

Twin threats come from the introduction of new expensive medicines for previously untreatable conditions and from the increasing, high volume use of drugs with important public health implications—for example angiotensin converting enzyme inhibiting drugs, lipid lowering agents, new antidepressants, and antipsychotic drugs. Our management plans involve a number of initiatives given below.

Aims and initiatives

Cost effective prescribing—Doctors should prescribe the most cost effective treatment for their patients. We are encouraging this with a “drugs of choice” programme that will lead to some drug substitution. The aim is to create sufficient leeway within the budget to accommodate treatment advances. This can be achieved without detriment to patient care by “good housekeeping” measures covering short and long term prescribing.

Proved worth—All expensive (and sometimes not so expensive) new treatments need to be sufficiently cost effective for the committee to advise the health board to support their purchase. If hospital specialists (and general practitioners) cannot show that a treatment provides measurable and worthwhile benefit, it will not be purchased. Further expansion of this system is planned.

Educating the public—An initiative will be developed to educate the public about the success, limitations, and dangers of drug treatment. A programme pointing out

the importance of cost effectiveness and a realistic assessment of sustained efficacy is an essential part of a coordinated strategy.

Integration and cooperation—The development of the Glasgow system demands continuing integration of all its contributors. Rapid access to up to date data on new and established drugs is a particular need. Cooperation between health boards is essential too to ensure consistency of decision making and to minimise the problem of “rationing by postcode.”

Drug evaluation unit—Our eventual aim is to set up a drug evaluation unit to coordinate these activities, perhaps in partnership with elements of the pharmaceutical industry. An editorial board has been set up to oversee Glasgow Area Drug and Therapeutics Committee publications and a website has been established on which the Glasgow Formulary and other relevant prescribing material has been posted (<http://pc47.cce.hw.ac.uk/gghb/adtc>).

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Theories in health care and research

Theories of race, ethnicity and culture

Naomi Pfeffer

Advice on which of the many possible definitions of race, ethnicity, and culture is most appropriate has been published in some medical journals.¹ Sensitivity to what these words may mean to an individual and, in a collective context, their explosive potential, has been encouraged partly by the latest phase in what has been called the “race policy environment.” Its history can be summarised briefly. The “race neutrality” of British public policy that emerged in the postwar period, which contributed to the entrenchment of inequality, was supplanted in the mid-1960s by assimilationist policies informed by a belief that disadvantage in “racial” minorities might be eradicated if they adopted indigenous cultural behaviours such as the English diet. These policies were replaced in the 1980s by others promoting “racial harmony,” a blending of identities as a means of defusing racial tension. In the current phase, there is a recognition of the importance that people attach to having their distinctive identity acknowledged and respected, and moreover, recognition that the structure of British society and institutional racism both contribute to the disadvantages experienced by minorities.²

The old terminology

The current phase of this race policy environment is stimulating research into whether, how, and when

Summary points

Race, ethnicity, and culture should not be perceived as problematic “facts” or “things”

The category “white” is too broad—and often meaningless

Research into the relevance of race, ethnicity, and culture should address everyone’s health, not just that of the victims of inequality

Globalisation, displacement, and social movements are undermining the capacity of one nation to fix people’s identity

racism and race, ethnicity, or culture influence susceptibility to disease and access to or use of health services. Investigators, however, are encountering difficulties in selecting their own terms, and understanding those used by others. Although there has been some acknowledgement of the influence of present day racism on terminology, the terms race, ethnicity, and culture are sometimes still used interchangeably in defining characteristics of research subjects,³ which

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suggests that they mean the same thing. Moreover, when one word is preferred, no clear explanation is given, making comparisons difficult.⁴ Another complaint is a lack of specificity—for example, applying the term “Asian” to people who have come to Britain from many different parts of the world, most notably India, Pakistan, Bangladesh, Uganda, Kenya, and Tanzania, and from peasant or urban middle class backgrounds; they are also differentiated in their religion, language, caste, kinship obligations, diet, clothing, health beliefs, and birth and burial practices.⁵ There is growing recognition that the category “white,” which cover a diverse range of people including people of Irish origin and Jews, is unspecific.

