



VOICE EXPEDITION INTERVIEW TRANSCRIPT
The Oral History of Nephrology
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Interviewed by Dugan W. Maddux, MD
May 24, 2017

DWM: (0:00 - 18:32)

And periodically I'll be keeping an eye just on this to make sure that everything looks like it's recording right and the levels look good and all that. In fact, I'm going to move it just a little closer to you so we're, I can move this real gray a little bit. That should be good.

So today is May the 24th, 2017 and I'm in Nashville, Tennessee speaking to Christy Price Rabbitoy. Christy, thank you so much for being a part of the Nephrology Oral History Project. I look forward to talking to you today.

CPR:

Thank you. I think this is an extremely important project that you're doing, preserving history.

DWM:

Very good.

So I'd like to just start with where you were born and raised.

CPR:

I was actually born in Syracuse, New York, upstate New York and spent my early childhood up to graduate through high school in Syracuse. And then I decided Syracuse weather was just not my cup of tea, so I went down to Florida.

And I lived in Fort Lauderdale for many years.

DWM:

Did school take you down there?

CPR:

Well, I actually went two years of school in New York.

I went to Cortland State University, Syracuse University for a little while, Cortland State University, finished up two years. And actually at that time I was a math major. And then I decided that that wasn't fun anymore, even though I really liked math.

But so I went to the down to Florida and kind of had a lot of fun. And then I went to the University of Florida, and I went got my bachelor's degree, finished out for four years at the University of Florida in Gainesville. Graduated in December of 1977.

DWM:

From there... And what what degree did you have then?

CPR:

Bachelor's of Science, BSN.

DWM:

So you were not thinking of nursing or you were that was a bachelor's?

CPR:

No, when I went back to school, then I confirmed in my mind that I wanted to pursue nursing. When I was a...

my mother was an RN, old diploma graduate, hospital-trained in Syracuse. And I think it was just one of those things where you you kind of want to do something different than maybe what your parents did. And I loved math in school.

I was very, very good at... used to do math projects. But anyway, when I just went back to school, I had confirmed I was in my early 20s then that what I really wanted to do is be a nurse.

So when I went to the University of Florida, I was then in the nursing program right from the start. And finished up the last two years there. Got my degree there.

DWM:

So what year was that when you finished your nursing?

CPR:

77. Okay.

And how I got into nephrology was very early on because back then, you know, student nurses could be nursing aides and work throughout the hospital. And since, you know, I needed to have some extra cash coming in, I got onto the hospital program. And one day, I was working up in pediatric intensive care.

And in Shands Teaching Hospital, at that time, the pediatric intensive care unit was right next door to the pediatric dialysis unit. So... and then the pediatric floor.

So I, as a nurse's aide, was working in the intensive care unit and walked by the dialysis unit one day, and I thought, wow, that looked really interesting. And I walked in and I asked the charge nurse, who was Serena Gilman, one of the people that I had referred you to, and I said, well, what do you do here? And, you know, she was just great, and she showed me around and the machines.

And I have always been technically inclined. I actually, at one time, had a certificate from Motorola for working and analyzing the original pagers. So I was always technically and used my math skills.

So when I saw this, I realized that dialysis had a lot of math in it, in my mind. Calculating baths and looking at labs, etc. I loved working with children, and so, you know, so at any rate, so I asked her, I said, do you have any jobs for nursing?

I was a student as a nursing assistant. She said to me, you got your shoes with you? I actually started working in the dialysis unit for the rest of the time I was in college, weekend, you know, part-time, and as an aide, but, you know, you could do certain things.

It was all within scope of practice, but I learned a lot, and I learned...

DWM:

Hold up right there. So when you were a nursing aide at the Peds Dialysis, what did you see?

What did things look like to you there? And how many patients were being dialyzed? Do you remember this was like the mid-1970s?

CPR:

Yeah, this was the mid-70s. One of the first things I remember is that Serena told me that they just started paying for dialysis, which, you know, 1973, which the history of dialysis I then learned later on, but as a nurse's aide, you know, I would, you know, welcome the patients when they came in, meet the parents. I could weigh them, take their blood pressure, pulse, temperatures, you know, get them into the bed, and there were about eight.

It was in about an eight-patient unit, and we had the big travenol bathtubs. I could never mix the baths, but I could use the oar to stir them around as an aide.

DWM:

Were you all still literally using a wooden paddle?

CPR:

Oh, yes, we used the wooden paddle. It was a canoe oar. It really what it was, and you know, the nurses at the time would mix the jugs, and you know, they would check the conductivity, and I would verify, I mean, you know, just as a nurse's aide and verify it.

It was interesting because back then they used to add glucose to the baths because it wasn't in the jugs, and so I remember that very distinctly later on that that's what we had to do for some of the patients because of cramping is what, you know, they would say. So anyway, so then the nurses, and they had a lot of AV fistulas. To be honest with you, they did not have a lot of catheters, although that was originally where I was introduced to the single needle device back then.

I later on used it in my career, too, but and we used a lot of femorals. You know, these were kids. I remember we used to have to restrict their movement because, you know, and so during the course of treatment, you know, playing with them, talking with them, checking their vital signs.

I was allowed to do that, and and then afterwards take them off, hold the sites, and then, you know, weigh them, help them out with their parents, but and then could clean up, you know, wash down the machines, beds, etc., and what was just so striking, it was so all-encompassing to me. I mean, I dealt with kids who were, one girl I remember distinctly was getting ready to get her driver's license, and at that time there was this, I think more so than later in my career, there was a push to try to keep kids in normal progression, and since I had, you know, been interested in developmental tasks of kids, you know, the natural transition of achievement of tasks, age-appropriate, so I remember helping this girl study for her license through the book during dialysis, and and other kids were, I mean, we dealt with very sad, you know, year, 18 months, three-year-olds, five-year-olds, teenagers.

DWM:

What kind of diseases were, do you remember what most of them were?

CPR:

Lupus, Lupus, the, not Brzez, I'm trying to think of, polycystic kidney disease, a lot of them were childhood malformations, or lack of development of the kidney, so they were mostly those that I recall now. Oh, I remember one of the senator's son's daughter got a strap infection, and that's when, all of a sudden, we started getting a few more amenities in the dialysis unit, because we treated her daughter.

She did well. Her daughter, they were, I think the girl was like seven years, eight years old, so, you know, a real good experience, and she came off dialysis, and so that was good, but so, but the thing is, is that what I recall is, for instance, we had a schoolteacher that came in, the kids had lesson plans, for those that were appropriate, for those that were younger than five years old, you know, the social worker was there, we actually had access to a play therapist that served the whole pediatric population in the hospital, not just dialysis, and so there was a lot done to help these kids grow up through their experience. We had one kid, we had Wilm's tumor, those are not so good, neuroblastoma, we, they would get a transplant, and they would come back, you know, failure, and so those were hard, and so it was, it was, one of the professors at the University of Florida's son ended up on dialysis, and so she, I don't know if you know her, Annette Fromman, she went to North, she taught at North Carolina and Emory afterwards, but so as she used to stay out of the dialysis unit, it, not wanting to be an overprotective parent type thing, but, you know, but there was a lot done, or a lot assisted in the kids, you know, and they used to do some weekend type things where you, you know, take them to a park or take them on a trip of some sort nearby, a lot of lakes in Florida and stuff like that.

DWM:

So it sounds like maybe the kids themselves also spent time together as a group as well, and was that beneficial to them, you think, to be sort of part of a group?

CPR:

I do think so. I think the more the teenagers or the preteens, not so much the little kids, but yeah, the preteens, and it was very helpful because they understood that they were not the only one, and you know, that peer support, and the kids used to, you know, yell across the

room about what was going on, and well, you don't have to do this, and I have to do this, because we used to have a cycler PD patient in there, too.

Very barbaric cycler, but you know, and so we used to be doing that on the side, and so they shared their experiences, which was, I think, very beneficial to the kids. I really do.

DWM:

So you were there as a nursing aide, and overall that was a good experience?

CPR:

It was a really good experience, and actually when I graduated, when I got my degree, I stayed on as an RN, and that was the first job I had as an RN, and so I worked there at Chan's in the pediatric unit, and of course all the role responsibilities increased. I started, you know, being able to initiate dialysis, and I was very technically good at needles and initiating dialysis, sterile technique, you know, and so it was just, it was very fascinating, but then I decided after about six months, in the spring of that year, then I told Cy that I needed not to be so specialized, so new in my career, so I told her that I was going to move, and I did move to Fort Myers, Florida, and took a job in a med-surg unit hospital, and I did that because I really, and I'm glad I did that, because, you know, then I was dealing with, you know, the staff nurse, staff nursing, all different diagnosis categories, but they had a dialysis unit, so I used to go down to the dialysis unit, and I used to poke my head in and just kind of talk with the nurses, you know, talk with the patients, so I never really took my foot out of the water, but I did want that other experience, so I stayed there for about two years, and was a medical surgical nurse, and that's where I started the other part of my career, which was in leadership and development skills, because I got them to organize a staff nurse committee in a community hospital, and I could see that the staff nurses didn't quite have the voice that I thought nursing should have in a hospital, and the other thing is, when I worked there, I worked, it was very interesting to me, looking back, that the physicians truly recognized the, just sort of the expertise I had in nursing, because what they would, all the physicians would, you know, if I was on foot, well, it's Christy there, you know, and I would talk with them about their patient, whatever it was, and they became very trusting, and they actually, in the end, the anesthesiologist offered me, they would pay for me to become a nurse anesthetist, and if I would join their practice afterwards.

I gave it some thought, and then I said, well, you know, I didn't kind of really want to do that. I wanted to be very clinical with patients that were awake, so after two years, I moved to San Antonio, Texas. Drove across, and I started graduate school at the Health Science Center in San Antonio, and at the time, the nursing field did really not have much of a development for the nurse practitioner program, so back then, you were a clinical nurse specialist.

