

IN THE SUPREME COURT OF THE STATE OF CALIFORNIA

CALIFORNIA ASSOCIATION OF	)	
PSYCHOLOGY PROVIDERS, et al.,	)	No. S 002524
	)	
Plaintiffs/Respondents	)	Court of Appeal
	)	No. B 020113
v.	)	
	)	
PETER RANK, DIRECTOR,	)	Los Angeles Superior
DEPARTMENT OF HEALTH SERVICES	)	Court No. C 502929
et al.,	)	
	)	
Defendants	)	
	)	
CALIFORNIA HOSPITAL	)	
ASSOCIATION, et al.,	)	
	)	
Moving Parties/Appellants	)	

**BRIEF OF AMERICAN PSYCHOLOGICAL ASSOCIATION AND CALIFORNIA
STATE PSYCHOLOGICAL ASSOCIATION AS AMICUS CURIAE
IN SUPPORT OF PLAINTIFFS/RESPONDENTS**

Review of Decision of the Court of Appeal
Second Appellate District, Division Three

Appeal from the Judgment of the Supreme Court
of the State of California in and for the
City and County of Los Angeles

Honorable Charles E. Jones, Judge

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Zimet & Weissberg, <u>The Emergency Service: A Setting for Internship Training</u> , 16 <u>Psychotherapy: Theory, Research and Practice</u> 334 (1979).....	7
Zusman, <u>APA's [Amer. Psychiatric Ass'n.] Model Commitment Law and the Need for Better Mental Health Services</u> , 36 <u>Hosp. & Comm. Psychiatry</u> 978 (1985).....	43

IN THE SUPREME COURT OF THE STATE OF CALIFORNIA

CALIFORNIA ASSOCIATION OF PSYCHOLOGY PROVIDERS, et al.,	)	No. S 002524
	)	
Plaintiffs/Respondents	)	Court of Appeal
	)	No. B 020113
v.	)	
	)	
PETER RANK, DIRECTOR, DEPARTMENT OF HEALTH SERVICES et al.,	)	Los Angeles Superior Court No. C 502929
	)	
Defendants	)	
	)	
CALIFORNIA HOSPITAL ASSOCIATION, et al.,	)	
	)	
Moving Parties/Appellants	)	

BRIEF OF AMERICAN PSYCHOLOGICAL ASSOCIATION AND CALIFORNIA
STATE PSYCHOLOGICAL ASSOCIATION AS AMICI CURIAE IN
SUPPORT OF PLAINTIFFS/RESPONDENTS

INTEREST OF AMICI

The interest of amici American Psychological Association (APA) and the California State Psychological Association (CSPA) are set forth in their Application for Leave to File Brief as Amici Curiae in Support of Plaintiffs/Respondents.

INTRODUCTION AND SUMMARY OF ARGUMENT

In arbitrarily restricting psychology's scope of practice in hospitals to a presumed set of mental disorders not organic in origin, the Court of Appeal rendered a decision devoid of empirical or legal justification. Although it may have intended to engage in the task of statutory interpretation it soon converted its role to that of super-legislature. Despite its apparent good

intentions, the decision serves the interests of those who seek to perpetuate anachronistic, anticompetitive stereotypes, and deprives members of the public of their freedom to use the qualified mental health professional of their choice, to effective and continuous care, and of the opportunity to receive cost-effective mental health services when the spiraling expenditures for health care is of national concern. This Brief Amici Curiae seeks to supply corrective information without duplicating the arguments of Plaintiffs/Respondents whom amici support.

Psychologists are uniquely trained independent professionals who are well qualified to provide mental health services in a wide range of settings, including hospitals. Before psychologists in this State can practice independently they undergo a rigorous education leading to a doctoral degree, involving didactic coursework (including the biological bases of behavior), clinical practica, and a one year full-time closely supervised internship in hospitals, medical centers, or clinics. This is followed by a postdoctoral year of supervised experience and demonstration of academic knowledge and clinical skills on both written and oral examinations. Only then is a psychologist in California permitted to engage in the diagnosis, prevention, treatment, and amelioration of all mental disorders. That licensed psychologists are recognized as independent providers of mental health services is clear by virtue of a substantial number of federal and California statutes, overlooked by the court below, which leave no question that

psychologists are authorized to diagnose and treat mental disorders with the use of any techniques consistent with the scope of their licensure and their competence. Point I.

California's licensure law makes no distinction between types of disorders psychologists are authorized to diagnose and treat. The scientific literature does not support the appellate court's assumption that mental disorders can be divided into those that are organic in origin and those that are not. It does show that many physicians routinely fail to recognize psychologically based disorders, the presence of organic brain injury, and the emotional and behavioral components of such injury. Point II. Psychologists, on the other hand, are qualified and competent to diagnose organic disorders, including injury to the brain, through the use of objective and valid tests which uncover the presence, site, and extent of injury that often elude standard medical and psychiatric procedures. Point III.

The data show that psychologists have been relied upon by the health care system to diagnose and treat mental disorders irrespective of cause. Through comprehensive psychological assessment, development and implementation of treatment plans, and the evaluation of those plans, psychologists, as independent professionals, have created substantial benefits to patients hospitalized with severe mental disorders such as schizophrenia and manic-depressive psychoses (both now recognized as having significant organic components). As a result, hospital stays for these patients have been significantly reduced. Further, psychologists

have successfully treated patients with physical disorders for whom no medical treatment is available and for patients for whom psychological intervention is a necessary concomitant of medical treatment. Point IV.

Finally, recognizing psychologists as independent competing professionals will benefit consumers by offering greater choice of providers and treatment alternatives at reduced cost. The ethical and professional standards of psychologists and hospital accrediting agencies, as well as California law, protect patients, and ensure that they will receive all required medical care. The appellate court's decision not only is unnecessary to that outcome but it unreasonably discriminates against psychologists, disserves the public interest, unduly interferes with patients' freedom of choice, and is in sharp conflict with current and accepted practice. Point V.

ARGUMENT

I. LICENSED PSYCHOLOGISTS ARE FULLY TRAINED AND QUALIFIED TO PROVIDE COMPREHENSIVE MENTAL HEALTH SERVICES TO PATIENTS WITHIN AND WITHOUT THE HOSPITAL SETTING.

The appellate court held, in the absence of any trial court record, that only physicians may diagnose patients whose mental disorders are organic in origin or develop treatment plans in those cases where the mental disorder "is susceptible to treatment by drugs, surgery, or electro-convulsive therapy [ECT]. . . ." Opinion at 12 (emphasis added). The court ruled that in those cases physicians must have "initial and ultimate responsibility," for such patients. Id. In perpetuating physician

domination of diagnosis and treatment of patients hospitalized for mental disorders, the court lacked awareness of the qualifications and skills of psychologists, failed to understand the ethical, professional, and hospital-based constraints under which psychologists work, precluding the negative effects on patient care the court contemplated, and overestimated the role of psychiatrists and other physicians in independently and unilaterally diagnosing mental disorders organic in nature or origin.^{1/} So this Court may render a more informed opinion concerning the issues in this case, each of these topics are discussed in turn.

A. Psychologists are Qualified to Independently Provide Comprehensive Mental Health Services.

The practice of psychology, as defined by this State, encompasses the rendering of services involving the application of principles, methods, and procedures for understanding, predicting and influencing behavior, including diagnosis, prevention, treatment, and amelioration of psychological problems and emotional and mental disorders to individuals and groups. Cal. Bus. & Prof. Code § 2903 (emphasis added). Psychologists, by virtue of their training and

^{1/} The appellate court's opinion reinforces discarded "stereotypes from the 1950s" when "psychiatrists 'treated' the patients; psychologists administered tests to them; . . . nurses handed out the medications; and the attendants kept the patients company by playing cards." Blum & Redlich, Mental Health Practitioners: Old Stereotypes and New Realities, 37 Arch. Gen. Psychiatry 1247, 1247 (1980).

experience, are recognized as fully qualified to diagnose and treat all mental disorders so long as that treatment does not involve drugs, surgery or ECT. Id. at § 2904.

1. The Doctoral Degree

The entry level degree for psychologists is the doctorate. Generally, a doctoral level program in clinical psychology requires four to five years of rigorous and extensive didactic and field placement experience, with approximately three years devoted to coursework and practica, one year to a full time supervised internship at a hospital, clinic, or other training center, and one year of research.^{2/}

All clinical psychology programs combine the teaching of basic science and methods of psychology with the theory and techniques of clinical practice. In addition to developing competence in such skills as diagnosis and treatment, students gain a sound graduate education in the cognitive and affective bases of behavior (e.g., learning, memory, motivation and emotion), social bases of behavior (e.g., group processes and organizational theory), and individual behavior (e.g., personality theory, human development, and abnormal psychology). Most relevant, clinical psychology programs provide for education in the biological bases of behavior, including, for example, physiological

^{2/} See generally Edelstein & Brasted, Clinical Training in The Clinical Psychology Handbook 35 (M. Hersen, A. Kazdin & A. Bellack eds. 1983).

psychology, neuropsychology, and psychopharmacology. See APA Accreditation Handbook (1986) at B-6.

Internship training, an essential component of doctoral training in clinical psychology, provides doctoral students with the opportunity to take substantial responsibility for carrying out major professional functions in the context of close and careful supervision. See id. at B-17. Of 342 internships accredited by APA as of July 1988, 233 (65.2%) are in hospital settings.^{3/} Several internships programs now offer training in hospital emergency rooms.^{4/}

The combination of these intensive educative and training experiences ensure that clinical psychologists are fully prepared to render independent psychological services. As a result of their solid grounding in the scientific method and the scientific foundations of mental disorders, as well as the acquisition of skills in the diagnosis, assessment, and treatment of all mental disorders, there is no question that they possess the ability to diagnose mental disorders organic in origin, and to uncover those disorders that are not simply environmentally caused.

