Mr. Chairman, I do not want to take too much time here. I would like to close by clarifying another point.

At the present time, do psychologists and psychiatrists confer and in general what is their working relationship?

Dr. MELTZER. I would like to attempt to answer that question.

At the present time psychologists and psychiatrists do confer and I would distinguish two different kinds of conferring.

In the first instance, the psychiatrists will refer a patient that he has seen and who has been given a medical and psychiatric work-up, he will refer such a patient to a psychologist for clinical testing. And the testing, along with every kind of available information, is made part of the psychiatrist's ultimate determination of diagnosis, prognosis and treatment plan. In that sense the psychiatrist is using the psychologist's services somewhat in the form of the way other medical practitioners make use of other kinds of investigations, X–rays and laboratory tests and the psychologist's examination is by no means the sole determinant of the psychiatrist's responsible decision in terms of diagnosis and treatment.

This is a very useful service that the psychologists provide and is one that is made use of extensively.

In the second kind of conferring, and this is after the traditional model of the hospital and mental hygiene clinics, where psychologists who have been exposed to psychotherapy have received the training that has introduced them to this. The traditional model is that the physician in the hospital or mental hygiene clinic sees the patient, examines the tests, makes the diagnosis, correlates the medical and physical data and then, in selected instances that have to do with minor mental illnesses which are within the competence of the psychologist, refers and delegates psychotherapy to the psychologist for him to do under the continuing supervision of the psychiatrist.

In fact, this works out in clinics and hospitals. For instance, a psychologist may see the patient who has been referred to him two or three times a week and will have one supervisory session a week. So there is a very close and intense planning regulation and overseeing. This kind of thing also goes on but not nearly so frequently, as Dr. Legault suggested, in areas of practice outside of clinics and institutions.

There is the custom wherein a psychiatrist who has seen a patient, who was worked him up, has made the diagnosis and evaluation, has assessed the hazards in treatment and so on, will refer such a private patient in a noninstitutional setting to a psychologist for such treatment, and these are usually people who know each other very well, who have worked together extensively and who have a useful collaboration and liaison with each other. There, too, it is after the model of supervised delegated treatment.

Dr. Malcolm Meltzer referred to I think, or implied, another kind of relationship in which the patient is first seen by the psychologist. In such a setting, if the patient is first seen by the psychologist, the psychologist does not have available through his own skills the opportunity for the full medical evaluation, the evaluation of psychosomatic factors and I cannot comprehend, by the way, how a psychoso-