be increased during oral contraceptive treatment¹; the authors conclude that the level of the observed drug interaction remains to be clarified.

We have recently studied prothrombin complex activity in female rats treated with an oestrogen-progestogen combination (lynestrenol, 5 mg, and mestranol, 0.3 mg/kg body weight) at the lowest concentration which gave 100% infertility in this species. The Normotest clotting time was already significantly ($p < 0.001$) longer in oral-contraceptive-treated (37.7 ± 0.5 sec) than in control rats (31.0 ± 0.4) after treatment for only one oestral cycle, and the difference was even more marked after treatment for 10 cycles.²

Although, to our knowledge, a similar finding has not been reported in women on the pill, it could well be that only in special conditions, such as during anticoagulation, does the oestrogen-induced "lability" of the prothrombin complex, clear as such in rats, become apparent in humans. Alternatively, liver dysfunction, known to occur in women on the pill,³ could account for reduced metabolism of warfarin, thus making the anticoagulation more effective. Clinical pharmacology studies are warranted to substantiate hypotheses about the interesting interaction between oral anticoagulants and oral contraceptive drugs.

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¹ Poller L. *Br Med Bull* 1978;34:151-6.

² Roncaglioni MC, Pangrazzi I, Donati MB. *Thromb Haemost* 1980; in press.

³ Anonymous. *Br Med J* 1974;iv:430-1.

Psychoanalysis, psychotherapy, and health services

SIR,—Professor M Shepherd in his article "Psychoanalysis, psychotherapy, and health services" (15 December, p 1557) ends by commenting on the difficulty of validating the therapeutic claims of psychoanalysis. I suggest that this is not difficult but impossible and that the impossibility is inherent in any system of medicine that is exclusively dynamic in outlook.

This is an age-old problem and is illustrated by the experience of the German scientific school in the mid-nineteenth century. The Germans revolted against the sterile nihilism into which the French school had fallen. True, this school had classified many chronic illnesses on the basis of morbid anatomy and displayed a prognosis where there was little or none before. But it offered so little hope of cure that it was summarised by the sour comment that the acme of medicine was a diagnosis by Skoda confirmed at postmortem by Rokitansky. The Germans' slogan was "We want to cure, not classify." They pointed out that a knowledge of the pathogenesis of a patient's illness would reveal a chain of events in which some links might be seen to be breakable, and thereby suggest remedies. The last 100 years have shown how right they were; but success depended on one condition they soon found they had to accept, and that was that a classification had to be preserved if chaos was to be avoided. Psychoanalysis is a similar dynamic system, but the discipline of classification was ignored.

The argument is as follows. The effect of a cure cannot be judged unless it is known what would have happened without it. The only way of knowing what treatment has done to patient Z is to compare his state with patients A to Y, untreated, who had the same thing. "Having the same thing" is, of course, a classification, separating one group of patients from all others on the basis of criteria presumed to have some biological meaning. Hence the paradox that a nosological system can validate cures it cannot suggest while a dynamic system can suggest cures it cannot validate. The sterility of pure nosology is obvious enough to be a source of public mockery. The danger of the second is that hopeful therapy slides into unchecked fantasy, all the more beguiling because of its activity and seeming rationality.

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Antenatal diagnosis

SIR,—Your contributors Barbara J Culliton and Wallace K Waterfall, discussing antenatal diagnosis (8 December, p 1488), state that the alarming increase in the caesarean section rate in the USA must be attributed not to fetal monitoring but rather to more cases of cephalopelvic disproportion.

This does not sound plausible unless (a) obstructed labours were widely neglected prior to the increase in the section rate (surely unlikely); (b) an environmental factor has suddenly caused a considerable increase in the prevalence of acquired pelvic contraction (surely unlikely); or (c) the criteria for making a diagnosis of cephalopelvic disproportion have changed. It is naive to suppose that such a change in criteria would not have been influenced by fetal monitoring.

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An ABC of medical prejudice

SIR,—It seems Dr A Paton (22-29 December, p 1652) needs a geriatrician to rehabilitate patients he has treated. So why does he want to abolish geriatricians?

I wish him a happier New Year.

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Unwillingly to school

SIR,—Those of us who work with children will have been struck by the sense and sensibility manifest in Dr G F Goddard's special article (5 January, p 21). That most children don't like school most of the time has been obvious since Shakespeare drew our attention to the phenomenon ("creeping like snail unwillingly to school"); that their dislike may be based on something more than laziness and original sin has been pointed out by our greatest imaginative writers, Wordsworth ("shades of the prison house"), Blake, and Dickens among them; and that schools themselves are more than partly to blame for their inadequacies is obvious from Rutter's recent study.¹

Could I make three comments? The first is that before extending the school age down-

wards as we have—often disastrously—upwards we should make sure that our schools can cope with their present load. There are sensitive, imaginative, inspiring, and competent teachers but the supply is limited, as it is of adequate baby minders. The second is that, given ordinary good parents and potentially normal children, there is no place like an ordinary good home for rearing young children and that those who don't relish the commitment involved don't have to take on the responsibility; there is always contraception or, for those who feel that the world needs their DNA, adoption in an already overpopulated world. Freedom to reproduce as the fancy takes one should be limited by consideration of the limitations on the freedom of the resultant children which irresponsible parents unwittingly impose, and which ultimately limits the freedom of all of us. Thirdly, should we now not give some consideration to Winnicott's suggestion² that we create two kinds of school—one for the deprived, whatever their intelligence quotient, which would be primarily therapeutic, and one for ordinary children, which would be primarily concerned with education in its academic sense? There would then, I hope, be no question of removing children from good homes for the sake of their academic education.

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¹ Rutter M. *Fifteen hundred hours: secondary schools and their effects on children*. London: Open Books, 1979.

² Winnicott D. *The child, the family and the outside world*, ch 30. Harmondsworth: Penguin, 1964.

SIR,—Devotees of the apparently realistic BBC series *Grange Hill* could not fail to identify the source of "sarcasm, rudeness, . . . threats of violence, and physical violence" not only with children's peers, as Dr G F Goddard describes in his interesting personal paper (5 January, p 21), but also with the controlling adults—whether teachers or others. While we must not neglect the commercial implications, perhaps the words of the present most popular record may have some relevance to Dr Goddard's theme: ". . . no dark sarcasm in the classrooms . . . teachers leave those kids alone (Pink Floyd, "Another Brick in the Wall").

Given the contrived phenomena of schools it seems inevitable that the actions of adults—unchecked by normal social restraints, suspended for adults only on the threshold of the schools—could provide in some instances a more influential, even if less feared, model of poor behaviour, which cannot assist the management of children en masse. It was this latter aspect which Dr Goddard identified as the major problem associated with his referrals.

It is said that teachers receive little practical advice on achieving discipline in the classroom¹; in 1965 the majority of those teaching psychology in colleges of education had not experienced formal teaching themselves in that subject.² One can only commiserate with the individual teacher, and also wonder whether the still-entrenched reliance on physical punishment in British schools has compromised the attempts of young teachers to learn (with appropriate higher support) the art of control without resort to violence—the implied use of which, as a last or first resort, renders sterile the communication