^{3/} See Committee on Accreditation, APA Accredited Predoctoral Internships for Doctoral Training in Psychology: 1987, 42 Amer. Psychologist 1094 (1987). See also Eggert, Laughlin, Hutzell, Stedman, Solway and Carrington, The Psychology Internship Marketplace Today, 18 Prof. Psychology 165 (1987).

^{4/} See, e.g., Barlow, Psychologists in the Emergency Room, 5 Prof. Psychology 251 (1974); Zimet & Weissberg, The Emergency Service: A Setting for Internship Training, 16 Psychotherapy: Theory, Research and Practice 334 (1979).

2. Licensure and Certification

At present, and since 1977, all 50 states and the District of Columbia have enacted laws regulating the practice of psychology.^{5/} Most state licensure laws, like California's, establish as the minimum requirements for independent practice the doctoral degree in psychology (or its equivalent) plus two years of supervised experience (with at least one of those at the predoctoral level).^{6/}

State examining boards administering laws regulating the practice of psychology also require that applicants pass an examination, either written, oral, or both. California's test covers all major substantive areas in psychology, including physiological and biological aspects of behavior. In addition, as in other states, California requires applicants to undergo an oral examination in which they exhibit skill in recognizing disorders, including those organic in origin, and demonstrate a full understanding of their duty to refer patients to physicians for medical care.

^{5/} Stigall, Licensing and Certification in The Professional Psychologist's Handbook 285 (B. Sales ed. 1983). These laws, which permit psychologists to practice independently in all settings, provide for certification or licensure. Certification laws limit the use of the title "psychologist." Licensure laws, like California's, both regulate use of the title and define the scope of those activities for which a license to practice is required.

^{6/} See Cal. Health & Safety Code § 1316.5, subd. (c).

3. Ethical Codes and Professional Standards

To further ensure a high quality of professional practice, states have adopted ethical codes identical or quite similar to the APA's Ethical Principles of Psychologists.^{7/} Among other requirements, the Principles mandate that "[p]sychologists recognize the boundaries of their competence . . . [and] provide services and only use techniques for which they are qualified by training and experience." Id. at 634 (General Principle 2). They require psychologists to "understand the areas of competence of related professions," "make full use of all the professional . . . resources that serve the best interests of consumers," and obtain all "complementary or alternative assistance needed by clients." Id. at 636 (Principle 7(a)).

Psychologists who violate the ethical standards of their profession are subject to disciplinary action by the APA, including expulsion from the Association. And, because these ethical principles are reflected in state licensure laws, psychologists also risk revocation of their license which would preclude them from practicing their profession.^{8/}

^{7/} APA, Ethical Principles of Psychologists, 36 Amer. Psychologist 633 (1981). California reflects these principles in its licensure law and regulations. See Cal. Bus. & Prof. Code § 2960; Cal. Admin. Code tit. 16 § 1396.

^{8/} APA has adopted two other documents psychologists are expected to observe to promote the best interests and welfare of clients. The General Guidelines for Providers of
(Footnote Continued)

The Ethical Principles, General Guidelines, and Specialty Guidelines appropriately regulate and monitor the work of clinical psychologists in hospital settings as elsewhere. The drastic sanctions psychologists can suffer for violating the profession's code of ethics and the licensure laws provide significant protections to patients and other consumers of psychological services. Although the appellate court never had a record on which to base its concerns about psychological practice, it usurped the legislature's power to determine the scope of a psychologist's license and unnecessarily restricted the practice of psychology in hospital facilities.

B. ^{is Recognized} ~~Recognition of~~ Psychology as an Independent Profession.

Given their intensive training, rigorous licensure laws, and the ethical and other professional standards in

(Footnote Continued)

Psychological Services, 42 Amer. Psychologist 1 (1987), were "established by organized psychology as a means of self-regulation in the public interest," and cover any psychological service "at any time and in any setting." Id. The General Guidelines, although acknowledging that "psychologists pursue their activities as members of the independent, autonomous profession of psychology," id. at 8 (Guideline 3.2), also reminds psychologists to "limit their practice . . . to their demonstrated areas of professional competence," id. at 4 (Guideline 1.6), and "in the best interest of users, . . . to consult and collaborate with professional colleagues in the planning and delivery of services. . . ." Id. at 5 (Guidelines 2.2.6).

Similarly, the Specialty Guidelines for the Delivery of Services by Clinical Psychologists, 36 Amer. Psychologist 640 (1981), instruct clinicians to act within the bounds of their competence and to consult, cooperate, and collaborate with their colleagues from other professions. Id. at 644, 646.

psychology, it is not surprising that psychologists are generally recognized as independent professionals providing diagnosis and treatment on a coequal footing with psychiatry. This recognition is expressed not only in public attitudes but also in federal and state statutory and regulatory law and in private sector practices.

Almost all relevant federal statutes require direct recognition of clinical psychologists as independent health care providers, i.e., as persons qualified to deliver services without supervision by a physician. A comprehensive, but by no means an exhaustive list, includes: Federal Employees Compensation Act, 5 U.S.C. § 8101(2) (1982); Offenders with Mental Disease or Defect Act, 18 U.S.C. §§ 4241-4244 (Supp. 1985); Vocational Rehabilitation Act, 29 U.S.C. § 723(a)(1) (1982); the Civilian Health and Medical Program of the Veterans Administration, 38 U.S.C. § 601 et seq. (1982); Veterans Health Care Expansion Act, 38 U.S.C. §§ 612A; 613(b) (1988); Health Maintenance Organization Act, 42 U.S.C. § 300e-1 (1988); Disaster Relief Act, 42 U.S.C. § 5183 (1982); and Medicaid, 42 U.S.C. § 1396 et seq. (1982).^{9/}

The most notable examples of federal statutes recognizing clinical psychologists as independent providers of mental health services are the Federal Employees Health

^{9/} Most of these statutes are described in Brief of Plaintiff-Respondents at 27-28.

Benefits Act (FEHBA), 5 U.S.C. § 8902(k) (Supp. 1986), and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), 10 U.S.C. § 1071 et seq. (Supp. 1986). FEHBA establishes conditions and funding of group health plans for federal employees and their beneficiaries. There are currently about 20 plans, that cover about 10 million people. CHAMPUS protects almost 9 million people, including dependents of military personnel, retired military personnel, and dependents of deceased personnel. It covers both inpatient and outpatient services.^{10/}

State law just as explicitly recognizes psychologists as independent providers of mental health services. Forty states, including California, embracing more than 90% of the United States population, have enacted laws establishing direct recognition of and reimbursement for psychological services. See Cal. Ins. Code § 10176. These statutes amend state insurance and related codes to require third party payors to cover the independent provision of services by licensed psychologists if those same services are also provided by physicians. These "freedom of choice" laws broaden the range of providers who can render the covered

^{10/} For a fuller description of these two programs as well as the other federal statutes listed, supra, see Dorken, Health Insurance and Third-Party Reimbursement in The Professional Psychologist's Handbook 249 (B. Sales ed. 1983); DeLeon, VandenBos, & Kraut, Federal Legislation Recognizing Psychology, 39 Amer. Psychologist 933 (1984). See also Omnibus Budget Reconciliation Act of 1987, Pub. L. 100-203, adding payments for qualified psychological services under Medicare, 42 U.S.C. § 1395 et seq. (1988).

service, permitting patients direct access to qualified psychologists if that is the patient's choice.

In addition to freedom of choice legislation, California confers independent status for psychologists in several and diverse areas: Cal. Unemp. Ins. Code § 2708; Cal. Lab. Code § 3209.3; Cal. Penal Code § 1369; Cal. Penal Code § 1027; Cal. Penal Code § 1203h; Cal. Penal Code § 2962; Cal. Civ. Proc. Code § 2032; Cal. Welf. Inst. Code § 5361; Cal. Civ. Code § 232; Cal. Welf. & Inst. Code § 5008 et seq.^{11/}

This is but a partial listing of federal and state laws that evidence legislative recognition of the qualifications of psychologists to provide independently, and regardless of setting, a broad diversity of mental health services to all kinds of patients, including those with severe mental and organic disorders. The plain import of these provisions is that psychologists are permitted to perform all diagnostic services so long as they do not use drugs, surgery, or electro-convulsive devices. Cal. Bus. & Prof. Code § 2904. The appellate court, in its cramped and insufficient analysis, failed to take these significant provisions into account. As a result, the court seriously misinterpreted the psychologist's licensure law and severely circumscribed, if not rendered nugatory, Cal. Health & Safety Code

^{11/} Most of these statutes and supporting case law are described in Brief of Plaintiffs-Respondents at 20-25.

§ 1316.5, permitting psychologists to serve on medical staffs of health facilities, which explicitly includes hospitals. See Cal. Health & Safety Code § 1250. A major purpose of § 1316.5 was to expand, not contract, the practice of psychology by making it clear that the licensure law applied not only to outpatient settings in which psychologists traditionally worked autonomously, but to inpatient hospital settings as well.

II. THE APPELLATE COURT'S DISTINCTION BETWEEN DISORDERS WITH AN ORGANIC ORIGIN AND THOSE WITH NO ORGANIC ORIGIN IS ARCHAIC AND UNTENABLE; SUCH A DISTINCTION MAINTAINED IN ACTUAL PRACTICE CAN JEOPARDIZE PATIENT CARE.

A. Mental Disorders Are Not Neatly Separated Between Those With Organic Bases and Those Without.

The appellate court assumed that certain mental disorders are discernibly and unequivocally organic in origin. It also assumed that if a mental disorder were organic in origin it must be susceptible to medical treatment for which only physicians could devise plans. Only when an organic basis for a disorder was ruled out could clinical psychologists diagnose and treat their patients. Such a simple division of labor is unsophisticated and unsupportable.

