



# The hidden ethical element of nursing care rationing

Nursing Ethics  
2014, Vol. 21(5) 583–593  
© The Author(s) 2014  
Reprints and permission:  
sagepub.co.uk/journalsPermissions.nav  
10.1177/0969733013513210  
nej.sagepub.com



**Evridiki Papastavrou, Panayiota Andreou  
and Stavros Vryonides**

Cyprus University of Technology, Cyprus

## Abstract

**Objective:** To explore nurses' experiences and perceptions about prioritizations, omissions, and rationing of bedside nursing care.

**Methods:** A total of 23 nurses participated in four focus groups. The interviews were based on a semi-structured interview guide; data were analyzed using a thematic analysis approach.

**Findings:** Four themes were developed based on the data: (a) priorities in the delivery of care; (b) professional roles, responsibilities, and role conflicts; (c) environmental factors influencing care omissions; and (d) perceived outcomes of rationing.

**Discussion:** The delivery of nursing care is framed by the biomedical ethos and inter-professional role conflict while the standards of basic care are jeopardized. Organizational and environmental factors appear to exert significant influence on prioritization. Failure to carry out necessary nursing tasks may lead to adverse patient outcomes, role conflict, and an ethical burden on nurses.

**Conclusion:** There is a need for further exploration and possible redesign of the nursing role, scope, and responsibilities, as well as addressing the arising ethical issues of rationing in nursing care.

## Keywords

Ethics, focus groups, omissions, quality of healthcare, rationing

## Introduction

In the light of scarcity, resources are inevitably either explicitly or implicitly rationed. Healthcare rationing has been extensively discussed in the medical profession and is understood as withholding beneficial interventions, mainly for cost-effectiveness reasons that occur at all levels and in all healthcare systems around the world.<sup>1</sup>

Rationing of nursing care is a similar phenomenon related to the issue of fair distribution of resources, but is relatively new on the nursing research and clinical agenda. In the face of insufficiency of nursing resources (e.g. low staffing levels, poor practice environments), nurses are forced to use clinical judgment to prioritize their assessments and interventions,<sup>2</sup> thereby increasing the risk of negative patient outcomes and contributing to reduced quality of care.<sup>3</sup> Therefore, rationing has been defined as the withholding of or

---

**Corresponding author:** Evridiki Papastavrou, Department of Nursing, Cyprus University of Technology, Vragadinos Street 15, 3rd Floor, 3041 Limassol, Cyprus.  
Email: e.papastavrou@cut.ac.cy

failure to carry out necessary nursing tasks,<sup>3</sup> or nursing care that has been omitted (either partially or totally) or delayed,<sup>4</sup> or care prioritization<sup>5,6</sup> due to inadequate resources such as time and staff.

Rationing of nursing care and nursing care omissions are two terms used synonymously in the nursing literature. According to the Missed Care Model,<sup>4</sup> care omissions or delays may occur at any stage of the nursing process and may be influenced by factors within the care environment that facilitate or inhibit the practice of nursing, such as the demands for patient care, resource allocation, and professional relationships.<sup>5-8</sup> Missed nursing care may also occur as a result of nurses' internal processes, for example, team norms; decision-making; habits, as well as attitudes; internal values; and beliefs that nurses hold about their roles and responsibilities.<sup>4</sup> The consequences of the missed care are extensive in terms of patient outcomes. If the missed care, for example, is not teaching a patient, this may result in complications and re-admissions, or if mouth care is missed in ventilated patients, they may probably develop pneumonia.

Literature reviews of quantitative studies on rationing of nursing care and missed nursing care reported links between limited nursing resources and patient outcomes such as mortality and adverse events including patient falls, nosocomial infections, and low satisfaction.<sup>9,10</sup> Nurses reported that communication with patients and families, patient ambulation, and mouth care were common elements of rationed care; nurse-patient workload and communication barriers were indicated as potential causes of rationing. Nurses also explained that not being able to deliver the care needed or requested by clients was frustrating and expressed low occupational satisfaction.<sup>10,11</sup> There is also a limited number of qualitative studies that used either focus groups<sup>9,10,12</sup> or one-to-one interviews<sup>7,13-15</sup> aiming to explore rationing, missed care, or prioritization and how limited resources influence nursing care. The data from many of these studies illustrate the continuous role conflict and guilt felt by nurses in prioritizing tasks by focusing on the medical needs of the patient at the expense of social and relational aspects of patient care.<sup>13,14</sup> The literature also supported that rationing care jeopardizes important values in the nurse-patient relationship, and in particular, the value of individualized and inclusive nursing care meaning taking into consideration all the needs that can be important for the patient.<sup>7</sup>

