Identifying, Confronting, and Addressing Systemic Racism in US Nephrology

By Crystal A. Gadegbeku, Tod Ibrahim, Anupam Agarwal, and Susan E. Quaggin

In the United States, people who are Black or African American, Hispanic or Latinx, Indigenous or Native American, Asian American, and Native Hawaiian or other Pacific Islanders (NHPIs) are underpaid, financially disadvantaged, and underrepresented in corporate leadership and government. When compared to White Americans, minoritized people have higher rates of unemployment, have been denied opportunities to build wealth, are more likely to have mortgage applications rejected, face higher debt for student loans, and are less likely to have the same educational opportunities.

Besides experiencing discrimination and being poorer with fewer professional opportunities than White Americans, Black and Latinx Americans are less likely to have health insurance, have less access to health care, and experience lower-quality care when they do have access. They also have higher rates of kidney diseases, asthma, cancer, cardiovascular diseases, diabetes, HIV/AIDS, hypertension, and obesity, to name a few chronic diseases. The COVID-19 pandemic has accentuated and exacerbated these health disparities and inequities: Black, Latinx, and Indigenous people are more likely to be infected by and die from the virus, whereas White Americans disproportionately received more vaccinations in the early stages of the rollout (1).

Addressing these disparities and inequities requires identifying and confronting racism on a systemic level. Health status closely correlates with racism and socioeconomic status (as does allostatic load), which is further stagnated by a lack of upward mobility through multiple generations. In addition to health and health care, these social determinants of health include economic stability, social and community context, neighborhood and built environment, and education.

Unfortunately, the educational system in the United States (including undergraduate and graduate medical education) disadvantages people who are Black, Latinx, Native American, and NHPIs. Black Americans are currently 13.4% of the US population, but racism undermines their opportunity to pursue professions like medicine where few apply (8.4%), matriculate (6.2%), match into residency programs (5.1%), work in academic medicine (3.6%), or reach the rank of full professor (1.9%) (Table 1). From 1970 to 2020, the percentage of Black Americans graduating from US medical schools has not changed, whereas, by comparison, the percentage of women has increased from 8.4% to 49.6% (2).

The Association of American Medical Colleges defines "underrepresented in medicine" (UIM) as "those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population" (3). Nephrology has a higher percentage of UIM fellows than most other internal medicine specialties, particularly cardiology, gastroenterology, hematology/oncology, pulmonary and critical care medicine, and rheumatology (4). "With the exception of rheumatology, the subspecialties with the lowest percentages of UIM fellows were also the largest fellowships and the more procedural specialties."

As illustrated in Table 2, US medical schools need to quadruple the number of Latinx and double the number of Black medical students to begin to make medicine more representative. Until this important goal is accomplished, every medical specialty is competing to attract a limited number of underrepresented students into their residency and fellowship positions. How limited? Of the 19,938 graduates of US medical schools in 2019, only 1,238 and 1,063 identified as Black or Latinx, respectively (5).

The situation is equally troubling for PhDs. Less than 2% of the PhDs who receive funding from the National Institutes of Health (NIH) are Black, Latinx, Native American, or NHPI researchers. As was asserted in a recent editorial, "The NIH director and leadership must recognize that its previous approaches, most of which have focused on filling the 'pipeline' without simultaneously addressing our profession's systemic racism, have failed" (6). It is impossible to have a leaky pipe when no pipeline exists, so it is not surprising that fewer underrepresented individuals receive funding for their research, hold key leadership positions, or become endowed professors.

Taken together, these sobering facts contribute to the current disparities and inequities we face in nephrology: Of the more than 37 million adults with kidney diseases in the United States, a disproportionate number are Black, Latinx, Native American, Asian American, and NHPIs. The kidney health consequences these Americans face are particularly horrifying (Table 3). To advance kidney health, the American Society of Nephrology (ASN) must address systemic racism that results in health-related disparities and inequities in social determinants of health.

