T
he world is a much smaller place than when I grew up, and I’m not even that old. I can wake up in my house in suburban New England, and go to bed in Kampala, Uganda. Which is what I did over a year ago, before COVID turned the world upside-down. I had never before travelled to a far corner of the world to try to understand and experience the delivery of health care in a developing country. Many of my friends who are surgeons take medical mission trips: dropping into some corner of the world and operating for days on end, making a tangible difference to the patients they serve. They change and save lives. There was always part of me that was jealous of them, since I had chosen a field that did not allow me to do anything dramatic to save those same patients. Nobody would line up patients in advance of my arrival to have serum sodiums corrected at 10 mEq/dL. I did not think I had much to offer.

For most of my life, global health was either tied to these medical missions or was synonymous with infectious disease: malaria, HIV, leptospirosis. But the world has changed. Noncommunicable diseases (NCDs) such as hypertension and diabetes are spreading like wildfire through the developing world. This is partially from diet and lifestyle, but also because more people are surviving the infectious diseases that so dramatically shortened life before chronic NCDs could take their toll. Now, the morbidity and mortality from NCDs is increasing with each passing year, and like here at home, chronic kidney disease is also on the rise.

I did not spend very long in Uganda. The pulls of being a program director and parent kept me from extended travel and work overseas. But while there, I met an extraordinary group of 10 Ugandan nephrologists who are the nephrology physician workforce in a country of over 40 million people. Just pause and imagine that responsibility for a moment. Ten nephrologists, a few dialysis units, and 40 million people.

I made rounds in the hospital in the morning. A 40-year-old man with HIV presented with lower extremity edema, a friction rub, a serum urea nitrogen of 330 mg/dL and a creatinine of 35 mg/dL. He was offered palliative treatment and was expected to die within the week. A 21-year-old woman transferred from an outside clinic after emergency cesarean delivery arrived obtunded, seizing, eclamptic, and septic. I watched her die within hours. A 27-year-old mother of 4 with recurrent joint pain and foamy urine presented with tachypnea, a prominent P2, and a parasternal heave suggestive of pulmonary emboli was being treated with prednisone and anticoagulation, with no laboratory tests. The nephrologists went bedside to bedside, examining carefully, listening to stories with purpose, and offered options depending on what could be achieved and afforded. I was simultaneously humbled by their expertise and precision, overwhelmed at the burden of disease, and inspired by the comfort they offered.

In the afternoons, they went to clinic. Easily 100 patients waited in a crowded courtyard for a chance at an appointment with one of 2 nephrologists; for a chance to get treatment for hypertension or diabetes. If they could not be seen that day, they would try back another day; persistence pays off. At the end of the very long day, my colleagues took a deep breath, and went home to do it all again the next day, while I went back to my room at the guest house, emotionally exhausted, and cried mixed tears of awe and frustration with the inequity I had witnessed. Despite this, I found myself eager to get up and do it all again the next day.

I learned so much from my Ugandan colleagues about treating relentlessly advancing kidney disease with ingenuity, compassion, and grace. I also learned that although there arefantastic and bold physicians who make it their mission to take all the skills learned here at home and then live and practice abroad, there is also a role for a homebody like me. After all, I’m an educator, a program director for a nephrology fellowship intended to prepare trainees to practice in this world we all inhabit. Training the physicians who will be practicing medicine for the next 50 years carries with it an obligation to train them to be ready for what the world will bring them.

Even if the majority of our trainees will stay in the United States and practice only here, we must give them a global perspective. Our trainees need to see and learn about this discrepancy in health care availability and delivery, experience the powerful connection made by community health workers, see cost-conscious care in action, and they need to grapple with the fundamental injustice of this at home and abroad if they are to practice in the world in which we live. We need to credit as absolutely essential those whose research interest is in the areas of global health, and not continue to define “real research” as at the bench or traditional epidemiology. Program directors like me can lead efforts in capacity building through opening opportunities for international physicians to participate in our educational programs and practices. In the last year we have all mastered videoconferencing and expanded our use of social media, and with these new tools, we can extend our educational reach to those without access to lectures and discussions, and we can work with our institutions to lead this charge.

As we all emerge from the challenges of the last year, it is time take a collective deep breath and look outward
again. This is a moment of enlightenment we must embrace and use it to restore ourselves, to reach out bigger and broader than before. If we, the nephrology community, decide to attack the problem of the world’s kidney health with collaboration, and creativity, we can make a tremendous difference and live up to our shared responsibility.

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doi: 10.1053/j.ajkd.2021.05.014

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CALL FOR SUBMISSIONS

“A doctor, like a writer, must have a voice of his own, something that conveys the timbre, the rhythm, the diction, and the music of his humanity, that compensates us for all the speechless machines.”
—Anatole Broyard, Intoxicated by My Illness

In this space, we hope to give voice to the personal experiences and stories that define kidney disease. We welcome nonfiction, narrative submissions focusing on the personal, ethical, or policy implications of any aspect of kidney disease in adults and children (acute kidney injury, chronic kidney disease, dialysis, transplantation, ethics, health policy, genetics, etc). Submissions from physicians, allied health professionals, patients, or family members are encouraged.

Types of submissions for this feature include essays of up to 1,000 words; short poems; or original visual art accompanied by 1-2 paragraphs of text. In submissions that refer to real patients, the patients must either be unidentifiable or approved by the patient(s) described.

Items for consideration should be submitted online at www.editorialmanager.com/ajkd.