However, there are several gaps and methodological considerations in both quantitative and qualitative studies reviewed, including the lack of robust instruments measuring care rationing and weak evidence of causal relationships between rationing of nursing care and patient outcomes. In addition, there was very little explanation on how the sensitive topic of rationing was approached by the qualitative studies, for example, whether the research questions influenced the participants' verbatim thus possibly creating social desirability bias. Furthermore, the themes arising from such data as well as the conclusions derived were not always supported by adequate extracts from the actual interviews.

The aim of this study was to explore the perceptions and experiences of nurses concerning prioritizations, omissions, and rationing of bedside nursing care through focus groups. Based on the findings of an earlier survey with nurses,<sup>12</sup> the intention was to explore rationing in more depth and to gain a better understanding of the pressures and influences guiding nurses' decisions to ration and give priority to certain care tasks over others.

## Method

A qualitative study design was used to explore participants' views and experiences of rationing of bedside nursing care. Qualitative data were elicited via focus group interviews aiming to capitalize on group dynamics and participant interaction that would not be obtained through individual interviews or other forms of group interviews.<sup>13</sup> Although in individual interviews participants can express their views on a topic without being overly influenced by a group setting, there is an acknowledgment that rationing of nursing care is a sensitive issue, similar to the tradition of concealing errors, and nurses do not easily admit to omissions in care.<sup>4,5,15</sup> Therefore, the security provided by the focus group encourages the exploration of

less conventional positions and facilitates conversation about sensitive events such as the admission of errors.<sup>16</sup> Additionally, listening to others sharing similar experiences legitimates own feelings and provides an atmosphere for openness and candor.<sup>17</sup> The data were analyzed based on inductive thematic analysis<sup>18</sup> as (a) it enables us to report the experiences and the reality of the participants based on a data-driven and systematic procedure and (b) allows searching across data sets to identify repeated patterns of meaning.<sup>18</sup>

### *Setting*

The sample was recruited from three general public hospitals of the three biggest cities of the Republic of Cyprus; all the participants were invited through face-to-face and poster invitations at the wards. The interviews were carried out at convenient locations selected by the participants, for example, conference rooms of their workplaces, so as to create an atmosphere facilitating trust.<sup>19</sup>

### *Participants and data collection*

A total of 23 nurses participated in four focus groups (group A: n = 7; group B: n = 4; group C: n = 6; and group D: n = 6) for a one-off interview which lasted between 46 and 75 min (mean = 62.5 min); four people refused to participate due to time commitments. All the participants were registered nurses, 17 female and 6 male, their age ranged from 24 to 48 years (mean = 35.5 years, standard deviation (SD) = 11.25 years), and their experience in nursing ranged from 2 to 25 years (mean = 13 years, SD = 6.5 years). The groups were homogenous in terms of education and nursing job level to encourage discussion among peers without being cautious in openly expressing opinions in the presence of more senior members and inhibiting the conversation due to status distinctions.<sup>20</sup> Three of the groups comprised staff nurses. As rationing of nursing care is also characterized as an organizational problem, it was decided to form another group of first-line nurse managers in order to compare their narratives with the other groups; this could also increase the external validity of comparison among the groups.<sup>20</sup>

The data collection ended after the completion of the fourth focus group when there were no additional issues arising from the data, that is, the data reached saturation.<sup>19</sup>

Purposive sampling was employed to ensure participants from various units, providing the amount of heterogeneity needed to elicit rich information.<sup>19</sup> The size of each group was based on the ease of group management in order to encourage adequate participation by all members.<sup>16</sup>

### *Development of the interview guide*

The discussion started by giving the participants an imaginary scenario to read which was developed by the researchers drawn from the model cases described in the concept analysis of missed care;<sup>4</sup> the scenario described a typical day on a busy ward with staff shortage. The participants were then asked to remember if and when they had a similar experience and were asked various questions (see Papastavrou and Andreou<sup>18</sup> for the complete interview guide).

