characterize the three-dimensional structure of glomerular loop development and mesangial arborization and the molecular cues that drive these processes will likely reveal novel aspects of glomerular developmental disorders.

DISCLOSURES

None.

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See related articles, “A Novel Role for GATA3 in Mesangial Cells in Glomerular Development and Injury,” and “Early B Cell Factor 1 (EBF1) Regulates Glomerular Development by Controlling Mesangial Maturation and Consequently COX-2 Expression,” on pages 1641–1658 and 1559–1572, respectively.

Another Example of Race Disparities in the US Healthcare System

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The medical literature is rife with studies showing how minority groups fare worse than their white counterparts in arguably every outcome and from cradle to grave. Black babies are twice as likely to die as white babies.1 Black people choose hospice a third less often than white people and disenroll at higher rates.2 Further, many a researcher has built an academic career pointing out these disparities, without ever suggesting real ways to overcome them. In this issue of JASN, Wen et al.3 provide us with yet another example.

When they examined trends of palliative care utilization among patients on dialysis who were hospitalized between 2006 and 2014, they found palliative care utilization was several-folds lower than for other serious illnesses, that utilization increased over time, and that blacks and Hispanic patients were 28% to 54% less likely to use palliative care services, respectively, than white patients.

These disparities persisted among all hospital and patient-level characteristics, except possibly for age which was not shown. Given that those who did not receive palliative care were younger and that black and Hispanic people tend to progress to ESKD faster and at younger ages than their white counterparts (another disparity!), this may explain some of the disparity.4

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The authors cite the lack of information regarding religion and cultural beliefs, to determine their effects on palliative care utilization in the data set, as a limitation. To specify this as a limitation suggests religion and cultural beliefs would explain differences in palliative care. Although most black participants in a 2014 Pew Center survey did report religion as very important in their life, clinicians should be careful not to make this assumption, as 25% of reported religion was just “somewhat” or “not at all important” in their lives. However, what truly underlies this commentary is an assumption that the root of disparities lies within the group, rather than how the system perceives the group. At best, clinicians seem to perceive disparities as the result of providers less well meaning or dedicated than themselves.

The authors were surprised to find that black and Hispanic patients received less palliative care even in high- and medium-minority hospitals compared with white ones, “where presumably providers were exposed to a higher volume of minority patients.” Not only does this finding underscore the importance of a diverse provider workforce, but also that nonminority providers must do more than simply exist with large minority populations if disparities are to be resolved.

The United States has a legacy of treating all but its cisgender, heterosexual, Protestant, white men unfairly. The healthcare system has been no different. The most egregious example is perhaps the Tuskegee syphilis experiment, in which the Public Health Service chose to observe the natural history of syphilis in black men for 40 years (1932–1972), 25 of which were after penicillin became available. No one has forgotten.

We must recognize that our patients do not check their knowledge and beliefs about how they are treated in this country like coats at our hospital and clinic doors. But perhaps more importantly, providers must recognize that we are not somehow immune to the effects of the society and system that raised us—even if we believe that we “do not see color.” The truth is, if we don’t see color and acknowledge the effect it has on our patients’ lives, then we can’t see—or equitably treat—all.

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See related article, “Trends and Racial Disparities of Palliative Care Use among Hospitaled Patients with ESKD on Dialysis,” on pages 1687–1696.

Variation in Kidney Transplant Referral: How Much More Evidence Do We Need To Justify Data Collection on Early Transplant Steps?

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Referral to a transplant center for a medical eligibility evaluation is the initial necessary step to receiving a kidney transplant among patients with ESKD. The data reporting this critical step are lacking because patient referral information is not captured in national surveillance data. Prior work has shown that barriers to early steps in the kidney transplant process may be different from other downstream steps. For example, barriers to transplant referral may not align with the barriers that referred patients face in accessing the waiting list.1 This suggests that the efficacy of specific interventions in improving referral outcomes will depend on the issues they address. For example, if a major barrier to starting the transplant evaluation is access to transportation, providing

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