

needs to develop women as well as men, especially in a situation where the majority of national leaders are still male. The main point is that the system needs to make the best of us all.

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## **Survival statistics**

The article by Neal *et al*<sup>1</sup> looking at survival from cancer by fast track referral is of considerable interest. It has some nice looking survival curves. However, we feel that they raise some issues around the appropriate interpretation and display of survival data, particularly when there are many censored observations, as is the case here.

The main points about the data display are:

- Table 2 contains mean survival times with standard errors and confidence intervals. We appreciate that the statistical package SPSS produces these as routine, but that does not mean they should be quoted, as this raises the question of how to interpret a mean when some of the data are censored? This is particularly apparent in the case of the urgent referrals for prostate cancer, in which there was only one death, and yet somehow a standard error and confidence interval was calculated. It would perhaps be more appropriate to refer to this as mean follow-up time. For this group the mean survival is given as 755.7 days, and yet Figure 3 suggests this will be exceeded by no more than 3 (out of 45) censored survival times.
- The survival curves have different starting points for the y-axis, giving the impression, for example, that mortality from prostate cancer is comparable to the others. A better plot is to show the cumulative mortality curves showing increasing curves, which all start at zero and have the same scales.<sup>2</sup>

- While it is a good idea to show the censored data on the survival curves, in the paper one of the labels for the curves is an open box, which is not used in the figures.
- Figures should always indicate sample sizes, and these do not. In order to improve the plots one suggestion is to give the numbers at risk along the x-axis. This would then make apparent why some of the curves drop suddenly to zero, the reason being the longest survival time is a death.

At a more fundamental level is the issue of when is a non-significant result indicative of no difference. Lack of evidence to support a difference is not evidence of no difference. A non-significant difference in, say, prostate cancer survival, does not necessarily mean 'no difference' as stated in the abstract. One should present an estimate of the hazard ratio and a confidence interval, and if this confidence interval is narrow enough to exclude a clinically meaningful difference, only then one can conclude there is no difference.

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## **REFERENCES**

1. Neal RD, Allgar VK, Ali N, *et al*. Stage, survival and delays in lung, colorectal, prostate and ovarian cancer. *Br J Gen Pract* 2007; **57**(536): 212–219.
2. Pocock SJ, Clayton TC, Altman DG. Survival plots of time-to event outcomes in clinical trials: good practice and pitfalls. *Lancet* 2002; **359**(9318): 1686–1689.

## **Authors' response**

We are grateful to Campbell and Freeman for raising issues relating to the presentation of data in our paper.<sup>1</sup> Interestingly, their comments do not

change our findings or their interpretation. We would like to respond to the points they raise in turn.

We acknowledge that survival data are positively skewed and therefore reporting a mean survival time is not always the most helpful statistic. We do not necessarily agree that this is best called 'mean follow-up time' as they suggest, but feel that a median survival time may do more justice to the data.

We agree that the four figures showing survival have different starting points for the y-axis, which can cause confusion. However the axes were clearly labelled and should therefore be easy to interpret. It is a question of style for a particular journal as to whether this is the norm or not. We originally chose to start the axes at different points in order to demonstrate the data as clearly as possible and because we did not directly compare differences between the four cancers. We are not convinced that there is consensus within the statistical community that cumulative mortality curves are better as they suggest.

We are grateful for their diligence in spotting the absence of open boxes on the figures. These appear to have been lost in final production of the paper, but their absence does not detract from the main messages from these data.

Again we are grateful for their suggestion of including the number of patients along the x-axis, and agree that in some circumstances this can add clarity to survival curves. However we do not believe that it has become routine practice. A quick look through recent similar papers has confirmed these beliefs. Perhaps it is time for journals to lay down explicit guidelines about the presentation of such data?

Lastly, they raise the issue of when a non-significant result is indicative of no difference. Certainly it is possible to calculate a hazard ratio and a confidence interval, but this should not detract from the more important question of when a statistical difference equates to a clinically meaningful difference.

