- 2 Ethnicity, race, and culture: guidelines for research, audit, and publication. *BMJ* 1996;312:1094. (27 April.)
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Links need to be maintained with census definitions

EDITOR,—The definition and meaning of terms relating to race, ethnicity, and culture are issues to which social scientists have devoted hours and pages of thought. Some doubt whether they are indeed real entities (like "society"), but, as many studies have now shown, they are real in their effects. Kwame McKenzie and N S Crowcroft's editorial and "style guide" are helpful pointers out of the maze.^{1,2}

It is important to emphasise that culture and ethnicity are multivariate. Researchers should (for example) make reference to religion as it is likely to be a key factor in behaviour. The style guide seems to omit language, which, at least in relation to people of South Asian descent, may provide as much useful information as does religion—and certainly more than the catch-all term "Indian."

The guidance also emphasises the need to let people identify their own ethnicity.² It is therefore good news for those who, like me, have advocated this and promoted ethnic monitoring that general practitioners in Leicester and Lincolnshire found the procedure so easy to operate.³ Hopefully, such open debate will reassure those who, by virtue of their uncertainty about the value of ethnic monitoring, make the collection of data problematic. The results will be of little value, however, unless linked to sound estimates of the population denominator. For this reason it is imperative that, however freely people are allowed to choose or describe their identity, a link is maintained to the complex and carefully designed structures used in the census.⁴ Without some degree of agreement we shall see no benefit in epidemiology or the delivery of services and a backlash against the collection of data may result.

The provision of well thought out guidelines is a useful start and may help to avoid the confusion that seems to have developed in the United States.⁵ We may now look forward to an end of the muddled thinking embodied in such old and ugly terms as "Europid" and the confusion between nationality as stated in a passport, which has no clinical importance, and ethnic group, which manifestly does.

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- 1 McKenzie K, Crowcroft NS. Describing race, ethnicity, and culture in medical research. *BMJ* 1996;312:1054. (27 April.)
- 2 Ethnicity, race, and culture: guidelines for research, audit, and publication. *BMJ* 1996;312:1094. (27 April.)
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- 4 Aspinall PJ. Department of Health's requirement for mandatory collection of data on ethnic group of inpatients. *BMJ* 1995;311:1006-9.
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Guidelines will encourage the thinking that underpins racism in medicine

EDITOR,—I am concerned that Kwame McKenzie and N S Crowcroft's editorial on the need to describe race, ethnicity, and culture in medical

research will encourage prejudice.¹ I am sure that that is not the authors' intention, but it is what they are most likely to accomplish if they continue in their present line of thought. They offer the spurious argument that "if researchers want to be able to compare results of studies now and in future, a framework is needed for the classification of ethnic and cultural groups." Not so. There are more meaningful criteria on which people can be compared, such as sex, age, place of residence, environmental conditions, occupation, income, and lifestyle.

McKenzie and Crowcroft go on to suggest that we need to "agree on how culturally and ethnically to demarcate the people of the world." Why? Can the authors not see that most of our problems are the direct result of just such demarcation? What do they understand to be the underlying cause of such phenomena as racism, "ethnic cleansing," the caste system in the Indian subcontinent, the pogroms in Rwanda and Burundi, and the "troubles" in Northern Ireland?

I am sorry that the *BMJ* lends credibility to the views of these two authors by producing guidelines on describing people by ethnicity, race, or culture in research, audit, and publications.² This only encourages the thinking underpinning the racism that is endemic in the selection of medical students and in the training, employment, and promotion of doctors in Britain.

We need to take a conscious decision not to "demarcate" people but to encourage people to think non-racially and non-ethnically. As one of the most widely read international journals, the *BMJ* is uniquely placed to take a leading role in this process. I would not support censorship, but I would support the *BMJ*'s rejection of all letters, articles, and papers that seek to divide people into distinct racial, ethnic, or cultural groups. This is not just because of a wish to stop supporting prejudice but also because, to quote the *BMJ* itself, "race has limited biological validity" and "culture is difficult to measure and describe."² Lifestyle does, but race, culture, and ethnicity do not, merit inclusion in our list of valid epidemiological variables.

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- 1 McKenzie K, Crowcroft NS. Describing race, ethnicity and culture in medical research. *BMJ* 1996;312:1054. (27 April.)
- 2 Ethnicity, race, and culture: guidelines for research, audit, and publication. *BMJ* 1996;312:1094. (27 April.)

Authors' reply

EDITOR,—We agree with David de Bono's comments and the findings of James McAuley and colleagues that there is as much variability in "white" groups as in any other. In fact, we had suggested that a "white" example should be included in the guidelines to make this very point. Unfortunately, this was not done. Part of the motivation for our editorial and the guidelines was to dissipate the myth that groups defined by skin colour are homogeneous in any meaningful sense other than that which corresponds to racialised thinking.

Mark R D Johnson points out the importance of language and of maintaining links between self coding and census categories so that population denominators are available. McAuley and colleagues' letter, however, underlines the limitations inherent in the use of any particular classification on its own.¹ Furthermore, individuals may change their self coded ethnic group as society changes, making interpretation of time trends problematic.

Ikechukwu Obialo Azuonye speaks from the heart when he calls for a world where racial, ethnic, and cultural differences are not important. We would all like to live in such a world, but we do not at present, and we have to deal with the problems of this one. There are ethnic differences in the rates of illness and in the uptake of health services.² There is racism in society. Research that recognises these facts can lead to better policies and services to combat inequity, and to a better understanding of the aetiology of diseases. How could appropriate interventions be developed if we were unable to measure and compare the effects of racism, genetics, poverty, and culture?

Thousands of papers are published every year that refer to race, ethnicity, or culture. If we are to use such information effectively to improve health and health care then we need a coherent framework within which to report and interpret findings. We wrote our editorial and the guidelines in the hope that such a framework could be agreed internationally and to start a correspondence on the subject. We hope that letters such as these published here will lead to the guidelines being refined so that they meet the needs of both researchers and the subjects of research.

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- 1 McKenzie KJ, Crowcroft NS. Race, ethnicity, culture, and science. *BMJ* 1994;309:286-7.

- 2 Cruikshank JK, Beevers DG. *Ethnic factors in health and disease*. Oxford: Butterworth-Heinemann, 1989.

Addison's disease

Secondary adrenal failure in critically ill patients is underrecognised

EDITOR,—C M Brosnan and N F C Gowing's lesson of the week is a succinct reminder of the diverse presentation of primary adrenal failure and emphasises the risk of shock that is unresponsive to inotropes in these patients.¹ There is a growing realisation that secondary adrenal failure can also occur in critically ill patients and is probably more common than previously thought.² Establishing the diagnosis may be difficult in these patients, since they do not exhibit the normal electrolyte abnormalities of adrenal failure and usually have a serum cortisol concentration in the normal range for the healthy population. Typically, however, they present with septic shock that is unresponsive to inotropes and has no apparent focus of infection.³

Treatment with physiological doses of steroids leads to a rapid resolution of the shock, and inotropes can usually be withdrawn within 48 hours of the start of such treatment.⁴ The adrenal failure is normally transient, so the steroids can be tapered off once the patient's general condition improves.

Adrenal failure in critically ill patients is underrecognised and may be life threatening. The diagnosis should be considered in any patient in whom septic shock occurs without an obvious source of infection.

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- 1 Brosnan CM, Gowing NFC. Addison's disease. *BMJ* 1996;312:1085-7. (27 April.)