DWM:

And what year would that have been?

CPR:

That was 81, 81, 82, time frame. So I graduated, I worked, well, I graduated from the University of Texas Health Science Center with a master's degree with a clinical nurse specialist, and it was sort of in a subspecialty in nephrology.

I created my own preceptor ships, all of which were in nephrology, and I had an actually great experience as a CNS, which I'll talk about in a minute, but unfortunately, nursing did not develop, and they let that role go. It's what it was designed to be, and they moved later on to the nurse practitioner.

DWM:

So what was the design for the clinical nurse specialist?

What was it designed to do?

CPR:

The design of the clinical was to be a sort of an expert operating in four different areas. One was clinical practice, and so a specialty in clinical practice, which for me was nephrology, a nurse educator for educating not just patients, but other professionals, colleagues, a nurse researcher, and being involved in research, which I have been involved in research, and then the last part was the leadership sort of administrative slash role, which I've also been very involved in.

But in practice, hospitals and nursing couldn't fulfill the four roles, to put it that way. Most of those clinical nurse specialists became nurse educators, and I did not want to do that. I've done a lot of that, published a lecture nationally, internationally, but I didn't want to do that on an eight-to-five basis, so.

While I was in San Antonio, I worked in an adult unit, dialysis unit, hospital-based. We also had some kids there, which this was back in the time when kids were more often... There weren't very many, still aren't very many, pediatric units isolated, so we had kids, mostly teenagers, young adults.

I liked working with them. I mean, I worked with the adults, too, but the age was from, say, 12 to 80, so that was a very interesting experience. I worked there, and then again, I was a student, so then I also had hours working in the ICU, pediatric ICU.

So I really enjoyed that, but it was really sad, because I had two five-year-olds when I was in pediatric intensive care. I'll never forget, ever. One was blowing backwards on a balloon, and one was running with a sucker, lollipop, and both of them ended up brain dead, and both of them donated their kidneys, and the two five-year-old little boys, perfectly healthy, and as you saw them laying there, you know, brain dead, it was really, really sad, and so, I mean, the good thing, sure, the kidneys went, but the bad thing was is that that happened, and and that was just so sad. Also had a case there, and this, after this, I never worked in pediatric intensive care again, because of these cases. They just, one little girl, and how I got involved in child abuse, was dipped in a bathtub up to her waist as a punishment for wetting her bed, and you started seeing things like that, and, you know, and the pain that these kids

went through, so that was the last that I worked in pediatric intensive care. So, I worked in the adult unit, and then I decided, I had lived in Florida, and I decided that everybody told me, don't go back to Florida, go to California, where real fun games is in place. So, anyway, I went from San Antonio to San Diego.

DWM:

So, what would have been, what was the good thing about what was happening in California that you were hearing about?

CPR:

Just the lifestyle.

DWM: (18:32 - 18:34)

The beach, nothing professional.

CPR: (18:34 - 23:42)

The beaches were good, and people told me, and this is rightly so, that if you think Florida is beautiful, etc., you need to experience lifestyle in California, make a decision yourself. I'm really glad I did that, but, so I went to San Antonio, I mean, San Diego, and I got a job there in the adult intensive care unit, originally, because it was the Naval Hospital, San Diego, and at that time, the Naval Hospital, San Diego, and all Naval hospitals hired very few civilian nurses, but they were, even at that time, this would have been a 1982-83 time frame, were having more and more difficulty with recruitment for nurses for the military. So, they started as a GS-9 position, and but while I was there, I used to go down to the dialysis unit, and I actually used to, in the intensive care unit, I would get all the renal patients, and unfortunately, there's a lot of renal patients in the military. Crush injuries, rhabdos, just, again, a lot of things that I really learned with service-connected disabilities were, I mean, Bourget's disease, again, onset of polycystic kidneys disease, adult, you know, when you start seeing these things, RPGNs, again, lupus, and so, anyway, I used to, I'd be assigned the renal patients in the intensive care unit, but then, one time, there was this patient, and the nephrologist was there, and so I went over and was talking to him, and I thought, well, I'm just, you know, going to use this opportunity to tell where my experience is, and what I'd like to do, so I was talking to a nephrologist, and asked if they had a position there in the, it was adult, dialysis unit, and at the time, didn't.

At the time, that was all military technicians, and again, being somewhat politically correct for nursing, I explained that they really needed to have somebody for assessment, and supervision, and it would be good to have an RN in the dialysis unit, so it took a little while, and then, though, I was invited to take that position there. They created the position for me, so I had, like, five or six Navy corpsmen, and they, of course, at the onset, weren't real welcoming to having a civilian RN telling, you know, what to do, and stuff like that. The patients loved it, so.

DWM:

So, what did you bring to the dialysis unit that was not there before, with just the corpsmen?

CPR:

What I brought was that every patient had an assessment before they were put on dialysis. I, you know, taught the, I taught the military people about assessing access, and then I worked with the patients again, and the techs were very military tech, and that's not a criticism, but they were very military tech, and they have a different role, you know, because they have to be worldwide service ready, and so their role was understanding a little bit different, but I really began to help them see, you know, response to therapy, and what was going on with the patient during dialysis, and they really got to the point where, hey, Christie, you know, come and help me, you know, and it got, it was, and it didn't take a long time, but, and then also helping them with their families, and helping them understand that this is an individual that has the family, and we used to deal with a lot of young guys, 22, 23 military guys. We also used to deal with a lot of guys who were going to be out of the military because of the disease, and the anger in that was phenomenal.

These people did not, you know, a lot of them, I remember one guy was head of purchasing, and he had polycystic, and he went on PD, and he was ever so grateful that I got him on PD. He was the first patient in the military in San Diego that I did that for, because they allowed him to finish out his time so that he could retire, because he didn't want to retire with a service-connected disability, and that's, in the military, that's pretty big for people that don't want to do it.

DWM:

So they let him stay in on peritoneal dialysis, but they would not have let him stay in on hemodialysis?

CPR:

They probably would have, but he didn't want to do hemo, and the main reason is he did not want to, now he was an officer, he didn't want to come down with the enlisted, and be in the dialysis unit, and he also was very independent, and wanted his own schedule, and his wife was an RN, so it worked out, because obviously she could help. We put him, originally was on CAPD, then he went to the cyclor, so it worked out for his life, and it worked out really, really well. I mean, it was the perfect setting for somebody to be on peritoneal dialysis.

It also really, really drove home to me that we need to get more people on home therapy, make them responsible for their own care, to the extent possible, but...

DWM:

Here you were in the, you know, early to mid 80s, and it sounds like the majority of people in San Diego, in this military setting, were on in-center hemodialysis.

CPR: (23:42 - 23:43)

Correct.

DWM: (23:43 - 1:09:22)

And was it just that they didn't have the expertise to start patients on peritoneal dialysis? Why do you think most people were on in-center hemodialysis?

CPR:

They had nobody to train them, nobody to do that.

They never had a nurse in the unit. So when I came, and then this particular officer, that showed them what could be done with home care. Then the Naval Hospital actually moved building.

I actually moved the hospital, and when they did, because I had a bit of a influence, we had a home training room put in, and so I started, and the nephrologist loved it, because we were dealing with active duty plus retired. So from there, you know, we went from one, two, three, in the end, I probably had about 20, 20, 25 people on peritoneal dialysis. Most of them were either retired, or they were military that were going to be disconnected from the military.

I mean they were going to be discharged, honorable discharged. Because I remember we had people coming from Northern California, and I had them on peritoneal dialysis, and they were just so happy. I mean, because they didn't have to, you know, be there.

Some of them, you know, peritoneal was not the option for them, so they couldn't do it. We had no home chemo at the time. So...

DWM:

And what was peritoneal, so if you had people coming from Northern California to do peritoneal dialysis through your...

CPR:

Well, mid-California, say Los Angeles town, or just a little bit of...

DWM:

So what was peritoneal dialysis like at the time?

What was the cyclor like, and how often were you seeing patients who were on home therapy?

CPR:

Well, they were on CAPD first, and it was, you know, the bag rolled up and tucked under, and then with Baxter, of course, you know that this was a perfect setting. They came out with a UV light disconnect, so because it was the military, I put all the patients on the UV disconnect system, and again, they loved it, because of course then they didn't have to worry.

I had no infections, practically no peritonitis. I thought that UV light was great. I realized it was expensive, but so they were all on that, and then it started to be that the cyclor, again,

we mostly used Baxter cyclor, you know, as military contracts, so we had them on the cyclor at night, and it just worked.

Most of these were the retired people, but it just worked really well. We did the training. At that time, then, the program got really big, and so I convinced the nephrologists that they needed another nurse.

In the end, I had, there were three of us, and I actually then was promoted in that time period to a GS-12, which is the highest GS rating you can have out of Washington, D.C., and I was a clinical nurse specialist in roles, so that was really good, because I had two GS-9s working for me, plus about five or six corpsmen working for me, and but that, what that did, where I started doing, I always did direct patient care, but I also did start educating throughout the hospital that the ICU nurses were just, you know, very appreciative of people helping them, you know, to understand renal, and then I used to round with the nephrologists, so I always had that opportunity to, you know, for the nursing input, and again, did some research with the nephrologists.

Back then, one of the, actually before it was approved, FDA approved, we were the first ones to start CRRT, which at that time was CAVH, and we used it in the ICU, and we borrowed the filter, sterile, we borrowed the filter from the VA there, and we actually started a patient before the VA did. They, what's his name, Lee Henderson, and the guys up at the VA were doing a lot of the research, but they never used it on a patient, and we had this patient that was a perfect, it was a rhabdo, 25-year-old gentleman, and very, you know, edematous, etc., and so we used it on him. Unfortunately, he didn't make it, but it wasn't for the renal failure, but so, you know, I published that, and I started lecturing on that, and I've been lecturing on CRRT.