### *Methodological rigor*

Several steps were taken in order to ensure the quality of the results. The moderator (P.A.) had a lot of prior working experience in interviewing and avoided the use of close-ended questions. In addition, she explained at the beginning that she was unrelated to the nursing profession with no involvement in patient care, thus very keen to listen to the participants' experiences at their wards in order to find out more about the factors related to prioritization of nursing care. Consequently, she was viewed as impartial with no vested interest in the participants' responses and enabled the participants to engage in the discussion from the early stages of

**Table 1.** Summary of research process stages.

Steps	Actions
1	Development of a working scenario and questions as an interview guide
2	Recording and transcribing
3	Data coding
4	Making links with the literature
5	Grouping of similar codes and supporting interview extracts into categories
6	Codes and categories analysis: revision of codes, comparing differences and similarities, exchanging ideas, and interpretations
7	Synthesis of categories into themes
8	Final agreement on the themes in relation to the literature and the available evidence
9	Selection of quotes illustrating the data analysis and the synthesis of the themes

the interview.<sup>20</sup> An observer (S.V.) was present during the interviews who noted the level of involvement and style of the moderator not exerting high influence on the control of the process and the interview.<sup>20</sup> Both the moderator and the observer noted the way the participants answered, clarification was sought on areas of ambiguity, and at the end, the participants were asked to verify the summary comments made by the moderator. Furthermore, the observer carefully monitored the level of interaction in the group and discussed all the observations at the end of the interview with the moderator. In addition, the analysis of the data was done in a systematic iterative process, following a prepared protocol, verified by another researcher (E.P.) and giving the opportunity for reflection and discussion with the research team.<sup>16</sup>

### *Ethical considerations*

The study was approved by the National Ethics Committee and the Ministry of Health (ethics reference number 5.4.05). The participants signed a consent form giving their permission to use the interviews, which were recorded, for research purposes only and asserting that their identity will be protected. They were also asked to use a pseudonym during the interviews in order to further protect their personal details. In case of giving information that identified other people and/or places, the details were omitted during the transcribing.

### *Analysis of data*

The focus group interviews were transcribed by the moderator and checked by the observer. The data were analyzed based on inductive thematic analysis as described earlier. Each interview was read and coded by hand separately by two researchers (E.P. and P.A.). At this stage, the codes were descriptive and inductive, based on what was actually discussed. For each interview, codes were written on one side of the paper margin, and on the other, the researchers noted arising thoughts, impressions, and possible connections among codes and with the relevant literature. At the following stage, both researchers compared their coding and discussed any discrepancies and differences. There were 699 descriptive codes from all interviews. Following this discussion, similar codes with the corresponding quotes were grouped together forming 35 categories. All the categories and their contents were then compared for differences and similarities through a cyclical process with revisions between codes, ideas, and interpretations. Any codes not grouped during the earlier stage were revisited to check whether the categories could be adjusted to provide a more comprehensive and accurate representation of the codes or excluded from the analysis. The aim was the continuous analysis and synthesis of categories into themes that were directly linked to the interview data, and at the same time enabling movement from a descriptive stage to a conceptual level. This process led to the

development of four themes, namely: (a) priorities in the delivery of care; (b) professional roles, responsibilities, and role conflicts; (c) environmental factors influencing care omissions; and (d) perceived effect of rationing on patients and nurses. The whole analysis process is presented in Table 1.

## Results

### *Priorities in the delivery of nursing care*

Participants had difficulty in describing what actually happens at the bedside, and very often, they referred to what ideally they would like to see, that is, what they should do at a theoretical level but not necessarily what they actually do during their everyday practice. In general, they emphasized their responsibility in responding to the patients' most vital medical needs, a task that they would rarely or never omit or delay. For instance, the priority mentioned by most of the participants was helping in doctors' rounds:

patients must be tidy and everything should be ready at 9 in the morning because we need to help with the doctors' round. (Nurse 2)

we have to prepare everything and accompany them during their rounds but we lose valuable time and don't do the nursing care we should be doing. (Nurse 4)

Participants from a range of clinical specializations also admitted that they prioritize care according to the perceived patients' medical requirements:

we assess the vital signs of those who are seriously ill, those who have fever or high blood pressure. (Nurse 6)

priority is to give the medicines, this is the most important task for the patient ... (Nurse 11)

Although there was agreement that giving medications was a priority, there were instances where medications were not given at the right time due to limited staff:

