there are still differences in the incidence of duodenal ulcer between non-secretors of different ABO blood groups. Nevertheless, it is surely worth bearing in mind the chemical nature of the mucus in gastric juice, which varies according to the blood group and secretor status, when considering the relationship between blood groups and the liability to develop peptic ulcer.

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1 Watkins, W M, *Biochemical Society Symposia*, 1974, 40, 125.

Prison control units

SIR,—Your leading article entitled "Cruel treatment" (9 August, p 337) states that the World Medical Association at its forthcoming meeting in Tokyo will consider a draft declaration providing "guidelines for medical doctors concerning torture and other cruel, inhuman, or degrading treatment or punishment in relation to detention and imprisonment." In connection with this we would like to raise the issue of the involvement of doctors in Britain in the allocation of prisoners to and their supervision within control units in prisons.

It has recently come to light in the press¹ that the control unit at Wakefield Prison is still in use. Control units in British prisons have been a controversial issue since their establishment at Wakefield and at Wormwood Scrubs in 1974. The units were designed "to provide a strict régime for the control of intractable troublemakers." By "intractable troublemaker" the Home Office means any prisoner "having the actual capacity to encourage, persuade, or coerce fellow prisoners to join in the challenge to authority."² Such challenges have included protests about prison food, sanitation, the failure to deliver personal mail, and the parole system.

For the first 90 days the prisoner in the control unit spends 23 hours of the day in solitary confinement and is allowed one hour's exercise. He is not permitted to speak to other prisoners and the warders say the minimum necessary. During the second 90 days limited mixing with other prisoners in the control unit is permitted. If the prisoner offends at any stage during the 180 days he returns to day one and starts the period again.³ This régime constitutes a form of prolonged sensory deprivation such as has been shown to result in the development of psychotic disturbance.³ After a spell in one of these units Mr Walter Probyn (founder of the Prisoners' Human Rights Committee) described symptoms of dizziness and disorientation, with difficulty in comprehending even the simplest conversation. There followed a six-month campaign by penal reform groups and criminologists against this stringent system of deprivation and punishment. At the same time attention was drawn to the Home Office's failure to defend or indeed explain its policies publicly. Early this year the Home Office stated that it intended to close the units. However, it has now emerged that three prisoners have been in the special punishment block at Wakefield since 22 May.¹

As members of the medical profession we are concerned at the possible abuse of professional ethics by doctors and psychiatrists lending their services to keep control units running. A prisoner must be passed as mentally and physically fit by a prison medical officer before he is allocated to the unit, and doctors are responsible for supervising his general mental and physical welfare while he remains there. How far a doctor is justified in certifying that a person is fit to undergo punishment which may have deleterious effects on his health is indeed a matter for debate. However, considering that a doctor's role is fundamentally that of relieving suffering, curing illness, and promoting and maintaining good health, it seems ironic, if not a direct transgression of our ethical premises, to be certifying any person as fit to withstand conditions which are likely to be severely detrimental to his future well-being. We are not simply suggesting that doctors make a protest on this particular issue; rather that they reject a situation which is blatantly incompatible with their code of practice.

We hope that the World Medical Association in its forthcoming declaration will condemn medical participation in such cruel and inhumane forms of punishment. Further, we would urge that the profession in Britain should lend its support to the groups campaigning for the closure of these units.

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1 *Guardian*, 11 September 1975, p 22.

2 Prison Department Circular Instruction 35/1974 (PDG/68 174/4/85 17/6/74).

3 Shallice, T, *New Scientist*, 1974, 64, 666.

Diarrhoea and colitis associated with antibiotic therapy

SIR,—With reference to the letter from Mr A R Crapp and others (26 July, p 227) we have estimated the incidence of diarrhoea and colitis in 1158 orthopaedic inpatients,¹ a group in which lincomycin and clindamycin are likely to be the drugs of choice since both antibiotics penetrate bone.^{2,3} The records of all admissions to the orthopaedic wards of the Guy's group of hospitals were examined for evidence of diarrhoea and colitis between January 1973 and August 1974, a period which covered the time before, during, and after the association of pseudomembranous colitis with lincomycin and clindamycin was recognised in the United Kingdom. The results are shown in the table.

The commonest causes of diarrhoea in this

population were lincomycin (22.2%), ampicillin with cloxacillin (17.2%), and clindamycin (15.3%). There were three cases of colitis (parenteral lincomycin two, clindamycin one). The low incidence of colitis (3.4%) following lincomycin and clindamycin as both separate and combined therapy justifies their continued use in orthopaedic practice.

We should like to draw attention to the use of cholestyramine⁴ in the treatment of colitis associated with lincomycin and clindamycin. This rapidly aborts the course of this condition. We have recently shown that simultaneous administration of cholestyramine with clindamycin does not impair the absorption of this antibiotic.⁵ Thus the development of colitis does not necessarily preclude the further use of lincomycin or clindamycin in a patient in whom these are the antibiotics of choice.

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1 Beavis, J P, *et al*, *British Journal of Surgery*. In press.

2 Grady, D C, and Stern, K F, *Antimicrobial Agents and Chemotherapy*, 1965, 5, 201.

3 Vacek, V, *et al*, *Chemotherapy*, 1972, 72, 22.

4 Burbidge, E J, and Milligan, F D, *Journal of the American Medical Association*, 1975, 231, 1157.

5 Parsons, R L, *et al*, *Proceedings of the 9th International Congress of Chemotherapy*. In press.

Use of bacteriological investigations by general practitioners

SIR,—The paper by Dr R J Taylor and others (13 September, p 635) seems to have been written "from the inside looking out" in spite of having two authors from general practice. May I be allowed to comment from the outside?

The single most important factor in this problem was omitted from the paper—that is, the percentage of positive results obtained from material submitted for bacteriological examination. From discussion with fellow general practitioners it becomes apparent that samples of urine sent to laboratories seldom yield useful information—they are too old on arrival. Similarly, vaginal swabs very rarely detect pathogens—this is not surprising when one sees gynaecologists finding it necessary to have their samples carried a few hundred yards by hand in order to arrive fresh. Throat swabs often detect pathogens, but it seems that samples of faeces are seldom informative. This is probably because specific bacteriological infection as a cause of diarrhoea is rare in the community at large. Parasitic stool infestation (other than threadworm, which is not difficult to diagnose) is also very rare.

Antibiotic	No of courses given	No of incidents of diarrhoea	Incidence of diarrhoea (%)
Ampicillin/cloxacillin	145	25	17.2
Co-trimoxazole	62	1	1.6
Clindamycin	59	9	15.3
Ampicillin	42	4	9.5
Tetracyclines	30	1	3.3
Lincomycin	18	4	22.2
Benzylpenicillin	17	1	5.9
Ampicillin/cloxacillin and tetracycline	20	1	5.0
Cloxacillin/tetracycline	8	1	12.5
Ampicillin/clindamycin	10	1	10.0
Total	411	48	11.7