Billionaire Information Packet

(a horrific look under the hood of Kidney Dialysis)

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DialysisEthics.org
Better Health Through Better Dialysis™

Executive Summary

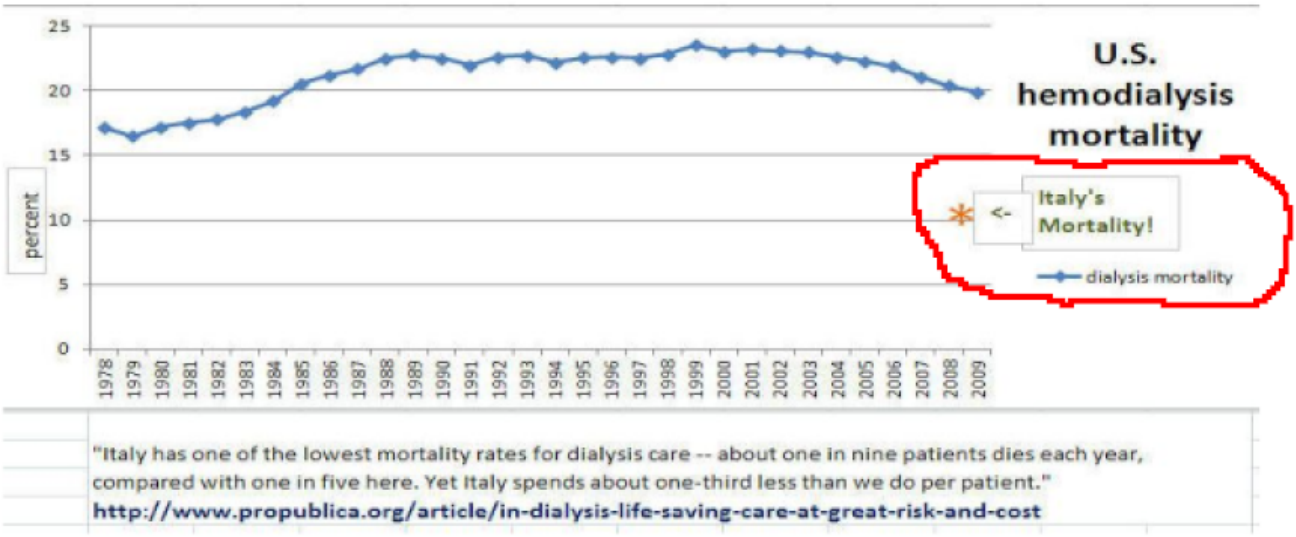
History of Kidney Dialysis:

***Kidney Dialysis has had <u>the highest mortality rate in the industrialized world!</u>**

***"Dialysis is unique in experiencing a <u>worsening mortality</u>. I believe the major reason for the miserable results of chronic dialysis is that we dialyze in an increasingly unphysiologic fashion"** *Dr. Carl Kjellstrand, winner of a lifetime achievement award in dialysis*

****The US large for-profit dialysis companies haven't been able to keep up with a poorer country like Italy when it comes to mortality and <u>Italy spends 1/3 less!</u>**

!!!From 2013 to 2019 mortality plateaued, **<u>still around 17%</u>**!!!



There have been comparisons between for-profits and non-profits with the non-profits coming out on top. However after some of us watching this for more than two decades, many of us feel the more important thing is to break DaVita up – and maybe care co-ops should be looked into!

More info: www.dialysisethics2.org/

A deadly error: Routine dialysis leads to Heights woman's death

By Lynn Moore | lmoore8@mlive.com
Chronicle/Kendra Stanley-Mills

It is too much for James E. Allen to talk about the day his wife died -- the day she left for her regular dialysis treatment and never came home.

By the numbers:

69: Muskegon County residents newly diagnosed with end stage renal (kidney) disease in 2007.
197: County residents undergoing dialysis for chronic renal failure as of Dec.31, 2007.
17,000: Estimate of county residents with diabetes.
— Sources: Renal Network of the Upper Midwest and Michigan Department of Community Health

It is difficult even for him to speak Ethel "Betty" Mae Allen's name. After 26 years of marriage, the two had become inseparable and her death has left him empty and alone.

"She was all I had," Allen says. "She was everything to me."

Aug. 15, 2007, started as many days did for Betty Allen. She showed up at the DaVita Inc. dialysis center in Muskegon just as she had three days a week for the preceding three years.

