commitment papers, or testifying in court as to legal sanity; these activities will be discussed later.)

With this fact in mind, we may proceed to the second of the two questions posed above: Do psychiatrists have a significant advantage over other therapists in the conduct of their day-to-day professional work? The preceding discussion makes it clear that this question must be subdivided into two questions: (*a*) Do psychiatrists have a significant advantage when functioning purely as "psychotherapists" in the usual sense—that is, without employing physical methods? (*b*) To what extent does the possibility of employing the physical methods mentioned above constitute an advantage for the psychiatrist?

Two main arguments have been advanced to sustain the claim that medical training confers an advantage on the psychotherapist: these might be termed the argument from knowledge and the argument from attitude and charisma. The proponents of the former maintain that the physician's knowledge of physical symptoms and disease constitutes an important part of the armamentarium of the psychotherapist and/or that this knowledge is essential because the therapist must assume what is termed "medical responsibility" for the patient.

The assertion that knowledge of physical medicine is important to the psychotherapist appears patently false when one considers the obvious fact that large numbers of nonmedical therapists function quite effectively without this knowledge. Therapists of every background, medical and otherwise, routinely make a practice of depending on general physicians, internists, and other medical men for opinions and recommendations regarding organic problems in their patients; and the suspecting of organic disease is most assuredly not limited to psychiatrists. Two situations known to the author are relevant in this connection:

"A psychologically sophisticated patient dismissed certain abdominal symptoms as being obviously "psychosomatic" because they appeared to be related to material with which she was dealing in therapy. Her therapist, however, insisted that she consult a physician. Examination revealed a twisted ovarian cyst. The therapist was a lay analyst.

A woman was seen in psychotherapy over a prolonged period because of persistent abdominal symptoms for which extensive physical investigations had revealed no cause. The therapist was convinced that the symptoms were somatic expressions of feelings related to the patient's intensely conflictual marriage; numerous connections between various symptomatic manifestations and the vicissitudes of the marital situation were observed in the course of the therapy. The treatment ended precipitously when the patient consulted a surgeon whom she had never seen before; this surgeon performed a laparotomy and found the patient's peritoneal cavity to be extensively invaded by a malignant tumor. The therapist in this case: a psychiatrist.

Further examples may be found in Eissler's (1965) *Medical Orthodoxy and the Future of Psychoanalysis.*

The term "medical responsibility" is often used but seldom defined. Operationally, one assumes responsibility when one agrees to perform a certain function (professional or otherwise). What, exactly, does one who assumes medical responsibility take upon himself? The answer, obviously, is that the responsibility varies according to the field in which the professional is working. The ophthalmologist assumes responsibility for diagnosing and treating eye conditions; he does not assume either diagnostic or therapeutic responsibility for other conditions. If a patient mistakenly visits his office with intestinal complaints, he does not assume any reponsibility for the patient other than to refer him to an appropriate source of help. If he has a patient in the hospital for an eye operation, he asks a general physician to do the routine physical examination. If the patient develops postoperative pneumonia, he will assume the responsibility for calling in an internist to treat the pneumonia; he will not take the responsibility for diagnosing and treating it himself because he (quite correctly) considers it outside his realm of competence. Thus even within the field of organic medicine, medical responsibility is not a global responsibility; institutional rhetoric and operational reality are two different things.

In the psychiatric field, the confusion is particularly important because an issue is made of the medical responsibility concept. The ophthalmologist is not criticized because he does not assume the responsibilities of the general physician or the internist, but the psychiatrist is admonished—albeit with no clarity of thought—to "assume medical responsibility for the patient." This injunction may be viewed from both sides—the psychiatrist's and the patient's. From the psychiatrist's side, one immediately sees a strange contradiction: The psychiatrist