for Kidney Scholars (TREKS) program at the University of Chicago has a disparities and outreach module. In addition, there are plans to provide educational resources including unconscious bias training with nephrology-specific clinical vignettes that can be used to train decision-makers, including division leadership and interviewers of nephrology fellowship applicants. Furthermore, the production of a report providing statistics on racial disparities in nephrology on all levels, including leadership, workforce, training programs, and patients, is expected.

To ensure accountability in the efforts toward building a more diverse workforce at all levels of training and leadership, we also propose a metric of performance: a diversity score. The aim of this score is for nephrology divisions to self-evaluate and reflect on areas of improvement. Although it is encouraging to see this topic start to gain the attention it deserves, it will take time to see improvement up to the leadership level. It is time to come together and put an end to institutional racism in nephrology training and build a culturally competent community to ensure equitable care—an individualized but unbiased care. ■

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Table 1. Top 5 suggestions for training programs

1. Training
- Incorporating health equity and cultural competency training into the education curriculum
- Implementing unconscious bias training
- Inviting speakers with expertise in health equity and cultural competency
- Providing self-evaluation tools (proposed diversity score)
- Providing and nurturing a safe space for sharing experiences
- Bringing students, residents, and fellows to the discussion table (i.e., diversity and inclusion, recruitment, quality improvement, clinical competency committees)

2. Workforce
- Providing scheduled platforms for discussion, self-reflection, and brainstorming
- Inviting health equity champions including those from other specialties
- Providing self-assessment tools
- Creating health diversity, equity, and inclusion leadership positions within nephrology divisions

3. Recruitment
- Advocating for less stringent test score criteria for otherwise deserving applicants
- Opening doors for international medical graduates
- Presenting incentives to retain fellows of URM backgrounds as faculty including providing access to research grants to deserving fellows

4. Research and advocacy
- Focusing on data-driven care and encouraging research
- Arranging quality improvement projects and community work
- Collaborating with other departments such as public health, global health
- Creating a Research Oversight Committee looking into appropriate representation in research studies

5. Mentorship
- Providing opportunities to mentor undergraduate or medical students from different backgrounds
- Linking fellows with former graduates of URM background
- Expanding kidney MAPS and proposing URM pipeline program for mentoring and recruiting URM students and residents into nephrology training programs

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Higher Allograft Failure Rate for Biologically Related Donor-Recipient Pairs

After accounting for human leukocyte antigen (HLA) mismatch and other factors, survival of living-donor kidney allografts is longer for transplants from unrelated donors compared to related donors—particularly for Black or African American donor-recipient pairs, reports a study in *JAMA Network Open*.

The researchers analyzed 72,980 adult living-donor kidney transplants, identified using Organ Procurement and Transplantation Network data from 2000 through 2014, with follow-up to 2020. The median donor age was 41 years; 60% were women. In 59% of transplants, donors and recipients had some degree of biologic relationship.

Rates of death-censored allograft failure were compared for biologically related and unrelated pairs, with adjustment for number of HLA mismatches and other characteristics, including primary diagnosis of cystic kidney disease and donor race (African American versus non-African American).

Donors in biologically related pairs were younger (39 versus 44 years), less likely to be women (58% versus 64%), and less likely to be White (62% versus 77%). Recipients in related pairs were younger (48 versus 50 years), more likely to be women (42% versus 35%), and less likely to have cystic kidney disease (6% versus 15%). Biologically related pairs had fewer HLA mismatches: 3 versus 5.

Allograft failure occurred in 17% of unrelated and 19% of related transplants; recipient death rates were also 17% and 19%, respectively. After adjustment for HLA mismatch, the rate of death-censored allograft failure was significantly higher for the biologically related pairs: hazard ratio (HR) 1.26.

The association was attenuated but remained significant after adjustment for donor and recipient characteristics (HR 1.06) and study era (HR 1.05). On analysis stratified by donor race, the increase in death-censored allograft failure was significant only for transplants from African American donors: HR 1.12.

The proportion of living-donor kidney transplants in the United States has increased substantially over the past 2 decades. The effects of this trend on allograft outcomes remain unclear.

The new analysis shows a higher allograft failure rate among recipients of living-related kidney transplants from biologically related donors. The association persists after accounting for donor and recipient characteristics, including HLA mismatch. "These findings suggest that kidney donors who are related to their recipients may share genetic or socioenvironmental predispositions to kidney disease that shorten allograft longevity," the researchers write [Husain SA, et al. Association between donor-recipient biological relationship and allograft outcomes after living donor kidney transplant. *JAMA Netw Open* 2021; 4:e215718. doi: 10.1001/jamanetworkopen.2021.5718]. ■