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EDITORIAL

Worker equity in renal medicine

Introduction

The most important quality of the physician as a leader is to discharge duties (practice) with competence, integrity and courage, to the wider benefit of society, with cost-effectiveness, research, medical education and innovation. Physician qualities are humanistic, and practices are accountable to peer and societal expectations. We discuss two studies, by Rogers *et al.*[1] and Francis *et al.*,[2] published in this issue of the *Internal Medicine Journal*. Using different research methods, each having recognised limitations, the role of worker inequality with gender, ethnicity, professional role and leadership was examined. Both studies confirmed the contemporary existence of worker inequality within the field of nephrology and recommended progress on workforce advocacy and equity actions.

In the first study, themes and authorship of broad research area within abstracts published during 2005–2020 Annual Scientific Meetings of the Transplantation Society of Australia and New Zealand (TSANZ) and Australia and New Zealand Society of Nephrology (ANZSN) were explored.[1] Rogers *et al.* reported an increase in nonbasic science research abstracts, and female first authors of those abstracts during this time, although there were proportionately fewer female presenters of basic science research.[1] The total number of abstracts over time or the definition of abstract role seniority was not clearly defined, either by advanced technical expertise, hierarchies of competency, years in the industry or professional role assignment. Contextual observations by Rogers *et al.* acknowledged initiatives led by ANZSN and TSANZ to promote gender equity in conference participation as promoting factors to female basic science researcher participation. This was contrasted with an overall higher monetary investment across all Australian research (basic, applied and experimental), though proportionately fewer grants to senior basic scientists for female applicants, and sustained proportional decrease in basic science funding (63.6% in 1992, 41.4% in 2016).[3] In contrast, increased clinical and health services research abstracts may have occurred following Australia's implementation of activity-based funding in 2014.[4] The impact on the breadth and scope of societal benefit by both lower access to basic science knowledge discovery and lower access to gender-balanced research leadership was argued.[1]

The second study, commissioned by the ANZSN Equity and Diversity and Inclusivity Committee, invited ANZSN members to complete an online survey of workforce experiences.[2] Respondents were 21.6% of the membership, who identified as female (59%), of White race (61%), Australian born (40%), primary role identified as nephrologist (75%) and aged 40–59 years (51%).[2] Key findings included '88% of respondents believed inequities existed within the nephrology workforce', 56% had 'personally experienced inequity', where a majority of those members reported 'there was no one in the workforce to turn for assistance when experiencing inequity in their careers'. Options for the ANZSN to explore were invited. Some of the free-text responses noted ANZSN 'should not address inequity' or 'should focus solely on merit' while other responses, from 'females and males from racial minority groups, provided most of the suggestions to address inequities within the (ANZSN) society'. Overall, the authors felt 'the impact of discrimination appears profound' and warrants 'institutional change'. Although Francis *et al.*[2] sought to address equity in the survey, the questions were more so related to equality, and the difference between these two entities was not well defined in the survey for the participants.

> Nothing is more important than empathy for another human being's suffering. Nothing. Not a career, not wealth, not intelligence, and certainly not status. We have to feel for one another, if we're going to survive with dignity. – Audrey Hepburn

Equity and equality

Equality means each individual or group of people is given the same resources or opportunity (regardless of starting position or starting difference). Equity recognises that each person has different circumstances and allocates the exact resources and opportunities needed to reach an equal outcome. Inequities occur when biased or unfair policies, programmes, practices or situations contribute to a lack of equality in educational performance, results and outcomes (such as health or employment). Professor Camera Jones defined institutionalised racism as 'differential access to the goods, services, and opportunities of society by race … is normative,

sometimes legalised, and often manifests as inherited disadvantage … (and) often evident as inaction in the face of need'.[5]

Implementation of equality or equity can lead to dramatically different outcomes for marginalised people. While the relevant debates are both numerous and nuanced, many points of difference centre on divergent interpretations of fairness and equality, as highlighted by divergent views of 'merit' observed by Francis *et al.*, where one group but not all seeks intervention.[2] Since both perceptions exist, the instrument of leadership (or role seniority), which works for optimal workplace outcomes, is critical to support workers who experience inequity. Medical leadership has the opportunity and mandate to catalyse broad societal benefit, when applied systemically (at all levels of health organisation and career stage). Medical leadership that values holistically the intellect as a skill and humanistic conscientiousness, and is equipped to facilitate fairness for workers, may address the presently absent structured support identified by ANZSN survey respondents.[2]

Shaping and sustaining physician practices and leadership

Many inputs shape contemporary pathways to qualification, leadership style and physician practice. Australian physicians of the 1930s promoted 'active and energetic young men' of 'Anglo-Australian identity [of] the British empire'[6] in advocacy of a regionally responsive Royal Australasian College of Physicians (RACP). They sought distinction from the London-based Royal College of Physicians, whose creation in 1518 affirmed 'leading males' of England as the normalised occupation of physician.[7] Social and cultural constructs that normalised gendered employment are not universally recognised across all cultures or across time. The duties in delivering care by the physician remain connected to their 'souls' as an individual. Similar to an ancient yogic philosophy that understands that the masculine and feminine qualities exist within a given individual, whereby a living creature exists as an ungendered soul.[8]

