How (Not) to Argue for the Rule of Rescue
Claims of Individuals versus Group Solidarity[1]

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Published as: Marcel Verweij. "How (not) to argue for the rule of rescue. Claims of Individuals vs Group Solidarity" In: I. Glenn Cohen, Norman Daniels, and Nir Eyal (eds.) *Identified versus Statistical Victims. An Interdisciplinary Perspective*. New York: Oxford University Press, 2015: pp. 137-149.

1. The Rule of Rescue

The idea of the rule of rescue, as was is coined by Albert Jonsen (1986, 172), is sometimes invoked in discussions about priority setting in public healthcare, especially with respect to offering access to beneficial yet very expensive treatment. Appealing to this rule involves drawing an analogy between cases where persons in dire need can be rescued (the lone sailor lost at sea, trapped miners, or a child fallen down a well) and a patient whose life might be saved or at least extended for a longer time if some expensive treatment is made available. In the first type of case it seems morally inappropriate to suggest that rescue operations are to be abandoned because they are too expensive and that more good can be done by investing resources elsewhere. It might be easier to argue that there is no hope left for a successful rescue—but this suggests that at least all possible means to save the endangered ones have been tried and appear to be vain. In public healthcare, considerations of cost-effectiveness are, however, common, and, partly also for reasons of equality, not unreasonable. Some treatments may be considered highly worthwhile for individual patients—possibly even effective in saving or extending their lives—yet fail to satisfy some accepted thresholds of cost-effectiveness, simply because they are extremely expensive. This especially occurs in the case of uncommon diseases that are incurable, such as some congenital metabolic diseases. For example, patients with lysosomal storage diseases, such as Fabry or Pompe, might benefit from enzyme replacement therapy, but the effect of treatment will stop when the treatment is stopped. The costs of enzyme replacement treatment may amount up to €350,000 per patient per

[1] This chapter has benefited from a number of discussions with colleagues at King's College, Utrecht University, and the London School of Hygiene and Tropical Medicine. I am particularly grateful for comments by Norman Daniels, Clemens Driessen, and Rutger Claessen, and discussions with Nir Eyal and Angus Dawson. Nir Eyal helped me to articulate the argument in terms of ex ante and ex post perspectives.

year, which raises questions about whether funding or reimbursement is justified (Schlander and Beck 2009). Whether enzyme treatments are indeed effective in saving or extending the life of patients with these specific diseases is up for debate. For the sake of discussion I will assume that some medical treatments for uncommon diseases are indeed life-saving yet too expensive to be considered within an accepted range of cost-effectiveness.

I take the rule of rescue to be the general statement that saving the lives of some persons who are in need here and now may justify investing much energy and money, even if it is clear that society could prevent many more deaths by investing such resources in prevention. In this way, the rule of rescue involves a particular stance in the problem of identified versus statistical victims. Altough the rule of rescue is not always explicitly invoked in practice, societies are often much more prepared to invest money in curative treatment than in prevention (Nord et al. 1995; NICE Citizens Council 2006). This tendency can be easily explained, for example, by pointing out that it is much easier for most of us to sympathize and identify with victims who "have a face" than with unknown "statistical persons" who will die unless preventive measures are taken. Yet such explanation does not justify the rule of rescue; indeed, from a perspective of justice and equality, one should be suspicious toward allocation policies that are based upon feelings of sympathy. Arguably it is easier to sympathize with the nice-looking mother of two children who is in need of care than with the not-so-good-looking and unemployed single patient who has few family or friends to support his claims to treatment—but such differences may well be morally irrelevant. If we are looking for a moral justification for the rule of rescue, appealing to sympathy cannot be enough. This does not imply that sympathy as such is irrelevant. Giving some priority to rescuing persons with whom we sympathize (rather than prioritizing preventive measures that will save only statistical lives) may help to sustain an important moral sentiment, sympathy, that is indispensable in our moral practices. However, where resources are scarce and need to be allocated fairly, just following our sympathies will often be arbitrary and unfair.