The reality is, "We are not yet in a position to distinguish between syndromes due to anatomic and physiological processes and those due to overwhelming social and psychologic stress." Radomisli & Karasu, Medical and Nonmedical Models in Clinical Practice and Training, 31

Amer. J. Psychotherapy 116, 118 (1977).^{12/} Even in schizophrenia and manic-depressive psychoses, which now appear to have organic and genetic bases, "[b]y the time a patient suffering from one of these disorders is first examined, he shows complex maladjustments due to somatic etiology in interaction with psychosocial etiology in a series of layers. . . ." Radomisli and Karasu at 118. As a result, the simple fact that a disorder may have an organic etiology does not mean that a physical intervention is the treatment of choice.^{13/}

Diagnosis is a complicated and intricate skill requiring expert data collection, the identification of alternate hypotheses, the interpretation of the data collected in light of these hypotheses, and the eventual formulation of a diagnosis that best fits the data.^{14/} The "difficulty in precisely demarcating physical from psychic disorders," Shelp & Perl, Missed Physical Diagnosis: Conceptual and Moral Comments on the Psychiatrist-Patient Relationship, 2 Psychiatric Med. 389, 398 (1985), requires

^{12/} See Kandel, Psychotherapy and the Single Synapse: The Impact of Psychiatric Thought on Neurobiologic Research, 301 New Eng. J. Med. 1028 (1979) (classification of psychiatric illness into organic and functional diseases unwarranted).

^{13/} See, e.g., discussion in Point IV (A), infra, of psychotherapy for schizophrenia, a disorder now believed primarily organic in origin.

^{14/} See Elstein, Human Factors in Clinical Judgment in Clinical Judgment: A Critical Appraisal 17 (H. Engelhardt, S. Spicker & B. Towers, eds. 1979).

sophisticated interaction and collaboration among all relevant health care professionals, not an unenlightened dismissal of an essential body of qualified practitioners, like clinical psychologists, from the process.^{15/}

To best serve the patient, a diagnostic model must include the entire spectrum of etiological factors, including genetic, biochemical, developmental, anatomic, physiologic, intrapsychic, interpersonal, familial and societal:

The crippling flaw of the [biomedical] model is that it does not include the patient and his attributes as a . . . human being. . . . [M]any of the data necessary for hypothesis development and testing are gathered within the framework of an ongoing human relationship and appear in behavioral and psychological forms. . . .

Engel, The Clinical Application of the Biopsychosocial Model, 137 Amer. J. Psychiatry, 535, 536 (1980).

The lower court's failure to consider these complexities creates two significant risks to patient care. First, failing to include clinical psychologists as independent, coequal collaborators in the diagnostic process for all patients will cause many patients who present with what appear to be purely medical problems to be misdiagnosed and mistreated because physicians often overlook the presence of

^{15/} See Holt, Diagnostic Testing: Present and Future Prospects, 144 J. Nerv. & Ment. Dis. 444, 456 (1967) (clinical psychologist "first of all contributes to the understanding of etiology. He weighs the relative contribution of organic and functional factors . . . and the degree of functional and organic impairment"); Berg, Toward a Diagnostic Alliance Between Psychiatrist and Psychologist, 41 Amer. Psychologist 52 (1986).

mental disorders in such patients.^{16/} Second, as amici now discuss, physicians, even those specially trained in the diagnosis of neurological problems such as brain injury, a clearly organic disorder, do not have the diagnostic tools to detect the presence and location of brain injury or to assess the emotional and behavioral components of such injury.

- B. Frequently, Physicians are Incapable of Detecting the Presence of Organic Brain Injury and Fail to Recognize the Emotional and Behavioral Components of Such Injury.

There are some mental disorders that clearly have a predominant organic element. These are injuries to the brain or other components of the central nervous system. Such injuries may occur through illness, such as encephalitis, Alzheimer's disease, and acquired immune deficiency syndrome (AIDS) or trauma, such as a head injury.

^{16/} Primary care physicians are either untrained, unable, or unwilling to recognize mental disorders in those patients seeking their services. Kessler, Cleary & Burke, Psychiatric Disorders in Primary Care, 42 Arch. Gen. Psychiatry 583, 584 (1985) ("primary care clinicians tend to underdiagnose and underreport psychiatric morbidity among their patients" and do less well than a psychometric scale); Thompson, Stoudemire, Mitchell & Grant, Underrecognition of Patients' Psychosocial Distress in a University Hospital Medical Clinic, 140 Amer. J. Psychiatry 158 (1983).

These facts argue against artificial role dichotomies and for the elimination of "the question of 'psychological or organic' with the conflict this produces over who is going to treat the patient." Brodsky, Decision-Making and Role Shifts as They Affect the Consultation Interface, 23 Arch. Gen. Psychiatry 559, 560 (1970).

The consequences of injuries to the brain are manifestly different in different individuals.^{17/} However, like other disorders with an organic component, it is widely recognized that "mental sequelae outstrip the physical as a cause of difficulty. . . ." Lishman, supra note 17, at 304. These "mental sequelae" range from irreversible coma through mental retardation and mental illness, to only brief periods of mental confusion. There may be somatic complaints, cognitive or intellectual deficits, and psychological disorders, e.g. depression, anxiety, aggression, emotional withdrawal, neuroses, and schizophrenia.^{18/}

A fact of which the appellate court was ignorant is that the symptoms just described, as well as the presence of the organic injury itself, cannot routinely be detected through a mental status examination by a psychiatrist, neurological examination by a physician, or by typical

17/ Barth, Macciocchi, Giordani, Rimel, Jane & Boll, Neuropsychological Sequelae of Minor Head Injury, 13 Neurosurgery 529 (1983) [hereinafter Barth et al]; Lishman, The Psychiatric Sequelae of Head Injury: A Review, 3 Psychological Med. 304 (1973) [hereinafter Lishman]; T. Boll, Assessment of Neuropsychological Disorders in Behavioral Assessment of Adult Disorders 48 (D. Barlow ed. 1981).

18/ See Barth et al., supra note 17; Boll, Behavioral Sequelae of Head Injury in Head Injury (P. Cooper ed. 1982); Bond, Assessment of the Psychosocial Outcome of Severe Head Injury, Acta Neurochirurgica 57 (1976); Dikmen & Reitan, Emotional Sequelae of Head Injury, 2 Ann. Neurology 492 (1977); Levin, Grossman, Rose & Teasdale, Long-term Neuropsychological Outcome of Closed Head Injury, 50 J. Neurosurgery 412 (1979).

medical techniques such as X-rays or CAT scans.^{19/} For example, an X-ray of the skull shows nothing about the soft tissues of the brain; it can only reveal bone fractures which are infrequent in head injuries that result in the most serious and diffuse brain damage. Brain contusions that can be detected by a CAT scan also decrease over time, and usually disappear completely after six weeks.^{20/} Additionally, one of the most significant studies in scrutinizing the value of computerized tomography showed that almost one-half of the patients who were in deep coma had normal CAT scans.^{21/} The greatest limitations of X-rays and CAT scans are that they can provide no information on changes in patients' intellect, emotions, or behavior.

Finally, a neurological examination is extremely limited in its capacity to detect organic dysfunction, especially of the higher-order brain processes like those that underlie problem-solving, personality, and social behavior:

the restricted limits of regular neurological symptoms is a result of some very important facts: lesions of

^{19/} See Barth et al, supra note 17.

^{20/} See Kishore, Radiographic Evaluation in Head Injury 43 (P. Cooper ed. 1982); French & Dublin, The Value of Computerized Tomography in the Management of 1000 Consecutive Head Injuries, 7 Surgical Neurology 171 (1977) [hereinafter French & Dublin].

^{21/} French & Dublin, supra note 20; see Baker, Campbell, Houser & Assoc., Computer Assisted Tomography of the Head, 49 Mayo Clinic Proc. 17 (1974) (only 10 of 27 head injured patients [37%] had abnormal CAT scan); Barth et al., supra note 17.

the highest . . . zones of the cortex . . . do not result, as a rule, in any elementary sensory or motor deficits and remain inaccessible for classical neurological examination. . . . [T]hat is why one has to establish new complex methods that could be used to study dysfunctional disorders evoked by their injuries. It is thus necessary to apply methods of neuropsychology for local diagnosis of lesions of these complex cortical zones.

Luria, Neuropsychological Studies in the USSR: Part I, 70 Proc. Nat'l. Acad. Sciences 959 (1973) (first emphasis in original; second emphasis added).

In sum, the appellate court's ruling creates substantial dangers to patients whose emotional, behavioral, and organic problems are likely to be overlooked and whose treatment plans are likely to be inadequate. Not only is a psychologist's diagnostic expertise helpful, it is essential to the assessment and treatment of all disorders.

III. CLINICAL PSYCHOLOGISTS ARE QUALIFIED AND COMPETENT TO DIAGNOSE ORGANIC DISORDERS INVOLVING INJURY TO THE CENTRAL NERVOUS SYSTEM, INCLUDING THE BRAIN.

