different scales are used. In such a case the intraclass correlation coefficient computed for each method will indicate which is the more reliable, provided each method of measurement uses the same population, as in a dataset we recently examined.¹ In summary, we agree with Chinn when she says that "the intraclass correlation coefficient should be used only for comparative purposes. The within-subject standard deviation or 95 per cent range for change should be calculated as the absolute measure of repeatability."²

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Toxic dilatation and infective diarrhoea

EDITOR,—In their article on non-specific inflammatory bowel disease in the ABC of colorectal diseases S Pettit and M H Irving state: "Toxic dilatation is a life threatening condition which has to be treated by urgent colectomy . . . regardless of underlying aetiology."¹ Over the past decade the regional infectious diseases unit in Sheffield has seen 20 cases of toxic dilatation of the colon complicating acute diarrhoea (of less than three weeks' duration) of largely infective aetiology (unpublished data). Intensive medical management consisting of intravenous steroids, antibiotics, and supplementary nutrition similar to the Truelove regimen² resulted in resolution in 17 patients. Three patients required subtotal colectomy and ileostomy for actual (two) or incipient (one) perforation of the transverse colon, but none developed a severe peritonitis and all subsequently recovered with eventual reversal of the ileostomy.

Like others,³ we believe that in toxic dilatation with a likely infective aetiology initial aggressive medical treatment offers a good chance of recovery with preservation of the colon. Naturally, the risk of perforation must be minimised and any complication identified early. Our policy is to involve a surgical team in case medical management fails and operative intervention is necessary.

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Medical audit in general practice

EDITOR,—The North of England Study of Standards and Performance in General Practice claims to have shown that medical audit and standard setting can change doctors' behaviour and improve the care of patients.¹ A problem is that the study seems neither to have completed any medical audit nor set standards in the usually accepted sense.

In *Medical Audit Tools* the authors write: "An explicit standard is a declared, usually written,

statement. For medical audit it will describe a desired state of affairs and state a recommended level of performance."² I agree—as do most authors.^{3,6} On the other hand, in a report of this study they write: "A clinical standard is an explicit statement of what a doctor's performance should be. . . . The most common form is the structured essay. . . . We set out only to describe standards, not to make judgement of their quality."⁷ Such clinical standards are usually referred to as guidelines, which are usually much too diffuse and comprehensive to be used as a measure against which performance can be compared.⁸ It is this form of standard that the study used.¹

Again, the authors write that their objective was "to estimate the effect of medical audit, particularly setting standards, on clinical behaviour."¹ But setting standards—or, as I have suggested, developing guidelines—seems to be the only part of the audit cycle undertaken. No targets were set; although data were collected for research purposes, they were not fed back as part of an audit process—indeed, the paper states that after the end of the study data were well received by trainers; and no resolutions for change were made by comparing targets with performance.

So what did happen? Apparently, groups of trainers studied certain conditions and drew up guidelines for management. After that their behaviour changed to accord more closely with the guidelines they had developed themselves, but not in response to guidelines drawn up by others. That seems a believable and likely result of an educational exercise, but it is not standard setting in the usually accepted sense of the word and it is not audit. Such confusing use of terminology can only delay a generally agreed understanding of medical audit and setting standards.

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Agenda for health in Europe

EDITOR,—Surely in setting the agenda for health in Europe it must be relevant to include the public health problems of other parts of the world, particularly the Third World, otherwise the North-South divide will increase.¹ Any action undertaken in the developed world must not have a "dumping" effect on the developing world; this was the main theme of the earth summit in Rio de Janeiro.² It is not just environmental issues that are of global importance but also matters related to health.

Take, for example, the harmful effects of cigarette smoking. If the Western world is successful in reducing tobacco consumption and at the same time does not discourage the manufacturers from continuing to produce cigarettes these companies will inevitably sell their product in countries whose market can be exploited. These tend to be

the poorer nations of the world. The net result will be to shift the problem from a well organised society to an impoverished state. Several other examples of this exist, including the sale of discarded brands of drugs and the encouragement of artificial breast feeding.

What is needed, therefore, is a strategy that improves the health status of people in Europe without prejudicing the lives of people in other parts of the world. The global need for health must influence the European strategy.

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Black dog of depression

EDITOR,—The author of a recent personal view gives an eloquent and moving account of his 40 year struggle with depression; it is admirably free of the "tendency towards self pity and wallowing in gloom" that he fears may antagonise those who surround him.¹ How sad it is, therefore, to read that he is too embarrassed to reveal his identity and does not want the people he mixes with to know of his illness. Presumably if he had been reporting a lifetime as a doctor coping with blindness or some disabling neurological disorder he would have thought this a worthwhile struggle and one of which he need not feel ashamed.

Mental illness still, it seems, carries enormous stigma, and I am not suggesting that sufferers should be unwillingly "outed" in medical journals. Perhaps we should ask ourselves why a senior doctor, writing in a column that will principally be read by his professional colleagues, is unwilling to be identified as someone who has achieved success in both the personal and professional spheres of his life despite having a chronic incurable disability. I hope that psychiatrists are not alone in entreating patients and their families and colleagues to regard psychiatric illnesses as what they are: just illnesses. Mental illness is as deserving of attention and treatment as any other, and those who have overcome it equally deserve our admiration.

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Poland: collaboration or advice?

EDITOR,—Karin Chopin's article on aid to Poland¹ was published the day we left with five other clinical biochemists from Glasgow and Dublin to serve as lecturers on a postgraduate course on strategies in clinical biochemistry held in Professor S Angielski's department of clinical biochemistry in Gdansk, Poland. This was one of the activities of the joint European project "clinical biochemistry education in Poland" supported by the European Community's TEMPUS programme. It is a collaborative project between the departments of clinical biochemistry at the Western Infirmary and university in Glasgow, St James's Hospital and Trinity College in Dublin, and the Medical Academy in Gdansk.

The project's overall aim is to update undergraduate and postgraduate teaching in clinical biochemistry in Gdansk and to strengthen education on preventing cardiovascular disease. The