie and Rev. Stephen Hower.

My reason for making this contact with you is to enlist your aid as a member of the Ellisville Circuit of the Lutheran Church, Missouri Synod. Allow me to explain.

At present, I am in the final stages of my Doctor of Ministry work at Concordia Seminary, St. Louis. This last phase of my program of study involves completion of a Major Applied Project, defined by the Seminary as a "written doctoral level project...which addresses both the nature and the practice of ministry."

Since my ministry centers around family care and counseling, it is important that my project address a developmental need in that area. One need that I encounter most frequently is the need for a list of health care professionals from which to make competent referrals.

This is where the Christian community becomes an invaluable resource.

The Scriptures tell us that the Holy Spirit grants unto His people the gift of discerning hearts (1 Cor. 12:8, et al.) I believe that gift may be put to use in determining the quality and character of the doctors around us, those men and women who touch our lives so profoundly.

I am asking that you please fill out the survey on the backside of this letter. The survey will complete six months of research involving reading as well as consultations and interviews with health care officials in the West County area, key doctors, ethicists, and hospital administrators. In appreciation for your help, I will seek to share the results of the survey with each member who participates.

Since the procedure will differ with each congregation, I will ask your pastor(s) to inform you as to how to return the completed forms.

Thank you so much for your valued assistance. May the Lord bless and keep you in all that you do.

In Christ's Name,



Daniel P. Kriefall, Pastor

APPENDIX 7:
RECOMMENDED DOCTORS LIST

Recommended Doctors List



St. John's Evangelical Lutheran Church
15808 Manchester Road
Ellisville, Missouri 63011

Based on a congregational survey
Prepared by Pastor Daniel Kriefall
Spring 1993

FAMILY PRACTICE

DOCTOR		RECOMMENDED BY	
Bowe, Christopher MD 9701 Landmark Parkway Dr. Sunset Hills, MO 63127	842-5211	Raymond Hoemann	343-7943
Byrum, Fritz A. MD 15360 Manchester Road Ballwin, MO 63011	256-0062	M/M Mark Moyer M/M Max Cooper	256-7828 227-7887
Cannon, Michael MD 16555 Manchester Rd. Grover, MO 63040	458-0646	Everett Dunham	458-1563
Chao, Andrew DO 14551 Manchester Road Manchester, MO 63011	227-1511	John & Pam Stone	394-9001
Delcau, Carey M. MD 15601 Manchester Rd Ellisville, MO 63011	394-6505	Joan Roth	394-6734
DuPont, Ruth MD 16455A Village Plaza View Dr. Ellisville, MO 63011	458-4926	Cindy Linnemann M/M Ken Arnsmeier	938-3968 458-3184
Hiatt, H. Charles MD 206 W. Argonne Kirkwood, MO 63122	821-5798	Libby Tilton	227-0363
Hopper, James MD 16455A Village Plaza View Dr. Ellisville, MO 63011	458-4926	Brenda Wardenburg Julie Engerer Cindy Linnemann	394-3141 458-2247 938-3968
Izen, Brenda MD 16455A Village Plaza View Dr. Ellisville, MO 63011	458-4926	Julie Engerer M/M Ken Arnsmeier Cindy Linnemann	458-2247 458-3184 938-3968
Kennington, L. Joseph MD 14382 Woodlake Drive Chestfield, MO 63017	434-3333	Bryan Kiefer	227-4758
Livingston, Don G. MD 16455B Village Plaza View Dr. Ellisville, MO 63011	527-6960	William Lekar Norm Rethmeier M/M Don Kelemen Barbara Luttner	458-3865 256-7968 458-2087 391-6820
Lynch, Edward MD 103 W. Lockwood Webster Groves, MO 63119	968-4843	Susan Schmidt	343-0696