Medicine pays little attention to the innovative theories being developed within history, sociology, anthropology, philosophy, and cultural studies about how, when, and why the identities of some individuals and groups are brought under the rubrics of race, ethnicity, or culture. Expositions of theories may be uncomfortable to read because of their references to instances where medicine was dragged in to, or made itself available to, justify and regulate policies of exclusion and inclusion, in areas of scientific racism and immigration.⁶ None the less, as this paper will show, theories should be investigated because publications for a medical audience have been limited by a failure to acknowledge their many insights into the significance of identity in the late 20th century. Medicine could be described as watching the water pour from the tap—whereas theories are engaging with the impact of new technologies on the design of the plumbing; how changes in ownership, organisation, and work of water boards influence the flow and quality of the water; how charging policies and consumer behaviour regulate its consumption; and, moreover, what ideas are represented by these developments.

Racial facts

Health researchers mainly adopt a positivist approach: “facts” are observed and boxes ticked. Research into the significance of race, ethnicity, and culture uses as indicators marks and codes such as skin colour, religion, name, and nationality. Though investigators assume that these indicators are indelible, they are unquestioned constructs, readymade types intelligible only to those who draw on the same knowledge. Hence skin and not hair or eye colour is used in systems of classification based partially on phenotype, a method of aggregation which suggests that some shared biology is a valid method of organising people into social groups. Because they lie outside of their commonsense knowledge, many other potential commonalities are not considered by investigators, although they may be crucial to their research on subjects’ subjective identities. In explaining to me why she preferred a South Asian doctor to an English one, a Chinese speaking woman living in east London said it was because they had more in common as they both ate rice. Dietary rules are part of the scaffolding of social relationships and can exclude and include people as effectively as immigration laws.

In the absence of an explicit theory of when, why, and how racism and race, ethnicity, and culture influence susceptibility to disease, and access to or use



Yinka Shonibare's work examines the racialisation of everyday things, such as fabric and fashion

of health services, investigators construct categories themselves. They do so pragmatically and for reasons such as availability of resources. Some categories are borrowed from official surveys such as decennial censuses and the labour force surveys. Yet these surveys did not have medical or health research in mind. The most important customers of the 1991 census data, for example, are race equality officers charged with making sure local authorities carry out their statutory obligations to address racial discrimination and promote equal opportunities.⁷ These same obligations do not yet apply in the health service. Although there is general agreement that, in relation to race, ethnicity, and culture, reliability is notoriously difficult to achieve, the validity of borrowed systems of classification in health and medical research is rarely questioned.

In generally trying to explain why some people are more susceptible to disease, health researchers propose that one clear, essential set of characteristics is shared by everyone in a category. This essentialism assumes we each have a “true” identity inherent in us, and that we carry it from the moment of conception, or at least from the cradle to the grave. It suggests that everyone experiences the world in substantially the same way; but everyone’s subjective knowledge about the world is socially derived. Undoubtedly, researchers make important discoveries; however, essentialism supports scientific racism, which proposes that people can be allocated to racial groups on the basis of a shared biology, and that some racial groups are superior. Genetics research has mostly discredited belief in a biological basis of racial groups.

Essentialism can be social as well as biological. Essentialist versions of ethnicity (defined as a belief in a shared destiny) see history as an unchanging truth. This happens, for example, in Ireland. Essentialist accounts of culture are found in “factfiles,” information resources produced for health professionals. They present cultures as fixed products rather than dynamic processes. They seem to meet a real need and help to allay concerns about professional ignorance and inap-

appropriate behaviour. Yet attempts to help health workers to be more sensitive to cultural and individual differences can encourage unwelcome stereotyping. Patients may be pressed to conform with “cultural” practices they disagree with.⁸

Overcoming essentialism

It is sometimes suggested that one way of overcoming the pitfalls associated with essentialism is to offer people more choice.⁹ People can assign themselves to several categories which, together, might express the complexity of their life, such as “father born in Poland,” “father refugee in England,” “mother born in Britain,” “born in Britain,” “Jewish,” and “white.” This approach still fixes people in immutable categories. It takes no account of the dynamic and shifting nature of people’s identities, which interact between class, ethnicity, gender, religion, and many more cultural configurations within Britain and elsewhere.

