1/22/63

Memorandum No. 63-7

Subject: Study No. 34(L) - Uniform Rules of Evidence (Rule 27.1)

As background material for the psychotherapist-patient privilege, you should read pages 76-91 of the study. You should also read the letters attached as Exhibit I for an understanding of the nature of the problem this privilege is intended to solve.

At the October 1961 meeting of the Commission a draft of this rule was considered. The draft then presented consisted of subdivisions (1) and (2). Pursuant to the Commission's directives at that meeting subdivision (3) has been added. Certain changes in the language of subdivisions (1) and (2) have been made to carry out decisions made at that meeting by the Commission. The text of the rule that was considered by the Commission at the October meeting is found on page 87 of the study.

Subdivision (1). The principal change in the first two subdivisions of the rule which the Commission directed the staff to make was to extend the privilege from psychiatrists only to all medical doctors. The minutes of that meeting state:

> It was agreed to adjust the definition of "psychotherapist" and of "confidential communication" to make it clear that the privilege attaches where a general medical practitioner is engaged in psychotherapy. Because of the shadowy line between organic and psychosomatic illness, the Commission agreed that the privilege should not be limited to communications with persons who hold themselves out as specialists in the field. Rather the privilege would include psychotherapeutic treatment given by other physicians, particularly since it is probable that disclosure in the first instance would be made to a family physician in order for him to determine the nature of the ailment requiring specialized treatment.

To accomplish this change the definition of psychotherapist now embraces all medical doctors. Since all psychiatrists are medical doctors, it is

unnecessary to mention them specifically. In the definition of "patient" the staff believes that the change ordered by the Commission necessitates the removal of the word "sole" immediately before the word "purpose". This deletion, too, recognizes that emotional disorders may have physical repercussions and a person may go to a doctor for treatment both of the underlying emotional disorder and of the physical symptoms and manifestations to which it has given rise. The previous definition of "patient" defined him to be a person who consulted a psychotherapist for purposes of psychotherapeutic diagnosis and treatment. This definition caused no problem so long as the psychotherapist was defined to be a psychiatrist or a certified psychologist. Now that a psychotherapist may be an ordinary medical doctor, a more meaningful definition of "patient" is required. Hence, a patient is now defined as a person who consults a medical doctor or certified psychologist for the purpose of obtaining treatment of a mental or emotional condition. The text of the definition is very similar to the definition of "patient" found in Rule 27. Please note, however, that there is no psychotherapist-patient privilege if the patient merely seeks diagnosis. The physician-patient privilege does apply in this situation under revised Rule 27. Under Rule 27 the words "or submits to an examination by a physician" were included, but they were omitted from Rule 27.1. It would seem that this language should appear in both rules.

Should the definition of "confidential communication" be extended to include advice given by the psychotherapist? See the comparable definition in Rule 26, relating to the lawyer-client privilege.

Subdivision (2). The staff suggests that this be rewritten so that it is identical with the comparable subdivision in the previous two rules.

Subdivision (3). The physician-patient privilege contained in Rule 27 has an exception for commitment proceedings. Such an exception was omitted by the Commission from the psychotherapist's privilege. There is attached to the letter from Dr. Maleta J. Boatman--included among the materials attached hereto as Exhibit I--a model statute which has been endorsed by the Council of the Northern California Psychiatric Society. You will note that this model statute provides, inter alia, "there shall be no privilege for any relevant communications under this act . . . when a psychiatrist, testifying in a civil commitment proceeding, has determined that the patient is in need of care and treatment in a hospital for mental illness . . . ."

