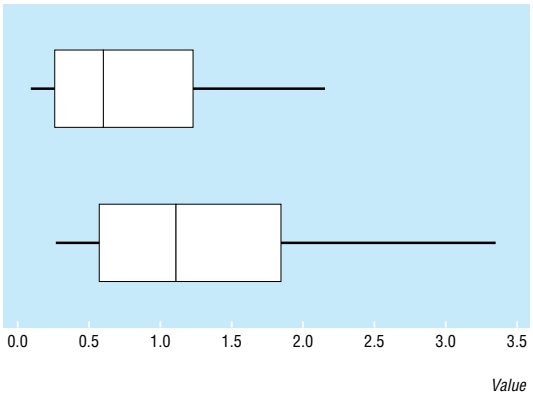

Fig 3 Box plots of samples of size 25 drawn from the distributions in figure 2. Vertical lines indicate the medians and boxes the interquartile range

with 11 (1 and 15) copies for the 55 committees in the standard group. Not only are the medians different, the distributions must also be different. About half of the fast track committees asked for two or three copies, whereas about half of the other committees asked for 11-15 copies. These differences, which the authors did not comment on, relate to shape as well as location of the distributions.

Macleod et al studied women with breast cancer from affluent and deprived areas.[8] One of their conclusions is "The time between the date of the referral letter and the first clinic was one day shorter in women from affluent areas." The median (interquartile range) time was 6 (1-13) days in the affluent area and 7 (4-20) days in the deprived area. Although the medians differ by one day, the summary statistics suggest that the data for the deprived group are more right skewed, and differences between the two groups might be much more pronounced for the higher waiting times. It would have been helpful to discuss this in the paper.

A similar feature is even more evident in data from a study of pain in blood glucose testing.[9] A visual analogue scale was used to record pain at the ear or thumb. The authors report "The median pain score was 2 mm in the ear group and 8.5 mm in the thumb group … the difference in median pain score is small." Although this is true, the box plots in the paper show that the spread of scores in the thumb group is much greater than for the ear group. In particular, at least three out of 30 people in the thumb group report a score that is at least twice the highest value in the ear group. Overall, values seem much higher in the thumb group. This is important because patients are likely to be more concerned with the worst pain they might experience than the median value.

Recommendations

Researchers should take care to describe their data and to be clear about the features that are most clinically important. They should use the statistical test that is most relevant for their hypotheses, and describe the features of the data that are likely to have caused a hypothesis to be rejected. As is always the case, it is not sufficient merely to report a P value. In the case of the Mann-Whitney test, differences in spread may sometimes be as clinically important as differences in medians, and these need to be made clear to the reader.

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1 Altman DGA. *Practical statistics for medical research*. London: Chapman and Hall, 1991.
2 Sprent P. *Data driven statistical methods*. London: Chapman and Hall, 1998.
3 Grande GE, Todd CJ, Barclay SIG, Farquhar MC. Does hospital at home for palliative care facilitate death at home? Randomised controlled trial. *BMJ* 1999;319:1472-5.
4 Williams JG, Cheung WY, Russell IT, Cohen DR, Longo M, Lervy B. Open access follow up for inflammatory bowel disease: pragmatic randomised trial and cost effectiveness study. *BMJ* 2000;320:544-8.
5 Barber JA, Thompson SG. Open access follow up for inflammatory bowel disease. Would have been better to use *t* test than Mann-Whitney U test. *BMJ* 2000;320:1730.
6 Thompson SG, Barber JA. How should cost data in pragmatic randomised trials be analysed? *BMJ* 2000;320:1197-200.
7 Lux AL, Edwards SW, Osborne JP. Responses of local research ethics committees to a study with approval from a multicentre research ethics committee. *BMJ* 2000;320:1182-3.
8 Macleod U, Ross S, Twelves C, George WD, Gillis C, Watt GC. Primary and secondary care management of women with early breast cancer from affluent and deprived areas: retrospective review of hospital and general practice records. *BMJ* 2000;320:1442-5.
9 Carley SD, Libetta C, Flavin B, Butler J, Tong J, Sammy I. An open prospective randomised trial to reduce the pain of blood glucose testing: ear versus thumb. *BMJ* 2000:321:20.

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When I use a word …

Attendee

Well, I don't. The verb to attend comes from the Latin, meaning "to stretch to." From this developed the meaning "to direct the mind or energy to," and later "to direct one's care to." The meaning "to present oneself at a meeting" is dated back to the 17th century.

The suffix -ee is given four meanings in the *Shorter Oxford Dictionary* and is admittedly a muddy area. However, none of the meanings comes near to denoting the subject of a verb (the person who does the thing, such as attending a meeting). It is I who attends the meeting, and not the meeting which attends me. The nearest legitimate use listed would be in the adoption into English of the past participle of certain reflexive verbs in French, such as "se refugier" (to remove oneself from a place in the interests of one's safety), which results in the word refugee. While I have taken refuge from meetings at times, I have never thought of attending a meeting as a reflexive activity. Perhaps "attendee" should be reserved for those who attend meetings in order to listen to themselves.

I may have occasionally been the smallest person at a meeting and might therefore qualify for the diminutive suffix, rather as a small coat becomes a coatee, but, since I was never an attend, even being small would not make me an attendee.

There are already two words for a person who attends, and they are attendant and attender. Curiously the *Shorter Oxford Dictionary* gives the former the meaning at issue, whereas I find the second the easier to use. But surely there is no need for a third.

My suggestion is that we learn to accept, when talking about what we do, that we probably haven't invented a new practice and so we probably don't need a new word.

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