

# Race and ethnicity in medical research

*To the Editor*—Racial and ethnic differences in health and disease are real. For example, in the field of neurology, intracranial stenoses are more common among the Chinese population, and multiple sclerosis is uncommon, when compared with whites from Europe and North America.<sup>1,2</sup> Studying various subgroups is important to detect different patterns of disease and to obtain aetiological clues; race also has implications in monitoring access to public health and in analysing treatment outcomes. In two of the five original articles in the February issue of the *Hong Kong Medical Journal*,<sup>3,4</sup> the descriptive label ‘Mongoloid race’ appeared as a term in the ‘key words’. The intention is to inform readers that the studies investigated a Chinese population and not, say, white Bostonians. Individuals belonging to the same race share a common biological inheritance, whereas members of an ethnic group are characterised by a distinctive history, culture, language, and sense of identity.<sup>5</sup> It is, however, becoming clear that the relative environmental and genetic contributions to both these concepts are complex; it is also difficult to disentangle them from related problems such as poverty and poor housing.

There are three reasons why the term Mongoloid should be avoided. Firstly, modern racial classifications originated from the 18th century taxonomists who categorised *Homo sapiens* into a hierarchy, using superficial characteristics such as perceived skin colour.<sup>6</sup> According to Von Linne’s classification, people who are assigned the label of *Homo asiaticus*—a synonym for Mongoloid—are “haughty” and “covetous”; the same classification describes *Homo afer* (blacks) as being “indolent” and “governed by caprice”.<sup>6</sup> Secondly, the categorisation of people into races has no scientific basis. Race is increasingly regarded as a social construct—only a small number of genotypic variations determine racial traits.<sup>7</sup> Thirdly, there is no clear definition as to what constitutes a Mongoloid person. This grouping is an oversimplification and masks the heterogeneity of people with different languages, cultures, religions, dietary customs, and perceptions on health and disease.<sup>6,8</sup> Regarding race as a mutually exclusive and clinically distinct subgroup results in misleading inferences or outcomes that are difficult to interpret. If race is used, it should be clearly defined. The *British Medical Journal* has made recommendations to

improve the value of ethnicity as an epidemiological variable.<sup>7</sup>

Is there a precedent for abandoning an outdated medical term that carries negative historical connotations? Yes, there is. For example, there is a growing consensus that the eponym Hallervorden-Spatz syndrome should be replaced. We now realise that the German pathologist who first described this syndrome, Julius Hallervorden, was closely connected to and benefited from the murder of disabled individuals designated as inferior by the Nazi regime.<sup>9</sup> Although the word Mongoloid does exist as an *Index Medicus* term, given the racist baggage and imprecise meaning of the term, the *Hong Kong Medical Journal* should consider discouraging its use and using the term Chinese whenever relevant.

ACF Hui, MRCP, FHKAM (Medicine)  
(e-mail: cfhui@cuhk.edu.hk)  
SM Wong, MRCP, FHKAM (Medicine)  
Department of Medicine and Therapeutics  
The Chinese University of Hong Kong  
Prince of Wales Hospital  
Shatin, Hong Kong

## References

1. Li H, Wong KS. Racial distribution of intracranial and extracranial atherosclerosis. *J Clin Neurosci* 2003;10:30-4.
2. Yu YL, Woo E, Hawkins BR, Ho HC, Huang CY. Multiple sclerosis amongst Chinese in Hong Kong. *Brain* 1989;112:1445-67.
3. Hong Kong Medical Coordinators on Child Abuse. Management of child abuse in Hong Kong: results of a territory-wide inter-hospital prospective surveillance study. *Hong Kong Med J* 2003;9:6-9.
4. Samman N, Mohammadi H, Xia J. Cephalometric norms for the upper airway in a healthy Hong Kong Chinese population. *Hong Kong Med J* 2003;9:25-30.
5. Lin SS, Kelsey JL. Use of race and ethnicity in epidemiologic research: concepts, methodological issues, and suggestions for research. *Epidemiol Rev* 2000;22:187-202.
6. Witzig R. The medicalization of race: scientific legitimization of a flawed social construct. *Ann Intern Med* 1996;125:675-9.
7. Bhopal R. Is research into ethnicity and health racist, unsound, or important science? *BMJ* 1997;314:1751-6.
8. Fullilove MT. Comment: abandoning “race” as a variable in public health research—an idea whose time has come. *Am J Public Health* 1998;88:1297-8.
9. Shevell M. Hallervorden and history. *N Engl J Med* 2003;348:3-4.