As a psychotherapist may now be any medical doctor, there seems to be an inconsistency between the exception for commitment proceedings in the physician-patient privilege and the lack of such an exception in the psychotherapist-patient privilege. The exception in the physician-patient privilege is probably destroyed by the lack of an exception in Rule 27.1. From a policy standpoint, it would seem that there should be some exception to cover the situation where a psychiatrist in the course of treatment finally comes to the conclusion that his patient is dangerous both to himself and to others unless he is locked up. In such a situation, the patient should not be able to prevent the psychiatrist from taking the necessary steps to protect him and others by the exercise of a privilege. It is apparent that it is this situation that the exception contained in the psychiatrists' model statute is intended to cover. It is likely that it was this situation that the Uniform Commissioners and this Commission had in mind when they put such an exception in the physician-patient privilege.

It is difficult to see why the physician-patient privilege should not apply upon an issue between parties claiming through a live patient while the psychiatrist-patient privilege does. In both of these situations, what the court is concerned with is the mental condition of the patient.

The exception in brackets in paragraph (g) was not approved by the Commission. The exception was considered and action was deferred pending a further report from the staff on the extent to which psychiatrists are required to report. Note that a similar exception appears in Rule 27, the physician-patient privilege. Bear in mind, too, that the psychotherapist's privilege now extends to all medical doctors. Hence, even though the medical doctor may be required to report the information and does, the information may be privileged insofar as the psychotherapist-patient privilege is concerned but not insofar as the physician-patient privilege is concerned.

Because all psychiatrists are medical doctors, psychiatrists have to report the same things that physicians have to report. Generally, these are as follows: Health & Safety Code Section 410 requires all physicians to report any cases of epilepsy as defined by the State Department of Public Health. Epilepsy is defined to include similar disorders characterized by lapses of consciousness. These reports, however, may be used solely by the Department of Motor Vehicles for the purpose of determining the eligibility of any person to operate a motor vehicle on the highways of the State. Otherwise, the reports are confidential. Health & Safety Code Section 3125 requires all physicians to report all cases of any infectious, contagious or communicable disease. Under Section 3123 of the Health & Safety Code the State Department of Public Health may establish a list of reportable diseases and this list

is changed from time to time by regulations of the State Department. Health and Safety Code Section 3222 requires every licensed physician to obtain a blood specimen of any pregnant woman in his care and to submit the specimen to an approved laboratory for a syphilis test. The laboratory returns an original copy of the test report to the physician and sends a duplicate to the local health department. These reports are confidential and not open to public inspection. Health and Safety Code Section 10005 requires all physicians to supply such information as they may possess regarding any birth, fetal death, death or marriage upon demand of the State or the local registrar of vital statistics. Section 11225 of the Health and Safety Code requires every person who issues a prescription or administers or dispenses a narcotic to make a record of the transaction showing the name and address of the patient, the date, the quantity and character of the narcotics involved, the pathology and purpose for which the prescription is issued or the narcotic administered or dispensed. The record is required to be preserved and open at all times to inspection by inspectors of the State Division and inspectors of the Board of Pharmacy. The record is also required to be open at all times to inspection by other law officers. Health and Safety Code Section 11425 requires a physician prescribing or furnishing a narcotic to an habitual user to report to the State Division of Narcotic Enforcement the name and address of the patient, the character of the injury or ailment, the quantity and kind of narcotic used, and a statement as to whether or not the patient is an addict. Section 11426 requires a physician to furnish any additional reports upon the treatment of the user as the State Division may request. Penal Code Section 11161 requires

every physician who has under his care any person suffering from any wound or injury inflicted by a knife, gun, pistol or other deadly weapon, to report such fact to the chief of police or sheriff.

The foregoing list may not be exhaustive but it gives a picture of the general duty of physicians to report diseases and conditions.

Should an exception be added to cover situations where two persons consult a psychotherapist jointly? See Rule 26.

