the Hungarian case-control surveillance of congenital abnormalities, however, was unable to confirm that griseofulvin used during pregnancy has a teratogenic effect.⁶

In my opinion, the anxiety and fear created by the notion that nearly all drugs cause congenital abnormalities may be more harmful than the drugs themselves.

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Medic Alert UK should start new section for patients with a difficult airway

EDITOR,—The Medic Alert Foundation is a worldwide charitable and voluntary organisation dedicated to disseminating information to doctors about potential hazards for individual patients. In anaesthesia its greatest contribution is to warn anaesthetists that a patient has a life threatening reaction to a drug, so that the drug can be avoided.

An unsuspected difficult airway can be life threatening in patients presenting for general anaesthesia. According to one survey, almost one third of all adverse anaesthetic outcomes are related to respiratory problems,¹ and about 41% of all deaths attributable to anaesthesia are related to difficulties with endotracheal intubation.² Unfortunately, preoperative tests on the airway have poor predictive value: nearly half of difficult intubations are not predicted preoperatively.³ Knowledge of previous problems with a patient's airway is of paramount importance. Generally, however, patients have only a vague idea of problems that occurred when they were given anaesthetics in the past. Usually, and especially out of hours, efforts to get the details of the previous incident and its management are futile, and so the patient is at risk of a further critical incident.

With patients' full consent, Medic Alert keeps relevant data, which can be obtained by authorised medical staff on a 24 hour basis. I propose that a national "difficult airway register" should be established (which could be based at St George's Hospital), to which all anaesthetists could supply relevant information on a standard form. Registered patients would then be approached to become members of Medic Alert UK, so that their record giving details of their difficult airway could be stored with this organisation and the information retrieved, if required, at any time. General practitioners would have access to this information and could include it in their referral letter to the hospital.

In the United States a comprehensive system for disseminating information about patients with a difficult airway, which incorporates Medic Alert, has operated for the past few years. Preliminary results indicate that access to this detailed information leads to fewer techniques

being used by anaesthetists and a reduction in adverse outcomes.⁴

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Describing race, ethnicity, and culture in medical research

"White" populations also need to be accurately described

EDITOR,—Kwame McKenzie and N S Crowcroft's comments about the recording of race, ethnicity, and culture are sensible and sensitive.¹ Their choice of examples, however, may inadvertently reinforce the misconception—widely held in the health service and not helped by the classification of the Office for National Statistics (formerly the Office of Population Censuses and Surveys)—that "ethnic" equates with "non-white." There is enormous ethnic and cultural variability in "white" populations, with both political implications (as in Ulster and Bosnia) and medical implications (for example, heart disease and diabetes). When appropriate, similar precision should be used in describing white population groups. I speak as a professional Malta-born, polyglot, Catholic pasta eater of Maltese, Irish, and English extraction who has been resident in Britain for 35 years.

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- 1 McKenzie K, Crowcroft NS. Describing race, ethnicity, and culture in medical research. *BMJ* 1996;312:1054. (27 April.)

Self defined ethnicity is unhelpful

EDITOR,—Kwame McKenzie and N S Crowcroft's editorial and recommendations on describing race, ethnicity, and culture are an important contribution to the debate on ethnic classification.^{1,2} While the authors discuss the complexities associated with ethnic classification of various non-white British groups, their recommendations fail to acknowledge the similar difficulties in describing what could be referred to as the indigenous population (that is, those who have been traditionally termed white). There is an implicit assumption in much of the work on inter-ethnic differences that this group represents an ethnic standard by which members of other ethnic groups may be judged.³ Our findings indicate that when people traditionally classified as "white British" are asked to define their ethnic background a range of complex responses is elicited.

As part of a larger study at Northwick Park Hospital examining psychosocial aspects of chronic disability due to low back pain, we attempted to determine the ethnic group to which patients felt they were affiliated. A question was designed that was based on five items (ethnic origin, religion, country of birth, length of time in Britain, and languages spoken); we thus used a similar approach to that recommended in McKenzie and Crowcroft's

Table 1—British patients' self defined ethnicity and country of birth

Ethnic identity	Country of birth	No
English	England (45), London (1), United Kingdom (3)*	51
British	Britain (2), England (20), United Kingdom (3), Wales (2)	27
White	Britain (2), England (7), Ireland (1)	10
White European	Ireland (2), United Kingdom (1)	3
Caucasian	England (1), Northern Ireland (1)	2
British Gibraltar	Gibraltar (1)	1
British White	England (1)	1
British/Irish parents	United Kingdom (1)	1
British Philippines	India (1)	1
English/Australian	United States (1)	1
English/Irish	England (1)	1
European	England (1)	1
Scottish	Egypt (1)	1
United Kingdom	United Kingdom (1)	1
White British	England (1)	1
White English	England (1)	1
Total		104

*Two patients did not state their country of birth.

guidelines² and used free text fields, because of the move towards the use of such fields in ethnic monitoring in the health service.⁴

Out of 297 patients, 235 (79%) responded to the question on self defined ethnicity. Analysis by χ^2 test indicated that this group was significantly younger ($P = 0.029$) than the 62 who failed to respond to this question. Altogether, 104 respondents were identified as "British" (table 1). Sixteen distinct responses fell in this category. The three most common responses were English, British, and white (total 88 patients); the 13 further groups comprised 16 patients.

Our data show the heterogeneity of this ethnic group—patients who were categorised as British. Thus, while use of the term "Asian" to describe people of Indian, Pakistani, Bangladeshi, and Sri Lankan origin is often said to lack specificity as the definition of an ethnic group,⁵ a similar case could be made for the ethnic term "British."

We conclude that it is more profitable for health service research to use a range of variables, such as language, religion, country of origin, and length of residence in the country, to investigate the impact of cultural differences. We recommend that ethnicity, even if self defined, should not be used on its own as a variable.

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