Perez, Robert MD 8793 Watson Road Crestwood, MO 63119	961-9080	Charles McKinnon	(129) 343-6546
Phillips, William MD 222 S. Woods Mill Rd. Chesterfield, MO 63017	576-6700	M/M Ray Kollmeyer	458-2502
Politis, Demetrios DO 11780 Manchester Des Peres, MO 63131	965-1965	Wayne King	984-9989
Reynolds, James A. MD 224 S. Woods Mill Rd., Suite 410 Chesterfield, MO 63017	878-7220	Ruth Augustin	391-1759
Sabet, Abdollah MD 15421 Clayton Rd. Suite G-1 Ballwin, MO 63011	227-7300	M/M Don Kelemen	458-2087
Scheef, R. J. MD 3009 N. Ballas Rd. Suite 243 St. Louis, MO 63131	991-0104	Russell Brethauer	227-2860
Schmidt, Edwin MD 1035 Bellevue St. Louis, MO 63117	644-0042	M/M Deborah Terrill	225-7025
Stegeman, Dale MD 15601 Manchester Rd. Ellisville, MO 63011	394-6505	Dorothy Sontag Walter (Bud) Selz	256-7275 394-2121
Tepper, Arnold MD 777 S. New Ballas Rd Creve Coeur, MO 63141	432-1128	Mildred Brethauer	227-2860
Thiel, J. Allen MD 621 S. New Ballas Rd. Creve Coeur, MO 63141	872-7958	Alan Lewis	349-2208
Walkenhorst, Donald DO 54-56 Manchester Mall Manchester, MO 63021	227-3241	John Brewer Christine Moritz	343-9173 458-9643
Wood, John MD 224 S. Woods Mill Road, Ste 500 S Chesterfield, MO 63017	878-6260	AnnaMary Lewis	227-6530

ALLERGY-ASTHMA

Bolinski, Robert MD 11722 Studt Creve Coeur, MO 63141	569-0510	Tony Wallach	938-9319
Friedman, Robert H. MD 3009 N. Ballas Rd. Suite 230 St. Louis, MO 63131	432-8636	Mary Borgschulte	938-6368
Kemp, Michele MD 1585 Woodlake Dr. Suite 201 Chesterfield, MO 63017	878-2788	Paula Rice	965-5286
Korenblat, Phillip E. MD 1040 N. Mason Road St. Louis, MO 63141	542-0606	Charlene Wurtz	227-6288
Pittman, Anne MD 1040 N. Mason Rd. Suite 115 St. Louis, MO 63141	458-4926	Cindy Linnemann	938-3968

CARDIOLOGY

Alegre, Jorge MD 222 S. Woods Mill Rd. Chesterfield, MO 63017	576-6700	Marilynn Koontz	394-4880
Bauwens, Daniel B. MD 222 Woods Mill Road South Chesterfield, MO 63017	434-8016	Rebecca Steinbrueck	230-3545
Coordes, Cordie C. MD 222 S. Woods Mill Rd. Suite 550 Chesterfield, MO 63017	434-3049	William Lekar	458-3865
Dwyer, James MD 533 Couch Avenue Kirkwood, MO 63122	965-9980	Charles McKinnon	343-6546
Ferrara, Robert P. MD 621 S. New Ballas Rd. Suite 3005 St. Louis, MO 63141	569-6168	Everett Dunham Harold Lehmann	458-1563 527-2400
Haikal Majed MD 222 S. Woods Mill Rd. Suite 500 Chesterfield, MO 63017	851-2982	John Hoerath	458-2082
Hamilton, William MD 621 S. New Ballas Rd. Creve Coeur, MO 63141	569-6168	Marilynn Koontz	394-4880

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Narkiewicz, Lawrence MD 533 Couch Avenue, G20 Kirkwood, MO 63122	965-5868	Carl Sontag	742-5281
Nelson, Roger MD 533 Couch Avenue, G20 Kirkwood, MO 63122	965-5868	Chuck Gudermuth	938-6399
Schlitt, David F. MD 1585 Woodlake Dr. Suite 106 Chesterfield, MO 63017	878-1905	M/M Charles Keller	227-9614
Strauss, Arnold MD 400 S. Kingshighway St. Louis, MO 63110	454-6095	Diane Carlstrom	938-3632
Westfall, Scott MD 224 S. Woods Mill Rd. Chesterfield, MO 63017	434-1211	M/M Ken Arnsmeier	458-3184
Willman, Vallee L. MD 3635 Vista St. Louis, MO 63110	577-8352	James Piel	966-2857
Zambrano, Anibal MD 222 S. Woods Mill Rd. Chesterfield, MO 63017	576-6700	Rachel Anderson	532-3276