Before discussing possible justifications for the rule of rescue, two clarifications are in order. First, the rule of rescue as presented above is about choosing for treatment or prevention, but it is does not necessarily imply that it is about the choice between life-

saving treatment of patients with a specific disease *X* and preventive measures against *X*. Such a choice might not be very realistic, for that matter, but anyway, the issue at stake is about resource allocation more generally: should investments in life-saving treatment of assignable patients be given priority even if this is much less cost-effective than other measures that prevent fatal disease. For the sake of discussion I will assume a fixed budget of health expenditures, so that accepting the rule of rescue, given its focus on interventions that are less efficient, would imply that more lives are lost (or less health benefits achieved) with the same resources.

Second, focusing on a general justification for the rule of rescue implies that many contextual factors—which could be relevant in specific situations—will be left out of the analysis. For example, zooming in on specific conditions and diseases may reveal particular features that may support funding expensive treatment without appeal to the rule of rescue. If society is in some way responsible for the fact that a patient became severely ill, this might be reason to offer access to treatment even if it is considered not cost-effective. And in the case of patients with severe inborn diseases, who have been ill most of their childhood and adolescence, and have had few opportunities to live a life of their own, offering very beneficial yet expensive treatment may be considered a way of promoting fair equality of opportunity. Such considerations may be central in specific cases, but will not play a role in our general discussion of the rule of rescue.

2. Individualist versus Collectivist Perspectives

It is tempting to understand the debate about the rule of rescue as being about a tension between what we owe to individual persons and what is best from a collectivist perspective. After all, the problem involves conflicting demands of caring for an individual patient in immediate need of treatment and saving more lives, which would reduce the risk within the population at large. Hence, one would expect that individualist normative arguments might support the rule of rescue, whereas collectivist or other utilitarian approaches would point in the opposite direction. Scanlon's contractualism seems to be a good candidate for defending the rule of rescue, because it restricts moral deliberation to claims of individuals and rejects the idea that very strong claims of one individual can be outweighed by impersonal concerns or by combining less strong

reasons of many individuals (Scanlon 1998). In this chapter, however, I argue that Scanlon's theory of what we owe to each other—with its specific focus on the strengths of claims of individuals—cannot render support for the rule of rescue. In contrast, a more collectivist approach that aims to promote group-related values does offer some support for favoring rescue.

3. What We Owe to Individual Patients in Need of Live-Saving Treatment

One of the basic ideas in Scanlon's theory of what we owe to each other is that actions should be justifiable to any other person who is motivated to find and endorse moral principles that can be accepted by all. Justification involves making clear that certain action is permitted by a general principle that no one (even those for whom the principle is least attractive) could reasonably reject. In practice such moral deliberation consists of exploring what the implications of different principles are for different persons concerned and weighing the reasons they have for rejecting or accepting such implications. These reasons should be *generic* reasons, that is, personal reasons people have in virtue of their situation and general characteristics: they are based upon what persons in such situations have reason to want—not on an individual's specific preferences or desires (Scanlon 1998). Moral deliberation then involves comparing the strength of reasons individual persons may invoke for rejecting possible principles. A very strong reason of one person *P* (e.g., *accepting this principle will imply that I will not be saved and hence will die*) cannot be outweighed by combining the much weaker reasons of many other persons Q_1, $Q_{2,\ldots,}Q_n$ (e.g., *not accepting this principle will be inconvenient for me*). Scanlon thus rejects an aggregative approach in such trade-offs. Yet if the trade-off is between conflicting reasons of comparable strength, the contractualist can make room for the intuition that "the numbers count" (Scanlon 1998; Hirose 2001).