The appellate court's assumption that the diagnosis of organic disorders, including brain injury, was not within the scope of a clinical psychologist's license is clearly erroneous and contrary to established fact. Many health care professionals are involved in the assessment, diagnosis, and treatment of brain damage including specialists in neurosurgery, psychiatry, rehabilitation medicine, and speech pathology. Psychologists, however, bring a unique

perspective to the assessment of central nervous system disorders generally and head injuries particularly.^{22/}

Because many organic dysfunctions occur in patients who have normal radiological findings and normal neurological examinations, see Point II(B), any genuine attempt to assess organicity must include a battery of scientifically validated tests to assess the presence, site, and extent of injury. This is one of the roles for which clinical psychologists are specially trained, particularly when a differential diagnosis between organic and purely psychological problems is required. "Some questions can be answered only by psychological testing. . . . [P]sychological testing proves far more efficacious and is often crucial in the diagnosis and treatment for organic conditions, the differential diagnosis between schizophrenic and organicity, ruling out of an underlying psychosis, differentiating between a strictly psychosomatic and a hysterical . . . disorder, or, if there is a need, for assessment of cognitive

^{22/} See generally C. Golden & P. Vicente, Foundations of Clinical Neuropsychology (1983); S. Filskov & T. Boll, Handbook of Clinical Neuropsychology (2d ed. 1986); I. Grant & K. Adams, Neuropsychological Assessment of Neuropsychiatric Disorders (1986); H. Hecaen & M. Albert, Human Neuropsychology (1978); K. Heilman & E. Valenstein, Clinical Neuropsychology (2d ed. 1985); M. Lezak, Clinical Neurological Assessment (2d ed. 1983); A. Luria, Higher Cortical Functions in Man (2d ed. 1980); R. Reitan & L. Davison, Clinical Neuropsychology: Current Status and Applications (1974); B. Rourke, D. Bakker, J. Fisk & J. Strang, Child Neuropsychology (1983); Sheer & Lubin, Survey of Training Programs in Clinical Neuropsychology, 36 J. Clin. Psychology 1035 (1980).

functioning." Lothstein, Role of the Clinical Psychiatrist and Psychologist in Primary Care Medicine, 4 Primary Care 343, 351 (1977).^{23/}

Psychological tests, which measure a variety of factors including intelligence and other aspects of cognitive functioning, personality, psychopathology, and visual and motor functioning, permit an accurate and objective assessment of the patient's functional and neurological abilities that are critical to a proper evaluation of brain injury.^{24/} In addition, psychological testing may be helpful in demonstrating deficits that are not evident clinically.

Psychological testing has been specifically recommended for two disorders which are clearly organic in origin, Alzheimer's Disease and AIDS.^{25/} Psychological tests are

^{23/} "A clinical neuropsychologist has the appropriate tools to investigate organic impairment and generally does a better job than a . . . psychiatrist." Id.

^{24/} "The organization of the interview and observational material by the psychiatrist . . . is liable to be quite subjective. . . . [P]sychological testing . . . compares the person's performance with others, with standards, and yields a diagnostic statement concerning a particular individual." Rabin & Hayes, Concerning the Rationale of Diagnostic Testing 579, 590 in Clinical Diagnosis of Mental Disorders (B. Wolman ed. 1978).

^{25/} See, e.g., Khachaturian, Progress of Research on Alzheimer's Disease, 40 Amer. Psychologist 1251 (1985); Grant, Atkinson, Hesselink, Kennedy, Richman, Spector & McCutchan, Evidence for Early Central Nervous System Involvement in the Acquired Immunodeficiency Syndrome (AIDS) and Other Human Immunodeficiency Virus (HIV) Infections: Studies with Neuropsychologic Testing and Magnetic Resonance Imaging, 107 Ann. of Internal Med. 828, 832 (1987) [hereinafter Grant et al]; Perry & Jacobsen,

(Footnote Continued)

useful in the early detection of these diseases, especially where clinical symptoms may mask the onset of these diseases.^{26/} They can measure deficits associated with the diseases such as memory loss, language deficits, and other cognitive impairments as well emotional concomitants such as anxiety and depression. They help evaluate the course of the disease once it has been diagnosed. And, tests help form and implement treatment plans to aid the patient cope with or compensate for these delineated deficits.

The two most popular groups of objective tests used by psychologists in evaluating brain injury are the Halstead-Reitan Battery and the Luria-Nebraska Neuropsychological Battery.^{27/} Psychiatric diagnoses that are based on the

(Footnote Continued)

Neuropsychiatric Manifestations of AIDS-Spectrum Disorders, 37 Hosp. & Comm. Psychiatry 135 (1986); Tross & Hirsch, Psychological Distress and Neuropsychological Complications of HIV Infection and AIDS, 43 Amer. Psychologist 929, 932 (1988).

^{26/} "[C]ognitive deficits may not be apparent on detailed mental status examination but may be revealed by standardized intelligence or neuropsychological tests." Perry & Jacobsen, supra note 25, at 137.

^{27/} See, e.g., R. Reitan & L. Davison (eds.), Clinical Neuropsychology: Current Status and Applications (1974); Heaton, Baade & Johnson, Neuropsychological Test Results Associated with Psychiatric Disorders in Adults, 85 Psychological Bull. 141 (1978); Small, Small, Fjeld & Hayden, Organic Cognates of Acute Psychiatric Illness, 122 Amer. J. Psychiatry 790 (1966). These batteries have "led to their use in the diagnosis of neurological disorders, psychiatric disorders, and the localization of brain lesions. Moreover, these batteries have permitted the further development of rehabilitation programs for traumatically brain-injured individuals." Edelstein & Brasted, Clinical Training in Clinical Psychology Handbook 44 (M. Hersen, A. Kazdin & A. Bellack eds. 1983).

usual nonstandard evaluations and fairly general criteria have not been found to be very reliable, even when made by experienced physicians.^{28/} In contrast, the clinical use of the Halstead-Reitan and Luria-Nebraska have been supported by studies showing that they reliably discriminate between patients with documented cerebral lesions or other brain damage from patients who have neither demonstrable cerebral pathology nor serious emotional disturbance.^{29/}

In sum, evaluation by clinical psychologists who are trained to assess cognitive, emotional, and behavioral functioning and whose diagnostic tools include standardized, reliable, and valid measures of organic damage, is critical to an accurate determination of mental and neurological disorder. The court below assumed distinctions between organic and nonorganic diseases are readily made and that it could assign diagnostic roles which would guide hospital practice. But such a fact-intensive issue cannot be decided

^{28/} See, e.g., Bazelon, A Jurist's View of Psychiatry, 3 J. Psychiatry & L. 175 (1975); Ennis & Litwack, Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom, 62 Calif. L. Rev. 693 (1974); A. Stone, Law, Psychiatry, and Morality (1984).

^{29/} See, e.g., Grant et al., supra note 25, at 832 ("Neuropsychological testing is generally recognized to be a valid and sensitive indicator of brain disease"); Golden, Validity of the Halstead-Reitan Neuropsychological Battery in a Mixed Psychiatric and Brain-Injured Population, 45 J. Consulting & Clinical Psychology 1043 (1977); Heaton, Baade & Johnson, Neuropsychological Tests Results Associated with Psychiatric Disorders in Adults, 85 Psychological Bull. 141 (1987); Spreen & Benton, Comparative Studies of Some Psychological Tests for Cerebral Damage, 140 J. Nervous & Mental Disease 323 (1965).

merely through judicial notice. See generally Annot.,
Judicial Notice--Diseases, 72 A.L.R.2d 554 (collecting
California cases).

IV. PSYCHOLOGISTS ARE VALUED MEMBERS IN MEDICAL SETTINGS
AND AS INDEPENDENT PROFESSIONALS PERFORM ESSENTIAL
FUNCTIONS NOT WITHIN THE EXPERTISE OF THEIR PHYSICIAN
COLLEAGUES.

Psychologists for decades have served in a variety of
settings and roles as independent providers of mental health
services and as consultants to primary care physicians.
Without incident and, in fact, with general approbation,
over 3000 psychologists are employed by the nation's medical
schools, more than 700 work on the staffs of public general
hospitals, about 2500 work in public psychiatric hospitals,
about 900 in private psychiatric hospitals, and about 1600
in Veterans Administration hospitals across the country,
providing diagnostic and treatment services, including to
patients with mental disorders organic in origin.^{30/}

Psychologists contribute to patient care in two essen-
tial and discrete ways. First, psychologists, as indepen-
dent and autonomous professionals, are responsible for the
diagnosis, planning, and treatment of hospitalized patients

^{30/} See, e.g., Burstein & Loucks, The Psychologist as
Health Care Clinician in Handbook of Clinical Health
Psychology (T. Millon, C. Green & R. Meagher eds. 1982);
Dunn, General Hospital Psychology, 27 Canadian Psychology 44
(1986); Clayson & Mensh, Psychologists in Medical Schools,
42 Amer. Psychologist 859 (1987); Stapp, Tucker & VandenBos,
Census of Psychological Personnel: 1983, 43 Amer.
Psychologist 1317 (1985); Thompson & Matarazzo, Psychology
in United States Medical Schools, 39 Amer. Psychologist 988
(1984).

with mental disorders. Second, psychologists make major contributions to the diagnosis and treatment of patients whose primary problems are physical but for whom psychological intervention is necessary.

A. Psychologists as Independent Providers of Services on Psychiatric Wards.

Psychologists have long been involved in the assessment and treatment of patients hospitalized for mental disorders. These patients usually suffer from severe difficulties like schizophrenia and manic-depressive psychoses. In many instances, these disorders may be organic in origin. The appellate court ruled that only physicians, including psychiatrists, could admit, diagnose, and develop, and implement treatment plans for these patients. Opinion at 12. This conclusion simply does not comport with reality.

First, psychologists because of their unique training and vast experience, are the only mental health professionals competent to perform reliable and valid assessments, through comprehensive testing, of patients.^{31/} As amici have shown, psychological testing is often crucial in arriving at accurate diagnoses of all disorders, including those organic in origin. Second, clinical psychologists'

^{31/} See, e.g., Lovitt, Current Practice of Psychological Assessment, 19 Prof. Psychology 516 (1988); Wade & Baker, Opinions and Use of Psychological Tests: A Survey of Clinical Psychologists, 32 Amer. Psychologist 874 (1977); Blum & Redlich, Mental Health Practitioners: Old Stereotypes and New Realities, 37 Arch. Gen. Psychiatry 1247 (1980).

knowledge of assessment and research methodology permit them to delineate the factors that powerfully influence the success or failure of treatment plans,^{32/} a role for which psychiatrists have not been trained.^{33/}

Most importantly, the failure to allow psychologists as autonomous professionals to develop and implement treatment plans for patients with mental disorders can lead to overmedication with the serious risks of powerful and debilitating side effects that antipsychotic drugs can produce. See Brief of APA and CSPA as Amicus Curiae in Riese v. St. Mary's Hospital and Medical Center, No. S004002 (Cal. S. Ct., filed Aug. 17, 1988). A number of effective interventions are available that create substantial benefits for hospitalized patients, either in conjunction with or as an alternative to medication.