DENTRISTY

Aylward, Mark W. DDS 9216 Clayton Road Clayton MO 63105	991-2950	Brenda Wardenburg	394-3141
Bond, Terrence DDS 123 W. Clinton Pl. Kirkwood, MO 63122	966-3200	Barbara Neels	343-3818
Burke, Leo DDS 421 W. Osage Blvd. Pacific, MO 63069	257-5515	Jane Rader	225-6158
Emery, R. Eric DDS 333 S. Kirkwood Rd. Kirkwood. MO 63122	821-7100	Shirley Mueller	965-8962
Fete, Joseph W. DDS PC 15991 Manchester Rd. Ellisville. Mo 63011	227-3553	Ruth Augustin	391-1759

Fleischut, Steve DDS 1410 Salem Hills Dr. St. Louis, MO 63119	962-7266	Cheryl Gutknecht	(132) 394-6249
Griffin, Jr., Jack DDS 97 Hilltop Village Eureka, MO 63025	938-6241	Lindsey Wallach	938-9319
Janas, Robert J. DDS 485 Wildwood Pkwy. Ballwin, MO 63011	227-8400	Charlene Wurtz Norm Rethmeier	227-6288 256-7968
Laffler, Joseph H. DDS 165 Clarkson Executive Pkwy. Ellisville, MO 63011	227-0507	Nadene Kalchbrenner	227-9345
Lammert, C. B. DDS 300 Ozark Trail Ellisville, MO 63011	394-3196	Debbie Grimes	527-7714
Levitt, Steven DDS PC 11709 Old Ballas Rd. Creve Coeur, MO 63141	569-6152	Mark Roenfeldt	391-1178
Lifsmile Dental Care DMD 1129 Gravois Rd. Fenton, MO 63026	343-5678	Raymond Hoemann	343-7943
Mattingly, John T. DDS 4110 Von Talge St. Louis, MO 63128	892-0200	Lois Loduca	349-2456
Miener, Clyfford A. DDS 485 Wildwood Parkway Ballwin, MO 63011	227-8400	Harold Lehmann	527-2400
Moorkamp, Jr., William B. DDS 485 Wildwood Pkwy. Suite 2 Ballwin, MO 63011	227-7055	Jack & Lori Reed	227-8479
O'Brien, Robert DDS 14780 Clayton Rd. Chesterfield, MO 63017	391-1186	Carol Kron	532-4482
Ortinau, Mark M. DDS 16081 Manchester Rd. Ellisville, MO 63011	391-0122	Bryan Kiefer Dan Kriefall	227-4758 394-4100
Richardson, Donald G. DMD 13603 Barrett Office Dr. #104 Manchester, MO 63021	892-4703	Shirley Morris	394-3953

Rothenberg, R. P. DDS 49 National Way Shopping Ctr. Manchester, MO 63021	391-6990	Russell Brethauer	(133) 227-2860
Staples, John DDS 206 W. Argonne Kirkwood, MO 63122	821-5121	Mary Altis	394-3640
Taylor, Richard P. DDS 14615 Manchester Rd. Suite 201 Manchester, MO 63011	394-4747	M/M James Sontag	256-738
Weiss, Matt DDS 16111 Manchester Rd. Suite 202 Ellisville, MO 63011	391-6030	Christine Moritz Libby Tilton	458-9643 227-0363
Zacher, Roger K. DDS 1548 Woodlake Dr. Chesterfield, MO 63017	576-3737	Esther Probst	225-1982