How to evaluate the rule of rescue following a contractualist approach? Arguably, any patient with a rare life-threatening disease whose life depends on access to treatment that is highly expensive has very strong reasons to support the rule of rescue and reject alternative policies that would imply that patients in this position will not survive. How do these reasons weigh against reasons to reject the rule of rescue? The rule of rescue allows implementing life-saving therapies for patients at the cost of more efficient

preventive policies, and thus has the implication that other lives are lost. This, however, seems to yield reasons for rejecting the rule of rescue that are comparable in strength to the reasons some patients have to endorse the rule.

Yet whose lives are at stake here? In a way, everyone who might benefit from the preventive strategy has reasons to reject the rule of rescue (Hope 2001). But how strong are their reasons compared to those of a patient for whom the rule of rescue means survival? The problem with prevention is that success mostly consists of bad things not happening, and it may be impossible to know even with hindsight who actually has benefited from a preventive policy. Persons who are vaccinated against several infectious diseases will never know whether they would have otherwise experienced a dangerous infection. Of course, they do benefit in the sense that knowledge about the fact that one is protected can take away worries about getting that specific disease. Everyone participating in a prevention program has a chance to benefit, but few will benefit in the sense of avoiding untimely death. And as far as the harms are counterfactual, there is not a specific person who benefits. The lives saved are statistical, not identifiable.

This raises the question of how contractualism is to take into account the points of view of persons who benefit from a principle that prioritizes efficient life-saving prevention over expensive life-saving therapies. The perspectives can be included ex ante or ex post. If we look at prevention ex ante we include the perspectives of healthy persons who might benefit from prevention. For them, opting for the rule of rescue rather than for the alternative principle implies a somewhat increased risk to their lives. That is a valid reason for rejecting the rule of rescue, but arguably it does not outweigh the conflicting reasons of a patient who has immediate need of expensive life-saving expensive treatment and for whom rejection of the rule of rescue will imply premature death. No healthy person who would benefit from prevention is, at this stage, as badly off as the patient is. Hence, it would be unreasonable to reject the rule of rescue: the alternative principle cannot be justified to patients whose life depends on the rule of rescue.

However, an alternative way to deliberate about the rule of rescue is to look at prevention ex post. This involves including the perspective of persons who (hypothetically) will have profited from life-saving prevention. Their reason for rejecting

the rule of rescue is not that it will rob them of a small chance to benefit from prevention; their lives depend on prevention, just as the patients' lives depend on the rule of rescue. For contractualism it does not have to be a problem that we cannot know in advance whose lives will be lost if the preventive measures are not taken. It is sufficient to know the generic reasons these persons would have: what any person would have reason to want given the situation she finds herself in. Now obviously, she will have reason to reject the rule of rescue if it implies that her premature death will not be prevented. This reason is exactly the same as some patients have for endorsing the rule of rescue and rejecting principles that favor prevention. Both the nonidentifiable persons who benefit from prevention and the identifiable patients in need of life-saving treatment can complain that they will die if they do not get what they need. But, as mentioned above, if the reasons for and against rejecting a principle are equally strong, then contractualists may accept that the numbers do count. We have defined the rule of rescue as prioritizing, at least sometimes, life-saving treatment over more cost-effective life-saving prevention. By definition, then, there will be more persons in the hypothetical situation whose life depends on prevention than persons whose lives depend on rescue, and the combined reasons of the former will outweigh the equal yet fewer claims of the latter. Looking at prevention ex post thus results in a reasonable rejection of the rule of rescue.[2]

4. Excluding Ex Post Perspectives?

So in thinking about the rule of rescue, do we need to take into account ex ante or ex post views on prevention or both? Contractualism will support the rule of rescue only if we exclude ex post perspectives. In a way the debate about the rule of rescue can be considered a debate about the relative weight of claims of patients in immediate need and persons who might be saved in the future. Hence, a contractualist argument for the rule of rescue that only takes into account ex ante perspectives would be begging the question. Proponents of the rule of rescue need an additional argument for that choice.

