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The ‘Rule of Rescue’ in Medical Priority Setting: Ethical Plausibilities and Implausibilities*

Abstract:

Not infrequently, the so-called Rule of Rescue gets invoked as an allegedly self-evident constraint to the CBE-goal of maximizing health benefit with a given health budget. In this paper this constraint is critically analyzed. It will be argued that some of its implications are worth considering—but not the inherently vague Rule as such.

1. Introduction

Our moral response to the imminence of death demands that we rescue the doomed. We throw a rope to the drowning, rush into burning buildings to snatch the entrapped, dispatch teams to search for the snowbound. This rescue morality spills over into medical care, where our ropes are artificial hearts, our rush is the mobile critical care unit, our teams the transplant services. The imperative to rescue is, undoubtedly, of great moral significance; [...]

It is in this wording that US-bioethicist Albert Jonsen (1986, 174) described what he experienced as a common ‘barrier’ to the logic of pure cost-effective allocation in health care. Those were the days when (relative) scarcity of medical resources began to invite philosophers to take part in rationing debates. Jonsen himself had been serving on various committees assessing new medical technologies. Drawing from these experiences he came up with the above-quoted moral diagnosis. Although he backed off from any systematic evaluation of the depicted ‘barrier’, he coined its enduring name: “rule of rescue”.

Since those days, the rule of rescue (hereafter: RoR) has been invoked as well as criticized by various parties in the context of medical priority setting. One prominent occasion to quarrel about the normative status of RoR was Oregon’s attempt, starting in the late 1980s, to set up a fair prioritization list for health interventions covered by Medicaid (see Hadorn 1991). A major attack was

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ridden against Oregon's originally purely cost-benefit-oriented approach (with severe methodological problems in assessing benefits that cannot be discussed here), because it presumably prompted the media-covered death of 7-year-old Coby Howard in 1987. The boy, suffering from acute lymphocytic leukemia, could most probably have been cured by a 100.000\$ bone marrow transplant which was, however, not covered anymore by public funding, but would have been available some 6 months before. This event induced major changes in Oregon's health policy—changes that gave room to RoR. In Australia as well as in the UK, RoR has even officially and explicitly been accepted as a constraint to cost effective allocation, although its proper and consistent impact remains an open question (see MacKenzie et al. 2008; NICE-Citizens' Council Report 2006). Cautioning voices have pointed to the increasing danger of a stakeholder-interested invocation of RoR (see Moynihan, Heath and Henry 2002).

Much in line with Jonsen's original thoughts, many people have come to accept RoR as a morally significant ingredient in people's moral make-up, as something to be respected in any acceptable health policy. In Germany, it has in particular been philosopher Hartmut Kliemt who introduced to a larger public the principle (which he named "Akutprinzip") and its relevance: The more acutely life-threatening a condition, the higher the priority of its treatment in publicly financed health care—this he considers to be a widespread maxim and a rational principle for prioritizing publicly financed health interventions (e.g. Kliemt 2006).

Although they give some examples of RoR-required therapies (renal dialysis, second chance transplants, artificial hearts) and identify some categories of interventions that get posteriorized by RoR (prevention programs such as diagnostic screenings), neither Jonsen nor Kliemt nor many other RoR-proponents go into much detail of RoR's exact definition and thus its extension in assessing medical interventions. Nor do they attempt to provide a systematic theory for RoR's exact place in justifying priority setting in publicly financed medicine.

Rather, starting from the fact that people when asked for their fairness-preferences in health care and otherwise have a strong inclination to follow RoR, Kliemt and others embrace the view that RoR has a predominantly symbolic function (Cookson, McCabe and Tsuchiya 2008; Kliemt 2006; McKie and Richardson 2003). According to this perspective, adopting RoR functions as social glue, expressing inter-individual respect among citizens and giving a signal of striving at a humane and caring society that wants to "save endangered life whenever possible, hang the cost" (Connor 1991, 5). Consequentialists might book "the enhanced feeling of security derived from knowing that one lives in a compassionate society, where those in desperate need are not ignored" under external utilities (McKie and Richardson 2003, 2411).

Maybe, this already marks the end of any more systematic evaluation, given that "it is hard to form even the vaguest guess about the magnitude of 'symbolic value'—not only because effects are indirect and long-term but also the same action may symbolise different things to different citizens" (Cookson, McCabe and Tsuchiya 2008, 543). In the following I want, however, try to pursue the

systematic analysis of RoR a bit further, thereby profiting from recent literature. In the end, I will come up with some quite tentative suggestions regarding RoRs proper role in health care allocation.