But routine quickly turned to tragedy as a fatal error on the part of a technician sent a corrosive and acidic cleaning solution -- rather than the life-giving hemodialysis solution -- directly into Betty Allen's artery.Her eyes rolled back in her head as she went into cardiac arrest. She was rushed two blocks to the emergency room at Mercy Health Partners' Mercy Campus where medical workers decided to send her on to Spectrum Health in Grand Rapids.

There, she clung to life for five days, suffering another two heart attacks and a severe brain injury. Finally, her family said she'd had enough. The next heart attack was her last -- she was not resuscitated and was pronounced dead at 3:49 a.m. on Aug. 21.

Ethel "Betty" Mae Allen, died in a dialysis accident Aug. 21, 2007. It was supposed to be a routine dialysis treatment, but a technician's error sent a cleaning solution directly into her artery.

There is no doubt about what happened to Betty Allen and DaVita's role in it. Her death certificate says she died after "exposure to Renalin during hemodialysis," giving DaVita's Muskegon address. Medical notes from DaVita and Spectrum repeatedly refer to her accidental infusion with Renalin during dialysis, as does the autopsy report.

Betty Allen's death, clearly an accident that could have been avoided, was never reported to any

authorities. DaVita wasn't required to. The technician who failed to rinse the dialyzing filter of its corrosive "Renalin" cleaner was required only to have a high school equivalency diploma.

And, despite the error and the potential dangers of reusing filters -- a practice that many dialysis centers have given up -- DaVita's Web site and a National Kidney Foundation executive indicate that it continues to reuse filters at its centers, including ones in Muskegon, Grand Haven and Fremont. It has received required state approval to reuse filters, according to a state offical.

DaVita officials are not talking about the accident.

"This is just a botched job," said Randall Fielstra, a Muskegon attorney representing James Allen in a lawsuit against DaVita.

A horrible death

Hypertension and diabetes -- which plague a higher-than-average number of people in Muskegon County -- are main causes of kidney disease. Nearly 200 Muskegon County residents receive dialysis on a regular basis to rid their bodies of wastes that their ailing kidneys no longer can filter out.

Betty Allen, 71, had suffered from hypertension as well as vascular disease. Her kidneys had failed and so her life depended on the hemodialysis she received at DaVita, 1277 Mercy Drive, provided by technicians whose training consisted only of instruction provided by the huge for-profit company.

During dialysis, patients are hooked up to a machine that pumps their blood from their body and through a dialyzer that cleans the blood with a dialysate solution before it is returned to the patient.

Dialyzers -- a sort of filter -- come in two types: single-use, which is thrown out after each treatment, and reusable.

DaVita uses reusable dialyzers -- assigning each patient their own -- which are cleaned after each treatment by soaking in Renalin, a solution of hydrogen peroxide, peracetic acid, acetic acid and water. After the soak, it is flushed with saline solution and tested to be sure none of the corrosive Renalin remains.

According to DaVita procedures, two employees are required to verify that dialyzers are appropriately cleaned.

But that apparently didn't happen when Betty Allen arrived at DaVita on Aug. 15, 2007. According to Fielstra and Spectrum hospital notes, when she arrived, she was taken to a dialysis machine, but it had a different patient's dialyzer in it. Technicians quickly sought out Allen's dialyzer, found it still soaking in the Renalin bath, removed it and inserted into the machine without the required rinse or testing, Fielstra said.

Allen was hooked to the machine for less than two minutes, the acidic solution coursing into her artery, before it was apparent something was horribly wrong. Betty Allen complained about burning pain at

the needle site, according to a DaVita employee's progress notes, and then she became "glassy-eyed."

"Boom, her eyes roll back," Fielstra says. "It must be assumed she was exquisitely horrified and uncomfortable."

Oxygen bubbles had been introduced into Allen's arteries, essentially blocking blood flow. She went into cardiac arrest and her brain suffered severe injury -- perhaps a stroke, hospital notes indicate -- due to a lack of oxygen. It took 12 minutes of cardiopulmonary resuscitation before rescue workers could find a pulse.

From Mercy, she was sent to Spectrum for treatment of the gas embolism with a hyperbaric chamber in an attempt to dissolve the bubbles and resume normal blood flow. But the brain damage was severe, and she wasn't breathing on her own.

James Allen remembers being called to Spectrum after the accident.

"I didn't want to see her like that," he says tearfully, describing her as "gripping my hand" with eyes that were open but didn't seem to see him.

The death certificate leaves no doubt the cause of Betty Allen's death, explaining that she had been "exposed to Renalin during hemodialysis."