One plausible concern about ex post perspectives is that including them makes contractualist deliberations extremely risk-averse. The argument is analogous to Elisabeth Ashford's (2003) analysis of the demandingness of contractualism, and it points at the

[2] Scanlon's rejection of discounting future harms by the likelihood that they will occur suggests that he endorses the ex post perspective. Cf. Scanlon 1998, 209.

fact that many practices and policies are beneficial to almost anyone, but also come with remote risk, more specifically, will cost the lives of some.[3] Air travel and livestock farming are two examples. Many people benefit from being able to fly. Yet some persons will be killed when an aircraft crashes in their city. Many enjoy consuming animal products like meat or cheese; yet some will be victim of an outbreak of epizootic disease such as swine flu. The likelihood that one will be harmed in this way may be extremely remote, but, being in that situation (hence, ex post), one will have very strong reasons to reject principles that allowed the risk in the first place. The complaints of victims against allowing air travel will easily outweigh concerns of all other persons that not being allowed to fly will be burdensome to them. This not only applies equally to livestock farming, but to any practice or activity that comes with a remote risk. Or, as far as certain practices are inevitable, they can only be justified if maximum precautions are taken to reduce the chance of fatal harm.[4] Taking maximum precautions may be burdensome to almost anyone, but those burdens do not outweigh the complaints a victim whose life the precautions aim to protect—unless the precautions themselves are so extensive that they create lethal risks themselves.

Such risk-averse implications of including ex post perspectives seem quite absurd, or at least unreasonable. This judgment of unreasonableness, however, depends on some form of aggregation in which the burdens of precautions for many people outweigh the very remote risk that someone will die if no precautions are taken—and this is exactly the sort of aggregation that Scanlon rejects. Hence, the argument that including ex post perspectives would have unreasonable risk-averse implications does not cohere with contractualism. Contractualists can argue that excessive precautions against remote risk may be unreasonable if every person—for example, as traveler or as consumer—benefits from allowing air traffic or livestock farming. This is because all of them may think that the clear benefits of traveling or consumption of animal products clearly outweigh the highly unlikely risk of being severely harmed by air traffic or epizootic disease.

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[3] The argument may not apply to cases where we can't know whether someone will be harmed at all. In this discussion however I focus on remote risks that we can reasonably assume will materialise somewhere, someplace.

[4] The example of air travel is more complex, because air travel enables us to save lives as well—arguably many more than the number of people who die on the ground as a result of airplane crashes. Taking ex post perspectives into account, the most reasonable principle would be one that adopted maximum precautions against airplane crashes, including restrictions on using air travel for "frivolous" purposes such as holidays.

Moreover, it would be unreasonable for a person who has always traveled by plane to reject principles allowing air travel by the time he realizes that it will ultimately cost his life. Such intrapersonal comparison and weighing of risks and benefits does not rely on interpersonal aggregation, and indeed Scanlon does endorse it (1998, 237). Yet, as Ashford (2003) argues in her discussion of the demandingness of contractualism, this response will not work if some persons (vegans in the case of livestock farming; poor people in the case of air traffic) cannot benefit from these practices and only can experience the risks, however small, that are imposed on them. Their strong (ex post) complaints against allowing a practice that may cost their lives are not unreasonable and cannot be outweighed by the complaints others would have against prohibiting air travel or livestock farming. Hence, including ex post perspectives would turn contractualist deliberations extremely risk-averse, but contractualism cannot accommodate the most plausible response: that it would require disproportionate and unreasonably demanding precautions.[5]

Let me sum up the argument so far. Contractualism seemed to be a good candidate for defending the rule of rescue, because it restricts moral deliberation to claims of individuals and rejects the idea that very strong reasons of one individual can be outweighed by combining weaker claims of the many. However, the contractualist defense of the rule of rescue only succeeds if it excludes from deliberation the ex post perspectives of persons who stand to gain from alternative principles (viz., favoring prevention). A very plausible argument for restricting deliberation to ex ante perspectives is that this avoids extremely risk-averse implications, but this argument involves considerations that conflict with the basic tenets of contractualism. Hence, unless we find a different argument for excluding ex post perspectives that is also coherent with contractualism, the theory does not appear to offer support for the rule of rescue. To the contrary, as far as contractualism allows aggregation of comparable claims, it will support principles and practices that save more lives rather than less.