Actually, I was the first person that coined the term CRRT in publication, and after that, you know, it became the umbrella for CAVH, or CAVU, or CVVH, or however you were doing it. In the beginning, I was against pump-assisted. The reason being is they were putting pumps in the critical care units, and they were walking away, and I never felt that was right for the critical care nurses, because I still, I was CCRN, I was double board certified, so I had an appreciation for what critical care nurses went through, so I was always against CVVH in the beginning, but I, you know, later on, understand.

Of course, the technology had a lot better, too, and it was a lot safer. I mean, they basically weren't even using, you know, air detectors on the system, so, you know. Yeah, so that first patient that had rhabdomyolysis where you used CAVH, what, do you recall any of the details of the setup, what that looked like, and had you read about it, and you said, oh, I've read about this, and I think we can do it?

DWM:

I mean, how what made you think of doing it?

CPR:

Well, the nephrologist actually came to me and said, there's this therapy, and I think this would be somebody we could use it on, and so they gave me some preliminary literature, I'm sure, and I read everything, and the package inserts, etc., and I talked to the VA nurses, and I talked to the VA nephrologists who were doing the research on this, and just like beginning nephrology, a lot of stuff is just kind of done from the, you know, seat of your pants, and kind of hope it works, and but the thing is, the principles were the same. It was, first of all, it was AV, so it was femoral artery to femoral vein. It was, but there's, you know, sterile technique, and securing the lines, and putting the filter in place, and I mean, I'll never forget, I mean, all the nephrologists and the intensivists were standing around this patient, and this filter starts ultra-filtrating like unbelievable.

Guy had a good blood pressure, and it was just phenomenal to think that you could do this, and, but we, we, the thing, the one mistake we made is that we didn't really understand the necessity of replacement fluids, and he didn't actually, didn't require much heparin because of his, you know, conditions, so it worked beautifully, except for we didn't replace enough fluid, and, but the filter worked for, probably was, I think it was about 12 hours, and had we replaced fluid more effectively, it would have worked forever, but at any rate, it was just an exciting time that we could do that, and about three months later, it was actually FDA approved for patient care, and then I started with CAV, and we started putting many patients, as many as possible on CAVH or CAVU, but, you know, I had it set up with the, this drip chamber, I had it set up with, you know, we were replacing fluids, I developed the formulas for replacing fluids for the critical care nurses, heparinization, and I used to be there, you know, like, I was always on call, but I used to check those things, you know, every two hours, or the nephrologist, some, we always supported the team, and, and at the time, this was the other thing, which was, I always thought was kind of ridiculous, we would run filters for three or four days, and now they change them every 24 hours, and I know it's sterile, and et cetera, I also thought it was a financial thing, but the thing about it is, I proved that you could run those with no infection, if you didn't open the system again, and we did this extremely successful for a long time, so then I started publishing and lecturing extensively, because I was one of the few nurses that were doing it, and I started setting up programs across the United States. I was invited, you know, to do that, and yeah,

DWM:

So this publication, where you first published about CRRT, where was that publication?

CPR:

Nephrology News and Issues.

DWM:

Nephrology News and Issues, and was it really focused toward the nursing care with CRRT, or?

CPR:

It was, yes, I mean, it was the technical aspect again, and then the nursing care, and then I published in, of course, the ANNA Journal, and a lot of that was patient focus, and

presenting patient case scenarios, and then when I started going around lecturing, which, you know, at the time, what was it called?

The Amicon Filter. I mean, that's what it was, and I was, you know, stipend to help to, you know, set up these programs, and then after that, Bard, out in Colorado, anyway, used to be invited, and I helped them write their protocols, because then they started getting in on CRRT, and I always you know, then I start lecturing a lot, and really the importance of patient nursing care to these patients, and monitoring, and helping the critical care nurses, so again, you know, really, really, very successful.

Then this, as I was, I had done that for many years, and you know, my personality is, then you kind of move on to something else. Then CVVH came in, and again, I was originally opposed to it. I understand it now.

The technology is much better, and things were being done a little differently, safer, probably, but at that point, I discovered a way, or came up with a way, well, let me, one other thing, we use the ready systems in the military, and the reason is, the ready system is what's out on the ships, and is in the field tents, because you don't, you know, you don't need water, six liters, and throw in your cartridge, so the thing about the ready system is that I realized early on, that the ready system, you could manipulate to basically talk, if you wanted to.

There, there was great, was a great machine. So, we had patients with myasthenia gravis. We had a patient with dig toxicity, and I realized, with the nephrologist, but I said, you know what, I can make a dialysis machine do plasmapheresis, with therapeutic plasma exchange, and at the time, it was the Japanese filter, and so, but again, it was membrane technology, and I said, well, membrane technology, that's what nephrology is all about, so we should be doing this.

Now, Trish was doing centrifuge at the same time I was doing membrane, and Trish and I co-presented, and again, the technologies, but then the patients, and she was doing, she'd always present on centrifuge, membrane, but anyway, I published therapeutic plasma exchange in the dialysis unit, setting up with the ready, and how to bypass the dialysate, and run the machines, because you had all the alarms, and you had the pump, and you had the air detector, and you know, priming a plasma flow filter, it was nothing more than, I mean, a little bit more than doing a dialyzer, so anyway, I developed that, published that, and then the next thing you know, I'm going throughout the United States, setting up plasmapheresis programs, and therapeutic plasma, and lecturing everywhere, and and it was extremely successful, and that real, that brought to nephrology the fact that, yes, and then, of course, I worked with many nephrologists, who then, this was a source of income, so they started, I was invited by, I mean, I was up in Boston, I was up in Cleveland, Paganini, I used to work with him, Tom Galper, you know, just, yeah, you can do this, you know, and you can do it safely, and I felt nephrology nurses were the best people to do this, so for about the next however many years, I was always doing clinical practice, but on the outside, in my other world, and I was also president of ANNA at this time, and various committees and boards, so, Let's talk a minute about the ready system, what, there are going to be plenty of people

that have no idea what the ready system looked like then, so can you describe the ready system, what it was? The ready system was basically a metal box sitting on a tripod with wheels, there was the alarm system, the arterial, the venous alarm system, but the system was based on a cartridge that actually was an RO system, in essence, plus you mix the custom bath for potassium or calcium, whatever you wanted, but with basically tap water in the field. When the water would go through the filter, it would take out, just like it, much like an RO system, it would correct for the electrolytes, such that at the end, through the connecting tubes to the dialyzer, you measure the conductivity, you measure, you know, it's the same thing as using on a standing machine, the nice thing, it was very light, I mean, it was filled with water, six liters, but still didn't even weigh probably 50 pounds, so you could move it, and so the thing about the ready system was that it was on the field, it was on the medical ships, the Navy ships, and that's why the Corpsman had to have, you know, the Navy.

DWM:

So, were all the patients in your dialysis unit dialyzing with the REDY system?

CPR:

Originally, yes, but when we moved over to the new hospital, because then we had, we went from like a basically a four-bed sort of isolated dialysis unit to, we also convinced them that we could be doing chronic dialysis in the military, so we moved, and we had like a 10 station unit, and we were doing two or three shifts a day, and again, military people cannot be discharged to the community if they're still active duty, they're supposed to be treated by a military facility, so San Diego being very big, I mean, Fresenius was there, and others, UCSD was there, but we did not, we could not send those patients, and they were not VA eligible yet for VA benefits, they couldn't go to the VA either, so we had these young guys and women that we would dialyze, so we had a 10 patient unit, we had a hepatitis room, which I had put in, and we did have somebody in there, and this also started the time of AIDS and HIV, and we had many HIV patients in San Diego, and so at the time, I had them done up on the hospital floors, and I told double isolation, etc., they didn't come down to the dialysis unit, this was, you know, very early on in AIDS, so we had a larger unit, again, we had, I had two RNs, plus, you know, and we had hospital machines originally, and the standard dialysis machines, which I could still do plasmapheresis on those. So when you think back about the time there in the mid-1980s, I mean, in the late 1980s, when HIV became really part of the clinical picture for dialysis, was it your impression that pretty much everybody that needed dialysis was able to get dialysis? Was there any screening out of patients saying, well, you're not eligible for dialysis because of certain diseases or certain conditions, or was it pretty much being offered to everybody, and how were patients doing?

DWM:

Was it your impression that the quality of life is pretty good on dialysis?

CPR:

You know, it was. Again, in the military setting, you couldn't refuse dialysis.

We wouldn't have anyway, but a lot of these were crush injuries, a lot of them were pre-existing conditions to their military career, but so they were all treated, and then because the this was going so well, we started doing more retired, and so, but again, the quality of life for those patients was great. I mean, again, they used to bring in cakes, celebrate birthday parties, Halloween, they got dressed. I mean, there was, it was a real focus on helping them maintain their jobs.

Now, military people could not maintain their job. They were given, you know, really light duty until they were service-connected, you know, discharged from the military. But, you know, a lot of them, I remember working with them to help them see that they would be able to go on the jobs they would be able to get.

We did not have a social worker at that time. We had a dietician that worked, but in the military, they have sort of a, it's not a discharge planner, but there was avenues to help these guys and women, you know, with what they're, because they're in their young 20s, maybe 30s. The retired people, the thing about the military people is they have a great affinity for wanting to be treated by the military.

It's phenomenally strong, and even afterwards, and some of them feel that they deserve it, but they, they want to be in the military. They don't want to be out in the community. They really don't, and so, personally, I think that it was an incredibly well-run unit.

The patients would talk. Patients, you know, one guy would come in playing his guitar during dialysis. I mean, there was a real nicety.

I stressed to my nurses and to the techs that they were, first of all, they were never allowed to put the patient on and walk away and come back an hour later. They were required to sit and talk with the patient, work with the patient. You know, if the patient wanted to sleep, okay, but we were always interacting.

