Tidsskriftet Tidsskrift for Den norske legeforening

When medicine is based on racial categorisation

OPINIONS

PATJI ALNÆS-KATJAVIVI

palnaesk@hotmail.com
Patji Alnæs-Katjavivi, specialist in obstetrics and gynaecology, senior consultant at the Department of Obstetrics and Gynaecology, Oslo University Hospital
The author has completed the ICMJE form and declares no conflicts of interest.

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.

> *«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»*

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). Fürst 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).

> ***«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»***

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.

REFERENCES

1. Statistisk sentralbyrå. Innvandrere og norskfødte med innvandrerforeldre. https://www.ssb.no/befolkning/innvandrere/statistikk/innvandrere-og-norskfodte-med-innvandrerforeldre Accessed 22.5.2025.

2. Helsedirektoratet. Legemiddelbehandling av høyt blodtrykk. https://www.helsedirektoratet.no/retningslinjer/forebygging-av-hjerte-og-karsykdom/legemidler-ved-primaerforebygging-av-hjerte-og-karsykdom/legemiddelbehandling-av-hoyt-blodtrykk Accessed 20.5.2025.

3. Mersha TB, Beck AF. The social, economic, political, and genetic value of race and ethnicity in 2020. Hum Genomics 2020; 14: 37. [PubMed] [CrossRef]

4. Shahu A, Herrin J, Dhruva SS et al. Disparities in Socioeconomic Context and Association With Blood Pressure Control and Cardiovascular Outcomes in ALLHAT. J Am Heart Assoc 2019; 8: e012277. [PubMed][CrossRef]

5. Sehgal AR. Overlap between whites and blacks in response to antihypertensive drugs. Hypertension 2004; 43: 566–72. [PubMed] [CrossRef]

6. Taylor D, Marchetto N, ChuLam M et al. Racial disparity in the treatment of severe hypertension with labetalol. ACOG 2019; 220: S295.

7. Vyas DA, Eisenstein LG, Jones DS. Hidden in Plain Sight - Reconsidering the Use of Race Correction in Clinical Algorithms. N Engl J Med 2020; 383: 874–82. [PubMed][CrossRef]

8. Pottel H, Björk J, Rule AD et al. Cystatin C-Based Equation to Estimate GFR without the Inclusion of Race and Sex. N Engl J Med 2023; 388: 333–43. [PubMed][CrossRef]

9. Fürst. Nyrefunksjon. https://www.furst.no/analyse-og-klinikk/kliniske-problemstillinger/nyrefunksjon/ Accessed 7.6.2025.

10. Metodebok.no. Medisinskbiokjemi (Nasjonal/NFMB). EstimertGFR. https://metodebok.no/index.php?action=topic&item=33352d78614e1031a2e6 Accessed 7.6.2025.

11. Nordic Federation of Societies of Obstetrics and Gynecology (NFOG). Obstetrics. Kapittel 29. Labor dystocia. Cephalopelvic disproportion. https://www.sundhed.dk/sundhedsfaglig/opslag-og-vaerktoejer/laereboeger/obstetrics-gynecology/obstetrics/ 0-29-labor-dystocia/ Accessed 23.5.2025.

12. Betti L. Shaping birth: variation in the birth canal and the importance of inclusive obstetric care. Philos Trans R Soc Lond B Biol Sci 2021; 376.. [PubMed]

13. Savage LC, Panofsky A. The Self-Fulfilling Process of Clinical Race Correction: The Case of Eighth Joint National Committee Recommendations. Health Equity 2023; 7: 793–802. [PubMed][CrossRef]

14. Rabay CJ, Lopez C, Streuli S et al. Clinicians' perspectives on race-specific guidelines for hypertensive treatment. Soc Sci Med 2024; 351: 116938. [PubMed][CrossRef]

Publisert: 7 August 2025. Tidsskr Nor Legeforen. DOI: 10.4045/tidsskr.25.0345
Received 23.5.2025, first revision submitted 8.6.2025, accepted 12.6.2025.