For the past decade, ASN has focused on promoting diversity and inclusiveness within the society to enhance the nephrology profession and the lives of people with kidney diseases through improved health care, research, and education. ASN supports two Harold Amos Medical Faculty Development Program Scholars from historically disadvantaged backgrounds, provides travel support for 25 ASN members each year to attend the National Institute of Diabetes and Digestive and Kidney Diseases' Network of Minority Health Research Investigators Annual Workshop, and requires implicit/unconscious bias training for the society's leaders and staff. Later this year, ASN will initiate a loan mitigation pilot program, funding six nephrology fellows annually from minority populations.

ASN fully recognizes the need to do more to address inequities that negatively impact the kidney community. Therefore, building on these initiatives, ASN in 2021 is prioritizing opportunities to address health disparities and influence social determinants of health in the United States and throughout the world, particularly in populations at risk for and overburdened with kidney diseases; highlighting specific health-equity issues that should be addressed on a policy level; working to achieve optimal care for all people at risk for and overburdened with kidney diseases; and helping to dismantle racist structures that impact social determinants of health and lead to health disparities and inequities.

This summer, the National Kidney Foundation (NKF)-ASN Task Force on Reassessing the Inclusion of Race in Diagnosing Kidney Diseases will inform the kidney community and other stakeholders on how to move forward with an inclusive, equitable measurement of kidney function that recognizes race as a social, not a biological, construct (7). Through this process, NKF and ASN have ensured that any change in eGFR reporting carefully considers the multiple social and clinical implications, be based on rigorous science, and be part of a national conversation about uniform reporting of eGFR within, between, and among health care delivery systems. ASN is proud that the kidney community is taking the lead in critically evaluating the use of race in this clinical algorithm, likely forging a path for other specialties to follow in addressing this issue.

Identifying, confronting, and addressing racism in health care, in general, and kidney medicine, in particular, will require a wide-ranging approach and partnerships with myriad stakeholders beyond the kidney community. For example, ASN agrees with "The Moral Determinants of Health," which include having the United States (and many other democracies) ratify "the basic human rights treaties and conventions of the international community," stating in statute "health care as a human right" (and a wise investment of resources to promote wellness that fosters opportunity for people to contribute meaningfully to society), "restoring US leadership to reverse climate change," "achieving radical reform of the US criminal justice system," "ending policies of exclusion and achieving compassionate immigration reform," "ending hunger and homelessness," and promoting "order, dignity, and equity to US democratic institutions and ensuring the right of every single person's vote to count equally" (8).

As a first step toward achieving these goals, the American College of Physicians (ACP) in January 2021 unveiled "A Comprehensive Policy Framework to Understand and Address Disparities and Discrimination in Health and Health Care" (9). This approach includes recommendations to "create safe, inclusive, and supportive educational and workplace environments"; "address disparities in coverage, access, and quality of care for racial and ethnic minorities"; and change "criminal justice and law enforcement policies and practices that result in racial and ethnic disparities in interactions, sentencing, and incarceration and disproportionate harm to these communities."

As a member of the ACP Council of Specialty Societies, ASN looks forward to working closely with ACP to help implement this framework. ASN and ACP are also members of the Council of Medical Specialty Societies (CMSS), a coalition that includes 45 medical societies representing more than 800,000 US physicians. CMSS has partnered with the Accreditation Council for Graduate Medical Education to launch "Equity Matters: A Diversity, Equity, Inclusion, and Antiracism Initiative for Physicians and Medical Leadership."

The United States offers tremendous opportunities, hope, and audacity difficult to match elsewhere. A promising future for this country, however, depends on overcoming systemic racism today for all Americans to enjoy healthy and happy lives. ■

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Table 1. Black and African Americans in academic medicine