Respectfully submitted,

Joseph B. Harvey
Assistant Executive Secretary

ADDENDUM

You should keep in mind that the physician-patient privilege applies when a patient consults a physician in regard to his mental condition. So also does the psychotherapist-patient privilege. Since this is so, the conditions for the existence of the privilege and the exceptions thereto should be scrutinized so that you are sure that what is done in Rule 27 isn't undone in Rule 27.1 and vice versa. For example, the Commission decided that the psychotherapist-patient privilege should not apply to consultation for diagnosis only. But the physician-patient privilege does apply even when the diagnosis sought is just for a mental condition. (This may be all right, for it means practically that only the psychotherapist who is not a medical doctor has no privilege of any sort when consulted for diagnosis only.) And the physician-patient privilege does not apply when the communication is relevant to an issue between parties claiming through a live patient, even though the patient was seeking diagnosis or treatment for a mental condition only; but the psychotherapist-patient privilege does apply in this situation. These variances may be proper, but the Commission should be aware that the existence of the word "mental" in Rule 27 and the definition of "psychotherapist" in Rule 27.1 cause a great deal of overlap between these two privileges.

Memo 63-7

EXHIBIT I

JOHN A. STROUD, M. D.

Sacramento 16, California

December 10, 1962

Mr. John H. DeMoully
Executive Secretary
California Law Revision Commission
School of Law
Stanford University, California

Dear Mr. DeMoully:

This is a dilatory letter written in response to your very kind inclusion of the staff study on privileged communication with respect to psychotherapist-patient privilege. I am sure I can speak for the majority of the Central California Psychiatric Society and give you a few general comments which probably would not be of any particular help, only to let you know our views.

I wanted to compliment you on the study as set forth. You seemed to have covered the area fairly well with various precedence from other states and from California. We might say, at the outset, that the psychiatric profession was seriously disturbed when the legislature passed a law giving privilege to clinical psychologists, but not including psychiatrists. We felt that the clinical psychologists should not have been accorded the standing that they have been and that this was a bad law. Our recommendation to you on this count, then, would be to recommend to the legislature that they repeal this section with respect to clinical psychologists, inasmuch as they exercise no medical responsibility, and have such a varied list of qualifications. We feel this would be in the best interests of the general public who might be treated.

As to specific examples, showing that lack of privilege would damage a therapeutic relationship (and, by this, I mean one involving the psychiatrist where medical treatment is the essential ingredient), there is no question but what lack of privilege would play on some cases. These would not be very numerous, and, I suppose, in civil matters, there is ample protection already, so far as doctor-patient communication is concerned. There have been recent cases under my care where the lack of privilege has not so much become a condition for the courts, but where an employer or a school or a governmental agency requires a confidential report to be given as a condition for continued employment or going to the school. Sometimes, in these matters with security clearances and all, the question of privilege in these areas is far more commonplace and far more difficult to deal with. I think the preponderance of opinion would be that these matters of privilege in court would occur very rarely; but, the knowledge that such a privilege did exist might help more people seek psychiatric help more readily.

I must, of course, underline the psychiatric aspects, since we feel that any other sort of psychotherapy without medical supervision is a violation of the Medical Practice Act and should be excluded.

Thank you very much for your kind letter, and please forgive my tardiness.

Sincerely,

S/ J. A. Stroud, M. D.
John A. Stroud, M. D.
Past President
Central California Psychiatric Society

cc: Fred M. Tetzlaff, M. D.
450 Sutter St., San Francisco, California

Elmer F. Galioni, M. D.
1320 K St., Sacramento (14), California

State of California
Department of Mental Hygiene
THE LANGLEY PORTER NEUROPSYCHIATRIC INSTITUTE
401 Parnassus Avenue
San Francisco 22, California

August 10, 1962

Mr. John H. DeMoully, Executive Secretary
California Law Revision Commission
School of Law, Stanford University
Stanford, California

RE: A Study Relating to Psychiatrist-Patient Privilege.

Dear Mr. DeMoully:

Our membership, and psychiatrists in general, have long been concerned about the problem dealt with in your above-named study. We want to express our appreciation of the careful work done by your staff, and to endorse its recommendation that a means be found for extending privilege to patients of psychiatrists.