Hospitalization is a form of treatment itself, especially if the hospital setting is structured as a therapeutic community. This form of treatment, commonly known as

^{32/} See, e.g., Clinical Psychologists as Health Professionals in Health Psychology--A Handbook (G. Stone, F. Cohen & N. Adler eds. 1979); Schraa & Jones, A Model Psychometrically Based Medical Psychology Program, 14 Prof. Psychology 78 (1983).

^{33/} See Kingsbury, Cognitive Differences Between Clinical Psychologists and Psychiatrists, 42 Amer. Psychologist 152 (1987) (author is a physician and clinical psychologist); Pasnau, The Remedicalization of Psychiatry, 38 Hosp. & Comm. Psychiatry 145, 150 (1987) (complaining of "the relative dearth of physician investigators in psychiatry, which in any case has not had a long research tradition").

"milieu therapy," has "been a significant part of inpatient treatment of schizophrenia since the 1950s" Bell & Ryan, Where Can Therapeutic Community Ideals be Realized? An Examination of Three Treatment Environments, 36 Hosp. & Comm. Psychiatry 1286, 1286 (1985).^{34/} It is "designed to teach appropriate interactional skills while discouraging inappropriate ones. It is also designed to provide motivation through positive and negative reinforcements and through the development of trusting, alliance-building relationships and staff." Dalton, Bolding, Woods, & Daruna, Short-Term Psychiatric Hospitalization of Children, 38 Hosp. & Comm. Psychiatry 973, 974 (1987).

"[A] recent series of studies have indicated that . . . [the] therapeutic power [of milieu therapy] can be equal to or even greater than that obtainable with drugs for some patients." Gunderson, supra note 34, at 327. Milieu treatment can also be used effectively in conjunction with drugs and is helpful in preparing schizophrenic patients and

^{34/} "Milieu therapy refers to those forms of milieu treatment in which the milieu itself is recognized as an active therapeutic agency to promote and facilitate 'positive' changes in specified directions." Gunderson, Defining the Therapeutic Processes in Psychiatric Milieus, 41 Psychiatry 327, 332 (1978). When properly implemented, the hospital milieu can safely contain patients and remove concerns over loss of self control, offer support, through interaction with others on the ward, create structure through a predictable organization of time, place, and person, foster involvement in the social environment, and affirm the patient's individuality. Id. at 328-332.

others for entering psychotherapy.^{35/} Because the very nature of milieu therapy requires greater decisionmaking by patients and nonphysician staff, the traditional hierarchical and authoritarian model under which physicians are trained may not make them as amenable as psychologists to active and effective participation.^{36/} Moreover, psychologists are uniquely trained and skilled in the development and implementation of effective milieu programs. Part of a psychologist's education includes work in the assessment of environments and the impact of groups, organizations, and systems on the individual.

Psychotherapy, for which clinical (among other) psychologists are trained, is also an effective option in the treatment of psychosis. For example, one well-known study examined the effects on inpatients hospitalized with schizophrenia of psychotherapy alone, medication alone, and psychotherapy and medications combined. For the first 20 months of treatment, patients who received psychotherapy

^{35/} See, e.g., Brown, A Short-term Hospital Program Preparing Borderline and Schizophrenic Patients for Intensive Psychotherapy, 44 Psychiatry 327 (1981); Lieberman & Strauss, Brief Psychiatric Hospitalization: What Are Its Effects? 143 Amer. J. Psychiatry 1557 (1986). "Milieu therapy is an essential part of every inpatient treatment program." Barton & Barton, 2 Mental Health Administration 552 (1983).

^{36/} See Gerten, Psychiatric Residents in a Milieu Participatory Democracy: A Resident's View, 135 Amer. J. Psychiatry 1392 (1978) (describing how psychiatrists felt threatened by milieu's demand that they give up traditional roles in interactions with patients).

only performed solely by psychologists averaged 88 days of inpatient stays; patients who received medications alone averaged 146 days of inpatient stays, and those who received combined psychotherapy and medication both administered by psychiatrists averaged 60 days of inpatient stays. For the next 20 months, the results were even more dramatic strongly favoring psychotherapy alone. From months 21-40, patients treated by psychologists doing psychotherapy alone averaged only 7.2 days in the hospital, patients treated by medication alone averaged 99.8 days, and patients given medication and psychotherapy by psychiatrists averaged 93.5 days.^{37/}

Finally, behavioral techniques developed by psychologists are highly effective means to deinstitutionalize chronic mental patients who have been hospitalized for lengthy periods. The most widely recognized such technique is a token economy program where patients receive tokens, like poker chips, when they engage in socially appropriate and rational behavior. "These programs safely teach community living skills and self-control over aberrant behavior through step-by-step learning with rewards for successful behavior." Levy, Improving Patient Care: Psychologist

^{37/} See B. Karon & G. VandenBos, Psychotherapy of Schizophrenia: The Treatment of Choice (1981); Karon & VandenBos, Cost/Benefit Analysis: Psychologists versus Psychiatrists for Schizophrenics, 7 Prof. Psychology 107 (1976).

Parity with Psychiatrists in Hospitals, 35 Clinical Psychol-
ogist 24 (1981).^{38/}

B. Psychologists As Independent Consultants in
Medical Treatment.

Behavioral medicine or medical psychology is a recog-
nized specialty in health care. It is concerned with the
integration of behavioral and biomedical science and the
cooperation between psychologists, scientists and physicians
in diagnosing and treating physical illnesses.^{39/} The field
stresses collaborative multidisciplinary efforts among

^{38/} In the most widely known study, 96.4% of chronic
mental patients in a token economy program were released
from the hospital into the community successfully although
they received no medication. In contrast, only 46.4% of
such patients whose sole treatment modality was medication
were released into the community. G. Paul & R. Lentz,
Psychosocial Treatment of Chronic Mental Patients (1977).
Similarly, another empirical study found that 72% of
patients who completed a token economy program and placed in
the community were still living outside the hospital three
years later. Fullerton, Cayner & McLaughlin-Reidel, Results
of a Token Economy, 35 Arch. Gen. Psychiatry 1451 (1978).
See also Liberman, Massel, Mosk & Wong, Social Skills
Training for Chronic Mental Patients, 36 Hosp. & Comm.
Psychiatry 396 (1985).

^{39/} See, e.g., Schwartz & Weiss, Behavioral Medicine
Revisited: An Amended Definition, 1 J. Behav. Med. 249, 250
(1978) ("The interdisciplinary field concerned with the
development and integration of behavioral and biomedical
science, knowledge and techniques relevant to health
diagnosis, treatment, and rehabilitation"); Gentry, Street,
Masur & Asken, Training in Medical Psychology, 12 Prof.
Psychology 224, 224 (1981) ("It refers to the cooperative
efforts between behavioral scientists and medical
practitioners in the diagnosis, treatment, and prevention of
physical illness and reflects an acceptance of the
importance of psychosocial factors in part or in whole to
aspects of physical illness").

independent professionals, not artificially-created dichotomies between professions.

A salutary benefit derived from these efforts is the consensus "that any number of physical diseases have psychological concomitants or specific syndromes associated with them." Pardes, Neuroscience and Psychiatry: Marriage or Coexistence? 143 Amer. J. Psychiatry 1205, 1210 (1986).^{40/} Further, even though a patient may suffer from a physical illness, the treatment of choice need not be physical at all. There are a number of diseases for which the primary intervention is psychological. And, for some physical diseases, there is no medical treatment available at all; in those cases psychological intervention is the sole choice. The effective use of psychologists in treating these diseases is demonstrable in a number of ways.

^{40/} Dr. Pardes is a recent president of the American Psychiatric Association. See Eisenberg & Jansen, Rehabilitation Psychologists in Medical Settings, 18 Prof. Psychology 475, 476 (1987) ("some behaviors exhibited by persons with disabilities, once considered strictly within the provinces of medicine and surgery because of their neurological etiologies, are amenable to modification by the methods of behavioral psychology"). See also Lipowski, Consultation-Liaison Psychiatry: An Overview, 131 Amer. J. Psychiatry 623, 625 (1974) ("medical training, with its emphasis on narrow specialization and purely biological aspects of disease, does not prepare physicians to recognize and deal with the influence of [psychosocial] factors on their patients.") [hereinafter Lipowski]; Wells, Golding, & Burnam, Psychiatric Disorder in a Sample of the General Population with and without Chronic Medical Conditions, 145 Amer. J. Psychiatry 976 (1988) (finding chronic medical conditions significantly associated with mental disorders).

For example, heart disease, which accounts for half of all deaths in America each day,^{41/} is preventable through psychological intervention. The risk of fatal or incapacitating heart disease can be minimized by reducing psychological stress,^{42/} and by treating the concomitants of stress such as smoking, drinking, and poor eating habits. In this regard, psychologists have developed a variety of techniques, such as relaxation training, biofeedback, and behavior modification, that help patients reduce stress, smoking, and obesity and increase physical fitness through exercise.^{43/} These techniques are not within the expertise of the general physician or psychiatric provider.

41/ See DHHS, Health United States 1980 (1980) (DHHS Pub. No. PHS 81-1232) [hereinafter DHHS Report].

42/ See M. Friedman & R. Rosenman, Type A Behavior and Coronary Heart Disease (1974). "[P]ersonality types A and B contribute to cardiovascular disease." Pardes, Neuroscience and Psychiatry, 143 *Amer. J. Psychiatry* 1205, 1210 (1986); Mitchell & Thompson, Research Problems for Consultation-Liaison Psychiatry in the DRG Era, 7 *Gen. Hosp. Psychiatry* 349, 349-350 (1985) ("[M]odest and inexpensive psychological interactions tended to shorten the length of stay of patients with acute myocardial infarction or following surgery.").