It was not the unfortunately, what is now today, the assembly line, put them on, take them off. We don't, we never, never did that. You know, we really worked with them.

DWM:

So, you think that your staff had more time?

CPR:

They had more time because there weren't as many patients. I mean, we weren't, you know, I mean, we weren't treating 50 patients or 100 patients in a dialysis unit.

DWM:

How long were patients dialyzing, and what kind of quality measures were you all looking at?

CPR:

They were dialyzed four hours, almost all of them.

DWM:

Was that just like a standard, everybody?

CPR:

No. But, first of all, we were dealing a lot with young, muscular men, and what we were following is labs. We didn't, towards the end, this would have been in the 90s, early 90s, you know, urea reduction came in, so we would look at that, but as far as KTOV, not a lot.

We just really dialyzed to labs, you know, if they were good labs, and they were, and quality of life. I mean, these people were doing really well. I was one of the first ones who gave epigen back then, and again, slight error because somebody's, a young girl's hematocrit went up too fast, and she did have a seizure, and so, you know, a lot of things you learn by experience, but, you know, then we learned really to how to titrate, and how important it was to titrate.

DWM:

Did you notice a difference in how patients felt before and after EPO came into use?

CPR:

Huge difference. I mean, first of all, using less oxygen, even during dialysis, but the, we also, even before and after epogen, used depo.

We used to give the male patients, and but after EPO, it was like, you know, I mean, they would come in and tell you about their sexual exploits over the weekend. I mean, they were happy and proud, and you, one guy, his wife was pregnant, and so, I mean, that's the kind, that became where they would tell you those things. They were so happy, and for me, it was like, wow, they're achieving their life tasks, you know, they're, you know, another one got married, again, achieving a life task, and that was really, really important, but I also, you know, helping people make that discharge from the military, which is really, really hard for most people, but I also, again, started working with end-of-life, when it's time to stop, and talking with patients, and started. So, even in the 1980s, you were beginning to see issues around end-of-life.

DWM:

What kind of situations did you see that you got involved with?

CPR:

I remember one lady, particularly, I mean, she just was not thriving. She just, you know, she was on CCPD, and you know, she came back in.

We had to put her on hemo. She went to CAPD, and her husband and her just said, you know, she's had a good life. This is enough, and they, you know, and I supported them through that decision.

I mean, I totally agreed. We were having access problems. She had gotten peritonitis, and it was time to stop, and so, and the nephrologist agreed.

It's time to stop, and we did involve hospice, and you know, we did that, and so, I really think it was more all-inclusive to the patient's lifestyle back then. I really do, because after San Diego, well, my, okay, so then I met my husband in San Diego, the nephrologist, and his next tour, we went up to Illinois, and they had no dialysis unit there, so I've also always been on faculty at the local nursing college, so I did some lecturing there through the nursing college, but that is where, basically, I was traveling every week setting up either CRRT or TPE programs, or lecturing, and I was, every week, I was gone.

You know, the guys, the limousine service from Chicago here knew me by name. You know, they knew when to be there, and when to pick me up, to take me home, so for about three years, I did that, but then, when he got out of the military, we went to Salt Lake City, and that was supposed to be just until youngest son got out of high school, like four years, but we stayed 14. Fantastic experience.

We had a great time in Utah, and I took a position as a clinical nurse specialist in a small dialysis unit out there, and it was privately owned. I was going to say, this was not a military dialysis unit. No, this was not military.

Well, he was out. He was out of the military. He went to work at the professor at the university, associate professor at the University of Utah, and it was interesting because one of his fellows, when he was in the military, is the one that networked to get him the job at Salt Lake City, so, you know, small world, but at any rate, so there was this, it was called Doxy Hatch Dialysis Unit.

He had been there forever, and it was competing at that time against Fresenius and DeVita, and, but they didn't want to give up, so I was invited to come in as a clinical nurse specialist, and I took that program from about nine patients, eight or nine patients, to a PD program of about 30 patients, and an in-center program running three shifts of about probably 30, again, not as big as many, but about 30. We did run three shifts on some days, limited by the number of machines, so, but I really focused on, we've got to get these, I mean, Utah is a perfect place for home dialysis.

DWM:

What makes it a perfect place?

CPR:

It's rural, and so these people, and it's a highly educated population. It is the most educated population, and it is a younger population than the rest of the United States, but more people have degrees in Utah than anywhere else, so you're dealing with some pretty, a lot of times, professional people, so, but not always professional, but I, and again, I had nurses there, and they loved doing PD at home, and I helped them see, you know, that it's not just put them on, take them off, and stuff.

DWM:

So how did you grow that from nine patients to 60 patients?

CPR:

Because the local nephrology group, all of a sudden, saw us, and like, wow, this nurse is doing something. So they started referring all the patients to me.

I also got to interviewing beforehand. I told the nephrologist that they needed to have choice, so I started doing pre-education for choice, which the nephrologist loved, and so you started doing treatment modality education, like a treatment option. Treatment options, and, and one.

DWM:

So it was not there at all before?

CPR:

No, people would put on, and one of the options was no dialysis. I firmly believed that no dialysis was an option, and some people took it, and these are elderly patients, multi-system failures, comorbidities, but, so we had that, but we drew, and, and this, I was president of ANNA, and, but we drew that PD program, and I also got some of the nurses involved.

We started writing case studies. We did research, and the nurses were just loving it, like this was a whole, you know, wow, and then that program, well, actually, it was, DaVita came in, so the nephrologist had a relationship with DaVita, and that program was encompassed into the DaVita program, so I had there, but during that time, I went back to the University of Utah and got my nurse practitioner. So that's the last time I went back to school.

So I became a nurse practitioner again. Everything was nephrology based. Actually, for a project that I had to do in that program, I took cardboard boxes and patient dummies, and I made a dialysis unit, and I taught the graduate school nurses what it was to be in dialysis.

I made them go on tour around in a dialysis unit, and it was just phenomenal, you know, to teach them and for them to understand. So then I went from this program, we transferred the patients over, and they had a 30-chair unit, and of course, we had a lot of other nurses and technicians, and it became, you know, more of what I would call dialysis today, and this was in the, let's see, this would have been late 90s to up to 2006, basically. They then put in another dialysis unit, another dialysis unit, and the other thing is is that the only thing is I was a nurse practitioner, and we had patients in like six or seven units because we had a few of them at the University of Utah, and then we had these DaVita units, and and then be what the nature is with dialysis, larger providers, and they just had a program, particularly their PD program.

I'm trying to think, I didn't use PD, but I used Baxter Supplies with PD for a long time. So I started that program, and I insisted on having a home training, and DaVita was very supportive of that, and we started PD, and then I started home hemodialysis there, and we had about a dozen patients before I left on home hemodialysis using the NxStage machine, and the reason I went to NxStage is I firmly believed in sterile technique, and I thought that the bags were sterile, and spiking the bags, you know, was safer than patients making up their dialysis, and the other thing is that that was the one machine that could be taken

anywhere. I didn't want to see a patient be at home having to have a dedicated dialysis room.

I wanted them to sit in front of the TV if they wanted to, with their family, and watch TV, or you know, travel with it, and take the machine with them, so I used the NxStage exclusively, and again, patients were traveling, and the PD patients, and people were staying at work. I had them on the cyclers, and it was great, and you know, but when it was time to withdraw dialysis, or when comorbidities, etc., you know, and then I did some rounding in the hospital for acute dialysis, but not quite as much, because there was another service there, which was the Mormon Hospital, and they had their own nurses, and they took it. They did the hospitals there, and then the university had theirs, and they did the hospital, and we, the VEDA never had a hospital.

It was always outpatient-based, so anyway, it was just a great program, and a great experience for the nurses, and they just really, really appreciated, again, I got some of them to publish. I got the nephrologist to publish, but towards those years, getting into 2000, and still do have a problem with what is going on in nephrology today, and the fact that it's not like it was in the 70s, and we're not doing total patient care, and we're not really holistic, and I started doing a lot of work in ethics, and actually, in 92, I wrote an article that, Is it Time for Selection Criteria Again?, and that started a whole other thing, because I was co-presenting Bill Logan, Paganini, Tom Gulper, another nephrologist out in California, about we need to look at what we're doing in the lack of selection, or the lack of appropriate dialysis in some cases.

DWM:

So what brought you to that topic, and when you first published about that, what was sort of your position, and how did that play out in the conversations that you had subsequently?

Why did you, why did you get involved in that?

CPR:

Because my position was, is that I already knew that we were dialyzing patients that were receiving no benefit from their therapy whatsoever.

DWM:

And what does that mean? What kind of, what kinds of things were you seeing that you thought, this is not what we should be doing?

CPR:

They were no longer interacting in a personal way with their families or society at large. I mean, literally, if not comatose, certainly beyond being able to do anything, and I saw the burden to their families, and I saw how it took away, even though I know they loved them very much, but I also saw the drain on the families, and families would be saying, you know, should we be doing this?

DWM:

So you had, you were seeing often families, patients who were not benefiting, and families who were tired, and were wanting to stop.

What was the barrier to discontinuing dialysis for those patients?

CPR:

Well, nephrologists didn't know how to say no. I mean, in many cases, they just didn't know how to say no, and they didn't, they didn't want to offer all options, which includes no treatment, because there is a feeling that you never know how somebody's going to do on dialysis, so everybody deserves a trial.

My position, when I wrote the article, was that we, that you should have a trial dialysis, but after three months, if it really, now I also know that once you get on chronic treatment, I know it's hard to stop, but my, my position was, and still is, that the nephrology community at large should be getting together and making these difficult decisions. There have been nephrologists who have said about 30% of the patients we dialyze receive no clinical benefit, and if that's the case, that what we're costing health care today, Medicare in particular, then we really, it is incumbent upon us to change that, because there are a lot of other disease processes out there that could use that money. I remember lecturing one time, and a nurse got up, this was in a mixed critical care nephrology, talking about dialysis, renal failure, etc., and she said, you know, you have the money for your patients, but she had a neuropatient that was paralyzed, and they didn't get the money for their patient, and she said, why are you taking the money?

