

times I wanted to write letters to you, but I was afraid, because I was not sure I could write in a way that I could reflect what was in my heart. I thank you because you did something that no one could do. I suffer from visual problems, so your programs with their independence of vision helped me a lot.

Mr. Speaker, the hundreds of such testimonial letters and e-mail messages that are received each month are proof that Special English makes a difference in the lives of people around the world. I invite my colleagues to join me in congratulating the Special English branch of the Voice of America on its 40th anniversary.

DR. PETER LUNDIN, A VERY  
SPECIAL ROLE MODEL

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, October 13, 1999

Mr. STARK. Mr. Speaker, kidney failure, and the need for dialysis 3 times weekly, is a devastating disease that grinds many people down.

One of the most remarkable people I know is Dr. A. Peter Lundin, who experienced kidney failure as a young man 33 years ago, but who entered the world of medicine, became a nephrologist, and has had a remarkable and successful medical practice since then. He has been President of the American Association of Kidney Patients and a tireless advocate for the Nation's quarter million renal patients.

He is truly a role model, a figure of courage and determination, to thousands. I would like to include in the RECORD at this point an article he recently wrote for *RenalIFE* entitled "Dialysis at the Beginning."

Thank you, Dr. Lundin, for the great help and inspiration you have given to so many.

DIALYSIS AT THE BEGINNING

(By A. Peter Lundin, MD)

Patients starting on dialysis today do not realize how easy and routine it has become. Since the 1960s when it began, dialysis therapy has grown into a well-organized, efficiently run, multi-billion dollar industry. From the perspective of the doctor and provider, it is no big deal to start a patient on dialysis today. Everybody who needs it, can get it. Patients really cannot be blamed for their ignorance of how relatively easy they have it because the emotional trauma of losing your kidneys and beginning a new and restricted life with dialysis has not changed. What has changed in this regard is much less attention today is paid to emotional adjustment. Patients are told when they need an access placed and when to start dialysis, often with little consideration of the impact of this new and dramatic event on their lives. Dialysis units are often compared with factory assembly lines where patients come, get their treatment and leave without so much as a word of concern.

It was not like this when I began on hemodialysis in 1966. Then it was available in only a few centers scattered across the country. You had to have a willing insurance company or pay for it yourself. Because there were very few slots available you were chosen by a committee based on your social worth. Only breadwinners or housewives caring for working husbands and children were eligible. You were expected to continue working after you started dialysis. If you

had another complicating disease such as diabetes or were over 50 years of age, dialysis was not even offered to you.

The therapy itself was cumbersome and took a long time. It was done in settings where lots of nurses and doctors were available because of the uncertainty of how stable patients would be. Everybody was carefully observed by a psychiatrist for signs of distress. Everything was being measured because there was much to learn about this new therapy. How much time to spend on the machine and how often during the week to dialyze were still being developed. The few medications available for high blood pressure had powerful side effects and were rarely effective. There were no replacements for the erythropoietin and active vitamin D, which the dying kidneys had stopped making, therefore we were all constantly anemic. To get my hematocrit (amount of red cells in the blood) above 20 percent I needed frequent blood transfusions. The only way to control phosphorous in the blood was to eat a diet without phosphorous containing foods and to take Amphogel, an aluminum containing antacid. In those days Amphogel tasted like chalk. It came only as large unswallowable tablets or in liquid form and was extremely constipating. Due in part to the unpalatability of this therapy, some patients already had severe crippling bone disease. Others were already running out of areas for new accesses, their arteries and veins having been used up by multiple external catheters.

In those days we did not have grafts or fistulas. We dialyzed through an external shunt in the arm or leg. In my case it was in my leg so I had more independence in putting myself on and off the machine. While I did not have to worry about getting stuck with needles, the shunts caused serious concerns of their own. They easily got infected, damaged the veins and arteries, and often clotted. All of these problems led to a shunt life expectancy of about six months. One of mine was chronically leaking from the arterial side, forcing me to walk on crutches from class to class. After getting heparin for dialysis it might take several hours with pressure to stop bleeding. When it clotted I had my own declotting kits. Sometimes it would take several hours to open the shunt up again.

