The historical record of psychiatry speaks clearly and loudly: the leaders of this fake medical discipline have a powerful penchant for prevarication and pomposity and are guilty of systematically imprisoning individuals innocent of lawbreaking. I believe, therefore, that my influence is due not to the failings attributed to me by Professor Roth, but to the fact that I tell the truth, call a spade a spade, eschew medicalized coercion, and am willing to defend, in court and out, the victims of psychiatric violence.

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1. See, for example, SZASZ, T. S. (1973) *The Second Sin.* Garden City, N.Y.: Doubleday Anchor; London: Routledge, 1974; and SZASZ, T. S. (1976) *Heresies.* Garden City, N.Y.: Doubleday Anchor.
2. SOLZHENITSYN, A. (1976) *Warning to the West.* New York: Farrar, Straus and Giroux.
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4. Quoted in: Hints on the chemical nature of schizophrenia. *The New York Times,* 7 November 1976, p E-7.
5. MENNINGER, K. M. (1976) Reading notes. *Psychiatric News,* 5 November 1975, p 8.
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PRENATAL PROGESTERONE

DEAR SIR,

I refer to Katharina Dalton's article in the *Journal,* November 1976, **129,** p 438, 'Prenatal progesterone and educational attainments'. There seems good evidence for the statement that 'pre-eclampsia is overwhelmingly a disease of the first pregnancy' (1). There is also some evidence that first-born excel in educational attainments (2). Might not these factors be a partial explanation for the findings of increased educational attainment in children who had been exposed *in utero* to progesterone as treatment for their mothers' pre-eclampsia? It would be interesting to know how many of Katharina Dalton's sample were first-born.

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'ANOTHER STYLE OF PSYCHOGERIATRIC SERVICE'

DEAR SIR,

Drs Baker and Byrne (*Journal.* February 1977, **130,** pp 123–6) are to be congratulated on the development of their psychogeriatric day services. These developments are desirable, but the authors' conclusions, we feel, are misconceived.

We think that they have presented an incomplete picture, and it is unfortunate that in making such far-reaching recommendations no reference is made to other published reports in this same field.

There is no mention of joint assessment of patients by Psychiatrist and Physician in Geriatric Medicine, or reference to the number and type of hospital beds and other facilities provided by General and Geriatric Medical services in the area. There is no mention of the provision of residential accommodation by the Local Authority Social Services Department, nor of its policy with regard to the mentally frail. These omissions are vital to the argument, since Andrews and his colleagues have clearly shown that in providing for the elderly it is the *total* provision of specialized accommodation that matters, including that provided in hospital by the General Medical, Geriatric and Psychiatric services as well as in residential homes.

Implicit in the report is a high degree of selectivity of patients to be admitted, in that, according to the authors, plans for discharge within a few weeks are agreed prior to admission.

In most areas of the country there are large numbers of elderly patients with predominantly psychiatric disorders who, even with the most sophisticated community services, still require twenty-four hours care and supervision.

Is it possible that in Gloucestershire the geriatric and other hospitals are providing the care for these patients, who appear to be ignored in this report? Indeed, AHA hospital statistics indicate that there is a relatively generous provision of such beds in the Cheltenham and Gloucester area.

Only 5 per cent of admissions, a remarkably low figure, are discharged from the in-patient beds to 'other' unspecified hospitals. If we compare these claims with previous published studies of hospital