Among their various functions, kidneys cleanse a person’s blood of impurities. When they fail, the body suffers poisoning from the inside out. The hemodialysis machine (commonly called the dialysis machine) can function as an artificial kidney. Invented in the early 1940s by Willem J. Kolff, a Dutch physician-scientist, the machine was first used to save the lives of people with short-term, acute kidney failure. It works by taking blood from a patient’s arteries, cleansing it of waste, and then returning it to the patient. Kolff and others struggled to find a way to use the machine over the long term, but most patients could receive dialysis only five to seven times. Each cycle of dialysis required surgery to connect arteries and veins to the machine. Patients whose kidney function did not improve soon used up all their possible arterial and venous connections and, so, had no way to connect to the machine.

In 1960, a simple invention called an implantable shunt made repeat use of hemodialysis over the long term possible. With the invention of the shunt, kidney failure was no longer life-threatening and, instead, became a chronic disease treatable by repeated dialysis. The implantable shunt was invented by University of Washington nephrologist Belding Scribner and his colleagues, especially biochemical engineer Wayne Quentin. The shunt created a connection between a patient’s artery and vein that the dialysis machine could connect to repeatedly.

As a result of the success of Scribner’s shunt, the Seattle Artificial Kidney Center at Swedish Hospital faced a serious problem: there weren’t enough machines or trained personnel to serve all the people who needed dialysis. Physicians in the community did not want the responsibility of choosing which few patients would receive shunts and use the machines.

The hospital formed the Admissions and Policy Committee to decide which patients would get dialysis. The committee was composed of seven volunteers from the community—a lawyer, a minister, a housewife, a state government official, a labor leader, a banker, and a surgeon—and two physicians.

Stop reading here and write your answer to the question below before turning to the next page.

In your opinion, what would have been the fairest way for the committee to distribute access to dialysis?
The Admissions and Policy Committee used several criteria to determine who would receive dialysis:

1. Only people who would benefit medically from dialysis (as determined by a physician) were eligible.
2. Only adults—no children—were eligible. The committee’s argument was that more children would benefit if their parents or guardians who needed dialysis received it. Most adults supported multiple children.
3. Only residents of the State of Washington were eligible. Residents paid state taxes, and state taxes paid for treatment.
4. Only individuals who were “valuable to society when their lives were examined holistically” were eligible. That is, the committee used applicants’ “social worth” or “value to society” as a criterion. Committee members used several factors to determine social worth: income, sex, marital status, net worth, nature of occupation, extent of education, church attendance, number of dependents (more dependents gave applicants a better chance of being chosen), and potential for rehabilitation. The factors helped the committee determine the probable loss to society if an applicant died, including the loss of economic support to dependent children who would then need state financial assistance.

Write your answer to the questions below.

Do you agree with the criteria the committee used for distributing access to the dialysis machines? Why or why not?