ORTHODONTICS

Elitt, Donald G. DDS MSD PC 15421 Clayton Rd. Ballwin, MO 63011	391-9220	Pat List Charlene Wurtz	938-9139 227-6288
Shaheen, Edward J. DDS 15340 Olive Blvd. Chesterfield, MO 63017	532-0085	Marilynn Koontz	394-4880
Taylor, Richard P. DDS 14615 Manchester Rd. Suite 201 Manchester, MO 63011	394-4747	M/M James Sontag	256-738

INTERNAL MEDICINE

Anslinger, David MD 12166 Old Big Bend Rd. Kirkwood, MO 63122	821-9150	Darwin Karsten	938-5637
Benedict, William W. MD 226 S. Woods Mill Rd. #56W Chesterfield, MO 63017	542-9989	Jordaan Eggers	227-5981
Brightfield, Kenneth R. MD 621 S. New Ballas Rd. Creve Coeur, MO 63141	569-6660	Harold Lehmann	527-2400

Carmody, John P. MD 10004 Kennerly Rd. St. Louis, MO 63128	843-2151	M/M Joe Loduca	(134) 349-2456
Cooper, Joel D. MD (Pulmonary) One Barnes Hospital Plaza St. Louis, MO 63110	362-6021	Bob Lewis	227-6530
Cunningham, E. J. MD 1585 Woodlake Dr. Chesterfield, MO 63017	434-3322	M/M Bob Horton M/M Cal Hopper	532-7839
Fischer, Robert MD 8793 Watson Rd. St. Louis, MO 63119	961-9080	Alene Lewis	349-2208
Gedney, William B. MD 806 Meramec Station Rd. Valley Park, MO 63088	825-2423	Barbara Neels	343-3818
Hintze, Paul MD 224 S. Woods Mill Rd. Chesterfield, MO 63017	878-6260	Marilynn Koontz	394-4880
Khan, Altaf MD 325 N. Kirkwood Rd. Kirkwood, MO 63122	966-6790	Susan Schmidt	343-0696
Lehman, Robert MD 3009 N. Ballas Rd. 63131 226 S. Woods Mill Rd. 63017	432-1111	Janie Reifsteck	391-0059
Leslie, Roger MD 621 N. New Ballas Rd. Creve Coeur, MO 63141	569-6922	Randy Schuermann	458-2413
Margulies, Thomas MD 621 S. New Ballas Rd. Creve Coeur, MO 63141	569-6922	Judie Davis	458-0870
Nelson, J. Roger MD 533 Couch Kirkwood, MO 63122	965-5868	Chuck Gudermuth	938-6399
Niesen, Anna MD 6400 Clayton Road St. Louis MO 63117	781-8405	Flavius/Joan Pernoud	965-3388
Ortbals, David W. MD 224 S. Woods Mill Rd. Suite 620 Chesterfield, MO 63017	434-8001	John Hoerath	458-2082

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Potts, Daniel E. MD 222 S. Woods Mill Rd. Chesterfield, MO 63017	527-6960	Barbara Luttner	391-6820
Pratt, Timothy MD 325 N. Kirkwood Rd. Kirkwood, MO 63122	965-7265	K. C. Meyer	965-6743
Proskey, Vincent MD St. Luke's Medical Bldg. 56W Chesterfield, MO 63017	542-9989	M/M Tom Guebert	391-3403
Rehm, Jr., Charles H. MD 621 So. New Ballas Rd. Creve Coeur, MO 63141	569-6660	Carol Kohler	227-5367
Richmond, Michael MD 11155 Dunn Rd. St. Louis, MO 63136	355-1660	Carol Kron	532-4482
Salibi, Habbouba MD 222 S. Woods Mill Rd. Chesterfield, MO 63017	878-4202	Carol Coughlin	230-0443
Scheperle, Mark A. MD 2340 South Hampton St. Louis, MO 63139	647-2200	M/M Joe Loduca, Sr.	349-2456
Schoenwalder, David M. MD 1585 Woodlake Dr. Suite 106 Chesterfield, MO 63017	878-1905	Karin Fagan M/M Charles Keller Elsie Becker	938-9359 227-9614 938-5567
Schutzenhofer, James L. MD 1585 Woodlake Dr. Suite 106 Chesterfield, MO 63017	878-1905	Jerry/Bev Troester	536-1758
Sommer, Rand MD 1034 Brentwood Blvd. Richmond Heights, MO 63117	721-0666	Oliver Kiefer	394-9139
Sullivan, William MD 12166 Old Big Bend Rd. Kirkwood, MO 63122	821-9150	Helen James	458-3804
Thompson, William MD 224 S. Woods Mill Rd. Chesterfield, MO 63017	878-6260	Linda Offutt	285-5054
Vatterott, Jr. Paul B. MD 1538 Woodlake Dr. Chesterfield, MO 63017	434-1600	Verlene Schmidt	458-2177