43/ See, e.g., Manuso, Psychological Services and Health Enhancement in Linking Health and Mental Health (A. Brokowski, E. Marks & S. Budman eds. 1981); Craighead, Brownell & Horan, Behavioral Interventions for Weight Reduction and Smoking Cessation in Behavior Modification: Principles, Issues, and Applications (W. Craighead, A. Kazdin & M. Mahoney 2d ed. 1981); Lichtenstein & Rodrigues, Long Term Effects of Rapid Smoking Treatment for Dependent Cigarette Smokers, 2 *Addictive Behav.* 109 (1977); Yates, Improving the Cost-effectiveness of Obesity Programs, 2 *Int'l. J. Obesity* 249 (1978); Wysocki, Iwata & Riordan, Behavioral Management of Exercise, 12 *J. Applied Behav. Analysis* 55 (1979).

For example, heart disease, which accounts for half of all deaths in America each day,^{41/} is preventable through psychological intervention. The risk of fatal or incapacitating heart disease can be minimized by reducing psychological stress,^{42/} and by treating the concomitants of stress such as smoking, drinking, and poor eating habits. In this regard, psychologists have developed a variety of techniques, such as relaxation training, biofeedback, and behavior modification, that help patients reduce stress, smoking, and obesity and increase physical fitness through exercise.^{43/} These techniques are not within the expertise of the general physician or psychiatric provider.

41/ See DHHS, Health United States 1980 (1980) (DHHS Pub. No. PHS 81-1232) [hereinafter DHHS Report].

42/ See M. Friedman & R. Rosenman, Type A Behavior and Coronary Heart Disease (1974). "[P]ersonality types A and B contribute to cardiovascular disease." Pardes, Neuroscience and Psychiatry, 143 Amer. J. Psychiatry 1205, 1210 (1986); Mitchell & Thompson, Research Problems for Consultation-Liaison Psychiatry in the DRG Era, 7 Gen. Hosp. Psychiatry 349, 349-350 (1985) ("[M]odest and inexpensive psychologic interactions tended to shorten the length of stay of patients with acute myocardial infarction or following surgery.").

43/ See, e.g., Manuso, Psychological Services and Health Enhancement in Linking Health and Mental Health (A. Broskowski, E. Marks & S. Budman eds. 1981); Craighead, Brownell & Horan, Behavioral Interventions for Weight Reduction and Smoking Cessation in Behavior Modification: Principles, Issues, and Applications (W. Craighead, A. Kazdin & M. Mahoney 2d ed. 1981); Lichtenstein & Rodrigues, Long Term Effects of Rapid Smoking Treatment for Dependent Cigarette Smokers, 2 Addictive Behav. 109 (1977); Yates, Improving the Cost-effectiveness of Obesity Programs, 2 Int'l. J. Obesity 249 (1978); Wysocki, Iwata & Riordan, Behavioral Management of Exercise, 12 J. Applied Behav. Analysis 55 (1979).

Next to heart disease and stroke, cancer kills most Americans. But, only one to two percent of cancers can be attributed directly to heredity with the rest attributable to smoking, environmental causes, diet, and alcohol consumption.^{44/} As with heart attacks, psychological intervention can treat excessive smoking, reduce alcohol intake, exposure to environmental carcinogens, and excessive stress that add to cancer risks.^{45/}

Psychological interventions have been shown repeatedly to speed recovery in both adults and children who undergo major surgery.^{46/} Group and individual therapy has shown promise for adjustment to mastectomy, leg amputation, and

^{44/} See DHHS Report, supra note 41. "[C]ertain psychosocial factors are clearly connected with a long life-span after the first diagnosis of cancer. . . ." Grossarth-Maticek, Social Psychotherapy and Course of Disease: First Experience with Cancer Patients, 33 Psychotherapeutic Psychosomatics 129, 134 (1980).

^{45/} See, e.g., Ashem & Donner, Covert Sensitization with Alcoholics: A Controlled Replication, 6 Behav. Res. & Therapy 7 (1968); Miller, Behavioral Treatment of Problem Drinkers, 46 J. Consulting & Clinical Psychology 74 (1978); Sklar & Anisman, Stress & Cancer, 89 Psychological Bull. 369 (1981).

^{46/} See, e.g., Streltzer & Leigh, Psychological Preparation for Surgery: The Usefulness of a Preoperative Psychotherapeutic Interview, 37 Hawaii Med. J. 139 (1978). A combination of instructions and training in self-management techniques developed by psychologists for children about to undergo surgery significantly increased postoperative food intake, reduced anxiety, and reduced parents' ratings of their anxiety, and improved parents' self-perceived competence. Peterson & Shigetomi, The Use of Coping Techniques to Minimize Anxiety in Hospitalized Children, 12 Behav. Therapy 1 (1981).

pelvic surgery.^{47/} Psychological techniques involving self-monitoring are more effective than simple instructions and reminders in increasing fluid intake to restore electrolyte balance in burn victims and a standard psychological procedure for phobia reduction has been adapted to patients' fears of hemodialysis.^{48/}

In addition to providing adjunct but necessary treatment in the prevention and amelioration of physical disorders, psychological treatment regimens have been developed and tested for a wide variety of physical disorders for which traditional medical treatments are ineffective. Psychologists have treated disorders of the neurological, respiratory, cardiovascular, genital, urinary, gastrointestinal, and dermatological systems.^{49/}

47/ See, e.g., Kerstein, Group Rehabilitation for the Vascular Disease Amputee, 28 J. Amer. Geriatrics Soc'y. 40 (1980); Lamont, De Petrillo, & Sargeant, Psychosexual Rehabilitation and Exenterative Surgery, 6 Gynecological Oncology 236 (1978); Witkin, Psychosexual Counseling of the Mastectomy Patient, 4 J. Sex & Marital Therapy 20 (1978).

48/ See, e.g., Sand, Fordyce & Fowler, Fluid Intake Behavior in Patients with Spinal-Cord Injury, 54 Arch. Physical Med. Rehabilitation 254 (1973); Katz, Single Session Recovery from a Hemodialysis Phobia, 5 J. Behav. Therapy and Experimental Psychiatry 205 (1974).

49/ See generally 1-3 Comprehensive Handbook of Behavioral Medicine (J. Ferguson & C. Taylor eds. 1980); Olbrisch, Psychotherapeutic Interventions in Physical Health: Effectiveness and Economic Efficiency, 32 Amer. Psychologist 761 (1977); Yates, How Psychology Can Improve Effectiveness and Reduce Costs of Health Services, 21 Psychotherapy 439 (1984).

For example, seizures for which no neurological basis could be found have been eliminated or reduced by psychologists using learning techniques and epileptic seizures are arrestible using biofeedback.^{50/} Debilitating migraine headaches are effectively treated by biofeedback and relaxation training.^{51/} Patients with chronic lung obstructions benefit from psychologically designed programs that produce more regular and intense exercise than other programs and are as cost-effective as medical treatments.^{52/} Although drugs are the treatment of choice for most cases of hypertension, psychological treatments for this cardiovascular problem have succeeded where drug treatments have failed.^{53/} Finally, eight sessions of a psychological treatment program significantly and substantially produced

^{50/} See Knapp & Peterson, Behavioral Management in Medical and Nursing Practice in Behavior Modification: Principles, Issues, and Applications (W. Craighead, A. Kazdin & M. Mahoney eds. 1976).

^{51/} See, e.g., Adams, Feuerstein & Fowler, Migraine Headache: Review of Parameters, Etiology, and Intervention, 87 Psychological Bull. 217 (1980); Harper, Wiens, & Hammerstad, Psychologist-Physician Partnership in a Medical Specialty Screening Clinic, 12 Prof. Psychology 341 (1981).

^{52/} See Atkins, Kaplan, & Timms, Behavioral Programs for Exercise Compliance in Chronic Obstructive Pulmonary Disease (November 1981) (unpublished manuscript available from San Diego State Univ.).

^{53/} See, e.g., Harrell, Psychological Factors and Hypertension: A Status Report, 87 Psychological Bull. 482 (1980).

fewer days of ulcer pain while reducing the amount of ulcer medication consumed.^{54/}

Most importantly, psychologists have contributed to the understanding and amelioration of physical diseases with little understood etiology and no known cure, as with Alzheimer's Disease and AIDS.^{55/} Traditional drugs exacerbate the symptoms of Alzheimer's Disease.^{56/} Psychologists have been helpful in providing cognitive retraining of patients with the disease and with developing innovative programs for counseling those who care for these

^{54/} See Brooks & Richardson, Emotional Skills Training: A Treatment Program for Duodenal Ulcers, 11 Behav. Therapy 198 (1980).

^{55/} Crook & Miller, The Challenge of Alzheimer's Disease, 40 Amer. Psychologist 1245, 1240 (1985) ("psychologists . . . can contribute significantly to solving the complex problems associated with the etiology, course, and treatment of A[lzheimer's] D[isease]"); Heckler, The Fight Against Alzheimer's Disease, 40 Amer. Psychologist 1240, 1243 (1985) ("There is a growing need for psychologists . . . to develop model support programs, to train caregivers to utilize psychological interventions that have proven successful, and to counsel patients and their families").

Patients with AIDS develop neurological and psychological symptoms that can be ameliorated even though there is no effective treatment for the underlying immune deficiency. But the anxiety, anger, depression, and suicidal ideation common in AIDS patients are treatable by psychotherapy and behavioral stress reduction. See Backer, Batchelor, Jones & May, Psychology and AIDS, 43 Amer. Psychologist 835 (1988); Faulstich, Psychiatric Aspects of AIDS, 144 Amer. J. Psychiatry 551 (1987) [hereinafter Faulstich]; Morin & Batchelor, Responding to the Psychological Crisis of AIDS, 91 Pub. Health Ref. 4 (1984); Morin, Charles & Malyon, The Psychological Impact of AIDS on Gay Men, 39 Amer. Psychologist 1288 (1984).