"This woman's death was horrible," Fielstra says. "No one deserves to die this way."

An inherent risk:

The Michigan Department of Community Health -- contracted by the federal government to oversee dialysis centers in the state -- was not aware there had been a death as the result of actions taken at the Muskegon dialysis center.

There is no requirement that dialysis centers report a death or severe injury, says Richard Benson, chief of the licensing and certification division of the department's bureau of health systems.

If there is a complaint, the state would investigate, but none was lodged in Allen's case, Benson says. Currently, the federal government expects inspections be conducted about every four years, he says. The last state visit to DaVita was in March because the center added new services, Benson says.

Dialysis centers are not licensed by the state, nor are employees required by the state to have certifications. Centers that want to receive federal Medicare reimbursement, the main form of payment for dialysis patients, get certified by Medicare and are required to have at least one licensed health professional -- physician, registered nurse or licensed practical nurse -- on the premises.

But a new federal law requires that technicians who hook patients up to dialysis machines -- known as patient care technicians -- receive training through state or national certifying organizations and pass a state or national exam by December 2009.

"It will add a certain level of professionalism to the role," says Dolph Chianchiano, vice president for

health policy at the National Kidney Foundation.

However, Chicanchiano says that does not include the "reuse technicians" who are responsible for cleaning and rinsing dialyzers. According to DaVita's Web site, reuse technicians' qualifications are a high school or equivalent diploma and completion of DaVita's reuse technician training.

Fielstra says he was told the reuse technician on the job at the time of Betty Allen's accident was fired.

DaVita officials, citing patient privacy laws and the pending lawsuit, declined to comment or answer questions about Allen's death and the company's procedures. The company issued a statement saying its "sympathies are with the family as they attempt to deal with this situation."

Chianchiano says there are no national statistics on how many patients die as the result of accidents at dialysis centers. However, he says Allen's death is the only one he has heard of.

Maurie Ferriter, director of programs and services for the National Kidney Foundation of Michigan, says some dialysis patients watch technicians "like a hawk" while others, especially older patients, are trusting "of anybody who wears a white coat."

"Every single time you get hooked up to a dialysis machine, there is an inherent risk in the process," says Ferriter, who receives regular dialysis.

Making money:

Dialysis was first successfully used in 1945 and its use became more common in the 1960s. In 1973, Medicare started paying for it, and most dialysis operations were in nonprofit hospitals staffed by licensed medical personnel.

By 1985, 44 percent of dialysis units were in hospitals and 56 percent were in freestanding clinics; 46 percent were operated by for-profit groups, according to the Centers for Disease Control and Prevention.

By 2002, 85 percent of dialysis units were in freestanding clinics, and 81 percent were for-profit.

"Over the years, as the for-profit industry started to get involved in dialysis, there were big changes ... unlicensed technicians or uncertified technicians instead of nurses," Ferriter says. "It has become more impersonal. When you think about it, it's the same principle as an assembly line."

For DaVita, dialysis is big business that is growing. It serves about 107,000 patients at 1,300 clinics. Dialysis treatments, which numbered 15.3 million in 2007, were up 5.7 percent over 2006, according to DaVita's 2007 annual report. Its net income for 2007 was $340 million.

The largest dialysis provider is Fresenius Medical Care, serving 173,863 patients worldwide at more than 2,200 clinics. Its net income for 2007 was $717 million.

One big difference between DaVita and Fresenius is the type of dialyzers they use. DaVita reuses them; Fresenius uses them once and tosses them out, says Chianchiano of the National Kidney Foundation.

"The reason why people reuse is because the dialyzers they use are so expensive," Chianchiano says.

A much smaller dialysis provider is Renal Advantage Inc., which operates a clinic at 1080 W. Norton in Roosevelt Park. It has 85 centers across the nation.

Sharon Burbage, vice president of clinical services for Renal Advantage, says the Roosevelt Park facility uses single-use dialyzers -- a decision made by local staff. Burbage says it is generally considered cheaper to reuse dialyzers, but the corporation leaves it up to each clinic to decide which ones to use.

"The bottom line is that if you reuse, you have to make sure appropriate safety measures are taken at all times," she says.

The loss

With DaVita not disputing that the actions of one or more of its employees caused Betty Allen's death, Fielstra had tried negotiating a settlement with the multimillion-dollar corporation.

But he says he was disappointed in the company's response, and so filed the lawsuit in May. The state caps noneconomic damages at $717,000 for medical errors causing brain injury; $400,000 for other types of injuries.