Time and place are crucial. “Asian” for example, has different meanings in Britain and the United States. In Britain, Asian mostly refers to people with some connection with the area sometimes now called South Asia, made up of India, Pakistan, and Bangladesh, nations shaped by the legacy of British imperialism. Asian is colour coded: it excludes “white” people born in this area. In the United States, Asian describes people with some connection with countries of the Pacific region, such as Japan, Malaysia, China. Their presence in the United States bears witness to another set of economic and political historical processes.

Postmodernists attribute essentialism to the European Enlightenment of the 18th century, which was also responsible for many astonishing transformations in science, technology, culture, and economics over the past 200 years. By elaborating, for example, the concept of separate diseases rather than “disease” the Enlightenment paved the way for cell theory and modern medicine. Although the ideas it produced laid claim to universality, many have been shown to be heavily Eurocentric, bolstered by a belief that people outside of the West are incapable of analytical reflection.¹⁰ The Enlightenment that promoted forms of humanist universalism, equality, tolerance, and fair play is also responsible for the creation of Western doctrines of “racial” and cultural superiority, which legitimated the Western genocide against aboriginal people, slavery, colonial domination, and the Holocaust.

The Enlightenment promoted the idea of a stabilised, individualised subject. It made possible, even encouraged, the marshalling of the peoples of the world into groups based initially on shared morphology (brain size, skin colour, and so on), then genotype, and, nowadays, culture or ethnicity. What started out as horizontal systems of classification were upended. The peoples of the world were organised in hierarchies, and white, Western males were placed at the pinnacle.

In providing a means of distinguishing “them” and “us,” classificatory systems order social life and provide the basis of systems of inclusion/exclusion. This process works through binary oppositions—white/black, male/female, heterosexual/homosexual—which convey value judgments such as healthy/unhealthy, normal/deviant, controllable/uncontrollable as well as

belonging/unbelonging.¹¹ Each side of a binary opposition implicitly evokes the other. Hence taunts such as “There ain’t no black in the Union Jack,”¹² a racist football chant in the 1980s, express the belief that whiteness and being British are synonymous. In operating between and within nations, dichotomies describe citizen and stranger both outside and inside a nation. Jews are said to epitomise the stranger within—they are always on the outside even when inside.¹³

Invisible whiteness

Postmodernists observe the tendency of the identity, the distinguishing features, of the dominant group, the “us,” to disappear. Hence in Britain, “white” is rarely experienced or questioned as an identity by white people.¹⁴ Explaining what incensed her about the introduction of ethnic monitoring in her local hospital, a middle aged white woman, born and currently living in London, protested to me, “Why should you have to say you are white and English?” Ethnicity, understood as a sense of belonging to a real or imagined community, is as much a characteristic of white as black people—yet “ethnic” is shorthand for minorities. Because it has been set up as the standard against which all others are measured, white ethnicity is invisible. The significance of being white as opposed to black is rarely addressed in health research. Almost all investigations into the relevance of race, ethnicity, and culture focus on oppressed minority groups; questions of inequality in health status are addressed through a focus on the victims of inequality. Yet by showing how variations in income distribution affect everyone’s health status, investigators have confirmed the value of considering entire populations.¹⁵

Postmodernists seek to unravel the processes that produce marginality and exclusion, and centrality and inclusion. When they investigate inequality in health status, for example, they might begin by documenting the origins, form, process, content, and consequences of racism, for both its perpetrators and victims. “Race” is not only a biological typology. It emerges through racialisation which can transform biology, ethnicity, culture, people, places, and processes and shape ideas about doctors and patients, about hospital practices, and even influence diagnosis and treatment—black people are disproportionately diagnosed with severe mental health problems.¹⁶ Moreover, in claiming that present day racism in Britain is the racism of a declining social formation and not of the “high imperial noon,” postmodernism takes a non-essentialist, historically informed view of racism. In addition to remembering the legacy of scientific racism, postmodernists seek out new forms of racism.