2. Specifying Uncontested RoR-Imperatives

Many of us will share Albert Jonsen's diagnosis of a commonly and strictly felt duty to 'rescue the doomed'. However, this approval seems to depend on a rather narrow reading of the conditions under which this 'rescue morality' is or should be binding. Indeed, paradigm cases for usually unquestioned RoR-reference—such as the lost sailors or the trapped miners—share a number of characteristics, namely:

1. the victims' visibility or identifiability;
2. acutely impending death of the victims;
3. a reasonable chance of effective rescue;
4. acceptable risks or costs to the rescuers;
5. exceptionality of occurrence.

Scenarios showing all of these features in once most likely qualify as situations where many or most of us intuitively feel strictly obliged to undertake rescue efforts. Moreover, we want others to feel correspondingly obliged. And we want to live in a society where following such obligations is considered the decent minimum. If there is such a thing as a common morality (as I believe it is), a duty to rescue in such paradigm cases is likely to be one of its central norms and a rescue *disposition*, a specification of altruistic dispositions, one of its central virtues. Being disposed to rescue the doomed means that facing a paradigm case one would not start to balance pros and cons, to calculate opportunity costs—but rather jumps in. Doing otherwise, would invite Bernard Williams' famous one-thought-too-much-argument that he held against consequentialism. To some extent, policies have to mirror and confirm our rescue dispositions. That's all water on RoR's mill.

However, as soon as one or more of the listed features is not or not significantly realized—a thesis that will be argued for below—the rescue disposition might and possibly should give way to weighing and justifying. To use Pettit's and Brennan's (1986) convincing metaphors: the disposition (*auto-piloting*) gets replaced by reasoning (*piloting*). Let us take a look now at how close alleged RoR-health care scenarios resemble the miner and sailor paradigm and discuss the implications of possible deviation.

3. Analyzing Potential RoR-application in Health Care Prioritization

As already mentioned, RoR in health care is commonly invoked as a constraint on cost benefit evaluation (CBE) which is in turn is frequently applied with the aim to maximize aggregate health benefit. It is important, however, to emphasize that quite often rescuing patients from life threatening disease is also the right thing to do in the logic of CBE. If CBE counts patient benefits in terms of, say, QALYs (quality adjusted life years—health economy’s standard summary measure for health benefit) then curing a fatal disease and thereby preventing a patient’s premature death and restoring her to good or full health will ‘produce’ quite a number of QALYs: the more (statistically expectable) life years gained and the better the resulting quality of life, the higher the benefit. Only if the costs of intervention are very high or else if the gain in extension or quality of life is only small, CBE-based policies might consider the rescue not worth its costs. It is here, that CBE critics possibly invoke RoR, demanding rescue without paying attention to cost.

Assuming that we are and want to be disposed to follow RoR in paradigm cases, the closeness or distance of health care interventions to just these cases becomes a paramount question. Let us look for answers with regard to each of those cases’ standard features, as listed above. In doing so, it is left open whether these conditions are usually seen as necessary or sufficient, since this seems to be at considerable variance in various authors. In any case, the moral relevance of these aspects is to be scrutinized.

3.1 The Identifiable Victims Condition

If there is any consensus in current prioritization debates, it is upon the importance of setting health care priorities *ex ante*, so as to furnish these decisions with impartiality and transparency. Following this suggestion does, obviously, imply that at the time of decision making neither beneficiaries nor victims of such policies are identifiable. Only later, when rationing decisions guide patient treatment, *hic et nunc* identifiability becomes an issue. RoR proponents who give moral weight to the identifiability aspect want health policy to give priority to patients who—now unknown—will at the time of potential intervention be identifiably sick over patients who—now unknown—will at the time of intervention still be non-identifiable, but might benefit more. This ‘second degree’ relevance of identifiability allows for a more distanced view of people’s inclination to privilege the visible than can be hold when being involved in an acute rescue situation.

From such a distant (educating) view one can realize some boldly irrational consequences: Rather than screening people susceptible for a potentially fatal disease and treat them early, effectively and at low cost one would wait until later—only to treat the very same patients at higher suffering, with higher risk and higher cost.

Moreover, it has repeatedly been stressed that victim identifiability being a morally irrelevant aspect cannot serve as a criterion for fair resource allocation because this would violate the principle of equality (Cookson, McCabe and Tsuchiya 2008; McKie and Richardson 2003; Sheehan 2007). This is even more obvious if one shifts to the aspect of victim visibility that is quite often put in one with identifiability, although the former implies the latter but not *vice versa*. Repeatedly and in different countries with different health care systems single patients or groups of patients who 'got a face' by media campaigns (sometimes explicitly referring to RoR) induced changes in health policies (Hadorn 1991 and 1996; MacKenzie et al. 2008) while at the same time inviting critique for the unfair contingency of such media influences. I can only mention *en passant*, that empirical research with sophisticated methodology looked for the psychological underpinnings of the priority reliably given to the rescue of identifiable victims (Jenni and Loewenstein 1997). According to these data the major cause is not the visibility factor but rather the impression that a very high percentage of the reference group can be saved (in the extreme case: the one single victim being the reference group). The blatant irrationality of this framing effect does not count in favor of the identifiability condition.