Our experience is that the psychotherapeutic process is not infrequently jeopardized by lack of legal means of safeguarding the patient's confidences in court. It is our belief that the social value of keeping the door to help open to everyone with mental and emotional difficulties far outweighs the occasional instance in which such a safeguard might operate disadvantageously.

In response to your request for examples of cases where therapy was interfered with or prevented by lack of privilege, we forward the enclosed clinical summaries and comments. They are excerpts from reports submitted by our members.

At our last meeting in the spring, our Council endorsed the enclosed "Act Concerning a Privilege of Non-Disclosure for Communications between Patient and Psychiatrist." It is very similar to the new Connecticut statute and has seemed to us to be the most desirable proposal of the many we have studied.

We thank you for affording us this opportunity to contribute our experience and thinking to this very difficult problem.

Sincerely,

EDWARD E. HAUSE, M.D., President

S/

Maleta J. Boatman, M. D., Immediate
Past President, Northern California
Psychiatric Society

MJB:LMH
Enclosures

MODEL STATUTE REGARDING

AN ACT CONCERNING A PRIVILEGE OF NON-DISCLOSURE

FOR COMMUNICATIONS BETWEEN PATIENT AND PSYCHIATRIST

adopted by the Council of the Northern California Psychiatric Society

As used in this act, "patient" means a person who, for the purpose of securing diagnosis or treatment of his mental condition, consults a psychiatrist; "psychiatrist" means a person licensed to practice medicine who devotes a substantial portion of his time to the practice of psychiatry, or a person reasonably believed by the patient to be so qualified; "authorized representative" means a person empowered by the patient to assert the privilege granted by this act and, until given permission by the patient to make disclosure, any person whose communications are made privileged by this act. Except as hereinafter provided, in civil and criminal cases, in proceedings preliminary thereto, and in legislative and administrative proceedings, a patient, or his authorized representative, has a privilege to refuse to disclose, or to prevent a witness from disclosing, communications relating to diagnosis or treatment of the patient's mental condition between patient and psychiatrist, and between members of the patient's family and the psychiatrist, or between any of the foregoing and such persons who participate, under the supervision of the psychiatrist, in the accomplishment of the objectives of diagnosis or treatment. There shall be no privilege for any relevant communications under this act: (a) When a psychiatrist, testifying in a civil commitment proceeding, has determined that the patient is in need of care and treatment in a hospital for mental illness; (b) if a judge finds that the patient, after having been informed that the communications would not be privileged, has made communications to a psychiatrist in the course of psychiatric examination ordered by the court, provided that such communications shall be admissible only on issues involving the patient's mental condition; (c) in a civil proceeding in which the patient introduces his mental condition as an element of his claim or defense, or, after the patient's death, when said condition is introduced by any party claiming or defending through or as a beneficiary of the patient, and the judge finds that it is more important to the interests of justice that the communication be disclosed than that the relationship between patient and psychiatrist be protected.

4/62

CLINICAL EXAMPLES OF PSYCHIATRIC CASES IN WHICH PRIVILEGED COMMUNICATION IS ESSENTIAL FOR EFFECTIVE TREATMENT

A 26-year old woman sought psychiatric treatment for attacks of panic and mental depression. Her husband was a chronic alcoholic and had beaten her and their five year old daughter. She expressed repeated concern that if she decided to enter psychiatric treatment with me, harm might come to her husband because he was a policeman and could be suspended from the police force for actions which she would have to disclose if she continued treatment. I explained that there was very little likelihood of the record being subpoenaed. However, on the fact that data could come to the attention of the authorities, she discontinued treatment after her second visit. In this case the interference with psychiatric treatment unequivocally was a result of lack of privileged communication.