Walden, Michael J. MD 621 S. New Ballas Rd. Tower A Creve Coeur, MO 63141	569-6660	George Koester	(136) 537-2421
Wiedner, John MD 16555 Manchester Rd. Grover, MO 63040	458-4800	Betsy Boren Gary Schwendinger	227-5985 458-9355
Wood, James A. MD 141 N. Meramec Clayton, MO 63105	725-4887	Jane Rader	225-6158
Wood, John MD 224 S. Woods Mill Rd. Chesterfield, MO 63017	878-6260	Annamary Lewis	227-6530
Zambrano, Anibal V. MD 222 S. Woods Mill Rd. Chesterfield, MO 63017-3417	576-6700	Helen Fink	227-2993

PSYCHIATRY

Vickar, Garry M. MD 1245 Graham Rd. Suite 506 Florissant, MO 63031	837-4900	Libby Tilton	227-0363
Hicks, Fred G. MD 3009 North Ballas Rd. Town & Country, MO 63131	567-5000	Judy O'Connell	458-2419
Malmberg, Virgil MD 3009 N. Ballas Rd. St. Louis, MO 63131	567-5000	Karen Krone	831-0583
Wehrmann, Stephanie 3009 N. Ballas Rd. St. Louis, MO 63131	567-5000	Barb/Tom Guebert	391-3403

COUNSELING

Barbour, Joseph PHD 13545 Barrett Parkway Dr. Suite 150 Manchester, MO 63021	984-0901	Dan Kriefall	394-4100
Holder, Brooks PHD 763 S. New Ballas Rd. Suite 302 Creve Coeur. MO 63141	569-1012	Janie Reifsteck	391-0059

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Johnson, Richard PHD 615 S. New Ballas Rd. Creve Coeur, MO 63141	569-6010	Karen Krone	831-0583
Marks, Jerry L. DSW 13611 Barrett Office Dr. Suite 203 Manchester, MO 63021	965-9064	Dan Kriefall	394-4100
Randall, Ronald E. MSW 1245 Graham Rd. Suite 506 Florissant, MO 63031	837-4900	Libby Tilton	227-0363
Salamone, Charles L. PHD 3009 North Ballas Rd. Town & Country, MO 63131	567-5000	Judy O'Connell	458-2419
Steiner, Donna MSW, LCSW 13545 Barrett Parkway Dr. Suite 150 Manchester, MO 63021	984-0901	Dan Kriefall	394-4100

CHIROPRACTIC

Baum, Kevin DC 14615 Manchester Ballwin, MO 63011	391-0424	Stu & Alice Brassie George & Elvira Motz	458-9078 527-2122
Burke, Laurie DC 242 Clarkson Road Ellisville, MO 63011	227-8191	Randy Schuermann	458-2413
Frisch, Todd T. DC 2190 S. Mason Rd. Suite 209 St. Louis, MO 63131	965-4048	Rebecca Steinbrueck	230-3545
Guse, Milton DC 10135 Manchester Rd. Kirkwood, MO 63122	966-5454	Wayne King	984-9989
Hilgartner, Roy J. DC 14615 Manchester Rd. Ballwin, MO 63011	391-0424	M/M Jim Sontag	256-8738
Holycross, Orville DC 14514 Manchester Rd. Ballwin, MO 63011	394-4490	Jack & Lori Reed Doreen Christianson	227-8479 527-8408
Kroupa, Joseph DC 6427 Hampton Ave. St. Louis, MO 63109	351-3124	Rev./M Dar Karston	938-5637