For James Allen, no amount of money could make up for the loss of the woman he dated since the 1960s and married in 1981. But he wants money to put a marker on his wife's grave at Mona View Cemetery.

"I don't hate them; I can forgive them," he says of DaVita. "Somebody's got to pay for it and do the right thing."

His constant companion these days is Duke, his dog. They sit together on the front porch of his Muskegon Heights home and sometimes "take a ride around the block."

He can't bear to go fishing anymore -- something he and Betty did every day, staking out their favorite spot on Muskegon Lake.

"I'll be thinking about her when I go fishing," he says. "I probably won't go anymore."

https://www.mlive.com/chronicle/2008/10/a_deadly_error_routine_dialysi.html

U.S. Senate Testimony by Brent Smith (patient)

Kidney Dialysis Patients: A Population At Undue Risk?
Statement of Brent Smith - U.S. Senate

Mr. Chairman and Members of the Committee. Thank you for inviting me to testify today. My name is Brent Smith. My exposure to the dialysis industry began in 1973, two weeks before my 18th birthday. A year later, I received my first transplant which was from my mother. Two months later, the kidney failed due to infection, and I returned to dialysis. In 1977, I received a second transplant from my grandmother. That transplant succumbed to complications in 1990. I returned to dialysis in the fall of that year. Soon after, it became all too clear that the entity providing treatment, its administration, the support staff, and many of the standard procedures with which I was familiar had changed drastically. Over the last ten years, as a patient, I have witnessed the gradual decline in competency of those given the responsibility of my care. In my view, efficiencies intended to enhance the financial position of the providing companies expose patients to great risk and may even hasten their demise. This trend continues and worsens each years as providing companies focus on bottom line management and not patient care. The major concerns of dialysis patients fall within the following five interrelated components. I have provided more detail in a longer statement submitted for the record. They are the following:

Adequacy of dialysis
Competency of patient care technicians
Knowledgeable and disciplined nursing staff
Facilities and technology (machines)
Accountability

Adequacy of Dialysis

The adequacy of my prescribed treatment relies heavily on me, my discipline with regard to diet and fluid restrictions, and my oversight of my dialysis treatment. Because I am very disciplined in my care, I can allow the dialysis machines to do their work. I have worked to become very knowledgeable in what is needed for my care. Other patients who are less familiar with the dialysis process are very vulnerable. One of the areas that needs to be addressed by research is adequacy of dialysis. I can only tell you my personal experience with the amount of time I dialyze. When I dialyze four hours each session, I feel better. When treatments have been shortened in the past, over time my energy levels are depleted. In addition, complications appear from fluid retention, such as higher blood pressure and shortness of breath. I, and other patients, feel lethargic and have little appetite. So, I can only conclude that the amount of time on dialysis is a factor.

Second, in the year I started dialysis, the care givers were mainly nurses from the top graduating classes, as well as medical students, and other medical technicians. Almost every technician had a college degree, and every technician had previous medical experience. Today, I see technicians with only a high school diploma. In Arizona, a manicurist is subject to more licensing than a dialysis technician. When I first returned to dialysis, I had technicians handle my blood and my life who were convicted criminals, strippers, and refrigerator technicians. The ratio of patients to technicians, at times, is now 5 or 6 patients to every technician. This is not safe, and it doesn't work. A main worry for dialysis patients is vascular access. A patient told me recently of a treatment where it took eight attempts by technicians to initiate her treatment - eight sticks by 16 gauge needle! Not only is this painful, it increases the risk of infection and could destroy that access. There are limits to vascular access with each patient. When vascular access runs out, a patient can no longer dialyze and can die. Many other patients have told me of similar occurrences. These examples, involving poorly trained, unsupervised technicians include the following:

target weight miscalculations that could cause blood pressure decline. On one occasion, staff miscalculated the projected amount of fluid to remove from me by a significant margin. When this happens, a patient feels extremely weak and lightheaded at best. At worst, a patient can severely crash, losing consciousness with a blood pressure far lower than levels needed to maintain life. Also, patients experience excrutiatingly painful cramping, and treatments will be shortened because the patients cannot withstand additional treatment.

too much or too little heparin, the blood thinning agent. Too much heparin thins the blood and could lead to the patient's inability to clot blood; so they could bleed to death. Too little heparin allows the blood to clot in the machine and stop the flow of blood back to the patient.

placement of a dialyzer on the wrong machine for the wrong patient. This is a potentially fatal error.