A 44-year old man came in for psychiatric treatment for chronic alcoholism and personality problems. He went into considerable detail about the confidentiality of his statements, in view of the fact that his wife was not only suing him for divorce, but was planning to bar him from seeing their children on the basis of his being an unfit parent. I explained to him that even if I were subpoenaed in court I would refuse to give testimony in his case on the basis that I could not, in good conscience, do anything to jeopardize my therapeutic usefulness to him. However, on the matter of possible subpoena of records, I could give him no assurance, and on the sixth psychotherapeutic interview he stated he was going to discontinue treatment for lack of privileged communication.

A 17-year old girl was referred for psychiatric treatment by a friend she had met at the California Youth Authority. She was terrified of her mother because of threats to call the police if she did not obey, and had actually called the police on more than one occasion. The girl was terrified that her mother would find out from the psychiatrist some of the things she was discussing. Therapeutic efforts did manage to keep her from discontinuing treatment, but treatment was certainly impeded by the inability to assure the patient of privileged communication. Treatment lasted over a period of two and a half years with irregular visits and the ultimate outcome was successful rehabilitation of this very emotionally disturbed youngster. Although there is no way of proving this, I firmly believe that her treatment would have progressed very much more rapidly and perhaps with an even more successful result if absolute privilege were granted patients of a psychiatrist by law.

Lastly, I can think of ten or twelve patients who were referred to me by the courts for psychiatric treatment over the past twenty years. In each instance probation was granted under the condition that the patient would actively continue in psychiatric treatment. In these cases the patient either comes out of fear and has very little to say because he is afraid that information conceivably could get back to the Probation Officer, or decides that this kind of sterile treatment is unproductive and discontinues psychiatric work. To counterbalance these ten or twelve cases, I had from eight to ten cases that were able to complete their psychiatric treatment even though they were on the defensive because of their status on probation.

In my mind there is no question that absolute privilege, similar to that which the law gives to clients of lawyers, is absolutely essential for the optimum conditions for psychiatric work. If we are not able to obtain legal privilege of communication, the repeated instances of failure of psychiatric treatment will certainly continue. Unfortunately, it tends to continue precisely with those patients who need psychiatric help the most. The continued suffering of these individuals alone would warrant the passage of absolute privilege for patients of psychiatrists. But even beyond the distress of the individual, society as a whole suffers from this lack of privileged communication because many of these patients are "acting-outers" who demonstrate anti-social behavior. The result is occasional infliction of suffering upon innocent members of the community, to say nothing of the increasing costs of our Youth Authority and other similar judicial agencies in the community.

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In 1955 and 1956 I had a patient referred to me by a local physician who knew of my experience with prison work and because of this he referred a patient who had a very long history of repeated incarcerations for major social offenses. This patient was referred for an emotional disturbance which related not only to his childhood but to very specific experiences in prison setting. The resistance to treatment became markedly increased when the patient was informed that what he might tell me could very well be used against him with respect to offenses which he had committed and which had not been detected. I cannot estimate whether or not he would have revealed this kind of material to me if there had been privileged communication but, under the circumstances, I felt that it was important that he be informed of this possibility so as to protect him in the event of his again being apprehended with the possibility of my records being subpoened.

Likewise, during my work at the Medical Center for Federal Prisoners at Springfield, Missouri treatment was frequently inhibited by the patient's knowledge that he was already

incarcerated and that he could be prosecuted for additional offenses. I feel that this latter type of situation occurred innumerable times, although I cannot evaluate whether or not this would be comparable to a situation occurring in out-patient psychiatric treatment which is sought by the patient when he is at liberty.

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1) A married woman in treatment was having an extra-marital affair. She wished to discuss this with me in order to understand its underlying motives, and in order to get help to stop doing this. She was afraid, however, that if this became part of her record, and if a divorce action should be initiated by her husband, she would lose possession of her children if the records were demanded by the court.

She felt it was too risky to deal with this, and this made therapy impossible.

2) A male patient had a history of homosexual acts in the past--almost five years ago. He was a government employee, working as a clerk for Social Security. An investigation of why he was coming to see a psychiatrist might result in the story of his past homosexual activities becoming known, and then he would be fired from his job. I thought this unlikely, but he declined to take a chance. Subsequently, army records were used against him to obtain this knowledge and he was fired.