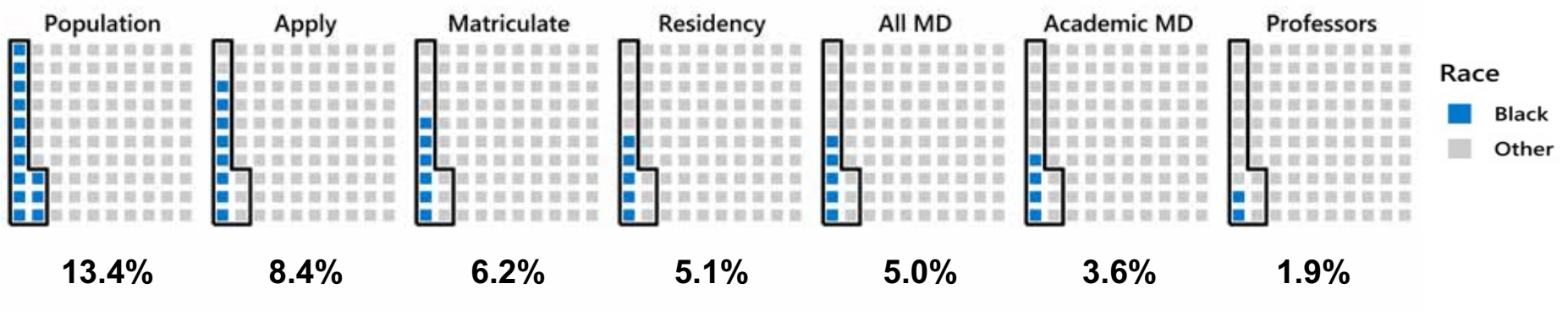

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Table 2. The US population and US medical school graduates by race and ethnicity*

	US population		US medical school graduates in 2019
	2020	2030	
White	60.1%	55.8%	54.6%
Hispanic or Latinx	18.5%	21.0%	5.3%
Black or African American	13.4%	12.8%	6.2%
Asian American	5.9%	6.7%	21.6%
Multiracial	2.8%	2.8%	8.0%
Indigenous or Native American	1.3%	0.7%	0.2%
Native Hawaiian or other Pacific Islanders	0.2%	0.2%	0.1%

*Does not equal 100% due to rounding and other counting issues.

Association of American Medical Colleges. Diversity in Medicine: Facts and Figures 2019. Figure 13. Percentage of U.S. medical school graduates by race/ethnicity (alone), academic year 2018–2019. Accessed May 24, 2021. https://www.aamc.org/data-reports/workforce/interactive-data/figure-13-percentage-us-medical-school-graduates-race/ethnicity-alone-academic-year-2018-2019

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Table 3. Kidney health disparities and inequities in the United States: A partial list

1	Black people comprise 13.4% of the US population but 33% of the nation's population on dialysis for kidney failure.
2	Kidney failure prevalence is about 3.5 times greater in Black people, 2.7 times greater in Native Hawaiians and Pacific Islanders (NHPIs), 1.5 times greater in Latinx people, and 1.4 times greater in Native Americans than in White Americans.
3	Kidney failure is increasing among Native Americans at an alarming rate (nearly 10% between 2017 and 2018 alone), while decreasing among White Americans during the past decade.
4	People who are Black, Latinx, Native American, and NHPI are significantly less likely than their White counterparts to receive any kidney care before kidney failure, missing key opportunities for intervention.
5	The median age of initiating dialysis is younger for NHPIs (57 years old) than for Whites (65 years old).
6	Black, Latinx, Native American, and NHPI people on dialysis are significantly less likely than their White counterparts to receive a kidney transplant and are also less likely to receive a living donor kidney transplant (the optimal type of transplant) than Whites.
7	Even though NHPIs experience better survival for kidney transplants, they have substantially lower transplant rates compared with Whites.
8	Black Americans have disproportionately high rates of kidney transplant (allograft) failure compared to White Americans, with up to a 60% higher risk of allograft failure.
9	When compared to White Americans, Black Americans are less likely to be placed on the transplant waiting list and, once on it, experience disparities in the time it takes to receive a kidney.
10	Every racial/ethnic minority group in the United States is significantly less likely to be treated with home dialysis than White Americans, and demographic and clinical characteristics are insufficient to explain this differential use: Home dialysis is 40% to 50% lower among Black and Latinx people compared to Whites.