Not all patients will receive their medication on time, especially in the night hours. (Nurse 9)

we don't have the time so we may give the medication later on. (Nurse 12)

The topic that generated consensus among the participants was about the tasks that were more often omitted which were frequently related to the personal hygiene of the patients:

Hygienic needs are not a priority. Patients are not at risk if we omit a bed-bath. (Nurse 17)

we may skip patients' hygiene or do it very superficially. (Nurse 9)

Participants viewed these tasks as "second choice chores" that undermined their skills:

You don't need a specialized knowledge to bath a patient. This could be done by someone with no special training. (Nurse 14)

we do things that anyone could do. (Nurse 6)

In addition, some tasks such as nutrition were considered as peripheral or less important:

it is not so urgent to help the patient to eat; the relatives will do this when they visit. (Nurse 3)

Similarly, nurse leaders agreed about the priority of certain tasks:

I think that mouth care and hygienic needs are not a priority. Instead I would not accept delaying or not administering patients' medications. (Nurse 2)

I will check if all patients received their medicines but I wouldn't consider so important if a bed-bath was not given. (Nurse 20)

Differences were observed between the hospital units depending on the nature of the work involved:

We may not check the vital signs; we are too busy to do that . . . (Nurse 11—oncology unit)

we will not bath a patient, we will check the vital signs, give the medication . . . hygienic needs are done last so sometimes they are omitted. (Nurse 10—intensive therapy unit)

### *Professional roles, role strain, and role conflicts*

The majority of participants expressed their dissatisfaction with "role pressure" because of the increasing demands of the profession, patients' expectations concerning the performance of nursing roles, and limited power to negotiate certain duties with other professionals. The professional role and role identity, that is, the difference between what nurses want to do as opposed to what they actually do, raised strong emotions such as anger, stress, and dissatisfaction. In several occasions, the participants described themselves as "robots," "The Jack of all trades," or as a "traffic controller":

the nurse has to co-ordinate everybody's work, the physicians, pharmacists, porters, and all other, like a traffic controller. (Nurse 1)

or

we are doing the work of others' at the expense of good practice and holistic care. (Nurse 1)

We have to do everything. (Nurse 8)

How much can you do at the night-shift? You work like a robot. (Nurse 18)

Many participants referred to a conflict of priorities where their decisions and opinions may be questioned by the ward manager, and they have to follow another priority than the one they think is the most appropriate one to the patients' needs:

it is not up to me to set priorities, it depends mainly on the manager, she may not agree with yours and you have to obey. (Nurse 15)

there are times that during urgent incidents supervisors pay attention to non-significant things such as whether the bed is properly done while the patient has fever and is vomiting. (Nurse 11)

From the managers' point of view, priorities are set according to the severity of patients' condition and the urgency of their needs. However, in their effort to satisfy all the needs of their patients, some participants reported a tendency to develop minimalistic standards rather than aiming at good or excellent practice.

Lack of communication among the levels of the nursing professional hierarchy and leadership insufficiencies were the central theme in most of the discussions. All the participants had strong views about the hierarchical relationships and the negative impact this may have had on the inter-professional relationships and the quality of care they deliver. The pressure on the junior nurses to do certain tasks could be considered as bullying. This was particularly evident when some participants were emotionally charged when talking

about how they were forced to do others' work at the expense of their own patients and not given the opportunity to develop new skills, leading to rationing of care:

The junior nurses will do the work for the patients they are assigned to and also for the patients assigned to others for example to more senior nurses. (Nurse 16)

(the junior nurses) have no opportunity to do certain tasks such as discharge paper-work as this is always done by the people at the hierarchy [ . . . ] the juniors have no opportunity to learn such tasks plus they have to do the tasks the more seniors don't do. (Nurse 12)

younger colleagues are bitter and fearful towards the seniors, they can't voice their concerns. (Nurse 13)

More experienced staff nurses also described a similar sense of unfair treatment by the ward managers:

those who are in a higher position are doing anything except bed-side nursing. (Nurse 14)

or

we don't have the courage to tell them that we are working very hard while they are sitting in their offices. (Nurse 12)

Similarly, nurses discussed their disagreements with doctors being bound to focus on addressing medical needs, while other needs and elements of care are neglected:

we develop a plan of nurse care priorities which is overturned by others such as the doctors. (Nurse 8)

there is a conflict of priorities between nurses and doctors e.g. doctors want us to first update the records for them whereas we have other tasks we need to do. (Nurse 13)