[5] Neither can contractualism accommodate the related concern that a good and flourishing society is one where people succeed in striking a reasonable balance between demanding precautions and protection against risk. Contractualist deliberation is about personal reasons of individuals, and collective, impersonal concerns are left out of consideration.

For that matter, even if we had convincing reasons for restricting the deliberation to ex ante perspectives, it is still not obvious that this would lead to accepting the rule of rescue for all rescue cases. This would depend on how we reconstruct the problem. If decisions about allocation of resources are made at the time and place where some patients need very expensive life-saving treatment, it will be clear that their actual concerns outweigh those of other persons, who only run a risk of harm. But the policy issue could also be one of deciding whether, for the upcoming period, a specific budget should be allocated for all persons who will need life-saving treatment in that period. Many of those patients may not yet be identified, and their ex ante concerns will not be more weighty than those of persons who run a risk that will be taken away if prevention is prioritized over rescue. On the other hand, some patients are known: notably those who have been ill already for some time; hence, in this scenario the rule of rescue is applicable to their case, but not to that of persons who will (in the upcoming period) unexpectedly become severely ill and need expensive treatment. In other words: if contractualists decide to allocate a specific budget for expensive life-saving treatment, the budget will only be available for patients who were in need of care during the contractualist deliberation. The timing of decision-making about resource allocation will thus be a decisive factor for answering the question whether a patient will receive expensive life-saving treatment or not. This would be highly arbitrary, if not unfair. How can such a policy be justified to patients whose need for some expensive life-saving treatment arises just after the policy is decided—and who therefore will not get treatment? Apparently contractualism does not offer a clear and convincing justification for the rule of rescue.

5. A Collectivist Argument for the Rule of Rescue

So far we have focused on the strength of reasons of individual persons whose lives depend on the rule of rescue. Instead we might ask what it would mean for us, as a society, to abandon the idea behind the rule of rescue and decide that, as far as human lives are concerned, we should always opt for saving most lives, including those we might save in the future. Think of mine accidents in which miners get trapped deep in a mine, and where no costs are spared to save them. An extreme example is the 2010 Copiapó mining accident: 33 miners got stuck in a Chilean copper and gold mine, 700

meters underground, and all were saved after a 69-day rescue operation. The successful operation cost between $10 million and $20 million, of which, according to the president of Chili, every peso was well spent. But what if not 33 but "only" three were trapped and saved? For our analysis, the question is if in such a case, for moral reasons, the money had been better spent on taking precautions to prevent more mine accidents in the future. A good government cares about current and future suffering, and prudent allocation of resources may imply favoring cost-effective prevention over expensive and uncertain rescue attempts. The Copiapó mining accident is a difficult case for a nuanced ethical analysis given the extensive media coverage that exposed and enlarged any detail of social interest. But also in mine accidents that receive less global public exposure, it is difficult to justify a choice to abandon further rescue operations and divert the money to making all mines and other workplaces safer. The government would be deemed insensitive, harsh, and lacking any compassion. Such concerns will be put forward first and foremost by the trapped miners' families, who probably would be willing to spend whatever they have to rescue their loved ones. Yet their reasons—reasons of love—are personal reasons, and other people cannot be expected to completely share those personal reasons. Fellow citizens can, however, empathize with the fate of the victims and the need of family members to see their loved ones come back alive. In times of disaster, often—certainly not always—people are prepared to share in the burdens of their neighbors or fellow citizens as they perceive the disaster not just as a problem for the victims and their loved ones, but as a disaster for their community at large. Diverting the resources from rescue to prevention might be rational if the sole aim is to save as many lives as possible, but it would in fact negate the importance of the fact that people are standing together, sharing hope and fear, and supporting each other in the face of—and fight against—disaster.