^{56/} Crook & Miller, supra note 55, at 1247.

patients.^{57/} And while there is no cure for AIDS, "supportive intervention may be quite effective in helping the patient establish structure and set comfortable limits on daily activities, . . . decrease hypochondriacal preoccupations, [and] reduce self-destructive acts. . . . Psychotherapy can also help provide a surrogate relationship to diminish the profound alienation that often accompanies this disease." Perry & Jacobsen, supra note 25, at 141.^{58/}

In sum, psychologists serve as effective independent professionals in hospital settings.^{59/} It would be wasteful

^{57/} Id.

^{58/} "Supportive psychotherapeutic approaches should involve issues such as . . . possible social isolation, and acknowledgement of the illness and any associated fear and anger. Provision of stress-management and problem-solving procedures could also be of benefit to these patients. [B]ehavioral stress reduction techniques have also been advocated." Faulstich, supra note 55, at 554. See Kiecolt-Glaser & Glaser, Psychological Influences on Immunity, 43 Amer. Psychologist 892 (1988). In addition, the "contribution of behavioral scientists is central in the prevention of AIDS and HIV infection. Because there is no effective vaccine, psychosocial models may provide the only tools to stem the spread of AIDS." Baum & Nesselhof, Psychological Research and the Prevention, Etiology, and Treatment of AIDS, 43 Amer. Psychologist 900 (1988).

^{59/} In a major study of the effectiveness of psychological consultation, the vast majority of physicians judged that psychologists provided valuable services such as conducting mental status examinations (98.7%), arranging transfers to psychiatric wards (87.3%), assisting in ward management of medical patients (97.5%), and the evaluation of the interaction of psychological factors and organic illness (93.7%). Over 96% said that they wanted psychological consultation available in more medical and neurological settings, almost 90% agreed that psychological factors were important in understanding the etiology of medical and neurological diseases, and 100% stated that

(Footnote Continued)

of scarce health care resources if clinical psychologists were not permitted to participate, as independent professionals, in the diagnosis and treatment of all patients.

V. THE RECOGNITION OF PSYCHOLOGISTS AS INDEPENDENT PROFESSIONALS SERVES A NUMBER OF PROCOMPETITIVE PURPOSES INCLUDING LOWERED HEALTH CARE COSTS AND MORE EFFECTIVE COLLABORATION AMONG MENTAL HEALTH PROVIDERS WITHOUT ANY HARM TO PATIENT CARE.

- A. Physicians, Particularly Psychiatrists, have Historically Made and Continue to Make Attempts to Preclude Psychologists from Participating as Members of Hospital Staffs.

Recognition of psychologists as independent health care providers and coequal members of hospital staffs has met with strenuous opposition from physicians in general and psychiatrists in particular. Psychiatrists view their "territory" as being "assailed from every side" by psychologists and view economic competition as threatening. Province of Psychiatry Questioned, Said to Need Defining, Clinical Psychiatry News, Nov. 1977, at 1.^{60/}

(Footnote Continued)

psychological factors were important in the treatment of these diseases. Schenkenburg, Peterson, Wood & DaBell, Psychological Consultation/Liaison in a Medical and Neurological Setting: Physicians' Appraisal, 12 Prof. Psychology 309, 313-314 (1981); See also Gabinet & Friedson, The Psychologist as Front-Line Mental Health Consultant in a General Hospital, 11 Prof. Psychology 939 (1980) (describing success of psychologist-consultant to wide variety of medical wards, explaining why psychologists have greater success than psychiatrists).

^{60/} It is noteworthy that appellate court review was not instigated by the original defendants, a state agency, but by a conglomerate of physician and hospital associations and practitioners whose major purpose in this litigation is

(Footnote Continued)

The oft-stated policy of the American Psychiatric Association is to do everything possible to keep psychologists and other professionals in a subordinate role under the direction of physicians/psychiatrists.^{61/} One example of this effort is the attempted "remedicalization" of psychiatry, i.e., an attempt to define all treatment of mental health problems as "medical treatments."^{62/} An official of the American Psychiatric Association has described the effects of the process as follows:

Medical care becomes equated with health care. This brings psychiatry back into the mainstream of the medical establishment, because the equation of medical care with health care is the basis on which organized medicine claims the right to exert control over the total health-care industry.^{63/}

(Footnote Continued)

to ensure that psychologists do not serve as independent professionals.

61/ See, e.g. Position Statement on Hospital Privileges for Psychologists, 128 Amer. J. Psychiatry 1456 (1971); Position Statement on Psychiatrists' Relationship with Non-Medical Mental Health Professionals, 130 Amer. J. Psychiatry 386 (1973); Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry, 130 Amer. J. Psychiatry 1058 (1973); Position Statement on Administration of Psychiatric Facilities, 133 Amer. J. Psychiatry 604 (1976); see also Guidelines of Psychiatrists in Consultative, Supervisory, or Collaborative Relationships with Nonmedical Therapists, 137 Amer. J. Psychiatry 1489 (1980).

62/ For example, the fourth edition of A Psychiatric Glossary (American Psychiatric Association 1974) introduced a new term, "medical psychotherapy." Advertising material emphasized this "new definition will be helpful to psychiatrists in relation to the third-party payment problem."

63/ Tension Rising Between Psychology, Psychiatry,
(Footnote Continued)

Despite these attempts, psychologists, as amici have shown, are now recognized as fully qualified to assess and diagnose mental disorders, including those organic in origin, and have been acknowledged repeatedly to be competitors of psychiatrists and independent providers of mental health services in federal, state, and private third-party reimbursement plans.^{64/}

Several bureaus of the Federal Trade Commission have commented on the procompetitive advantages of hospital

(Footnote Continued)

Clinical Psychiatry News, Nov. 1977, at 1 (summarizing remarks of director of membership services of American Psychiatric Association). See Pasnau, The Remedicalization of Psychiatry, 38 Hosp. & Comm. Psychiatry 145, 151 (1987) ("Psychiatry's future as a medical specialty will . . . depend on how psychiatry's role is defined. If it is defined as a specialty that diagnoses, treats, and studies disturbance of mental processes caused by organic dysfunctions of the brain . . . or caused by psychosocial and environmental stressors, psychiatry's future as a medical specialty is assured").

64/ See, e.g., Blue Shield of Virginia v. McCready, 457 U.S. 465 (1982); Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia, 624 F.2d 476, 485 (4th Cir. 1980), cert. denied, 450 U.S. 960 (1981) ("The record demonstrates that psychologists and psychiatrists do compete; indeed it is susceptible to judicial notice."). See also Point I, infra.

In fact, if the state action doctrine did not arguably exempt such conduct in this case, the denial of hospital privileges to an entire class of qualified licensed psychologists by the concerted agreement of medical practitioners and hospital administrators would violate the antitrust laws. See, e.g., Bersoff, Hospital Privileges and the Antitrust Laws, 38 Amer. Psychologist 1238 (1983); Dolan & Ralston, Hospital Admitting Privileges and the Sherman Act, 18 Houston L. Rev. 707 (1981); Rich, Medical Staff Privileges and the Antitrust Laws, 2 Whittier L. Rev. 667 (1980); Note, Denial of Open Staff Privileges: An Antitrust Scrutiny, 26 St. Louis Univ. L. Rev. 752 (1982).

privileges for health care professionals. They asserted that the resulting "competition should benefit consumers by offering choices and treatment alternatives to patients."^{65/} They further stated that these treatment alternatives could be offered "at prices that might otherwise be unavailable" and testified that the increased availability of qualified providers could "have a beneficial effect on health care generally."^{66/}

The arbitrary compartmentalization of services advocated by physicians and blithely accepted by the court below is

^{65/} Comments by the Bureau of Competition, Bureau of Consumer Protection, and Bureau of Economics of the FTC to the Board for Licensing Health Care Facilities of the State of Tennessee at 1 (Nov. 19, 1982).

^{66/} Id. at 2. The FTC's assertions have proven correct. Mental health professionals, including the use of independent psychological consultants in medical settings, "actually results in lower total health care utilization and costs for treated persons . . . even when the cost of mental health care itself is included." Holder & Blose, Changes in Health Care Costs and Utilization Associated with Mental Health Treatment, 38 Hosp. & Comm. Psychiatry 1070, 1070 (1987) (study of 27,000 families showed inpatient days per month dropped from .63 days before treatment to .52 days in first year after treatment to .39 days in following year. Inpatient costs dropped from \$167 to \$133 to \$106 in the same period.) See Mitchell & Sherman, Psychiatrist Behavior under Mental Health Insurance Regulation (1984) (research report submitted to Nat'l. Inst. Mental Health by Health Economics Research, Inc. on file with APA) (psychiatrists' fees less in freedom of choice states permitting patients to choose psychologists as well as psychiatrists as mental health providers; see Point I(B)). See also Mumford, Schlesinger & Glass, Effects of Psychological Intervention in Recovery from Surgery and Heart Attacks, 72 Amer. J. Pub. Health 141 (1982) (psychological intervention reduced hospitalization by two days below control group); Yates, How Psychology Can Improve Effectiveness and Reduce Costs of Health Services, 21 Psychotherapy 439 (1984).

at variance with the thinking of thoughtful observers and the data. When the American Psychiatric Association published its model civil commitment law excluding psychologists as an authorized professional able to certify the need for emergency psychiatric treatment and to participate in other legal proceedings involved in the civil commitment process,^{67/} it was severely criticized by both lawyers and psychiatrists.^{68/} The criticism was warranted because there are no data to support psychologists' exclusion, and there

^{67/} Stromberg & Stone, A Model State Law on Civil Commitment of the Mentally Ill, 20 Harv. J. Legis. 275 (1983).