I was an undergraduate student at Santa Clara University in California when my kidneys failed. I was not a candidate for transplant, and as a student I was not a dialysis candidate either because I would have to become dependent on my family again. Nevertheless by a series of fortunate events the future came about and I am here 33 years later to tell about it.

I learned how to dialyze myself at the University of Washington in Seattle in their Remote Home Dialysis Program. After three months of training I returned to Northern California and to school. I had the hope and expectation of becoming a medical doctor, and I transferred to Stanford University, feeling it would be easier to get into medical school from there. While taking a full course load of physics, chemistry, biology and mathematics I dialyzed at home. The treatments were done, then as now, three times per week, but they lasted for 10 hours. Clearly, to be able to go to school the dialysis sessions had to occur overnight. After setting up the machine I would get on about 7 p.m. and off at 5 a.m. Of course, I had to sleep and did while the machine was washing the blood.

When I started dialyzing at home, dialyzers and blood tubing did not yet come in clean packages out of a box. They had to be put together by hand. At first, I had specially made glass drip chambers and long roles of plastic tubing. Dialysis membranes

came in a large flat box. The open end of the tubing had to be softened by sticking it in acetone and was then attached to both ends of the glass drip chamber. The dialysis membranes were soaked and sanitized for several hours in a container filled with acetic acid. Carefully removed, they had to be stretched over long plastic boards. There were four membranes divided into two layers each between three boards. Then this construction was filled with formaldehyde overnight before the next dialysis. With practice I was able to put it all together in a bit less than an hour. Taking it apart when the dialysis was over took less time, but before the next dialysis it had to be put together again.

My break came in 1968 when I was accepted to medical school in Brooklyn. It was my salvation. I was put on dialysis for 14 hours overnight, three times per week. I felt much better. I was learning to become a doctor. I got my first and only fistula which works well to this day. It was from that period of my life I learned some very important lessons about how to survive with dialysis: the importance of good dialysis and a reliable blood access.

Getting dialysis treatments today is, in many ways, very much easier on the patient, who is on average older and having many more medical problems. Supplies, equipment, medications and ways to treat other medical problems have greatly improved over the years. While having one's access fail is no less traumatic today than it was back then, the future promises to bring additional advances to improve the lives of patients with kidney failure.

INTRODUCTION OF THE SOUTH-  
EAST FEDERAL CENTER PUBLIC-  
PRIVATE REDEVELOPMENT ACT  
OF 1999

HON. ELEANOR HOLMES NORTON

OF THE DISTRICT OF COLUMBIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, October 13, 1999

Ms. NORTON. Mr. Speaker, along with Chairman BOB FRANKS today, I rise to introduce the Southeast Federal Center Public-Private Redevelopment Act of 1999 (SEFCA) to develop the largest undeveloped parcel of prime real estate here in the District of Columbia—the Southeast Federal Center located in Southeast Washington. This bill follows a tour of the site at the suggestion of Rep. BOB FRANKS, Chairman of the Subcommittee on Economic Development, Public Buildings, Hazardous Materials and Pipeline Transportation, as a result of questions I raised to General Services Administration (GSA) officials at a congressional hearing on May 11, 1999, concerning the failure of the federal government to make productive use of this valuable federal land while the government pays to rent and lease space for federal facilities.

I recently held a town meeting in the District focusing on the development of the Southeast Federal Center and other properties owned by the federal government and the jobs and spin-off economic benefits that they inevitably have on their surrounding communities. Because the parcel is located in this city, the District of Columbia would gain immeasurably from the project at the same time that the federal government finally would achieve productive use and revenue from valuable property. The win-win approach embodied in this bill has clear potential for a new kind of partnership between hard pressed cities and the federal government.