Mechanisms of institutionally led health inequity

The impacts of colonisation and institutional racism continue to be experienced by Indigenous peoples throughout the world, including within the region of the ANZSN. Respondents identified ANZSN explore equity actions for Aboriginal and Torres Strait Islander people;[2] therefore, readers are invited to reflect on the mechanisms local to Australia of institutionally led health inequity, though may operate differently elsewhere. The year 1788 marked the British Imperial Empire's conquest upon sovereign lands of Aboriginal and Torres Strait Islander peoples, which established a local governance, legislative environment and policy- and government-directed work activity intent on colonising and subjugating First Nations Peoples. Excluded from the Australian Constitution in 1901, full federal voting rights until 1962 and citizenry rights, Aboriginal and Torres Strait Islander peoples were unable to contest the creation of laws that enforced their own subjugation through enforced land acquisition (land theft), displacement into vulnerable situations and denial of rights to hold land title, and did not require government responsibility to provide quality education, fair access to employment and equitable and fair wages. Family structures were also targeted, by restriction of marriage and provisioning removal of children from unwed women, who were Anglo-assimilated and concurrently punished for maintaining cultural connections and practices. Narratives that upheld those policies and since refuted included Terra Nullius (nobody's land) and a false benevolence to assist a dying race of Aboriginal peoples. Enabling those policies required a complicit healthcare system and health professionals who encountered 'at-risk' children (as defined by those policies) were referred for removal. Healthcare settings and health professionals were not places of trust or to safely access healthcare, health advocacy or health justice. Without challenge, those policies foregrounded social and cultural determinants of poorer health and inequitable health outcomes of Aboriginal and Torres Strait Islander peoples and are subspecialty focus areas of contemporary RACP generalist and specialist fellows. Federal and state government leadership, which has humanistic capability and accountable to societal expectation, have acted to declare the sustained harms of former government policy, such as the Stolen Generations policy, and committed to redress, 'as an investment in justice and truth'[9]; likewise, the RACP publicly acknowledges health harms of racism.[10]

Contemporary physicians workforce

In 2000, Australia implemented significant changes to address both the shortage and maldistribution of doctors' practice. Australia welcomed qualified international medical graduates, who served initially as clinicians and later in leadership roles, especially in outer metropolitan and regional areas. Additional medical school training centres were funded and resulted in a trebling of Australian medical school graduates and a diversified demographic. First was the sustained increase in

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commencing students who were female (54.3% in 2021, than 51% in 2000), second, approximately one fifth of medical students received rural health training,[11] and, third, a sustained growth in Aboriginal and Torres Strait Islander medical students (increasing from 1.97% in 2016 to 2.7% in 2020) was observed. Significant to this growth was leadership, advocacy and commitment of Aboriginal and Torres Strait Islander communities through the now 50 years of the Aboriginal Community Controlled Health sector, including the Australian Indigenous Doctors Association, which maintains strategic partnerships with college of medical deans and specialist colleges.[12]

Australia's health system has benefited in the past decade from that increase in locally trained medical graduates who have attained specialist credentialling and taken up clinical and leadership positions in medicine (and nephrology). Those embedded workforce innovations should have enabled more diverse and inclusive representation in nephrology in leadership and research. However, worker diversity appears not to be synonymous with worker inclusion, since the 2021 Medical Training Survey, which received over 11 500 responses, identified 31% overall and 52% of Aboriginal or Torres Strait Islander respondents either experiencing or witnessing bullying, harassment or discrimination (including racism) in medical training settings.[13] Those medical training survey findings significantly contextualise and affirm the clarity of expression of ANZSN members who described worker inequity and associated psychological and physical harms[2] and provide significant imperative for action by medical leadership and the ANZSN.

> Not everything that is faced can be changed, but nothing can be changed until it is faced. – James Baldwin

In Australia, individuals can access commonwealth-legislated protections for gender- and race-based discrimination and other worker support (https://www.fwc.gov.au/). Workplaces that enable equity of worker experiences should seek all workers to be safe to belong (inclusion), learn and grow in their role, contribute to the workplace, and (courage) ask questions and/or challenge issues that arise[14]; in medicine, this enables practice review and openness to innovate practice. Workplace equity actions should support marginalised or impacted workers to identify safely root causes of worker inequity, which require removal. Transparent and open dialogue was also called for by ANZSN respondents.[2] Contextually knowledgeable and skilled arbiters and field leaders in workplace equity will be crucial for medical leadership and the ANZSN to define and implement the 'Worker Equity in Renal Medicine' policy, which enables removal of root causes of worker inequity.

Conclusion

Energetic, competent and active physician leaders are invited to be celebrated, belong and advance health within the communities they practise without cultural-, gender- or identity-based discrimination. ANZSN with its individual members need to deliver nephrology practices across all professional roles that are accountable to peer and societal expectations of individual workers equity, safety and well-being while discharging professional duties.

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