

From the Editor-in-Chief

Who Lives? Who Dies?

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In the early 1960s, when hemodialysis for chronic kidney disease was new and there were too few machines and too little money to buy all that could be needed, allocation decisions were often made by committees. The committees had official names, but were most often referred to as the Life or Death Committee or the God Committee. In the case

of one of the first of these committees in Washington state, the committee was made up of seven mostly lay people whose identities remained anonymous. Their job was to decide who received the scarce resource of hemodialysis, and as a result, as the title of an article in the 1962 issue of *Life* magazine said, “who lives, who dies” (Alexander, 1962).

Fast forward almost six decades into the COVID-19 pandemic, and we were once again short of the resources needed for hemodialysis, but we were also short on ventilators, oxygen, hospital beds, etc. This time it didn’t matter if there was money to pay for the resources; they weren’t available. Now we looked for direction to Crisis Standards of Care (CSC), which had been developed over the years for use in disasters, but – in the everchanging resource shortages of the pandemic – were being used routinely (Hick et al., 2021).

Another Resource in Short Supply

Over the course of the pandemic surges, there has also been a growing realization about what may be the hardest resource to acquire and allocate – all the members of the health care team who are needed to keep people alive or help them die with dignity. As the country has begun to discover, and as Potter and colleagues (2021) noted, “without a nurse, a hospital bed is just a bed” (p. 1). There is a growing body of evidence to indicate that nurses, physicians, and other health care team members are not only leaving their jobs in record numbers, they are leaving their professions. And when they leave, their knowledge and expertise leave with them, and we become a less competent and less experienced health care system without them.

How Do We Fix It?

This pandemic has presented us with the biggest quality improvement project we have ever experienced, and

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there are no easy answers. Solutions, such as increasing production of supplies and equipment and paying health care workers huge sign-on bonuses, are short-term simplistic fixes for long-term problems. That’s not to say that added production capacity would not help or that nurses should not be paid more in the long-term, but neither will solve the whole problem we have now, position us better for the next pandemic, or create a health care system that produces better outcomes.

We must be thoughtful about solutions. The creativity, disruptive innovation, and collaboration that have abounded during the pandemic must continue. And we cannot ignore our pre-pandemic problems, such as unhealthy work environments.

What I know for sure is that we must find ways to work together within and across our professions, something we have not always excelled at in the past. We need to figure out the best contributions from each of the roles in our professions. To do that will require true collaboration, respect, trust, and a willingness at times to show vulnerability. As individuals and as professionals, we must decide whether we will be part of the problem or part of the solution. Who lives and who dies depends on it.

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