Introduction

The practice of clinical medicine and the science of epidemiology in Britain have been radically transformed over the last 20 years. With significant numbers of immigrants from both the West Indies and the Indian sub-continent, now living mainly in inner city areas, few clinicians can fail to be aware of the special problems of these minority groups. Diseases once considered rare in Britain including rickets, malaria and tuberculosis have returned and are relatively common in Asians. Sickle cell disease in West Indians is also an important medical emergency. Some of these diseases are imported and some are contracted after arrival. The pathogenesis of some may be at least in part associated with urban overcrowding often in poor areas. What is important is that some diseases, such as rickets, develop in immigrants after they arrive, and others are found in only one of the main ethnic minorities.

Both West Indians and Asians share the psycho-social stress of immigration and relative deprivation when compared with whites. The response in terms of morbidity in the 2 groups of immigrants is, however, widely different. Black people, mainly from Jamaica have fewer diseases which are distinctive to them and this may be because they come from a relatively more westernized country. There remains, however, the continuing mystery of hypertension in blacks. No clinician can fail to notice the high prevalence and severity of essential hypertension in blacks. The increased susceptibility of blacks to raised blood pressure may be due partly to genetic and partly to environmental factors. From a practical point of view, the large numbers of blacks suffering premature strokes provides a continuing challenge.

In addition to the clinical importance of ethnic differences in common disease, there is also the epidemiological view to be considered. Many epidemiological hypotheses on the cause of coronary heart disease and stroke depend on the comparison of widely different population groups. These inter-community differences are then extrapolated to provide explanations of the aetiology of diseases in single populations. The main problem with international epidemiological analyses is that there are always many variables including differences in fashion of diagnoses, the manner of reporting and documentation and multiple environmental factors which confound such studies. In Britain today, with 3 ethnic groups (black, Asian and white) present in significant numbers, we are in a position to conduct epidemiological comparisons between ethnic groups but avoid the problems of international comparisons. A study of the ethnic differences in common disease in Britain may well provide clues to previously unrecognized risk factors which would not have been apparent in a study of whites alone. There is, therefore, an epidemiological spin-off for the indigenous population from these ethnic studies.

There is some urgency here to obtain reliable data, because in national morbidity and mortality statistics racial or ethnic origin is not recorded. The only information in hospital records or death certificates is place of birth. At present, place of birth is a reasonably reliable indicator of race in patients over the age of 30 years. With increasing numbers of black and Asian children being born in this country, place of birth will cease to be a useful indicator of race. From the point of view of epidemiological research it is a pity that demographical and clinical data on patients are not classified, as in America, on the basis of ethnic origin. This is a politically sensitive issue where scientific opportunities are being lost.

In view of the clinical problems of immigrants and the fascinating epidemiological information that study of these problems provides, a special conference was held in the Birmingham Medical Institute and the proceedings of this are published in the present issue of the Postgraduate Medical Journal.

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