The participants were particularly worried when they had to undertake doctors' responsibilities regarding informing the patients about their condition:

the burden of explaining unpleasant events and answering to difficult questions falls on us. Doctors may say few things, examine the patient for a few minutes and leave . . . we are the ones who will inform the patient or his/her family. (Nurse 10)

### *Environmental factors influencing care omissions*

Although most of the arguments for rationing focused on the roles, responsibilities, conflicts, and professional relations, a significant part of the discussion addressed the factors perceived by nurses as contributing to rationing. The majority of these factors were attributed to problems in their professional practice environment that could influence their decision-making. The participants expressed their dissatisfaction with the lack of control and power to influence these factors, and at the same time, they considered this as their responsibility for not being able to change the situation or even being indifferent:

It is not just the work load, it is also about work allocation and in a way it is our own failure . . . (Nurse 18)

we sometimes just don't do things because we are a bit indifferent. (Nurse 14)

The factors central to rationing were related to the limited number of staff and staff misuse. They also felt that there was confusion and frustration regarding what the care-helpers could do or not with not much contribution to care delivery:

they are not allowed to answer to the patients' calls, or give the meals to the patients; what are their responsibilities anyway? (Nurse 7)

they are sitting in the kitchen all the time and don't help us when we really need them, they are not allowed by their unions they say. (Nurse 4)

On the other hand, in their attempt to do everything, nurses admitted that they are trying to involve family care givers in care by assigning them minor, as they labeled them, tasks such as patient feeding or changing patients' clothes.

Another factor raised by the participants as contributing to rationing was lack of material and resources:

If we had the equipment we need, things would improve . . . we need a lot of time to carry out certain procedures like mouth care because certain materials are not available . . . (Nurse 9)

we sometimes don't have enough clean sheets and we have to spend time calling around to other wards. (Nurse 11)

### *Perceived effects of rationing on patients and nurses*

A different issue raised by the participants was related to the consequences that rationing may have on patient care. A few nurses expressed their concerns that patients may lose confidence in the nursing staff resulting to loss of trust and patient dissatisfaction:

Patients want nurses to talk to them, they need to feel safe . . . if you stay with him for 5 minutes doing a procedure and not listening, next time he will not talk to you, he will be afraid to ask, will not want to bother you because you are busy . . . (Nurse 7)

However, the participants were not able to articulate the negative impact of specific omissions to the patients' general condition such as infections from a neglected mouth or the complications of reduced patient mobilization. Instead, much of the conversation focused on their own guilt for not having the time to offer proper care:

I go home and I feel nervous and depressed because I could do things differently, but I didn't . . . I woke up in the middle of the night because I remembered things that I left undone . . . my mistakes and my inappropriate behavior. (Nurse 19)

you go home and wonder if you did all the things you could have done. (Nurse 11)

## **Discussion**

The qualitative approach of this study allowed insights and valuable information that may partly explain nursing care rationing decisions and provided support to the missed care model.<sup>4</sup> The model suggests that antecedents to missed care are labor and material resources, communication, teamwork, and other organizational factors which are filtered by the nurses' internal processes. In this study, nurses admitted that certain elements of care are systematically omitted in general care hospitals, and it was shown that their decisions were influenced by the environmental constraints, the unit culture, and a biomedical ethos. These findings support the view that nurses work in complex work environments and tend to give priority to medical or technical interventions, whereas establishing caring relationships with their patients is of secondary importance. Considering rationing within the ethical reasoning and behavior framework,<sup>21</sup> it is clear that nurses experience various difficulties, including opposing values and norms that hamper their personal



decision-making process. In several instances, nurses admitted that they were unable to act according to their own professional standards because of practical circumstances, time limitations, rules and routines, or the expectations of others. This inconsistency between what nurses wanted to do and what they were actually able to offer to patients created a lot of negative feelings that might have resulted in ethical burden and moral distress that is evident in the findings of our study. It appears that priorities, as perceived by nurses, are largely framed by the biomedical model, while the standards of basic patient care are jeopardized; the low priority given to personal hygiene, ambulation, nutrition, and psychosocial needs, such as communication, is an example of the medical domination of care provision in that particular country, which is in line with previous work elsewhere.<sup>4,22–24</sup> Other researchers argued that nursing care rationing is more prevalent in areas where the impact is not immediately apparent: the impact of not ambulating or not educating patients may not be readily obvious until the time of discharge; similarly, compared to nutritional deficits, not taking medication is readily observable and thus is more likely to be attended to.<sup>14</sup> Nonetheless, some nurses admitted that not all perceived medical-related tasks, such as giving medication, are consistently implemented as expected.