Most therapists assure the patient of a confidential relationship, although there is, in fact, no legal basis for this. The fact that most therapists operate as if such a law existed does not obviate the need for such a law. I am sure that if it were made known to the public-at-large that there is no legal guarantee of confidentiality in the court, or if every therapist told each new patient that he could not guarantee confidentiality, our files would be replete with examples of very needful patients not undergoing treatment.

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About two months ago, I finished treating a case which was a combination of colitis and paranoid personality. This bright man in his late forties had been in treatment before with some temporary improvement. His interest, in the past, in a variety of left-wing organizations came up both in his previous therapy and in therapy with me. Each time his wish was that he could be reassured that I or his previous therapist could not reveal these facts to the authorities. While I did tell him that I would keep his confidence, I did not realize that it would have been at my own risk of contempt of court.

I feel that it would have been of decided help to have the law clearly on the side of the patient's protection and right

of privacy and that it would have had a beneficial effect in my case.

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MALE, AGE 32, seen for acute depression following suicide attempt. Known by me as marijuana user, alcoholic, and dependent on almost any drug available.

Arrested several months after first seen for possession of marijuana.

This seriously disturbed character disorder was difficult to deal with at times because there was some realistic reluctance on his part to discuss his use of marijuana, and thereby he avoided openly discussing whether or not it was a good idea to continue on it. He hid some of his various illegal activities from the therapist which seriously impaired therapeutic progress.

FEMALE, AGE 34, in throes of "messy" divorce, a suicide attempt. Various "acting out" patterns many of which were of dubious moral and legal character. Due to fear of exposure, there was significant lack of cooperation in discussing these events frankly, and therapeutic progress was impaired. There were numerous threats from the husband that he would force me to testify on several issues and events which would compromise her considerably. Since he was also doing things of borderline legal character and told me about it, he was in no very effective position realistically, but the threats of "exposure" made things worse than they were anyway.

MALE, AGE 16, referred by his parents for serious theft, unrevealed to authorities. Disturbed adolescent with transient delinquent patterns. Patients discussed his illegal activities circuitiously because of a realistic fear he would be turned in by me, to the police. Patient was referred to legal counsel and any attempt at therapy had to be dropped.

FEMALE, AGE 52, known narcotics user, not classified as an addict, for evaluation and treatment, following arrest. Eventually convicted, but still maintained denial and evasion of any use of narcotics for fear of further difficulties since, I suspect, she became a clandestine user, but more discreet and guarded in her use of drugs.

MALE, AGE 32, borderline sociopath, charged with illegal possession of certain drugs. Seen at his request, he was reluctant to give a detailed history or cooperate freely in therapy due to his fear that my records could be subpoened. They could, I believe, as he was charged with a felony. Treatment dropped by the patient.

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A specific case of mine that flared up after the _ _ case (in which a psychiatrist testified about confidential material) is much to the point. This was a patient who was originally referred for a long-standing psychiatric problem associated with and complicating orthopedic surgery. The patient was hostile to all psychiatrists, literally had me ejected from her room and avoided all psychiatric consultation until an active suicidal attempt six months later. It then developed that her refusal of psychiatric help was occasioned by a morbid dread of discussing intimate details which she feared might be disclosed to someone else. Even though the dynamic base for such suspicion had other meaning, it nevertheless continued to be the focal point for suspicion during a very hectic course of hospitalization, which slowly subsided as she began to develop increasing confidence in her therapist. There would be flareups from time to time, but nothing comparable to the storm that was liberated by the newspapers broadcasting that psychiatrists could be subpoenaed and forced to disclose what had transpired in the confidential environs of the consultation room.