^{68/} See, e.g., Zusman, APA's [Amer. Psychiatric Ass'n.] Model Commitment Law and the Need for Better Mental Health Services, 36 Hosp. & Comm. Psychiatry 978, 980 (1985):

One final aspect of the model law with which I strongly disagree is its authorization of nonpsychiatric physicians but not psychologists [to admit and otherwise participate in civil commitment proceedings]. Aside from the facts that the provision is against the trend, is likely to be ignored by states, and inflames our fellow mental health professionals with whom we should be working, the action is completely wrong. . . . Does anyone really believe that the average orthopedist or cardiologist has a better background in mental disease, mental health law, and mental health services than the average doctoral-level clinical psychologist?

Dr. Zusman is a professor of psychiatry who has practiced in New York, Florida, and California.

Wexler, APA's Model Law: A Commitment Code by and for Psychiatrists, 36 Hosp. & Comm. Psychiatry 981, 981 (1985) ("the model law gives only physicians clinical authority to hospitalize, unwisely ignoring the critical role that can and should be paid in the commitment process by nonphysicians"). Prof. Wexler is professor of law at the University of Arizona.

are, in fact, data to the contrary. The most recent study reviewed over 8000 mental health evaluations of patients seen in an emergency room over a 15 month period. The evaluations were conducted by nine doctoral level psychologists, three fully trained psychiatrists, and six psychiatric residents. There were no differences in diagnostic or referral patterns among the groups, including the diagnoses of organic disorders. The author concluded:

The exclusion of psychologists in the American Psychiatric Association's model commitment law was not supported by these findings Experienced psychologists appear as competent as psychiatrists and psychiatry residents, and possibly more competent than physicians, in the emergency "psychiatric" evaluation process. These results suggest that emergency room psychologists and psychiatrists should have equal rights and privileges in regard to the decision to hospitalize "psychiatric" patients.

Wood, Commitment Code Revision's Effect on Psychologists' and Psychiatrists' Decision to Hospitalize, 19 Prof. Psychology 58, 60 (1988).

To support their arguments against hospital privileges for psychologists, psychiatrists seek to promote the false impression that what they do is uniquely different from psychologists and that only they can provide total care for patients. Unfortunately that view is reinforced by the appellate court's opinion. But, like so many other aspects of that opinion, it is not supported by the data.

The most extensive study of mental health services provided by psychologists and psychiatrists was conducted

using CHAMPUS data,^{69/} the largest health plan in the United States. The data gleaned from this study are particularly relevant as almost one-quarter of CHAMPUS providers are in California. The author studied both outpatient and inpatient visits. With regard to outpatient visits, psychiatrists and other physicians "billed for procedures exclusive to them by license in only about 1 out of 200" cases.^{70/} With regard to inpatient visits, "only about 3 percent of psychiatric visits for . . . care in mental disorders involved procedures that could be provided only by a licensed physician." Id. As significant is the fact that psychologists' fees for these visits were from \$1.50 to \$6.50 less per hour than psychiatrists. Id. at 80-81.

Why psychiatrists are so strongly opposing hospital privileges for psychologists may be reflected in earnings they derive from providing inpatient care. The CHAMPUS data show that for fiscal years 1980 and 1981, psychologists as a group earned about \$504,000 from services provided to

^{69/} Dorken, The Expanding Role of Clinical Psychology in Mental Health Services: The CHAMPUS Experience in Professional Psychology in Transition 69 (H. Dorken & Assoc. eds. 1986).

^{70/} Id. at 77. "Thus, despite the considerable emphasis politically and interprofessionally on the essential and pivotal role of psychiatry and medicine in the treatment of mental disorders, . . . for over 99 percent of outpatient visits to psychiatrists, those services were within the scope of practice of some nonphysician providers. . . . [T]he extent of overlap between . . . psychiatrists and psychologists in services actually rendered is the overwhelming fact. . . . Id.

mentally ill inpatients. In contrast, psychiatrists earned over \$11,000,000. Id. at 89.^{71/}

- B. The Full Recognition of Psychologists as Independent Professionals Supports Patients' Health Care Interests and Furthers Effective Collaboration Among All Mental Health Providers.

No patient admitted to the hospital, whether by a psychiatrist or psychologist, will fail to receive a medical examination. Both providers, as a result of their ethical principles, see text at 9-10, and California's regulatory scheme, will make sure to rule out any physical anomaly that might mask an emotional disorder by referral to and consultation with a qualified physician. See, e.g., Cal. Admin. Code tit. 22 §§ 70577(e)(1)(2); 70707(d); 70717(d); 71203(a)(3)(B-C); 71517(d); 77073.^{72/}

The appellate court's opinion and that of the moving parties is at variance with the Joint Commission on

^{71/} "In round numbers, this \$10 million advantage to psychiatry from one program in one year is some explanation for the degree to which organized psychiatry is resisting the acquisition of hospital medical staff privileges by psychologists across the country." Id. at 88. In California, psychiatrists provided 89.3% of inpatient care; psychologists only 5.9%. Id. at 90-91. From a purely competitive viewpoint, it is clear why Cal. Health & Safety Code § 1316.5 was necessary.

^{72/} "[P]sychologists and psychiatrists function in much the same manner regarding the types of services they provide. Each refers to medical specialists for the physical problems of their patients and is responsible for the provision of psychotherapy." Tanney, Hospital Privileges for Psychologists, 38 Amer. Psychologist 1232, 1235 (1983).

Accreditation of Healthcare Organizations (JCAHO).^{73/}

JCAHO's mission is to ensure that patients receive quality care and service in organized health care settings. Admittedly bowing to antitrust concerns,^{74/} JCAHO amended its Accreditation Manual for Hospitals (1987) in 1984 so that the restriction of hospital privileges to physicians and dentists would be lifted. The Medical Staff Standards now state that the medical staff "includes fully licensed physicians and may include other licensed individuals permitted by law and by the hospital to provide patient services independently in the hospital." Id. at 109 (MS.1.1). Privileges no longer depend solely on degree but are granted on the bases of licensure, relevant training and experience, and current competence. Id. at 110 (MS.1.2.3.1.2.2).^{75/}

Like California's regulations, the JCAHO Accreditation Manual clearly contemplates that all patients admitted to hospitals have "a history taken and a comprehensive physical

^{73/} JCAHO, formerly the Joint Commission on Accreditation of Hospitals (JCAH), is nonprofit corporation sponsored by the American College of Physicians, American College of Surgeons, the American Dental Association, and the American Medical Association.

^{74/} See Widmann, Recent Changes in JCAH Standards Affecting the Accreditation of Psychiatric Facilities, 35 Hosp. & Comm. Psychiatry 1211, 1213 (1984).

^{75/} See also 42 C.F.R. § 482.12(c)(2). These regulations under Medicare specifically provide that patients may be admitted to hospitals by "licensed practitioners permitted by the State to admit patients to a hospital."

examination performed by a physician who has such privileges." Id. at 120 (MS.4.3.3). Physicians opposed to hospital privileges for psychologists, like the appellate court, overlook the interplay of all these safeguarding provisions in California law, federal statutes, accreditation standards, and ethical principles. They create the spurious spectre of inadequate medical care. Medical care is ensured.

Psychologists and psychiatrists (and other physicians) serve their patients best when they collaborate, not act in conflict. "The political and economic rivalry between psychology and psychiatry, along with internal identity conflicts, brings disruptive tension to interprofessional work relationships." Berg, Toward a Diagnostic Alliance Between Psychiatrist and Psychologist, 41 Amer. Psychologist 52, 52 (1986). Over a decade ago, a psychologist and psychiatrist writing together, expressing concern "about the lack of unity and amity between our professions," reminded readers that "[n]either discipline is so unusual that it should have exclusive control over the delivery of mental health care." Wallace & Rothstein, Toward a Reconciliation Between Psychiatry and Clinical Psychology, 28 Hosp. & Comm. Psychiatry 618, 618 (1977). Since then a number of

collaborative efforts have been described in the mental health literature.^{76/}

The appellate court, unaided by a factual record or precedent, and without analyzing the plethora of other state and federal statutes and regulations, singlehandedly converted the cooperative but independent relationship contemplated by § 1316.5 into a conclusive presumption that psychologists are incompetent to diagnose or develop treatment plans for patients who may be suffering from mental illnesses or diseases organic in origin. But the appellate court's decision has no rational basis, unreasonably discriminates against psychologists, disservices the public interest, unduly interferes with patients' rights, and is in sharp conflict with current and accepted practice.

CONCLUSION

This Court has the opportunity to redress the inappropriate judicial activism engaged in by the court below and reinstitute a rule that fully comports with the intent of this State's legislature as reflected in Cal. Health & Safety Code § 1316.5 and Cal. Bus. & Prof. Code § 2900 et seq. That rule would hold that psychologists are fully able to practice as independent and autonomous health

^{76/} See, e.g., Berg, Toward a Diagnostic Alliance Between Psychiatrist and Psychologist, 41 Amer. Psychologist 52 (1986); Froese, Kamin & Levine, Teamwork: A Multidisciplinary Pediatric-Liaison Service, 7 Int'l. J. Psychiatry in Medicine 47 (1976-77); Mindell, The MD-Therapist Connection, Amer. Med. News, Feb. 12, 1988.

care professionals in hospital facilities in carrying out their roles as skilled diagnosticians and treaters of patients with psychological problems and emotional, mental and organic disorders and, that consistent with their ethical and legal responsibilities, they refer patients to physicians for appropriate physical examinations upon admission of their patient to the hospital.

For all the foregoing reasons, amici APA and CSPA respectfully urge this Court to reverse the decision below.

Respectfully submitted

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