Why did you get it? And we're the only universal, that John Oliver, we are the only universal health care in the United States, and I always say, it's the reason there'll never be a one single system payer, because what we've done with that program, although extremely beneficial, you know, the price of access to what we have now, was not what the original nephrologist intended at all. I don't believe, nor the nurses.

So, at any rate, I started really thinking, you know, of course, I think everybody starts thinking towards the end of their careers, what are you really doing here? And so I just, I just challenged the nephrology community to think about what you're doing. You can do something technically, but, you know, is it really what you should be doing?

And so I started lecturing, I started, I was on the original DOQI guidelines, I was on the Alvin Moss, the guidelines for initiation, appropriate initiation. I thought we were going to make headway with that guideline, and that we would begin to really do effective choices where people were not, and or that we withdrew dialysis at an appropriate time. I'm not so sure that, you know, that it's really happening, but I really had a lot of hope back then, and the other thing I did back then was, I was the first one in Vanderbilt, Tom Golper agreed, I wanted to have a committee on acute care, what was going on in acute cares, but related to dialysis, but also related to who was doing dialysis, and the way it was being done.

A nurse would be called at 2 a.m., and the nephrologist wouldn't go in. The nurse was required to go in and dialyze a patient. Orders been written by an intensive, yeah, I mean, what was going on?

So I talked to him, Tom, and I said, he said, if you want that committee, and you want the RPA, we'll do it, but ANNA is taking the lead, and you are going to chair it. So I chaired the committee, and met with the nephrologist, and we, again, started to make headway about some of the stuff going on in acute care that really needed to be changed. Whether we made any headlines or not, I don't think so.

I actually, working with RPA, we got the position statement on nephrologists and nurse practitioners, collaborative practice for the care of the renal patients. I also worked with Tech Association for the appropriateness of tech, technical assistance position on use of technicians in dialysis. So, you know, I felt good about starting to get some of this stuff on paper that I really felt, you know, needed to be followed, needed to be done.

You know, techs now have to be nationally certified. That's a good thing. Nurses still don't.

The other thing, and this is an aside, I am extremely against two-year nursing programs. I think every nurse should have a bachelor's degree, and I've also lectured extensively, and I have fought with ANA and nursing forever about that, and I continue to do that. So I just really thought that, you know, the professionals needed to be professionals, and we, and by being a professional meant, and this is how you were trained, is that you, you, it wasn't a disease process.

It was all-encompassing of a patient that had a disease, and that you, you interacted to your best extent with, you know, every domain of the patient. Again, I worked a lot with achievement of age-appropriate tasks, so gone through, you know, voting, or, you know, getting a job, or having a family, all these age-appropriate tasks, and, and I felt that this, I still think that's what we should be doing, and I don't, and I know now it's a very busy field, and, and there aren't very many dialysis, you know, nurses in a dialysis unit anymore, and, you know, the social workers, they're there, but, you know, the social workers I originally worked with were doing job applications with patients, and helping them. You know, the dieticians, great men and women, you know, really sitting down, and many of them still do, I think, but their caseloads are very large, sitting down and working with them, but it really is incumbent upon the professionals. If we are going to offer treatment to these patients, then we really need to interact in every aspect of their life, not just putting them on a machine, and we don't do that.

I mean, in my opinion, we don't do that. So, again, towards these last several years, I've been invited, because I will get up and say that in, in, in a lecture hall, and, you know, I've been booed, and I don't care, criticized, and, and telling me that, you know, you're trying to play God, and I'm not trying to play God. If anything, I'm trying to play human.

This is what, you know, we were educated. This is what we professionally agreed to do. Do no harm.

Well, you are doing harm if you're offering somebody something that's giving them no benefit. I mean, you know, the way I look at it. So, you know, I started very much involved in ethics, and very much involved in end-of-life care.

I wrote an article on palliative care at the end of life for the renal patient, a very clinical article based on what other palliative care is, you know, for population at large. Very well received, often quoted, you know, I've written, you know, chapters and books, again, just trying to get people to think about what they're doing, and also offering care. I was asked by Rehabilitative Nursing, and I've written a couple of chapters on renal rehabilitation for Rehabilitative Nursing textbooks.

Again, they wanted that. What is it that we're supposed to be doing when we see these renal patients? And again, explaining home dialysis to them, and why, you know, in collaboration with nephrology, but the rehab nurse has a great role in that, you know.

Written in critical care books. I used to write the exams for renal, for critical care. I was to test questions.

I was on the, I've written multimedia at least three or four times. I worked with this one nurse doing the renal content for multimedia for training critical care nurses. And, you know, again, to educate them to see what it is.

But I've never, even though I'm a very clinical person, and a very technical, I have always made people understand that, you know, you need to go outside that technology. And so, you know, that's been a big part of it, is I, you know, more or less you know, ended up my clinical career, so to speak. Because actually, just last year, I let my nurse practitioner license go, because I'm not going to be working clinically, probably.

I'm keeping my RN license because I can, because I don't need the clinical hours. And I don't think I ever, what I see going on with RNs, I probably would never work again as an RN, but you never know what you got to do. So, but the other reason I do that is, I've been a member of ANA, my whole career, of every state nursing organization, and ANNA.

And I will forever, if I see something written that just isn't appropriate, I still challenge, I wrote an article to ANNA that nursing was not a profession, it was a vocational trade group. And then I explain my point of view. But if you do not have a professional degree, and you go to a technical school, which is what the community junior college, in my opinion, is, people coming out of there do not get to take the same exam as somebody coming out of a four-year degree.

And I've forever tried to help nursing see, because they say, oh, nurses aren't on these boards. I've been on every board there is. But they keep saying, why aren't nurses on the hospital boards?

It's because we don't have the degree to do that, to, you know, to influence those health care decisions. That's one of the problems, is that there aren't enough nurses that can help

influence the health care decisions. And I firmly believe it's based on our lack of education, standardized education.

So I've written about that. But, you know, then gotten into just, ANNA has, ANNA has a beautiful website now. They've really developed their blogs and their websites and everything like that.

And it's just, it's somewhat discouraging, is that, you know, the nurses now, they're talking about the same things we used to talk about 30 years ago. And I think, come on, you can fix that. So let's talk about that a minute.

DWM:

So let's talk about nursing over the last 30 years. What do you think nursing was when you first started? And what do you think has happened, good and bad, for nursing over the last 30 years?

CPR:

When I started in nursing, when I went to school at the University of Florida, see, in 1965, nursing wrote a position statement that all nurses by 1975 would have a baccalaureate degree. And it was their position statement in 1960. So when I was in school in 1975, the faculty at the University of Florida actually said that all nurses would have a baccalaureate degree.

And this is why you have to, you know, but they didn't achieve it by then. So then I wrote an article, you know, in 1975, saying, you know, basically, when are you going to, you know, why are you reneging on your position statement? I wrote the same article in 1985.

And I wrote it in 1995. Because what I thought nursing would be was a very all-encompassing professional group of educated, mostly women I know, but some men eventually, and that they would be really have a very, I don't like the word nurturing, because that comes up with nurses and, you know, we're number one for nurturing, you know, professional group. But, you know, if we have an advanced education where you can utilize the principles of education to, you know, to educating others, to actually looking at research and why things are what they are, that's what I thought nursing was going to be.

And they never reinforced. And actually in 1985, they reneged on it. And they said that they were not going to support the BSN degree.

They said they were going to have a stepwise approach where they would start with an ADN degree and then get a BSN degree, which most 75% of nurses who go to a junior college do not get a baccalaureate degree. But that was their focus. They stopped back and said, we can't do it.

And that's, I know it's the economy, I know it's the availability of education, etc., but it was also the easy way out. One of the things I didn't like what nursing said is that because you can't afford to go to college, and I used to point out that everybody else has to somehow afford to go to college, and nursing is the only one that uses that as an excuse, that we can

have this two-year degree and then take the same exam as somebody that's got actually a three- or a four-year. At one time, there were 650 diploma schools in the United States, and it was the greatest thing for nursing.

I mean, that's how it was, my mother. We got down to 69, and now they are going back up again. Now, the only good thing is that the diploma schools that are hospital-based that are opening are tied into either a university or a junior college.

You don't actually get a diploma, you get a degree out of there now. But, you know, my point was is that nurses should be professional. And, you know, a trade school, which I'm all for, if you want to be a plumber, engineer, beginning computer science, you can do that in a stepwise approach, but only nursing doesn't insist that you go on and get a baccalaureate degree.

And I think that's, for me, professionally, that is a... it's a real impairment to the profession in getting the influence and recognition that we should have had. People will say to me, well, look all you've done.

And it is true, and I have been able to be influential throughout my career. But the sad thing is that as I move on, there aren't people behind me doing it because they're just not prepared the same way, or maybe they're not involved the same way.

DWM:

What do you think, when you look back when you first started in the 70s and 80s, what was the relationship that nurses had with physicians then?

And how did that change over the years? I mean, obviously, you were always in a leadership position, but maybe partly for you, but what did you observe sort of as the physician-nurse relationship for other nurses as well?

CPR:

Well, I think that originally, now where I worked, the nephrologists were really it was very much a group work at the University of Florida.

DWM: (1:09:22 - 1:09:24)

A team, a multidisciplinary team.

CPR: (1:09:25 - 2:06:10)

Very much so.

DWM:

And so that being the case, what do the nephrologists perceive as their role? How did they behave as part of the team that made it feel like a team to you?

CPR:

Well, I mean, they were always respected as having a different body of knowledge, but I think what was different is they respected the body of knowledge that nurses had. I mean, it

was really teamwork and relying on each other. And the nephrologists would ask, you know, what's this patient doing?