A new vocabulary

In challenging the idea that race, ethnicity, and culture can capture everything there is about a person, a non-essentialist perspective does not deny the existence of these features. It does not, however, accept what race, ethnicity, and culture might claim to reveal about a person. Instead it encourages a consideration of when and why these features are brought into the foreground in thinking about people. An instance of particular importance is citizenship, where a nation

state acts as an authority in deciding who is “them” and who is “us,” as happened in the distinction made between “Old” and “New” Commonwealth: Old speaks of an established white British ethnicity, New conveys the impression of unwelcome incomers.

Old and New Commonwealth are artificial social orders which, like the decennial censuses and labour force surveys, are constructed by modern nation states to manage populations.¹⁷ The power of states to impose and order identities has been challenged by “new social movements,” which emerged in the West in the 1960s in peace and antiwar activism and civil rights. Cutting across traditional political allegiances such as social class, these movements are organised around the identities—the sense of self—of their supporters. Identity politics associated with feminism appeal to women, black civil rights movements appeal to black people, and sexual politics appeal to lesbian and gay people. The politics of these groups of people has been instrumental in the shift to self identification in censuses and surveys.

In celebrating a group’s uniqueness—for example, by subverting the pejorative connotations of “black” as happened in the “Black is beautiful” rallying cry, and claiming this uniqueness as a basis of political solidarity—some new social movements have fallen into the trap of essentialism. In resisting this trap, other movements emphasise the protean nature of identities and go out of their way to show how identities change at particular points in time. Moreover, they sometimes are changed at will. Stripped of its biological associations with sterility, “hybridity” describes deliberate, productive mixing of elements of other cultures and different systems of thought, as can happen when patients and medical practitioners judiciously use both biomedicine and complementary medicines.

Postmodernists contrast the fixity and rootedness conveyed by essentialism with the displacement, flight, exile, and forced migration of many people as nation states collapse. They recognise that the capacity of one nation state to define people’s identity is being undermined by globalisation. Increasing numbers of racially diverse people live in one place and feel a sense of belonging to another. Their experience demands a

new vocabulary. “Diaspora” is being redefined to describe identities which exist outside of, and sometimes in opposition to, the political forms and codes of modern citizenship.¹⁸

A new vocabulary is being developed which captures people’s identities more effectively than any definition of race, ethnicity, and culture. Instead of thinking about identity as an accomplished fact—an independent, unproblematic variable in research—postmodernism encourages investigators to explore the processes, never complete, which shape identity. Any attempt to capture (sometimes only for a moment) people’s slippery identities must acknowledge the impact of new social movements, globalisation, racialisation, and racism.

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A memorable interview

Saved by the chaplain

The year was 1967. I was working as a registrar in Queen Elizabeth Hospital, Adelaide, South Australia, preparing to appear for part two of the membership examination of the Royal Australian College of Physicians. In those days, I was one of very few Indian doctors on the staff of the hospital.

One day I had an urgent call from one of the surgical wards. A sailor had been admitted with acute abdominal pain a few hours earlier. There was difficulty in taking a history, as he was an Indian who spoke only Hindi. I was the natural choice to help out. The only problem was that, as one hailing from the southern part of India, I did not speak a word of Hindi. With the patient groaning away, tension was building up. Then wisdom dawned on a bright resident who remembered that the hospital chaplain, an Englishman, who had spent several years in north India might be the right person. He was called in and his knowledge of the

language was superb. The crisis was defused and I started recording the history. The sheer irony of this scene must have pleased the gods, seeing two Indians conversing with each other with the help of a white interpreter.

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We welcome articles of up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for “Endpieces,” consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.