Disregard for the Universal Antiseptic Code, the protocol that protects both patient and technician alike from infectious germs, viruses, and bacteria. This is one of the largest and most common reasons patients are hospitalized.

Another example of the training deficiency among dialysis technicians stems from my personal experience. In 1994, I suffered an extended period of appetite and weight loss. As part of my routine assessment prior to each dialysis session, I explained that I had not been eating properly. I reported this for almost four months. The food I was eating did not provide me with sufficient potassium for my prescribed potassium bath. During the fourth month, during the third hour of a four hour treatment, I suffered a cardiac arrest attributable to the low potassium in my system. The attending technician did not recognize this problem. Another technician took over to attempt resuscitation until the paramedics arrived. Upon arrival, Emergency Room records reflected a potassium level of 2.9, well below the 3.5 recommended range. Discharge Summary records showed fibrillatory arrest, secondary to hypokalemia, which is low potassium. The dialysis technician did not correlate the loss of my appetite with the low potassium bath. The seriousness of the problem and possible results were never brought to my attention or to the attention of the charge nurse, the dietitian, or my physician. THIS EVENT WAS COMPLETELY PREVENTABLE.

Knowledgeable and Disciplined Nursing Staff

In addition to competency and training of dialysis staff, I believe that the staff must be knowledgeable and disciplined. I have witnessed instances where floor nurses lacked familiarity with the machines and their functions. These are complicated machines that stand between life and death of dialysis patients. Lack of knowledgeable staff exposes patients to dangerous circumstances. Moreover, lack of discipline or failure to PAY ATTENTION is a primary source of incidents, affecting patient care. On one occasion soon after my return to dialysis, staff drained off too much fluid from me during dialysis. This exposed me to a crash in my blood pressure and loss of consciousness. I am aware of another instance where a patient bled to death, because no one was watching, while the patient's blood inadvertently drained into a trash can while the patient slept. It is instances like this that cause me to do everything in my power to stay awake throughout my four hour dialysis and try to watch every move of the staff attending me and to watch the fluctuations on the dialysis machine.

Facilities and Technology (Machines)

Not all facilities where I have dialyzed have been well maintained. Too often poorly trained or overworked staff will choose speed over substance in attending to patients. Worn, older, overused machines are not as effective and efficient. One problem in dialysis is the way dialyzers are reused. Even though they are labeled for "single use only" many are reused in this country as much as 30-50 times. I do not reuse dialyzers. However, as a patient advocate of many years, I have observations and experiences with regard to reuse of dialyzers from other patients. The efficiency of the dialyzer can decrease as much as 20% over the span of reuse. In turn, it is as if the patient's treatment time has been reduced by 20%. No adjustments are ever made to compensate for this loss. As a result, the patient's lab reports get worse as the patient's condition gets worse. Moreover, many patients aren't aware that they don't have to reuse dialyzers and that the mortality level is higher with reuse. I know of one woman who could only reuse eight times before she felt very bad. In addition, I have been told by staff that Medicare pays for a new dialyzer after each session. However, my experience is that dialyzers are used as much as 30-50 times. In fact, facilities have had to establish elaborate procedures to clean, sterilize, and catalogue dialyzers to ensure that patient receives their own dialyzer during sessions. I am aware of one technician who processed one patient's dialyzer bar code and passed and approved all other patient bar codes on that basis. This violated the procedural rules and, of course, exposed patients to potential harm.

Accountability

One of the most important aspects of patient care relates to their relationship with the dialysis staff. Staff must be accountable for the level of care provided to patients. They must demonstrate strict adherence to set policy and procedure. Appropriate discipline must be administered for breach of policy and procedure. This is a life or death situation. In my experience, technicians are rarely written up for minor or major infractions, involving patient care. I have seen technicians abuse the glove policy, exposing patients to possible infection. I have seen technicians reading magazines while on duty rather attending to patients. I have seen technicians engage in distracting conversations when inserting or removing needles from people. In all my years on dialysis, I have never seen a government surveyor

review a facility where I have dialyzed. In fact, I am unaware of any surveys of any facilities where I have dialyzed. I am greatly concerned as a dialysis patient about oversight of this industry. In closing, throughout my life I have strived to avoid the label, "dialysis patient," and the stigma associated with it. Yet, today I appear before you, in the public forum, as a dialysis patient, because of the importance of the issues being discussed here today. Patients can and do lead productive, purposeful lives. However, it has become an increasing burden to do so. Monitoring a technician's abilities during every treatment, week after week, is a tremendously stressful undertaking for a dialysis patient. Enduring the limits and inadequacies of the present system of dialysis compound the already difficult treatment into an intolerable, unjustifiable, and inexcusably frustrating experience. My purpose today in appearing before this committee was to present the life of a dialysis patient to you. It is my life, and that of many others. We live it every day. You cannot possibly understand it. I sincerely hope you or a loved one will never experience it, but I do implore you to do something about it.