What's happening here? Now, in other areas of nursing, I do think it was more of a paternalistic role, physician-to-nurse. I've been very fortunate in that I haven't really totally experienced that.

Even when I worked in the community hospital for two years in Fort Myers, Florida. Physicians, when they recognize that you have a true leader, they latch onto that as almost a security thing because they know they can trust it, and that's important. A lot of what I did as a nurse practitioner is I've really tried and I can't say succeeded, but I really tried to get nephrologists to understand that it is a collaborative practice role with nurse practitioners.

It has to be. And I think in some respects, I think that's true, but not always. But it really should be collaborative practice.

I mean, that's really what we're talking about. That's where you take the body of knowledge, the expertise of all sides, and you work together. And that is the way we are going to bring out the holistic care of patients with renal failure.

Because relying on each other, trusting each other, referring to each other is really what's important. And I don't think we I don't think most practices do that for a variety of reasons. And I realize people are very busy, and I understand that.

But, I mean, I'm equally disappointed in what's happening with nephrologists because a lot of nephrologists are foreign medical graduates. They go through the VA system. Americans are shying away from nephrology.

DWM:

You've written about it. The workforce of nephrology is a critical issue to the United States. Because if American-trained nephrologists, physicians don't stay in nephrology, you know, and now, even with having a nephrologist, the hospitalists do the acute care, you know, the intensivists.

CPR:

As a matter of fact, it was Tom Golper that used to call himself a dialogist. You know, we don't and you all shouldn't be doing that either. That's taking you out of your role of, you know, what you should be.

But I understand people are busy, but anyway, in the world that I would think that the patient with renal failure would be, in the ideal world today, is that every single patient would get modality education because people would be seen from their primary care physician to a nephrologist when they were at least in stage 3 or stage 2, which is when most people are found out. And then have a team approach to helping that patient decide what type of modality. And if they weren't going to do dialysis, that's perfectly okay.

We had a lot of patients that chose not to do it. They lived a quality of life right to the end. And it was far better than what some of these people that were treating with dialysis.

But, you know, the nephrologist, the social worker, we would work with that patient. And then when the initiation of dialysis, I personally don't think you should be putting AV fistulas in 90-year-olds. I've done it.

It doesn't work very well. But there are other avenues like Gore-Tex graft or synthetic graft works because their life expectancy is so short. The other thing I started doing was a lot of legal work.

You know, expert witness. And when you see things going on in the legal world. But I think then we would be able to not see these John Oliver things that are coming up now once again.

Because, you know, for a while it was the Bloody Mary thing in Washington, D.C. I mean, nephrology with a collaborative practice approach, looking at all, giving patient modality education, helping them understand what we can provide for these and what we can't provide. And having a more realistic view of how we should be treating patients with both acute and chronic renal failure. Either or.

I just don't think we do that real well anymore. And I would really like to see us get back to what we were doing in the 70s. I mean, to me, that was holistic care.

Nephrologists, nurses, nephrology nurses, you know, having a team approach was really really good and a rewarding experience because, you know, and your oral history, but a lot of nurses now they've been in for less than 10 years and they don't know that history and they don't understand how it used to be. And again, just like maybe nephrologists, nephrology nursing isn't an attractive field for nurses anymore. So, you know, we really need to do something with nephrology in general.

DWM:
We really do.

CPR:
You know, I talked with Belding Scribner. I mean, it went to his retirement. He signed my book.

I mean, they are disillusioned. But then how much did they have in not trying to have it develop as it is today? So let's talk about Belding Scribner.

DWM:
Did you meet him? Did you know him? And what when you say people who started dialysis in the 60s might be disillusioned with where we are today.

Why? What turned out differently do you think? And can you talk about Dr. Scribner in particular?

CPR:

Well, I met Dr. Scribner actually on two occasions and briefly had the opportunity to talk with him. But I mean, I've heard his lectures and he actually indicated that what he did to bring life to people you know, it didn't totally turn out that we were providing the life of what he and I think some of the early people had intended. When we had selection criteria, when the Life magazine came out which I have a copy of that when that came out you know, it was I think that they were being very realistic it was an incredibly hard decision who lives, who dies.

But they also understood that not everybody can live. And they also understood that those that lived had to have productive lifestyles. One of the criteria was that they were meaningful to society that they worked.

And I'm regardless of what you'd agree about you know, first of all, kids weren't often dialysis back then, you know. And but they really felt that they were providing a treatment that would allow somebody to go on and have a normal lifestyle. And we have cases I had a patient that was on home hemodialysis for 30 years and she did live every bit of a normal lifestyle, had children you know, was married.

And I think that's what the original nephrologists and nephrology nurses thought we were creating with the End Stage Renal Disease Program. I thought that we were going to put it in the homes so we could treat more patients rather than have these large centers. And even if we had to have large centers or centers because not everybody could do it at home but the first focus would be keeping that at home.

And why? Because the intent was to keep them with their family their children. So they could do their homework with their children.

That was the original intent. And now our home dialysis rates are pretty dismal. I know for a fact that many of the nephrologists that I actually worked with never heard about peritoneal dialysis in their training.

Don't know anything about home dialysis. They do now, but I mean I'm talking back even in the 90s. They didn't realize that you could offer dialysis at home.

And when I started these various programs over that time and they saw their patients thriving. I mean they began to understand that this is really what it should be all about. The other thing is that you hear the nephrologists that are some of the, well not the original many of them have passed on, but you hear in later years you hear them talk about nephrology or publish about nephrology and they're now saying to the younger nephrologists we really should be doing something different.

DWM:

So let's talk about ANNA.

CPR:

So with ANNA, when did you get involved with that and talk about your leadership position? I was the Western Region Vice President. ANNA is regional, so back in it would have been the 80s late 80s.

So I was the Western Region Vice President on the National Board for a few years and then I became President Elect and then I was President and I lived in Salt Lake when I was President. So what year would that have been? 95, 96.

And then still on the Board another year. I was on the Editorial Board for the ANNA Journal for probably 15 years and the Manuscript Review Board along with a lot of other nursing journals that I used to review manuscripts for. So I was and I even tried to get ANNA to understand what just how really important it was to support that role as a nephrology nurse and that's why I started got them to agree to position statements and trying to work with RPA.

When I was President and on the Board of ANNA I had a really good working relationship with RPA and I first hand called them called me and we did a lot of work together and they I think recognized okay here's somebody that wants to address the issues the acute care situation, the need for guidelines, Alvin Moss and I said come on we've got to do something this isn't what we're doing here and he of course was great and done a lot of work there and even Bill Owen he said it's fun what it's supposed to be I think he had a hard time with it. So when you started with I'm not sure exactly when ANNA began do you remember what year? Back in the 60's they're almost 50 years old.

DWM:

So when ANNA started by the time you were involved in the 80's were they pretty well organized and what was the role they had for nephrology nurses at that time in the mid 80's?

CPR:

In the mid 80's a lot of it was education we got a core curriculum written for the first time we started doing modules for education because everybody could kind of see that as the workforce was exploding there was a lack of education a lot of it technical but I have to say a lot of it also understanding the role of the nurse and also looking at the patient holistically as a family or as their individual position in society I think they did a really good job on that so educational services programming when I was president just like all organizations there's about 18,000 practicing nephrology nurses maybe 20 now it's hard to say but when I was president there was like over 12,000 members of ANNA and now it's down to probably less than 8,000 a lot of organizations are dwindling but there's also less interest in organizations in general it's a generational thing there was a lot of camaraderie there was a lot of colleagues working together there was a lot of sharing of information there was a lot of wild partying the ANNA meetings were really good ANNA has always had a very good relationship with corporate America always I use the Shiley Catheter I have a Shiley Catheter back when single needle machines back then the first dual lumen catheters, the insert catheters all of that came out the original PD supplies but the pharmaceutical and that's how I got Bob Janosko's slides because he knew that nephrology was not ready to preserve

the history but he had those slides which was the history he gave them to me and said I know that when the time comes you will get these into the right hands I knew this was the right time you were going to do the history I actually don't know if he's still alive but I know he'd be extremely pleased to know the history is being preserved still his last name J-A-N-K-O Janosko J-A-N-S-K-O I have to check on that I also think that back then in society at large I think people really wanted to preserve what nephrology was doing back then both RPA, ANNA and then ASN which doesn't exist anymore but I think there was a real pride that they had discovered and brought from infancy this medical specialty that was phenomenal in saving lives but it was also phenomenal in realizing that people have a position in society and we should help them maintain that position in society, whatever it is and achieve developmental tasks I think we sort of forgot that along the way but this birth of nephrology which is relatively new compared to all medical specialties there was a great sense of pride in what we were doing I don't know if we'd say that anymore so and now I don't see the same really good working relationship between ANNA and RPA I think that's really unfortunate you wrote the article on the workforce and I responded to that article because you called the nurses dialysis nurses and I have fought ANNA forever I got up in a meeting years ago because the president kept saying dialysis nurse and I said all due respect I am not a renal replacement therapy nurse I am a nephrology nurse I take care of patients I educate patients I do research I look for their families I practice holistically I do not operate a machine and for ten years every time dialysis nurse was written I responded it's a nephrology nurse and then they let it go and that's very discouraging to me because that is so non-professional to call somebody a machine replacement nurse I said we don't call critical care nurses machine monitor nurses we don't call dermatology nurses skin nurses and I went through the whole medical sub-specialties and I said we don't do that only in nephrology do we call them by a machine well that's gone by a dead sign because now they are machine nurses and I don't believe in the term home therapy nurse PD nurse, transplant nurse we are nephrology nurses all encompassing you are a nephrologist all encompassing you practice in all areas and I believe nephrology nurses should be practicing not necessarily practice in all areas I understand some nephrologists don't do transplant I understand that but you still have to have a working knowledge of that so that you can refer your patients to somebody who has a better understanding or maybe is a surgeon it is incumbent upon nephrology nurses to have that same body of knowledge such that when it's outside your immediate expertise that you can refer them to somebody who has more immediate expertise or working in that field directly and I think that's another problem with nephrologists I mean when you start calling yourself dialylogist that's pretty sad which I think is so wrong when you give up your hospital work to the hospitalist believe me they are not getting the same care as a nephrologist they are not so what is nephrology going to be in another 25 years what are you what am I what is it going to be this birth of nephrology that occurred say in the 60s and by the time we get to say 2000 2050 2040 what is it going to be as a medical subspecialty and who are going to be and what are they going to call themselves or name themselves the practitioners I have heard nephrologists say that I only work in chronic dialysis units that's what I do you know that's just not right I mean you know what do you think it should be like 25 years from now what do you hope it will be like you know I really hope that both the nephrologists and the nephrology nurses but I think that they need to go back somewhat and read the history and understand their roots and