Again, I do not want to belabor the dynamic meaning of such behavior, but the practical aspects illustrated by such a case are that neurotically founded guilt feelings and fear of disclosure and, at times, even fear of prosecution keeps patients from seeking help as early as they might otherwise. Anything that incites their suspicion and dread on a reality basis immediately puts a damper on the free flow of material, with the subsequent interference with psychotherapeutic progress.

This particular patient illustrates both these points dramatically. Many others have delayed their therapy for months and even years because of material they felt would subject them to prosecution and the dread that their therapist was required to report them to the authorities.

Another group of patients may have real cause for guilt and real fear of prosecution because of the commission of real and not fantasied acts against society. Working through the guilt associated with these acts and then working through the character basis that led to the performance of these acts has resulted in a mature, constructive, valuable asset to society. The mere fact that such an individual would seek therapeutic help and undergo the prolonged vicissitudes of psychotherapy is sufficient indication of the positive motivation to achieve such a status as a member of the community. It is to society's benefit to make this possible. It requires freedom from subpoena and the threat of disclosure in the courts if these beneficial results are to continue.

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SOUTHERN CALIFORNIA PSYCHIATRIC SOCIETY

November 16, 1961

Mr. John H. DeMoully
Executive Secretary
California Law Revision Commission
School of Law
Stanford University, California

Dear Mr. DeMoully:

I was very interested indeed to receive from you on your mailing of October 18th a copy of "A STUDY RELATING TO A PSYCHIATRIST-PATIENT PRIVILEGE".

I am turning this report over to my Committee on the Relations between Psychiatry and Law and also to the Committee on Legislation regarding the Practice of Psychiatry.

Your detailed, sober and dignified analysis and report is a model of thoroughness and the most profound deliberation on this matter that I have seen.

We will try to collect examples which would show that the lack of a privilege has resulted in either a patient not undergoing treatment or making treatment more difficult.

Parenthetically, may I say as a personal opinion and not an official one, that I deplore the day that psychotherapy became identified as something that might be separated from the practice of psychiatry. As your struggles have shown you, there is almost no possible definition of psychotherapy. There is, at a theoretical level, the potential of psychotherapy going on whenever any two people meet and discuss any kind of thing. At a theoretical level, there is hardly a committee meeting where some group benefit is not being tied up by somebody. For these reasons, as you indicated, all kinds of persons who have no scientific or special training in this particular psychiatric technic can defend logically before any legislative body that they indeed are doing some good.

I do not plead that "psychotherapy" as a technic of treatment can be separated from the overall technics of treatment subsumed under the word "psychiatric" anymore than the practice of psychiatry can be separated out from the practice of medicine. Just as the physiotherapist may be licensed to do certain aspects of an orthopedic surgeon's work under the direction of the orthopedic surgeon as the responsible person, so can I see that certain persons might be licensed to do certain aspects of the psychiatrist's work with the psychiatrist physician in this sense remaining the responsible person. I do not think that in this day and age

any shortage of orthopedic surgeons would cause us to certify or license anatomists to do orthopedic surgery, yet in this same day and age because of a shortage of psychiatrists, academic psychologists are being licensed to practice psychiatry. The word "psychotherapy" became overly invested in the decade before the present one because it was in a certain sense a discovery during that decade and, consequently, the psychiatrists themselves are partly to blame for the confusion. They should have insisted from the beginning that the disciplined treatment of emotional or psychiatric illness is to be defined by the word "psychiatric treatment" of which psychotherapy is one of the several tools available.

Instead of attempting to define the word "psychiatry" and the practice of psychiatry, we have all got sidetracked onto the impossible proposition of attempting to define the word "Psychotherapist". In the process, psychologists have become certified are sometimes licensed to become a healing art separated entirely from the tradition and discipline of medicine; and I refer here to the academic clinical scientific discipline and not to any institutional or organizational discipline.

I hope that this Psychiatric Society can forward to you useful information within the next month or two, so that this very important question can come to a wise resolution.

Sincerely,

S/

J. Victor Monke, M. D.
President

JVM:jh