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**REFERENCES:**

1. Neal RD, Allgar VK, Ali N, *et al.* Stage, survival and delays in lung, colorectal, prostate and ovarian cancer. *Br J Gen Pract* 2007; 57(536): 212–219.

## Mental health workers

Primary care mental health workers (PCMHW) can go beyond the supplementation of services for those with mild to moderate depression and anxiety, as described by Elizabeth England and Helen Lester.<sup>1</sup> In our inner-city locality we have had a wider impact on mental health services, by changing the quality of care for people with severe mental illness, contributing to the assessment work of mental health teams, providing an additional client-based service within these teams, and engaging in research and service development.

Case management of people with severe mental illness is poorly developed in general practice, and despite much exhortation over a decade or more there is little evidence of shared care of patients with schizophrenia, severe major depression and bipolar disorders. We have demonstrated that PCMHWs can act as case managers for patients with severe mental illness, collating clinically and socially relevant data and capturing it in electronic templates that are modifiable in routine consultations.<sup>2</sup> This process of data capture involves using structured checklists in interviews with patients, and similar structured data extraction tools for analysing community mental health team records as well as those in general practice.

Moving between primary and secondary care also allows the PCMHW to contribute to community mental health team work, particularly in assessments of new referrals, and by providing a client-

centred service to those who do not meet the criteria for secondary care provision. Working under supervision of secondary care and being part of this supportive team helps with the professional development of PCMHWs. This training then becomes an asset in expanding the range of practice-based services for patients with mild to moderate anxiety and depression. Finally, research and development work includes promoting training in identifying and responding to depression in teenagers, using a modified form of cognitive behavioural therapy, during routine GP consultations.<sup>3</sup>

The description of the tensions in developing the role of the PCMHW given by England and Lester resonates with our experience, where the roles of the new workers have been jointly negotiated by practices, the mental health trust, the PCMHWs themselves and the primary care trust. These negotiations have been fruitful, but funding problems, particularly around supervision, remain an obstacle to continued development of PCMHW roles.

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**REFERENCES**

1. England E, Lester H. Implementing the role of the primary care mental health worker: a qualitative study. *Br J Gen Pract* 2007; 57(536): 204–211.
2. Gallant C. Getting it on the record. *Health Matters* 2006; 64: 20.
3. Gledhill J, Kramer T, Iliffe S, Garralda E. Training general practitioners in the identification and management of adolescent depression within the consultation: a feasibility study. *J Adolesc* 2003; 26(2): 245–250.

## Handshakes and spoof publications

The Letter 'The meaning of the handshake towards the end of the consultation'<sup>1</sup> from

the April edition of the *BJGP* brought much amusement whether this is an 'April fool' or a piece of 'off the wall' research. I have to assume it is a joke for several reasons:

- If it was real, only 1.2% of his patients are pleased with his consultation style (ergo-98.8% may have some significant reservations about him and therefore he would be unwise to let his appraiser know.
- If it was real why didn't he get it published in the normal way? Easy to answer that one; no sane ethics committee would let this one past. And how could you justify spending time getting consent from the participants for such nonsense?
- If it was real he should have looked more broadly at the topic. Why do others not shake hands? What difference does cultural background of patient or doctor make? What about class, socioeconomics or education?

Anyway, what difference does it make except that you would have to wash your hands again.

Anyway, nice one. You nearly had me fooled into thinking both the Editor or the doctor had been daft publishing this when I realised it was April.

A more important debate is whether any journal be permitted to publish spoof material in Medline searchable format. I have long been of the opinion that for internationally-read journals the practice should be banned and that any breach should be regarded as research fraud. You may feel this is an overreaction but unfortunately I have seen spoof articles referenced in serious papers. The distinction is not always clear even to those whose first language is English and I believe it is insulting and arrogant to deceive other professionals who have to waste time trying to work out what is real.

At least the *BJGP* have not fallen into the practice of publishing pretend original research (or have they?)

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