Thank you.

Frank Brown's Story

(These are excerpts from a long article at: https://dialysisethics2.org/testimonials/19-frank-brown-s-story)

"But the people (early staff) were much higher quality than the dialysis staff I deal with now. They were all registered nurses then; they all had degrees, and they were kinder, gentler, nicer. They taught us everything about our own care; that was part of the program -- we had to learn everything about it if we had the ability to do it."

"There are supposed to be watchdogs out there (renal networks) but they're not. They don't take care of anybody and they're very industry-friendly. You make a complaint and you're labeled a troublemaker. Then you're black balled and you get a hard time from all the people who are supposed to be helping you."

"To save on the expense and use of the cleaning solvent, they pump more of your blood through less cleaning solvent! (killed a patient)"

"They started hiring people off the street who didn't know what they were doing; people who just had a basic education that didn't cover much medical ground, and nothing like the nurses I first knew. I used to operate the apparatus myself most of the time. I set up the machine, did the medications, put the needles in my own arm, set the parameters on the machine. But that was then, now is now."

"The decisions about how everything is done are made at the corporate level; the people working for the corporation here in Santa Rosa either do it the corporate way or they're out the door. They sympathize with the patients but they're not going to risk their jobs."

"On June 26th, 2000, the United States Senate's Special Committee on Aging convened hearings entitled, "Kidney Dialysis Patients: A Population at Undue Risk?" Frank Brown, having been on dialysis longer than anybody in the country, was invited to testify. "I couldn't get there myself, but I wrote up what I had to say and my statement was included in the Senate's final report."

"Sculley (Thomas Sculley, Administrator of CMS under George W. Bush) harassed hell out of witnesses who testified from inside the corporations. Now Bush the Second has appointed him the head of Medicare!"

"We had to evacuate immediately, losing all our blood that was in the machines. Three fire trucks, with about 20 guys in full rig put the fire out. Not a word in the Santa Rosa Press Democrat. They won't even write up a fire, let alone a big scandal like the dialysis racket!"

"Three weeks after he (engineer activist) wrote up and published on the internet the cost savings to the company from cutting back on dialysate he was found shot to death."

"They fired her so she sued them and went through a long suit and finally won. Meanwhile she was harassed. They broke into her house, stole her diary, slashed her tires, followed her... She went underground and I heard from her one time last year"

"I (staff member turned activist) could not be a party to what I was seeing anymore. We went from being a non-profit with excellent care to a for-profit with care that was often dangerous to the patients."

"Fresenius has paid $483 million in fines for defrauding the government"

"There is no oversight. The beauty of it for a dialysis company is that the technicians don't really know what they're doing so if they kill a patient simply out of carelessness or incompetence or from having to watch too many people at once on too many dialysis machines, the privately-owned clinic can say, We're only as good as our machines."

Dr. Kenneth Bays US Senate Testimony

Kidney dialysis patients : a population at undue risk? : hearing before the Special Committee on Aging, United States Senate, One Hundred Sixth Congress, second session, Washington, DC, June 26, 2000.

Washington : U.S. G.P.O. : For sale by the U.S. G.P.O., Supt. of Docs., Congressional Sales Office, 2000.

Statement of W. Kenneth Bays

I am a retired dentist, 72 years old, who practiced from 1952 until 1995. In August of 1995 I was diagnosed with a massive cancer of the liver. At the time, I was semi-retired and living in North Georgia. Having practiced dentistry for over 43 years, I was very aware of educating patients and offering different treatment options. It had always been my belief and practice that patients themselves have the right to final determination of their treatments. I was about to find the concept of patient education and patient determination would not exist in the world I was about to enter.

Other than a loss of my kidneys, the treatment for cancer was successful. I was, however, not prepared for what was coming next. It was much later before I understood the treatment options and choices available to me. I was of course entering into a very different world of the dialysis patient. In this world of dialysis, even though I am a dentist, and understand medical terms, I was appalled to find that dialysis patients have no rights of self-determination. Never before had I been in the position where treatment options were not even offered, much less explained.

