
When medicine is based on racial categorisation

OPINIONS

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The current practice of categorising patients by country of origin, ethnicity or race is subjective and can result in differential treatment with potentially harmful consequences.

In my experience as an obstetrician, the citizens of tomorrow are born as a unique combination of their parents, both genetically and phenotypically. Ten per cent of Norway's population originates from regions outside Europe, North America and Australia, and therefore bears less resemblance to the majority population (1). I grew up in London with a Norwegian mother and a Namibian father, and according to Statistics Norway, the UK is my country of birth. I have brown skin, and some people have wrongly assumed my country of origin to be Italy, Lebanon, Brazil or India, among others.

As a patient with a recurring stress fracture, I was referred for a bone density scan. The healthcare worker I reported to registered me in the system as 'Asian', presumably based on my appearance. When I pointed out the error, I was shown the four categories into which the DXA machine's software divides the entire world's population: White, Black, Asian and Latino.

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Dividing patients according to country of origin, ethnicity or race is often misleading and, at worst, harmful. Take, for example, a case where 'someone like me' is diagnosed with uncomplicated hypertension. The Norwegian Directorate of Health states that '... in individuals of African descent, renin-angiotensin system inhibitors often have a reduced antihypertensive effect, making calcium channel blockers and diuretics more appropriate first-line treatments' (2). However, genetic differences are known to be greater within population groups than between groups classified by ethnicity or race (3). The Norwegian recommendations align with international guidelines and are particularly supported by US studies that compare participants at the group level, divided into 'black' or 'non-black' skin colour. Given that ACE inhibitors show in excess of 80 % overlap in efficacy between black and white patients (4, 5), such guidelines risk denying effective treatment to black patients who would benefit from it. Conversely, white patients who do not respond to this treatment are still likely to receive it.

Also in obstetrics, we find that minor clinical differences are often overstated when framed within a black–white racial dichotomy. For example, it has been pointed out that black pregnant women with hypertension 'do not respond' to labetalol. This interpretation is based on findings that 48 % of black women responded to an *initial* bolus of labetalol, compared to 56 % of white women (6). For all practical purposes, the response rate in both groups was around 50 %, making the result akin to tossing a coin.

Classification by race and ethnicity has therefore been removed from recent guidelines and treatment algorithms (7). For the Norwegian context, I would like to highlight a few examples of work that remains to be done in this area: estimated glomerular filtration rate (GFR) can now be calculated independently of ethnicity using a new Norwegian method (8). Først Medical Laboratory still states that the value should be multiplied by 1.16 for patients of 'African origin' (9), but the Norwegian Society for Medical Biochemistry no longer does this (10). The Nordic Federation of Societies of Obstetrics and Gynecology still cites an e-textbook that refers to ethnicity when describing pelvic shape in pregnant women (11). At worst, this takes the focus away from the far more important relationship between pelvic size and the risk of severe obstructed labour (12).

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A fundamental problem is the lack of consensus and guidance for doctors and other healthcare personnel on how to categorise patients by ethnicity or race (13). When guidelines continue to differentiate based on ethnicity or race, their application depends largely on the doctor's subjective judgment (14). Allowing the patient to self-define can be equally subjective.

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