While there was convergence of opinions on what nursing tasks were omitted or delayed, there were also disagreements between the participants within the same focus group. The priorities of some nurses were not necessarily shared by other colleagues. Their decisions are also highly influenced by other factors, for example, shortage of staff, the ward culture, and the emphasis placed on certain tasks by the nurse manager of each ward, supporting the view that nurses often capitulate to the demands of others, which results in a conformist way of acting and providing less individually adapted care.<sup>21</sup> When discussing their omissions, participants repeatedly justified their actions of not putting patients at risk even though they acknowledged the omission per se. This finding is in accordance with previous research supporting that nurses use this kind of behavior as a coping mechanism to deal with their feelings of guilt or low self-esteem relative to their performance.<sup>14</sup>

It was evident that factors within the care environment may influence nurses' priority setting behavior, partly supporting other studies,<sup>13</sup> which include factors such as the philosophy of care. Philosophy of care refers to personal beliefs, values, and ideals that relate to nurses and what nursing tries to achieve.<sup>2,13</sup> Such philosophy can be influenced by a range of elements, for example, education and training, working environment, professional code of ethics, and the profession as a whole. For example, experiencing the limited resources in healthcare and their allocation, nurses may perceive the humanistic and holistic care as not realistic, and thus they develop their own personal standards of care to cope with the resource limitation.<sup>13,23</sup>

Professional roles and role conflicts were recurring issues that were consistently discussed by the participants as factors influencing rationing. This issue has also been extensively described<sup>13</sup> where the authors argue that nurses are narrowing and limiting their professional role because they are trying to respond to the needs of medical treatment. However, role conflict is also described among nurses of different levels suggesting that rationing may also be influenced by the level of professional power and position in the nurses' hierarchy. This finding can be explained by another paradox in the nursing profession where the transition from the bedside nursing to the managerial level is connected with role ambiguity and role conflict.

### *Limitations*

The study used a qualitative design that does not allow for generalizations of the results to the whole nursing population. It is also possible that nurses who accepted the invitation to participate in the study may have different experiences to discuss from other nurses who were not willing or able to participate, but there was no feasible way to assess this dimension. In addition, participants in a group setting may be encouraged to share their views particularly if these are similar to those already shared in the group but less willing to do so if they diverge from the group norm.<sup>16</sup>

## Conclusion and application

The emergence of nursing care rationing on the healthcare agenda has been a product of a number of factors affecting care receivers worldwide. An escalating economic crisis combined with dramatic shortages of the nursing workforce, increased patient expectations, and growing evidence linking care with patient outcomes are examples that have brought to the fore the reality that rationing of nursing care needs to be recognized as a major patient safety issue and openly discussed at a policy level.

Nursing care rationing involves a multitude of factors including the work environment, inter-professional relations, managers, physicians, and nursing care consumers. Nurses often adopt a series of dogmas based on priorities defined by the medical profession such as doctors' rounds, diagnostic procedures, or medicine administration. At the same time, other values of professional care or ethical beliefs may be easily underestimated as nurses concentrate on the medical-related priorities of care and not on the patients' actual needs. The arising ethical issues of rationing in nursing care, including patient neglect, nurses' complaints that it is impossible for them to practice according to their own professional and ethical values, and recognizing ethical actions that cannot be adopted, may provoke feelings of discomfort and suffering that may lead to significant negative consequences for both nurses and patients. It is therefore important for healthcare professionals to encourage greater reflection and discussion concerning their roles. There is also a need to have further exploration and possible redesign of the nursing role, scope, and responsibilities that cannot be restricted to ethical decisions made by other professionals, and to focus on the wide range of decisions nurses themselves have to make in their daily practice. Limited resources will always generate difficult decisions coupled with ethical and moral choices, and the nursing profession needs to explicitly articulate and openly discuss the criteria used for rationing and at which point and for which tasks nurses accept or reject rationing and the repercussions of such decisions.