Vascular access is the key to proper dialysis. Without the proper working access you cannot dialyize a patient. I was referred to a vascular surgeon. There was no preceding exam or discussion of treatment. I was just set up for surgery. A vortex graft was put in instead of a A-V fistule. The graft is a treatment of last choice. I was now becoming fully involved in the wonderful world of numbers and dollars. I was just another money cow with a market value of $100,000.

I next went to the nephrologist in North Georgia who turned me over to his physician's assistant. I tried to get some information but was cut off with the remark "patients who have never been sick have a hard time accepting." I was taken on a walk through the clinic and my treatment was set up on a time slot basis so as to maximize the number of patients per day. I was dialyzed twice a week. As a result of the inadequate treatment, my back itched as if there were a thousand mosquitoes biting it. This was due to a build up of phosphorus. This caused me to rub my back raw on the door facing. I had to force myself to eat, as well as watch my diet and fluid intake carefully. I was also taking 8 times the normal dosage of blood pressure medications because of the build up of toxins.

I was sick all the time. Dialysis was "HELL." The cramping, changes in blood pressure, and the pain of being "roto-rooted" with needles the size of a ten penny nail by untrained personnel with no medical background made me a "nervous wreck." The cramping and changes in blood pressure were a result of removing the fluid from the blood too fast. I was at this facility for seven months. I do not wish to name the facility in particular as this is a systematic problem with the industry.

I had to go to South Georgia on business, so I set up an appointment at the Mitchell County dialysis clinic. The facility is a branch of the Archbold Hospital in Thomasville, Georgia. Archbold is a non-profit public hospital.

As of that day, I moved into a different world of medicine, and the caregivers were nurses trained in dialysis. My new doctor, Dr. Merrill Hicks, the nephrologist on rounds that day, stopped to talk. He explained to me home dialysis existed. He further explained to me if I would do my part, I would have to take very few medications and would not have any diet restrictions. I now do dialysis 6 nights (8 hours at a time) a week.

I have now been doing home dialysis for three years. The total cost of my care is substantially less than the average dialysis patient. I have become a productive member of society again. I expect to live a normal life within the confines of my impairment. I am one of the very fortunate few that had the means to get adequate treatment.

Approximately 2 years ago, I became involved with the Network "6." I was first on the consumer committee and then next on the board of directors. The Board consisted of 18 industry members and 2 patients. I found out very quickly that the Network was constructed to work for the betterment of the industry. One of the primary problems the Network was concerned with was non-compliance of patients, and how to handle them. There is one particular that I remember quite well. A patient wanted to continue working. This interfered with the clinical scheduling so he was judged non-complying.

The statistics that are collected by the Network are, in my opinion, a joke. If you want to get true data, you should get if from the backs of the machines and comply it by a central computer. Wal-Mart keeps track of tens of thousands of items from thousands of stores. It would be child's play to create a database of dialysis patients from the data collected by the machines. It is my belief this would upset the gravy train if this was done.

I never reuse a dialyze. Reuse according to the literature, degrades the efficiency of the dialyzer to remove the larger more toxic particles and the chemicals effect the proteins in the dialyzer to produce toxins.

Fact Sheet presented to Colorado state legislators in 2007 supporting the need for Hemodialysis Technician Certification

1. From ’91 to ’01 expenditures for End Stage Renal Disease nearly tripled, while the number of patients only doubled – yet deaths were up 123%

www.usrds.org Annual Data Report 2003 pg 172, population up 106%, deaths up 123% from ’91 to ‘01 (I should add the for-profit companies – such as Davita – were taking over this area of medicine during this time period)

"In 1991 Medicare expenditures were $5.8 billion, and non-Medicare costs from heath plans and other coverage were $2.2 billion—a total, then, of $8.0 billion from all sources (see Figure p.6 on page 17). By 2001, costs of the program had reached $22.8 billion, almost triple the earlier level of expenditures" 2003 USRDS Annual Data Report

2. Mortality rate for hemodialysis patients is the highest in the industrialized world:
“The cumulative survival of Japanese hemodialysis patients is more than 2.5 times better than that of dialysis patients in the United States (U.S.). The difference is particularly pronounced in older patients, being 4 times better in patients over the age of 50 years. The mortality in U.S. patients has increased from 10 to 25% over the last three decades, but has remained stable at around 10% in Japan.”

“Japanese physicians also appear to be better trained in dialysis and to spend more time with their patients. The nursing shortage in the United States may also contribute to the increased mortality.”

