

# A Call to Action for Addressing Disparities and Increasing Diversity in Academic Nephrology

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As a Black woman growing up in the Southern United States, I was accustomed to seeing “the look,” the look of ineptitude, incapability, and inferiority from many White people in my community. This was something I grew to expect, to be seen as a person not good enough and not belonging because of the color of my skin. My experience was no different than any other Black person in my community. It was the same look our ancestors experienced, but, because it was now the 21st century, there was no longer supposed to be racism—or so was the illusion. However, on May 25, 2020, America finally got a chance to see the look we as Black people knew was always there, the look of disdain and disregard for life when George Floyd was savagely murdered by police. His murder erupted an outcry for racial justice, awakening an awareness among many that systemic racism exists in not only criminal justice but also in education, housing, employment, wealth generation, access to health care, and more. It has been well described over the past several decades that racial disparities exist in each of these areas, with studies showing disparities in employment, where companies show preference for White applicants compared with applicants of color by as much as 50%–240% (1). Also, there are disparities in housing, where segregated neighborhoods persist, causing not only worse health outcomes from a lack of access to parks, sidewalks, healthy foods, and physical fitness facilities, but also worse-performing public schools, because school funding relies heavily on property tax dollars and the tax base generated from these neighborhoods is substantially lower than predominantly majority neighborhoods (1,2). Furthermore, disparities exist in wealth generation, where White people possess more than ten times the wealth of Black individuals, and in access to health care, where rates of uninsurance are higher among Black compared with White people (1). Moreover, Black individuals have disproportionately higher rates of chronic illness, including greater risk of progression from early stage CKD to ESKD (3).

Over the years, little has been done to close these inequity gaps across our society and across our academic institutions. In academic nephrology specifically, Black people make up only 1%–5% of the nephrology faculty, with very few in key leadership positions (4). This has not gone unnoticed by patients of color, where studies have shown their preference for

medical care from physicians of color (5). Unfortunately, the lack of racial and ethnic minority physicians has been a tragedy for both recruiting and retaining more diverse faculty, and has become a criticism of many for leaving academia altogether. Therefore, to increase diversity in academic nephrology, there must be both short-term and long-term strategies involving faculty recruitment and promotion and community outreach to build a pipeline for future nephrologists of color. Perhaps the biggest change, however, will need to come from a renewed research agenda that no longer focuses solely on describing racial disparities, but also includes greater efforts to erase them. The work of describing disparities is important, but too often this is where the effort stops. The current practice of only enumerating racial disparities, without simultaneously doing more to address them, serves to further cement the racial divisions forged by institutional racism and reinforces the false premise that minorities are somehow inherently different and not victims of generational disenfranchisement. Instead, research and research funding institutions should travel a new path that actively seeks disparity elimination by funding more projects with this goal. Given America’s complex and insidious past with racial discrimination, these funding efforts will need to support not only academically centered clinical trials but also community-based research endeavors to be effective.

There are many racial disparities already well described in literature regarding CKD and kidney transplantation, for example, with studies showing an increased risk of progression to ESKD among Black individuals, but few studies demonstrate a clear approach to relieving this disparity (3). Not only that, but there is also a scarcity of research to reduce the disparities in outcomes among patients of color with diabetes and hypertension. Furthermore, research to increase Black participation in clinical trials is lacking because many still feel reluctant after the dehumanizing treatment of Black people during the Tuskegee study. Finally, there is a dearth of studies examining ways to reduce barriers in kidney transplantation among minorities because their rates of transplantation are less than that of White patients (3). Unraveling these disparities will be complex and will require a multifaceted approach involving multiple agencies and institutions, including community-based organizations like faith and civic agencies.

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In addition to these research efforts, there will also need to be a greater investment in community outreach programs that target underserved minorities, with the goal of expanding the pipeline for future diversity in academic nephrology. Outreach efforts will need to be comprehensive, encompassing various aspects of the community to include education and health awareness. For example, many high-school students of color do not pursue careers in science or health care, in part, because of a lack of exposure to these professions and from seeing a paucity of other minorities who look like them in these careers. Therefore, both minority faculty of color and majority faculty can be incentivized to establish mentorship programs in underserved high schools to increase their exposure to academic nephrology. Ideas for mentoring, especially in the age of the coronavirus disease 2019 pandemic, can include 1-hour virtual sessions explaining what it means to be a physician or basic scientist in nephrology and how this is helping to treat diseases that are disproportionately high in communities of color. Other ideas for high-school outreach include establishing education programs or partnering with local entities to teach high-school students about the kidney and the risk factors leading to kidney disease. Furthermore, community outreach can involve giving high-school and undergraduate students of color the opportunity for summer science research programs and physician-shadowing experiences to increase their exposure to the field.

If academic nephrology divisions are to embrace these progressive research and community-oriented diversity initiatives, then there will also need to be a renewed approach to how faculty of color are recruited and retained. For recruitment, the goal should be a substantial increase in racial and ethnic minority faculty over the next 5–10 years. This may require changes in the manner in which faculty are recruited and, perhaps, would require a candidate of color to be considered, along with other candidates, for every available open position to ensure that openings are not invariably filled by majority candidates. These recruitment efforts will endure if supported by improvements in retention. First, retention will be enhanced if there is a clear path to advancement that highlights strategies for timely promotion and tenure, and does not obligate faculty of color for service responsibilities that distract from career-advancement goals. Ways this can be achieved are through the establishment of faculty-mentoring programs and through the assurance that candidates of color will be afforded the same career-advancing opportunities as majority candidates. These mentorship programs will need a guarantee of effectiveness by providing protected time for mentorship and furnishing incentives once certain benchmarks are achieved. Other strategies for retention include creating a welcoming culture for diversity, such as hosting diverse speakers for lectures to teach topics that are not just diversity related but also encompass basic science and key principles in clinical nephrology. In addition, a welcoming culture can be created if issues surrounding bias are clearly addressed and not dismissed, and if there are clear policies and procedures in place that deal with racism from patients. Moreover, racial and ethnic minority faculty may be more likely to remain in academia if their presence and success is highlighted, such as through media campaigns.

These diversity initiatives and renewed research objectives are just a starting point to help our academic nephrology divisions look more representative of our society

and of the people we serve. Increasing diversity not only benefits minorities but it also benefits the institution as a whole by allowing the organization to see things from a different perspective, to have more creative ideas, and to approach problem-solving from a unique point of view. These things, in turn, lead to greater productivity, a greater sense of community, and enhanced patient care. Also, there will be a dedicated workforce of more faculty of color, and hopefully majority faculty, to work on these important goals. Furthermore, it could increase the appeal for a greater matriculation of students of color into medical school, graduate school, and residency programs that would also further the pipeline of more academic nephrologists and research scientists.

The American Society of Nephrology is already making great strides as a leader in the promotion of diversity and inclusion with the commencement of new initiatives, such as their loan-mitigation program for aspiring nephrologists who are underrepresented minorities, and their society having a more diverse council and more diverse speakers and moderators during their 2020 Kidney Week. These actions, along with embracing a more progressive research focus, will be a great step forward to having a new look of diversity and inclusion that our society desperately needs.

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#### Author Contribution

C. Lyas wrote the original draft.

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