and medical school experience, with the single exception of the specifically psychiatric courses and clerkships, was irrelevant. The required premedical courses in biology, chemistry, physics, and mathematics were also, of course, grossly irrelevant. Courses in English composition and literature fared somewhat better, the former as training in the organization and presentation of thought and the latter as an exposure to some of the vagaries of human behavior. Two elective college courses in philosophy and ethics seemed to have more direct relevance to the kinds of problems with which I deal than did all the endless hours of chemistry, zoology, pathology, surgery, and the like. (I do not, of course, mean to imply that all of these "irrelevant" courses were totally worthless in terms of general educational background; I am concerned here only with the question of more or less direct relevance to a particular professional task.)

What, then, did prepare me to be a psychotherapist? Very simply, residency training *in therapy*, reading, and experience (including experience as a patient, both in analysis and in analytically oriented psychotherapy). For none of these was my medical background necessary or even significantly helpful.

Figure 1 is an attempt to present the interrelationships among the various elements in my professional background.

The other argument in favor of medical training for the psychotherapist is the argument from attitude and charisma. It is sometimes held that "only the doctor" (i.e., the physician) can assume the proper therapeutic attitude toward the patient and command the supposedly necessary degree of reverence from him (Zilboorg, 1943). The patently institutional assertion that physicians have a monopoly on therapeutic attitudes is one which seems too manifestly false to warrant detailed refutation. Anyone who has open-mindedly worked with physicians and with nonmedical psychotherapists knows that attitudes toward patients and modes of relating to them vary with the personalities and theoretical orientations of the professionals and cannot be related to academic background in any direct way. Further, it has been repeatedly and clearly pointed out that the nature of the relationship between psychotherapist and patient is distinctly different from that between physician and patient (Sobel, 1964; Wheelis, 1958). Specifically, it is worth noting that physicians habitually speak of "taking care of" their patients; the psychotherapist is frequently actively concerned with getting the patient to "take care of" himself and speaks of "seeing" or "working with" a patient. Thus one might well question the desirability of a traditional "medical attitude" in dealing with the psychotherapy patient.

One particularly subtle way in which psychiatric writers sometimes imply that nonmedical therapists are "inferior" is exemplified by the familiar statement that the threat of suicide represents a *medical* emergency; one writer (Lesse, 1965) has compared it directly with threatened coronary occlusion. The hidden implication in this statement is that conditions or situations which are "serious" are *ipso facto* "medical" and that only physicians "can" or "should" deal with them. That the threat of suicide is a serious problem very few would deny, but conditions which are serious are not necessarily medical; the threat of suicide might more appropriately be termed a "humanistic emergency," a "psychological emergency," perhaps even an "existential emergency." There is no logical reason for placing a problem in the domain of medicine simply because of its importance or seriousness; the substantive content of the problem should be the determining factor. Similarly, there is no reason to assume that the ability to behave in a responsible manner, both in a general human sense and within the framework of a professional role, is inextricably linked with medical experience.

It may be granted that for some patients the charisma of the physician is an important determinant of attitudes and behavior (Frank, 1961). For reasons of status, because of misinformation regarding professional functioning, or for manipulative reasons, certain patients insist on having medical therapists. This sort of behavior on the part of a patient, however, is clearly irrational; and for psychiatrists to capitalize on it as a justification for asserting a therapeutic monopoly is strangely ironic. They frequently do, however; and nonmedical therapists often fall into the trap, defining themselves into a state of "inferiority"—and hence of lessened therapeutic efficacy—as a result of exposure to the medical "party line."

It seems clear, then, that whatever advantage accrues to the psychiatrist functioning as a psychotherapist stems not from his medical knowledge but from irrational attitudes on the part of his patients, his colleagues, and himself (or, of course, from nonmedical training experiences).