- http://www.blackwell-synergy.com/doi/abs/10.1046/j.1492-7535.2003.00008.x

"There is no obvious difference in patient selection. The Japanese accept almost as high a proportion of diabetic patients as does the United States, and the mean age of incident patients is higher in Japan."

http://www.ncbi.nlm.nih.gov/pubmed/19379344?dopt=Abstract

(above articles by Dr. Christopher Blagg – former Executive Director of Northwest Kidney Centers, where modern dialysis began – and Dr. Carl Kjellstrand – winner of a lifetime achievement award in hemodialysis)

“Gross mortality as a simple percent has been quoted by many investigators as being 24 percent in the U.S., 12–14 percent in Europe, and 9 percent in Japan.” – USRDS 2006 ADR pg. 129

3, Infection rates for this field of medicine have skyrocketed – USRDS 2006 ADR

vascular infections

Blue line is Hemodialysis vascular access infections
2006 ADR pg. 24 graph

Since 1993:
Pneumonia – up 12%
Cellulitis – up 20%
Bacteremia/septicemia – up 16%
2006 ADR pg. 130

Since 1991:
children age 10–19, mortality due to infection – up 19%
(children age 10–19, cardiovascular mortality – up 62%)
2006 ADR pg. 160

4. Patients' overwhelming complaint according to Colorado's Department of Regulatory Agencies are needle sticks with the complication of infilitration (a needle can be inserted in one part of a vein and come out internally and possibly ruin an access – a person has only a limited number of accesses)

"In my many presentations to both the (Arizona) House and Senate, I brought along a pair of 14 & 15 gauge dialysis needles to permit the Health Committee Members (usually 10-14 individuals on each panel) to "physically see and touch" both the size and length of the dialysis needles, thus they would truly get a first-hand look to knew we were not talking about pin-size sewing needles. The goal was to allow each member to realize these needles were capable of causing death if used incorrectly and the only way to prevent injury or death was to have stringent and effective rules/laws in place to govern same."

Dale Ester - person dealing with ESRD - testimony for Arizona
SB1304 - bill for dialysis technician licensing

5. 25-50% of hospitalizations of hemodialysis patients are due to vascular access problems:

"About 25 to 50 percent of all hemodialysis patient admissions and hospital days are attributable to vascular access placement and related complications, contributing over $1 billion to total Medicare inpatient costs annually" Federal Center for Medicare and Medicaid Services press release, March 17, 2005

6. Techs work under an RN's license making the recruiting of RNs difficult for this field of medicine

"Techs who do not have adequate training have caused the death of patients. In states that do not have tech licensing, the techs work under the RN license and that puts the RN at risk of losing their

license for a tech mistake. Hence many RN's do not want to work in a unit where the techs are putting the RN license on the line. I sure don't!" Founding RN, DialysisEthics

7. Regulations promulgated by the Colorado Department of Health and Environment require one RN with at least one year of experience in the area of dialysis, to be in attendance in all certified dialysis facilities during operating hours. Due to the nursing shortage RNs with NO dialysis experience are many times in attendance.

8. Things that can go wrong with patients' treatments:
- Low potassium causing cardiac arrest
- Needle infiltrations causing loss of current treatment and possible loss of access
- Reused kidney filters not checked for cleaning fluid causing severe hemolosis and death
- Blood not rinsed back to patient before going to the bathroom, patient can die
- Water cultures not checked, patients become ill and require hospitalization
- Figure for fluid removal calculated wrong - severe cramping can happen (seen described as worse than childbirth) or not enough fluid is removed and the patient ends up in the hospital in CHF

9. According to the Department of Regulatory Agencies Hemodialysis Technicians starting pay is around $10.00 per hour
- Radiological Technicians earn $22.77 per hour
- Respiratory Therapy Technicians earn $19.08 per hour

http://www.dora.state.co.us/opr/archive/2006HemodialysisTechnicians.pdf pg. 8

10. 2980 Dialysis Patients in Colorado
USRDS 2006 REF_06 Table J.12

quotes:

"From 1991 to 2001, the prevalent ESRD population
grew 106 percent, the total number of deaths 123 percent,"
2003 USRDS Annual Data Report

"In 1991 Medicare expenditures were $5.8 billion, and
non-Medicare costs from heath plans and other coverage were $2.2 billion—a total, then, of $8.0 billion from all sources (see Figure p.6 on page 17). By 2001, costs of the program had reached $22.8 billion, almost triple the earlier level of expenditures"
2003 USRDS Annual Data Report