Sex or gender?

Should "Declining sex ratios in Canada" (*Can Med Assoc J* 1997; 156:37-41), by Dr. Bruce B. Allan and associates, be reconsidered as "Altered gender ratios at birth"? If there has been a decrease in the proportion of male births, then there has been an obligatory increase in the proportion of female births. Using male gender as a default reference for sex ratio represents (approximately) one-half of the picture.

The use of loaded language such as, "the loss of 5.6 male births per 1000 from 1970–1990," or "the significant decline in male proportion," or "the excess of female births" is inconsistent with the recognition of equal worth of both genders. Neutral terms more accurately represent study findings without subjective judgement of data.

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[The authors respond:]

Ms. Smith and Dr. Tummon raise interesting points. However, the term "sex ratio" has specific meaning within the discipline of reproductive toxicology; in order to communicate with other researchers in this field, standard terminology is required. Sex ratio is a parameter used to monitor biologic health in animal and human populations and refers to the ratio of biologic males to biologic females. In this case, "gender" is not a substitute for "sex" for, although "gender" may imply the biologic makeup of an individual, this is not necessarily so. By using the term "gender" in science, and in toxicology in particular, there is a risk of confusion over whether it pertains to biologic sex or to the masculinization or feminization of that individual. Within toxicology this is a very important distinction, which implies different mechanisms of action. Using "gender" would lead to misclassification problems.

The term "sex ratio" was developed to determine whether or not there is stability within a species as a whole, not to identify whether the specific subsets within the definition (females and males) are increasing or decreasing. Instability is of greater concern to toxicologists. Although the authors' point regarding "loaded language" is well taken, the article uses terms that have well-defined, well-utilized and very specific meanings in biology and toxicology; none is subjective. Until there are widely accepted neutral terms and language, science cannot afford any type of misclassification of an extremely important outcome.

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Inappropriate practices in prescribing: Who decides and how?

Although I support the effort to define and guide optimal prescribing, and I agree that elderly people are an important group, I have reservations about the methods employed in "Defining inappropriate practices in prescribing for elderly people: a national consensus panel," by Dr. Peter J. McLeod and colleagues (*Can Med Assoc J* 1997;156:385-91), and about the meaning of the findings.

Some aspects of the methods are not described, including the method by which the expert panel was recruited, whether any of those approached had declined (and any reasons for doing so), and whether there was an evaluation of the validity of the source lists from standard textbooks. It is not stated whether any of the experts are authors of the lists on which the project was based. It would be interesting to know the degree of agreement on items contributed by individual panel members compared with those assembled from independent lists. We should also know whether panel members were excluded from ranking their own submissions. The method of handling the suggestions for lower-risk alternative therapies was not specified.

The panel members scored the clinical importance of the potential adverse effects of each practice on a 4-point ordinal scale. There is no indication of advance agreement on the scoring process, and the instrument does not discern between the likelihood of a problem and its potential severity. The method of analysis is a simple arithmetic mean, whereas a Delphi technique (alluded to in the introduction but not clearly employed) would have permitted better resolution of any disagreement.

Some of the specific panel views are difficult to reconcile. In Table 1, ß-adrenergic blocking agents are deemed relatively inappropriate for the treatment of hypertension in patients with heart failure. Without access to the scenario, we cannot know whether heart failure is likely to result from impaired systolic function, which is key to the issue. Despite their agreement on that point, only 78% of panellists could agree with