This collective attitude of standing together, sharing burdens, even accepting grave risks in attempts to save or protect some whose lives are endangered, is a form of "solidarity" par excellence. Solidarity is a complex concept (Prainsack and Buyx 2011). Some solidaristic practices involve standing together, sharing costs and risks in such a way that all participants benefit. By joining forces it becomes possible to attain goods that otherwise were not attainable. In such cases, solidarity is just a matter of joint action

for a common interest, and hence it is rational for individuals to participate in such joint actions. Cooperative insurance programs are good examples of such *rational solidarity*. In relation to the rule of rescue, a different form of rationality—*constitutive solidarity*—is more relevant (Dawson and Verweij 2012). Constitutive solidarity goes beyond acting for a common interest. As a value it is not universally valid or applicable, but dependent on an existing (or at least emerging) sense of community within a group of people. By seeing solidarity as a reason for acting, hence by sharing in the burdens of some, people attach meaning to their living together. For a value like solidarity to be action guiding, it is essential that a threat to some members of the community be felt as a threat to the community as a whole. Arguably such feelings are evoked much more easily if a threat is real and acute and if it concerns identifiable persons who—together with their loved ones—are indeed considered to belong to the community. Mine accidents where workers are trapped in a mine are paradigm cases—not only because it is easy and horrible to envisage their fate but also because often miners and their families, colleagues, and friends live in a community, city, or region in which identity is strongly linked to the mining industry. Moreover, the disaster and rescue operation will further strengthen this identity, by means of narratives highlighting the perseverance, courage, and trust of both the victims and the rescue team. Note that this appeal to constitutive solidarity goes beyond appealing to the idea that "this could happen to me as well." This latter thought will be shared by all miners, and indeed for them rescue policies would be a matter of rational solidarity as well. The argument in terms of constitutive solidarity implies that the threat to some miners is felt as a threat to the whole community—which could be the village, but also province or country.[6]

From the perspective of the community, solidarity is both instrumentally and intrinsically valuable. It is instrumentally valuable as it engenders social cohesion and hence promotes collective and individual well-being (Lanzi 2001). Solidarity is intrinsically valuable as far as it is constitutive to the community itself and connecting the

[6] Experiencing a threat to the community will be most easy when the threat is real, as in a war or a natural disaster. The argument of solidarity I suggest, however, involves a threat that is in important respects symbolic. The risk that a trapped miner will not survive is perceived as a threat to the larger community—but arguably the community itself will not break down if the miner dies before he can be saved. But if an expensive rescue operation of a trapped miner is abandoned because more lives can be saved by preventive measures—that will be a real threat to the community.

lives and narratives of individuals in a meaningful way. Policies that insist on cost-effectiveness and accept that "rescue" attempts that are not sufficiently cost-effective should be abandoned, negate the collective dimensions of some rescue operations and the ways such operations signify that victims and their loved ones are not left on their own, but that we as a group are standing with them. Solidarity may render support to the rule of rescue, in the sense that communities in some cases have reason to give special weight to protecting or rescuing threatened community members and hence sharing the concerns of the loved ones of those endangered persons. The value of such concerted actions is not just their outcome in terms of the number of lives saved but also the meaning this joint action and attitude has for the community as such. Moreover, protecting identifiable persons against an immediate threat, and standing with their loved ones resisting the threat, sometimes even involving heroic action or self-sacrifice, may express and promote a sense of community in ways that are unattainable by policies that reduce more abstract risks.