Rosso, E. J. DC 9717 Manchester Rd. Rock Hill, MO 63119	961-9333	Shirley Morris	(138) 394-3953
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EAR-NOSE-THROAT

Craig, Robert MD 777 S. New Ballas Rd. Creve Coeur, MO 63141	567-4868	Ruth Hunter	537-3162
Donovan, Thomas MD 621 S. New Ballas Rd. Creve Coeur, MO 63141	997-4430	Janet Judd	256-3455
Reichert, Timothy J. MD (Pediatric) 777 S. New Ballas Rd. Suite 129E Creve Coeur, MO 63141	872-8338	Judy Kupferle	394-6872
Viers, Wayne A. MD PC 220 West Argonne Kirkwood, MO 63122	966-5252	Libby Tilton	227-0363
West, Joseph MD 220 Argonne Kirkwood, MO 63122	966-6656	Ruth Kiefer	394-9139

NEUROLOGY

Dunn, Robert MD 621 S. New Ballas Rd. Creve Coeur, MO 63141	569-3620	Howard Brockmann	391-1969
Green, Barbara MD 621 S. New Ballas Rd. Creve Coeur, MO 63141	569-6507	Walter Selz	394-2121
Mantovani, John MD (Pediatric) 621 S. New Ballas Rd. St. Louis, MO 63141-8277	569-6515	Bill Stegmann	256-9136
Wippold, Jay MD Neuro-Radiology Section Mallinckrodt Institute of Radiology at Washington University Medical Center 510 S. Kingshighway St. Louis, MO 63110	362-5949	Paula Rice	965-5286

CANCER TREATMENT

Hildreth, Craig R. MD 12166 Old Big Bend Rd. Kirkwood, MO 63122	965-6411	Phyllis Mann	938-5056
Marion, Jay MD 3015 N. Ballas Rd. St. Louis, MO 63131	569-5151	Mary Borgschulte	938-6368
Stuphen, Eric J. MD 6150 Oakland Avenue St. Louis, MO 63139	768-3068	James Piel	966-2857
Stutz Mark/Susan Luedke MD 777 S. New Ballas Rd. Creve Coeur, MO 63141	991-4430	Charlene Wurtz	227-6288
OB-GYN			
Ahlering, Chris MD 621 South New Ballas Rad. Creve Coeur, MO 63141	569-6980	Elaine Kumm	394-2003
Anstey, John MD 3009 N. Ballas Road St. Louis, MO 63131	432-2880	Cathy Wussler	532-2828
Beatty, William R. MD 15421 Clayton Rd. Ballwin, MO 63011	739-8500	JoAnn Lehmann Mary Altis Michelle Schmiderer	527-2400 394-3640 256-8084
Blaskiewicz, Robert MD 2821 North Ballas Rd. St. Louis, MO 63131	872-7400	Susan McGinnis	532-3117
Botney, Catherine MD 16455 Village Plaza View Dr. Ellisville, MO 63011	458-9117	Wendy Arnsmeier	458-3184
Bryan, Bruce MD 1034 S. Brentwood Blvd. St. Louis, MO 63117	725-9300	Susan Cosentino	241-5357
Chirino, Octavio R. MD 9701 Landmark Pkwy. Dr. Suite 207 Sunset Hills, MO 63127	842-4802	Phyllis Mann Linda Offutt	938-5056 285-5054
Hamilton, E. G. MD 222 S. Woods Mill Rd Chesterfield. MO 63017	878-8160	Merry Hopper	227-3636

