Some years ago I felt it necessary to take up my pen on behalf of the hapless uremics in Britain who were being refused dialysis because of a variety of inadmissible reasons, namely age over 50, intercurrent disease, lack of ability to speak English, and so on. There were a few ripples, some snide attacks and a few outright lies of denial even echoed their way westward across the Atlantic, but some stalwart nephrologists in Britain pressured the government into making major improvements in the availability of dialysis in one form or another, and so numerous patients were allowed to live who would otherwise have died quietly and without a fuss. In this issue of Nephron we deal with a far larger problem and one which is less readily solved, namely the problem of dialysis in the third world. Here unfortunately the problem is not only confined to regular dialysis but also embraces acute dialysis for acute renal failure. The financial constraints in third world countries are massive. There is too low a gross national product to allow anything but the most primitive medical services to the population as a whole, although the rich can usually obtain the necessary services in public hospitals, private clinics, or abroad. Hemodialysis machines are expensive, the disposable kidneys cost foreign currency and must be reused repeatedly if they can be obtained, and the dialysate solutions are also difficult to pay for if you only have foreign debts and there are no foreign currency reserves. Peritoneal dialysis is also costly, both for the minimum cost of catheter and tubing, and for the much higher cost of dialysate. In the current issue the article by Dr. Onwu-balili of Enugu, Nigeria, gives one a sense of the size of the problem in a country such as Nigeria, with a huge population, some oil wealth and much disease. Can we in more fortunate countries do something more to aid them, other than selling them weapons and strengthening their usually oversized armies? Many countries give money for research and surplus food. They send volunteers such as the Peace Corps. Voluntary organizations such as Care distribute food to ward off starvation. The United Nations does less than expected. One reasonable suggestion which merits further examination is that the major dialysis companies should be asked to donate some of their traded-in used artificial kidney machines outdated or unpopular disposable kidneys continuous ambulatory peritoneal dialysis fluids and equipment to third world countries. The response to the dreadful Armenian earthquake from Baxter-Travenol and others was heartwarming but this was a donation to a first class power with a massive economy and a huge military budget. Would it not be appropriate for the holders of high office in the various national and international Societies of Nephrology to tackle this problem and ask their voluntary agencies...
dialysis corporations and even their governments to plan to ease this terrible problem of human misery? As scientists and physicians nephrologists have correctly concentrated their efforts on advancing the borders of knowledge in all aspects of renal disease and they have succeeded spectacularly. But now the time has come for them to play a more constructive worldwide role in planning for the nephrological services of the world as a whole. This is not an easy task but many of the leading nephrologists in office have access to their governments and are respected by them so their advice may be heeded. Perhaps this editorial will stimulate them to grapple with this immense problem and perhaps as a result contribute to the solution of this aspect of the human dilemma.