understand what the intentions were for this medical specialty and then and I realize there are restrictions but then get back to incorporating again what we originally intended and what we intended back in the 60s and 70s was to extend somebody's life for as long as possible with a quality of life we understood that the quantity the life expectancy was going to be different we understood that but we never anticipated that the quality would be much different we thought they would have a good quality of life doing all the age appropriate tasks which is something I just use as a frame of reference because it's kind of easy to frame reference that and not a John Oliver approach do you think we can get back to that is it reasonable to imagine that we can get back to that my feeling is to get back to that we first need to decide who should be on dialysis and who shouldn't because I think we burden both the nurse and the nephrologist by having to care for patients that get no benefit from the therapy or that are more the benefit they receive is so minimal that palliative care would be a better choice and I think if we could get back to and if it is estimated by some very you know by nephrologists because when I started attacking it they said ok 30% and it's in publication but 30% if they don't get a benefit a clinical benefit then maybe there's other ways to do it now maybe one of the ways is to get them on home dialysis so maybe there would be a clinical benefit but I think if you stop over burdening the nephrologist and the nephrology nurses with this half a million patients and say we got it down to 350,000 and let's just say out of the 350,000 we got at least 30% on home dialysis of some kind and then transplant is difficult because there's not enough organs but let's say 10-15% were transplanted then you would be dealing with and I often thought in the chronic units you would be dealing with about 50% less patient population the other thing I think is not only do they not benefit from dialysis but it is sad to say that dialysis is one of the main places where patients can absolutely abuse their treatment and their therapy and the medical regimen and yet we still provide care but not just care, extra care I mean when patients are coming in potassium is nine, well the nurse has to stay longer or 15 kilos over and I've done that why are we saying to patients that you're different we will teach you we'll give you extra treatment I know we try to educate but why don't we just say no frame of reference is that if you post MI and you go into the cardiac rehab and you're not doing what you're supposed to do they discharge you from the rehab clinic they say no now you can say it's life or death but isn't post MI cardiac rehab life or death I mean really so why can't we say to patients who refuse to participate even make any effort to participate in their therapy that we're not offering you why are we fighting with dialysis units to refer to the other dialysis unit and then make them sign a contract to keep the patient why are we putting the nephrologist through that why are we putting the nurses through that why in society are we saying that it's okay to abuse your body abuse yourself, not follow the medical regimen but we're still going to give you care that needs to be answered because other specialties answer that question and they do stop care and I know you can't use this thing that it's life and death you can't use that anymore if we got to that where we really reasonably were dialyzing say 250,000 in center 300,000 patients and personally believe see how can you encourage ANNA is trying these preceptorship programs bringing in a nurse say when they're in their last year and having them around dialysis unit to be honest with you most of them never come back it discourages them but if they saw patients like I saw patients back 40 years ago that we actually made an influence in a positive way on their life it is a wonderful field to practice because you see them frequently you are able to interact with

their family their kids you are able to follow them through a life their lifetime and as hard as it is but the absolutely most and I used to tell my patients all the time the most rewarding thing you can give any patient is end of life with dignity and the opportunity to say goodbye and so when people understand that and that they stop dialysis and the family members have an opportunity to say goodbye there is nothing more powerful after they're gone than to realize that their last days on earth were happy days not being stuck with a needle or whatever and so I think that it would be an incredibly fulfilling practice because we would be able to go from you know beginning to end and make a positive change and nurses nephrologists would see that wow all these years of training and they're paying off because we're actually making a difference and would you make as much money probably not but the millionaire nephrologists take it off I mean it's not going to be the same and I understand what happened with dialysis as far as the large dialysis but even you see that stuff and them competing criticizing each other etc.

and still having a role for some of the independents I think that's important that the independents still have a role and I think that that the economy of scale you're going to have somebody in any area where you're going to have a bigger manufacturer you're going to make more bigger planes, bigger cars, whatever competition is not bad competition brings out the worst of the best I would like to think that in nephrology competition would bring out more good and I would like to see that the independents and the larger providers would actually sit down and say you know we really need it it's incumbent upon us, we created this situation why are we not changing it why are we not making it better because you know you see that stuff come out that YouTube and you think wow man that thing has gone viral millions of people have seen that and now think of what they think you know and then when I was getting ready to do this I thought wow I better go read my CV and then I thought oh yeah I did that and you think through it and then you think okay you're one of the ones I'm still involved in the sense that I will take every opportunity to respond but you also have a sense that however much longer you're around you're not going to be able to influence what should be done right and that for me personally is a very sad thing because I really delved into this wholeheartedly believing I could make a change and that I could do something really good and I did do something really good you know one nurse when I was at the University of Florida told me one time she said you know you'll be a clinician and you'll be an excellent clinician you'll go out there and take care of a lot of patients and then someday you'll realize that that's not all you can do and to increase your sphere of influence you're going to have to teach and you're going to teach a whole new group of nurses how to do what it is that you have done so well and I did that and then she said and then you are going to get in a position where you are going to go beyond and you're going to have to write and publish and do the research that you can even influence a greater sphere of nursing and I never thought you know you're back you graduate you think oh god I just got to get the blood pressure right and I thought well you know I said well I'm glad you believe in me but you know probably not going to happen but I realized that has happened but you still don't have the influence that you wanted to happen and that's probably a lot of people who end up feeling that way

DWM:

It's interesting to hear you talk about that because that's really a career of educating yourself getting practical experience in your own area of expertise talking to others about that helping a few others in your immediate surrounding become also you know benefiting from your experience and then writing about it which enlarges your influence pretty tremendously is a leadership pathway and that's I've been thinking about that actually a lot lately so I get the feeling talking to you that you definitely consider yourself a nursing a nephrology nursing leader is that so?

CPR:

Absolutely

DWM:

Do you feel like you fulfilled that? Did you set out to do that and do you feel like you fulfilled that?

CPR:

I can't say I started out to do that because I think young in your career you don't think about you know you're told first of all on a baccalaureate nursing program you're told you're going to be a leader but that's somebody telling you something you're still trying to write your thesis Did I achieve nephrology nursing leadership?

Absolutely I am I say this totally unashamed that I am one of the absolute few nephrology nurse leaders that still stands today I still get people if I comment I get people calling back to me I get people responding to me I get people still asking me for you know what would you do in these kind of situations so clearly Christy Price stands as a nephrology nursing leader almost for all times in the sense that I operated in every avenue I also very technically was across fields acute and chronic the publications are out there they're still quoted they're still referenced so yes I feel that but again my my desire would have been to change what I see going on now and you know people always tell me you had a fabulous career and I ended up from a financial perspective from a positional perspective a leadership perspective I couldn't ask for more or have been better and I've traveled international lecturing I've been in every state I mean I've done all that but when in the end when you start to think about but the field isn't where you would have liked to have been you thought it was going to be I really did not believe that what is going on in dialysis today would be it I really felt that the nephrologists and the nephrology nurses working together would see that some of the stuff they're doing just isn't quite right and I really felt that they would change I felt Woody Moss would change it Do you think nephrologists and nephrology nurses have the power to change?

I do very much so but I think they have the courage to do it you know early on in your own company originally Early On Roots they had the courage to do it you know there was a book The Courage to Fail they had the courage to fail and I think what we need again maybe is the courage to fail it's a whole different world but anyway what is a better time to have that courage with what we're dealing with healthcare in the entire United States I mean if you're spending one dollar inappropriately in healthcare today then I really think that there should be somebody saying look we gotta change that and I've always said I wish that the the

nephrology community would change it before the government comes and tells you to because I think the government telling you to change it is a poor way rather than you changing what's going on you know I said that to nursing I said if you don't mandate the BSN degree then you're gonna have society mandating it for you and that's a coward's way out and that is what's happening because if you don't have a baccalaureate degree in a hospital it's BSN preferred and I'm really happy to see that so you don't get a job now unless you are BSN preferred or in many places they won't even accept it but that was not nursing doing that what society's saying because the research shows that a baccalaureate degree over a two year graduate produces a better quality care and the research shows that fewer patient complications so you know healthcare the organizations are saying hey we don't want complications those are expensive plus they give us a bad name so we'll hire the people that are less likely for that to happen so it does it can change so what advice would you give a freshly minted BSN nephrology nurse today? I would encourage them to learn the technology and the ins and outs of dialysis I think you need to understand the physiology of what is going on I think you need to understand the pathophysiology of the disease process very much so and then I think that once you're comfortable with that which is somewhat easier to learn I think that what you need to do is realize that your role is not just dealing with the pathophysiology and the physiology of the technology and how it's done I think you need to understand that your role is encompassing all of that so that you can make a positive change in the patient's life and meet the patient where they're at and take them further and if it's noncompliance if it's just a horrible disease process and they realize that their life expectancy is going to be shorter than they had otherwise hoped but then take them to get them to the high school graduation the college graduation teach them how they can make it work with them and they will make it and the nurse will have an incredibly rewarding experience getting them through the technology to those important events in life and I also think and it's better in the United States but I think if people understand that end of life is not a bad thing it can be such a dignified and we're all going to go there anyway but do it in a dignified fashion and help our patients do it in a dignified fashion don't have them be there as the last option help them to be there through a pathway where they have time to interact with their families do the things that are important maybe make that one last trip and then get there and I think I would encourage a nurse to make sure she stays involved in all aspects of what is going on and don't ever get into the rut of on and off and just looking at the labs and making sure that you're meeting the guidelines so that you get paid I mean I understand that but don't just get into that rut because there's a lot more important things to a patient's life than what their URRs or KT over V I'm criticizing that now they don't want to use it what's important is that they have labs that allow them to live a good life a quality of life for ever so long as it can be maybe they're not going to be 85, 90 years old I understand clearly and nurses understand that average life expectancy starting dialysis today in the United States is 7 years so if that is true then that's average then that is going to be the only 7 years that you're going to have to influence that patient's experience that individual's experience on earth do it the best and the most fulfilling way averages are meant to be broken and I really think that we should face and a nurse should face if you start an 80 year old on dialysis that's fine but don't let them think they're going to live to be 95 be realistic and say you might have 2 years less I understand but let's fulfill those 2 years in the best way possible and not try to make them understand their disease.