3.2 The Acutely Impending Death Condition

Giving priority to lifesaving, as RoR wants us to do, without an eye to calculating opportunity cost, has at least two sources of intuitive plausibility: the urgency aspect and the biggest value aspect. In searching for people buried by an avalanche every single hour of delay may significantly reduce the chances of survival. And if rescue efforts are indeed successful, the beneficiaries commonly get back into their lives in full health or so the paradigm makes us believe: reasonably enough, we presume the doomed to be healthy skiers or sailors who could get out of the tragedy pretty much undamaged, perhaps with some vexing memories and surely with a lot of gratitude. And since losing one's life is typically seen as losing everything, the resulting gain is enormous. Both aspects cannot simply be transferred to healthcare scenarios (nor into safety-planning in road traffic).

First, the urgency aspect, though part of daily work in emergency rooms and intensive care units, disappears in *ex ante* prioritization. Here there is time enough for weighing probabilistic benefits and risks, for calculating direct and indirect costs. In such a privileged situation the heuristic advantage of an 'act-don't-calculate!'-imperative cannot be inferred. Second, many patients, who survive disease or accident by means of medical interventions do so at reduced quality of life or only for a limited time and possibly at skyrocketing costs. This is where medical lifesaving gets into tension with CBE.

To be sure, in many instances CBE itself favors to intervene in life threatening conditions because patients are likely to profit extremely, gaining many more QALYs for money than do the less severely ill. But again, this does not hold where improvement potentials are limited or treatments very costly. Giv-

ing priority to medical life saving, even if this means a cut back in overall health benefits, is nevertheless considered fair by many, at least to some degree. This holds true for both lay people and experts in ethical theory (Brock 2004; Hadorn 1996; Ubel et al. 1996).

In ethical theory the problem in question is often framed more general as the tension between the two principles ‘sickest-first’ and ‘maximizing aggregate benefit’ (CBE), where the ‘sickest-first’ principle is interpreted as a specification of John Rawls’ *difference principle* that wants us to improve chances of fair opportunities of the the worst off with priority. Some authors (e.g. McKie and Richardson 2003, 2409) see an important difference between both norms, because in their eyes RoR—but not the Rawlsean principle—requires the identifiability condition. But not only is this condition one of the implausible RoR-ingredients, as I have tried to argue above. RoR is, moreover, explicitly formulated by some institutions without reference to identifiable patients. And, finally, several authors do not take RoR to be confined to lifesaving but extend it to patients with severe suffering from nonfatal disease (for instance Hadorn 1996). Indeed, confirmation of the difference principle might turn out to be RoR’s most plausible aspect.

I can see three different ways to approach the tension between the lifesaving-first-principle and the goal of maximizing overall health benefit. One is to live with it on a muddling through balance, in line with a more fatalist reading of Dan Brock’s observation:

“However, there seems no objective, principled basis for determining how much priority to give to the sickest, that is, how much aggregate health benefits should be sacrificed in order to treat or give priority to the sickest. Instead, the most one can say is that most people and many theories of distributive justice have a concern both for maximizing overall benefit with scarce health resources and for helping the worst off or sickest, but there is large indeterminacy regarding the proper trade off between these two concerns when they are in conflict.” (Brock 2004, 213; see also Sheehan 2007)

The second approach would indeed give lexical priority to life-saving (or improving the fate of the otherwise sickest), thereby violating the principle of maximizing utilities across areas and patients. The third way, most promising from my genuinely consequentialist perspective, would look for a (consequentialist) explanation of the sickest-first-rule, one that might ideally serve as the missed ‘principled basis’ for the trade-offs in terms of aggregate health benefit in standard measure. One such approach has been suggested by Eric Nord with his “cost-value-analysis” to replace standard CBE (Nord 1999 and 2009). In a nutshell, Nord suggests to place value not linearly on any extra week of life or on any extra unit of life’s quality gained by treating some patient by some intervention. Rather he favors to build upon the idea that dying an unwanted premature death interferes with one’s hopes for realizing one’s life plans or one’s potentials—pretty much regardless of age and to a certain extent regardless of

quality of life. This approach invites for re-evaluating and recalculating the benefit side of standard CBE, adopting the idea (behind RoR as well as behind some prominent CBE critique (e.g. Brock 2004; 2005)) that within limits, life-saving interventions deserve extra weight. It does, however, remain within the foundational structure of consequentialist ethics since it aims at spending available healthcare bucks for maximal overall benefit—benefit that is conceptualized more plausibly. This seems to be a promising road.