Hickey, James L. MD 621 S. New Ballas Rd. Creve Coeur, MO 63141	569-6950	Esther Probst	(140) 225-1982
Kovac, D. Robert MD 621 S. New Ballas Rd. St. Louis, MO 63141	991-0300	Judy O'Connell	458-2419
Kumari, Vijaya MD 3009 N. Ballas Rd. Bldg. C Suite 359 St. Louis, MO 63131	872-9200	Cindy Linnemann	938-3968
Mathew, Ruby MD 224 S. Woods Mill Rd. Chesterfield, MO 63017	878-2233	Lori Reed Doreen Christianson	227-8479 527-8408
Mid-County Gyn 3009 N. Ballas St. Louis, MO 63131	567-9199	Ruth Kiefer	394-9139
Morley, Mary Ann MD PC 226 S. Woods Mill Rd. Chesterfield, MO 63017	469-0001	Barb Kollmeyer	458-2502
Ostapowicz, Tamara MD 1035 Bellvue St. Louis, MO 63117	644-6262	Deborah Terrill	225-7025
Pearse, Carlton MD 224 S. Woods Mill Rd. Chesterfield, MO 63017	458-9117	Julie Engerer	458-2247
Pearson, William MD 1611 New Smizer Mill Rd. Fenton, MO 63026	961-2125	Jan Karsten	938-5637
Pignotti, Blase MD 621 S. New Ballas Rd. Creve Coeur, MO 63141	993-6401	Chris Fultz Cheri Nazaruk	391-1447
Ricketts, Jack MD 12166 Old Big Bend Rd. Kirkwood, MO 63122	821-3500	Lisa Hoemann	391-3724
Riley, Louis T. MD 226 S. Woods Mill Road Chesterfield, MO 63017	469-7878	Judith Paul	532-3174
Shaner, Thomas MD 2821 N. Ballas Rd. St. Louis, MO 63131	872-7400	Pam Stone	394-9001

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Shroff, K. J. MD 533 Couch Avenue Kirkwood, MO 63122	965-2215	Joan Roth	394-6734
Snowden, Kent MD 621 S. New Ballas Rd. Creve Coeur, MO 63141	993-6401	Cheri Nazaruk	458-0679
Taute, Herman MD 2821 N. Ballas Rd. St. Louis, MO 63131	872-8636	Mary Borgschulte Marilynn Koontz	938-6368 394-4880
Thompson, M. Bryant MD 224 S. Woods Mill Rd. Chesterfield, MO 63017	576-6166	Barb Guebert	391-3403
Walker, J. Leslie MD 11709 Old Ballas Rd. Creve Coeur, MO 63141	567-6580	Judith Paul Carin Shulusky	532-3174 225-4058

PEDIATRICS

Diehl, Elizabeth MD 533 Couch Avenue Kirkwood, MO 63122	966-3324	Janet Judd	256-3455
Duvall, Joseph M. MD 621 S. New Ballas Rd. Tower B Suite 5002 Creve Coeur, MO 63141	432-3033	Raymond Hoemann	343-7943
Fliesher, Edward MD 15421 Clayton Rd. Ballwin, MO 63011	391-6300	Barbara Moore	391-8239
Gellman, Elliot MD 456 N. New Ballas Rd. Creve Coeur, MO 63141	567-7337	Denise Sneed Gail Marsh Mary Altis	527-5931 257-5098 394-3640
Hartenbach, David MD 77 West Port Plaza Suite 168 St. Louis, MO 63146	878-3221	Cheryl Gutknecht	394-6249
Harwell, J. Larry MD 950 Francis Place, Suite 302 Clayton, MO 63105	726-6464	Marilynn Koontz	394-4880
Lins, Robert MD 481 Lafayette Center Manchester, MO 63011	256-0400	Dianne Sutcliffe Carin Shulusky Joan/Floyd Uthe	742-2624 225-4058 532-3196

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Lowther, Gerald MD 16555 Manchester Rd. Grover, MO 63040	458-5858	Karen Bahr Judie Davis Verlene Schmidt Mary/Norm Eatherton	394-5438 458-0870 458-2177 458-1926
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