We do it with other diseases you tell somebody that's had 4 bypasses, look you're not going to make it or you tell somebody that's a diabetic overweight, we're realistic with them you don't lose 40, 50 pounds you're just not going to be around we tell people about their disease processes why do we not tell a patient who's got renal failure the truth their life expectancy don't paint an over rosy picture but paint a realistic picture where they can encompass what they need to do but they also have to cooperate and be part of the picture they have to be part of the process and that would be just like for me, that would be a very rewarding career very rewarding and I think that we could get nurses back to understanding that and feeling that really good sense of having accomplished that I think it would change a lot of things.

DWM:

I actually think nephrologists the same thing So who have been your nephrology heroes?

CPR:

Nephrology nurses nurses well one of the first nurses Annie Correa was out in Los Angeles she wrote the handbook of she and handbook of dialysis C-O-R-E-A I'm not sure she's still alive but I talked with her she started in dialysis she was dialyzing animals and then they used to clean the machines and dialyze people back when so I talked with her and she has an amazing background of what real early nephrology was all about really amazing some of the somebody that I Nancy Sharp that was a go-getter I mean she was a leader she didn't take no for an answer she was past ANNA president she spoke her mind and that was one of the things when I saw her just up there speaking her mind and people would oh Nancy Sharp I thought yeah she's trying to make a change and she was dynamic Kathleen Smith again she she knows early dialysis she was in she has probably a better appreciation than I of the technician role from the very beginning because I dealt with military a lot but she understood and does understand the political legal regulatory like she said it may not be pretty but this is how you have to do it but she understands that and she was really helpful to me in just understanding my appreciation of why some of the things are how they are but you can still change that you know Trish McCarley and I have been friends and fighters we would fight there was a hotel room once we sat and fought we were trying to co-author an article I am so A and she is so B it was fun but she's just very it was very very fun to be with Chris Mudge who is out at UCSF great nurse great colleague worked with her a lot Serena Gilman is again the first head nurse in dialysis that I worked for because she was just the detail oriented really showed me the particulars of dialysis and also the particulars of incorporating again this was pediatrics but really really dynamic the physicians that I have worked with Paganini and I Emil Paganini again we used to challenge each other we did a presentation which I did should the role of a nephrology nurse be expanded in the dialysis unit he was adamantly against it but we got up and debated it was a mixed I think it was a NKF meeting and you know and actually he came to me afterwards and he said you won but it was really and we worked together and his nurse and I worked together on CRRT a lot we used to call back and forth talking about that but he was the nephrologist instigator he really got up there Tom Golper I have talked with him many times he understood what I was trying to say I understood what he was trying to say really trying to push for better patient

care Bill Owen great guy he actually in some ways felt bad about some of the things going on but and Woody Moss when I got more involved in palliative care and end of life care talking with him and being at those meetings he he wants to see things different too and he doesn't know how he's going to achieve it either but so there's so many so many that so many nephrologists I've known over my lifetime so many nurses that I've known but those are the ones that stuck out what I was really happy about and I don't see this happening now is that nephrologists would be just as comfortable asking my opinion as I would be asking theirs and I don't see that happening as much anymore I think that's unfortunate but so you know it's been a career it's been a good career and but I think everybody not everybody I think people who end up their careers kind of still wishing things would be different that's kind of unfortunate yeah I'm fulfilled yes I got all the awards medals well papered etc but we're not where we need to be so I think the onus goes to you to do it uh oh so is there anything that we have not talked about during this time that you definitely want to make sure that we include in this interview um no can't think of anything I mean I I've done it all and it's been rewarding it's been difficult but it's been mostly good um and I've benefited in every way um one of the reasons I get into being an expert witness which I did for 20 years is um it was another way of trying to educate people about what the care of a renal patient and a lot of it was negligent on the nurses part and I always said I will not allow a nurse to be negligent and so many many cases I mean you know prescribing morphine for somebody that was written allergic to bleeding access that they knew was bleeding and then ruptured and the nurse did nothing I mean and the thing about it is again expanding your sphere of influence is up until a few years ago once you're out of practice I would have attorneys calling me and asking and I would review charts for them and they would be asking because they would after the recorder was off they would just sit there and tell me about dialysis tell me about what's going on and so I had the opportunity to educate attorneys as to what you know what is going on in that world because they don't understand it at all I mean they don't I think they try to but you know one attorney I'll never forget it was from it was from Georgia and this patient died on dialysis and I just said to the attorney I'm just going to tell you right out I've read this thing the nurses did everything possible patient came in fluid overloaded she had an MI but I said I'm going to tell you and she was like 75 years old in a court of law and this is what I could say to an attorney in a court of law you will not win because the nurses did every single thing right the patient was not particularly compliant with the medical regimen and so therefore that will come up in court and I said and furthermore her life expectancy because awards are based on life expectancy at that point was well less than two years and he could not believe that and I said no I said you're not going to win this case I would you're not going to win this case against them because everything was right and because you're dealing with a disease process that doesn't have a long life expectancy at best and that disease process requires that the patient really cooperate and follow the regimen to the best extent possible so I was able to tell attorneys and they would come back and say we talked to some other people you're right so they didn't take it to court they didn't take it to court but I would help them see we're not all about suing because somebody dies, people die everyday and sometimes it's the way it is so that was another avenue and that was an avenue that I really enjoyed because helping attorneys understand which was another whole domain what renal failure was what dialysis was and for them to understand it also helped them to understand on

future cases what you look for when you decide you're going to sue or somebody's going to sue a case I did with CRRT where the lines became disconnected because they were under the sheets and after that every protocol was that the lines must be over the top of the sheets, you cannot have the filter under the sheets and they used to say well no way it was a disconnect patient blood and I'd say you're going to win on that one so get them to settle, they're going to pay I used to say they're a big company, they're going to settle and actually one attorney I said look this was a poor black lady in Georgia and I said look I'll tell you right now, for that thing to go away they'll give her \$50,000, just do it I said everybody wins but I mean I could help them I just think that's putting everything and I guess I'm so reality based that's putting things in realistic terms help this lady get \$50,000 she died but attorneys really of course now now it's not good because the attorneys are fighting with the nephrologists, it's not good they're fighting with the big units they're fighting with the they try to nitpick and find every single thing that was done wrong during a treatment but it's not always the provider's fault things happen people are sick and renal disease is one of the sicker diseases especially multi-system failure you know

DWM:

I think that's one of the things about dialysis and nephrology is that sometimes dialysis looks pretty straight forward and yet it's very complicated it's complicated because individual patients have individual needs that you've spent a lot of time talking about today and it's complicated because the technology is complicated so when things patients don't do well it's actually sometimes more surprising to me that patients do well as often as they do in the sense that it's complicated again

CPR:

you hear this term routine dialysis orders and I say there are no routine dialysis orders every patient is different how they're going to respond to the treatment is different but in the acute care setting now the nephrologists they say routine dialysis what are you going to tell me is routine about dialysis you know standard orders for dialysis in the chronic units I know the baths etc there's some standard everybody's on a 2k or whatever but in the acute setting they say standard orders and that's that's where you get into trouble I think because if you want to say that you work in a disease process that is all encompassing and both pathophysiology, physiology difficult to manage sometimes at best but then how can you say you write routine orders so those are still the things that come up but I think that's partially why the John Oliver's come up is because people try to say it's routine that anybody can do dialysis that anybody can be put on dialysis and then you say well wait a minute they say the professionals say anybody can do this anybody can put on dialysis we need to backtrack and say that's not the message we want to put out there you know so I think it's you know it is a phenomenal you know disease process you know I always used to say it's not the heart that rules the body but you know but there are so many ways to damage them too I mean so I think I've had the opportunity to say everything I thought well this is putting my whole career you know out there and I appreciate the opportunity to do that I so appreciate that you're doing this oral history I think it's critical and Trish always said well wait till you meet her but I am so happy because I'm so happy that a nephrologist listened and took the opportunity to hear and to record the nursing side of it because you

know when I mentioned that to you I thought well I'm going to do this she's probably going to say yeah okay fine but you know the fact that you responded back and then we've had this ongoing dialogue for over a year that just means a lot and that also gives me hope that you know things will be different in the future because I think you're reaching out and I think that's really important

DWM:

These nursing stories have been very important to record so I'm privileged to have the opportunity to do it

CPR:

Yeah I think you get a very balanced side of you know what was going on for sure

DWM:

Christy I thank you very much for being here today and to be a part of the Nephrology Oral History Project

CPR:

Thank you, thank you very much