drugs, this specialization appears inevitable and appropriate. The relevant conclusion in terms of the larger question being considered here is that *awareness of indications* for electroshock and its *availability* are important for most psychiatrists while the actual giving of the treatment is frequently left to those who make a specialty of it.

Of the three distinctly medical techniques under discussion, then, only one—the prescribing of drugs—is commonly employed by large numbers of psychiatrists. It is important to note that the list of drugs used by psychiatrists is a very short one in comparison to the entire pharmacopoeia, being limited, with most practitioners, to tranquilizers, antidepressants, sedatives, and energizers, The implications of this observation will be developed further later in the discussion; a question may be posed at once, however, as to whether it may be realistically claimed that 4 years of medical education is an operationally necessary prerequisite for the prescribing of four very limited classes of drugs.

There are, as noted earlier, certain administrative behaviors which are almost invariably performed by psychiatrists and hence could serve to identify the subject in our imagined experiment; such behaviors would include hospitalizing patients, giving and withholding privileges on psychiatric wards in hospitals, signing commitment papers, testifying as to legal sanity, and the like. When the suggestion is made that such activities could just as effectively be carried out by—for example—clinical psychologists, the outrage of the psychiatrist frequently finds expression in some such question as: "Would you want anyone but a doctor to make decisions like these?" It is asserted that only the physician can "take the responsibility." This sort of assertion indicates not only "status panic" but also a complete confusion of operational and institutional considerations. When the psychologist states that he "cannot"—for example—sign commitment papers, he is saying simply that institutional regulations *do not permit* him to sign them; he is *not* saying that he lacks the knowledge or judgment to do so. If one is careful to avoid the institutional trap, it appears obvious that medical training is not in any way operationally necessary for the performance of the administrative behaviors being considered here. What *is* necessary is the observational skill and judgment which comes only from experience with disturbed people—experience which is common to psychiatrists and other mental health professionals but not, frequently, to general physicians, who, because of the institutional rules, "can" make various administrative decisions about people who come under this scrutiny (e.g., sign commitment papers).

One type of professional behavior which is sometimes mentioned as inherently "medical" is the applying of diagnostic labels. Here again one encounters confusion between institutional rules and operational realities. As an example, in Florence Hollis's recent book entitled *Casework: A Psychosocial Therapy* (1964)—which is, as one reviewer pointed out, a treatise on psychotherapy as practiced by caseworkers—the author makes this statement (p. 195): "An opinion about the nature of a mental disturbance becomes a medical diagnosis only when it is expressed by a physician." If a social worker labels a client "schizophrenic," this is "a casework diagnosis . . . designed for casework treatment." Presumably, then, a similar diagnosis made by a psychologist would be a "psychological diagnosis"—something different from a "casework diagnosis" and different also from a "psychiatric diagnosis." In reality, all three professionals are saying the same thing, performing the same professional act, when they state that a patient (or "client") is schizophrenic, provided only that they agree on the meaning of the term. If disagreements arise among professionals of different disciplines about matters of diagnosis, they are true disagreements, not artifacts resulting from differences in professional origin.

I have defined the "mental health" field as "that area of human endeavor devoted to helping persons with emotional or psychological problems"; it is, to be somewhat more expansive, the field of man's anxieties, depressions, irrational doubts and fears, irresponsibilities, disturbed social relations, maladaptive behavior, disturbed thinking—the field of the *psychic* problems of man *as man*, a social, symbolizing being, not man as a biological machine. It is altogether appropriate to ask, from an operational viewpoint unhampered by any prexisting institutional rules, what we need to know about man in order to help him with these kinds of problems (and—if need be—to make decisions about him when he becomes socially incompetent in the course of trying to deal with them).

This sort of question may be approached from a theoretical base or from the practical, purely operational surface, with subsequent inquiry into the relevant underpinnings of operational knowledge. From a theoretical point of view, to an