## Acknowledgments

The authors express their gratitude to the participants of the study.

## Conflict of interest

The authors declare that there is no conflict of interest.

## Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

## References

1. Stretch D, Persad G, Marckmann G, et al. Are physicians willing to ration health care? Conflicting findings in a systematic review of survey research. *Health Policy* 2009; 90: 113–124.
2. Schubert M, Clarke SP, Glass TR, et al. Identifying thresholds for relationships between impacts of rationing of nursing care and nurse- and patient-reported outcomes in Swiss hospitals: a correlational study. *Int J Nurs Stud* 2009; 46(7): 884–893.
3. Schubert M, Glass TR, Clarke SP, et al. Rationing of nursing care and its relationship to patient outcomes: the Swiss extension of the International Hospital Outcomes Study. *Int J Qual Health Care* 2008; 20(4): 227–237.
4. Kalisch BJ, Landstrom G and Williams RA. Missed nursing care: errors of omission. *Nurs Outlook* 2009; 57(1): 3–9.
5. Nortvedt P, Hem MH and Skirbekk H. The ethics of care: role obligations and moderate partiality in health care. *Nurs Ethics* 2011; 18(2): 192.

6. Tønnessen S, Førde R and Nortvedt P. Fair nursing care when resources are limited: the role of patients and family members in Norwegian home-based services. *Policy Polit Nurs Pract* 2009; 10(4): 276–284.
7. Tønnessen S, Nortvedt P and Førde R. Rationing home-based nursing care: professional ethical implications. *Nurs Ethics* 2011; 18(3): 386–396.
8. Papastavrou E, Andreou P and Efstathiou G. Rationing of nursing care and nurse-patient outcomes: a systematic review of quantitative studies. *Int J Health Plann Manage*. Epub ahead of print 7 January 2013. DOI: 10.1002/hpm.2160.
9. Bourgeault IL, Armstrong P, Armstrong H, et al. Everyday experiences of implicit rationing: comparing the voices of nurses in California and British Columbia. *Sociol Health Illn* 2001; 23(5): 633–653.
10. Kalisch BJ. Missed nursing care: a qualitative study. *J Nurs Care Qual* 2006; 21(4): 306–313.
11. Arvidsson E, André M, Borgquist L, et al. Priority setting in primary health care-dilemmas and opportunities: a focus group study. *BMC Fam Pract* 2010; 11(1): 71.
12. Bittner NP and Gravlin G. Critical thinking, delegation, and missed care in nursing practice. *J Nurs Adm* 2009; 39(3): 142–146.
13. Halvorsen K, Slettebø Å, Nortvedt P, et al. Priority dilemmas in dialysis: the impact of old age. *J Med Ethics* 2008; 34(8): 585–589.
14. Nortvedt P, Pedersen R, Grøthe KH, et al. Clinical prioritisations of healthcare for the aged—professional roles. *J Med Ethics* 2008; 34(5): 332–335.
15. Halvorsen K, Førde R and Nortvedt P. The principle of justice in patient priorities in the intensive care unit: the role of significant others. *J Med Ethics* 2009; 35(8): 483–487.
16. Kevern J and Webb C. Focus groups as a tool for critical social research in nurse education. *Nurse Educ Today* 2001; 21(4): 323.
17. Papastavrou E and Andreou P. Exploring sensitive nursing issues through focus group approaches. *Health Sci J* 2012; 6(2): 185–200.
18. Braun V and Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006; 3: 77–101.
19. Krueger RA and Casey MA. *Focus groups: a practical guide for applied research*. 4th ed. Thousand Oaks, CA: Sage, 2009.
20. Stevens CA and Finlay PN. A research framework for group support systems. *Group Decis Negot* 1996; 5: 521–554.
21. Goethals S, Gastmans C and de Casterlé BD. Nurses' ethical reasoning and behaviour: a literature review. *Int J Nurs Stud* 2010; 47(5): 635–650.
22. McLafferty I. Focus group interviews as a data collecting strategy. *J Adv Nurs* 2004; 48(2): 187–194.
23. Freeman T. “Best practice” in focus group research: making sense of different views. *J Adv Nurs* 2006; 56(5): 491–497.
24. Webb C and Kevern J. Focus groups as a research method: a critique of some aspects of their use in nursing research. *J Adv Nurs* 2008; 33(6): 798–805.