3.3 The Reasonable Chance Condition

Chances of success in rescue situations count in two dimensions: the chance of rescuing as such (to find the buried miners alive, to restore heart beat by reanimating the pulseless patient) and the chance of afterwards getting those victims to an acceptable state. In paradigm rescue scenarios, chances of the first kind will depend on circumstances, for instance on the time interval between accident and rescue mission; often they are hard to calculate, leading to an *dubio pro reo* attempt to undertake rescue efforts. However, as with very slim response rates in medicine, even the slimmest rescue chance would seem worth the effort if they were not all too expensive. *Ex ante* planning for helicopter or track hound capacities do not seek to provide the resources for worst case scenarios—for reason of costs. Public health expenditures cannot afford billions to rescue a single patient. This sensitive of super-costs will again be taken up below.

The second dimension of rescue chances, getting the beneficiaries in an acceptable state, does as we have seen above not play an important role *outside* medicine—but very well *inside*. Once more, this means a problem for the transferability of RoR to medical priority setting. As we all know, many health interventions do have but a very limited potential for clinical benefit. Even in best responding patients they might extend life time but for some weeks, improve their well being by few percents only. Generally excluding such marginally effective treatments from the list of publicly financed interventions seems reasonable in times of tight budgets, given that individual trade-offs are but very tiny (see Buyx, Friedrich and Schoene-Seifert 2009). However foregoing to save a patient's life, even if only for short time, violates RoR.

It does, but for good reasons. If our above analysis is plausible in that RoR rightly reminds us to reevaluate the benefit currency in standard CBE, foregoing marginal individual benefits is legitimate. After all, they do not noticeably help patients to realize their life plans or potentials (the key idea of Nord's (1999) cost-value analysis). Hence RoR would have to be adopted in this respect.

3.4 The Acceptable Costs Condition

As already stated, rescue efforts that are super-expensive or rescue planning for slimmest chance cases are a sensitive issue, both within and without medicine. Where RoR seems deaf with regard to responsible social cost planning and where Kantian ethics postulates the pricelessness of human life, real world politics

can't follow such ideals. It never could. This lesson has to be learnt even with regard to health care, but this seems difficult both with regard to find reasonable cut off points and with regard to general acceptability.

Witness a development to the contrary: According to a quite recent decision of the German Constitutional Court, German constitutional right requires that statutory health insurance pays for non-standard medical interventions for patients with otherwise untreatable life-threatening conditions if only there is some evidence of “a not totally distant chance of healing or else a noticeably positive effect on the course of disease” (BVerfGE 2005). Following this direction, there seem to be almost no limits to the obligation to provide potentially life saving treatment—given that the Court decision neither refers to upper cost limits nor to scientific evidence. As has been made explicit by various experts (see Dannecker 2009) this is the wrong way. Most probably, however, RoR was the Court's background intuition.

3.5 The Exceptionality Condition

Paradigm rescue scenarios do not occur on a regular basis. They remain sudden tragic unexpected events. This fact contributes to RoR's intuitive plausibility. Hence, it does not come as a surprise that the explicit adoptions of RoR in Australian health services as well as by the Citizens' Council to the UK *National Institute for Health and Clinical Excellence* (see Mac Kenzie et al. 2008; NICE-Citizens Council Report 2006) have included an exceptionality condition. Both limit RoR to small groups of patients—a restriction that has come to be criticized as broadly unfair, discriminating against patients who happen to suffer from a non-orphan disease. Maybe the suggested reverse discrimination could be justified with the disadvantages those patients have, given that research often takes little interest and little effort in coming up with treatments against rare diseases. But apart from that, an exceptionality conditions for high cost spending seems unfair and unlikely to be publicly accepted on the long run. It does, however, provide further proof of the muddling through character of balancing alleged social glue against standard CBE.

4. Tentative Conclusions

In paradigm sailor cases, RoR gains intuitive plausibility due to several contextual peculiarities. Transferring RoR into the context of medical priority setting is much less convincing. Given its largely under-determined concept, one should resist the temptation to allude to RoR whenever standard CBE would rule out life saving treatments of a certain kind.

There is, however, a lesson told by RoR for medical resource allocation. Some people (Hartmut Kliemt possibly among them) believe that CBE should be counterbalanced by the social glue from following RoR in health care prioritization or by its contribution to real fairness. But the lesson can also be understood dif-

ferently: RoR-inclinations might result from the insight that the benefit of being kept alive by medicine should not simply be translated in the number of QALYs gained. This would require revisions of standard CBE that might prove worth more effort.

A final remark to the importance of a rescue *virtue* mentioned at the beginning of this paper. Surely, such a virtue seems particularly desirable in medical doctors (see Conner 1991; Hughes and Walker 2009). My critical analysis of RoR is by no means incompatible with this view. Being virtuously inclined to rescue patients whenever possible should be constrained, however, by the given frame of limits set *ex ante*. Much like bay watchers have to do best with the given amount of rescue boats, physicians have to realize the best for their patients within the socially set medical limits.

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