6. Limitations of the Argument

This justification of the rule of rescue is, however, not unlimited. One limitation of the argument is related to its pluralist nature: the argument takes both solidarity and saving lives to be of value; hence it would be unreasonable to invest all available resources in rescuing people here and now and discard any concern about how many more lives can be saved by investing in prevention and precaution. A second limitation of the argument of solidarity is that it requires telling a story about community identity that is not always there. Some risks or situations are more easily conceived of as threatening the community than others. As explained above, the situation of workers trapped in a mine is a paradigmatic example. The fate of the workers is clearly connected to the identity of the village community, and the identity of the mining village—and of any other mining town—connects to the economic history of the country as a whole. The village community would disintegrate if the miners were just abandoned and preference were given to more cost-effective prevention policies. Mining industries often have an important role in the history and economy of the country that offers meaning to national appeals to solidarity, and national support for rescue attempts. The rhetorics that are used

in such support ("a national disaster," "no cost will be spared to save our fellows," "we are all standing together in this rescue operation," etc.) and the perseverance and sacrifice of rescue teams, witnessed by the public at large, may further strengthen shared feelings of solidarity.

But in what other situations is someone's need experienced as a threat to the community at large? More specifically, would this argument for the rule of rescue work in the context of resource allocation in public healthcare? Suppose that several patients with a very rare disease can be saved by giving them lifelong access to extremely expensive treatment. Patient groups and family members may be successful in mobilizing public concern and support for making treatment available, but it is less clear in what sense the disease—or a decision to refrain from offering treatment—is to be understood by the community as a collective evil. Of course, there is no reason for thinking that a strong community could not perceive it as a collective threat or evil. The strength of the solidarity argument, however, depends on the possibilities of telling a story that connects the threat to certain individuals with the identity of the larger community, and such a story is much more obvious in the example of the trapped miners than in the case of severely ill patients. It may be easy for everyone to empathize with the patients and their needs, if only because we all will sooner or later become ill and face death, but that is not sufficient to perceive the threat to those patients as a threat to one's community and oneself. Therefore, applying the rule of rescue to life-saving medical treatment is not intrinsically and instrumentally valuable in a way that is comparable to the mine accident example.

The appeal to solidarity in support of concerted action to rescue some individuals is not only limited in scope, it can also be morally problematic itself. As argued above, solidarity as a moral argument can only be effective if there is already a sense (or emerging sense) of community in place, and if the persons to be rescued are in fact considered as belonging to the group. But is it morally justified to let decisions about saving someone's life depend on collective judgments about whether that person does or does not belong to "us"? Many features may then play a role that, from a moral point of view, are irrelevant: how attractive, popular, or sociable a person is, how long he has been living "here," the influence of his family in the community, and so on. Such

partiality is especially problematic in public policy. Certainly in modern healthcare, where resources are always limited and resource allocation requires a continuous weighing of competing claims, decisions to offer expensive treatment need to be fair and just, and the fact that some persons or their families are more popular or influential than others should not play a role at all.

This is not to say that there is no place for solidarity in healthcare. To the contrary, public healthcare systems that guarantee universal access to basic care can be understood as an institutionalized form of solidarity in which the costs of collective provision are shared by all. Yet if such a system is in place, then the competing claims for finite resources should be dealt with in a just and fair way. In this discussion, a solidarity-inspired rule of rescue does not have a place. The analogy with rescue operations in mine disasters does not succeed, and, moreover, decisions should be based upon considerations of justice and fairness, not solidarity.

7. Conclusion

The rule of rescue holds that special weight should be given to protecting the lives of assignable individuals in need, implying that less weight is given to considerations of cost-effectiveness. This is sometimes invoked as an argument for funding or reimbursing life-saving treatment in public healthcare even if the costs of such treatment are extreme. At first sight one might assume that an individualist approach to ethics—such as Scanlon's contractualism—would offer a promising route to justification of the rule of rescue. In this chapter I have argued that contractualism cannot endorse the rule of rescue, whereas a collectivist approach that appeals to group solidarity would offer support for rescue cases. The argument, however, has its limitations, and though solidarity is of central concern in shaping public healthcare, there are good reasons for not endorsing the rule of rescue as a moral basis for allocating scarce resources in clinical care.

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