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The ethical dimension of nursing care rationing: A thematic synthesis of qualitative studies

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Abstract

Background: In the face of scarcity, nurses may inevitably delay or omit some nursing interventions and give priority to others. This increases the risk of adverse patient outcomes and threatens safety, quality, and dignity in care. However, it is not clear if there is an ethical element in nursing care rationing and how nurses experience the phenomenon in its ethical perspective.

Objectives: The purpose was to synthesize studies that relate care rationing with the ethical perspectives of nursing, and find the deeper, moral meaning of this phenomenon.

Research design: A systematic review and thematic synthesis of qualitative studies was used. Searching was based on guidelines suggested by Joana Brigs Institute, while the synthesis has drawn from the methodology described. Primary studies were sought from nine electronic databases and manual searches. The explicitness of reporting was assed using consolidated criteria for reporting qualitative research. Nine studies involving 167 nurse participants were included. Synthesis resulted in 35 preliminary themes, 14 descriptive themes, and four analytical themes (professional challenges and moral dilemmas, dominating considerations, perception of a moral role, and experiences of the ethical effects of rationing). Discussion of relationships between themes revealed a new thematic framework.

Ethical consideration: Every effort has been taken, for the thoroughness in searching and retrieving the primary studies of this synthesis, and in order for them to be treated accurately, fairly and honestly and without intentional misinterpretations of their findings.

Discussion: Within limitations of scarcity, nurses face moral challenges and their decisions may jeopardize professional values, leading to role conflict, feelings of guilt, distress and difficulty in fulfilling a morally acceptable role. However, more research is needed to support certain relationships.

Conclusions: Related literature is limited. The few studies found highlighted the essence of justice, equality in care and in values when prioritizing care—with little support to the ethical effects of rationing on nurses. Further research on ethical dimension of care rationing may illuminate other important aspects of this phenomenon.

Keywords
Care rationing, ethical perspectives, ethics, nursing values, professional role, thematic synthesis

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Introduction

Nursing is based on solid ethical foundations regarding humanity, life, and health. Inherent in nursing practice is the obligation to protect patients from harm and the respect of human rights, cultural rights, rights to life and choice, human dignity, and the need for respect in care.[1] Thus, nursing activities are often guided by these values and the commitment to providing safe, compassionate, comprehensive, individualized, humanistic, and quality care to patients—without any discrimination.[2] Nurses are obliged to offer respectful care with justice[3] and without restrictions regarding age, color, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, and race or social status[1,3–5] while maintaining safety and quality in care.[6–8]

However, certain difficult circumstances may sometimes limit nurses' abilities to act according to their professional or personal values and norms[9] leading to a gap between the ideal ethical decision and the actual behavior.[10] Nursing practice is not solely influenced by the decisions of individual nurses (micro level) but additionally influenced by other factors at an organizational (meso) level and political (macro) level.[11] Thus, nursing practice is often fraught with political decisions, organizational and socioeconomic circumstances, or limitations that may inevitably lead to decisions on the allocation of scarce resources, the latter being a pressing and contemporary issue, faced by all healthcare systems and governments globally.[12–14]

The recent financial crisis resulted in a need to contain public spending on healthcare[15] and large spending reductions in many countries[16–18] that affected negatively healthcare organizations[16,19] and staff, including nurses[17,20] by cutting wages, reducing hospital staff and beds while increasing co-payments for patients.[19] Nursing is often considered as a ''cost'' and therefore a constant target for reductions.[21] This, combined with the permanent shortage of nurses, is making nursing care rationing an increasingly prominent feature in healthcare.[22]

Due to finite resources and unlimited patients' needs, rationing is expected to occur, either explicitly or implicitly, across all levels in healthcare, all systems, professions, and cultures. For example, rationing in medicine is understood as the withholding of beneficial interventions to patients, mainly for cost effectiveness reasons.[23] However, in nursing, it is expected to occur mostly implicitly at the bedside as an attempt of fair distribution of insufficient nursing resources (e.g. low staffing levels, skill mix, time, poor practice environments, etc.), using clinical judgment to prioritize assessments and interventions.[22]

As suggested in most professional codes of ethics, the nurses' ethical action is grounded, among others, in the fundamental ethical principles of beneficence, nonmaleficence, justice and respect of autonomy,[24,25] equality, and fairness. These ought to be also the principles on which rationing of nursing care should be based that is mostly grounded in the idea and theory of distributive justice and fairness. Bearing these in mind, one should logically expect zero tolerance to missed nursing care. First, according to the principle of justice, all the patients have a right to healthcare[24,25] and no one should violate this right.[26] Furthermore, in accordance with this principle, those who are equal in their needs should be treated equally and therefore the available resources should be allocated in an equitable manner.[24] However, the dominating view is that when resources are not sufficient, for nurses to provide all the needed care, this insufficiency may inevitably minimize their standards of care,[27] and thus they are forced to ration their attention across patients or across nursing activities.[28,29]

However, the ethical or the unethical action in nursing, as in most humanistic professions, can be partly explained using the ethical theories that refer to estimates which nurses consider, when making moral judgments. Thus, an ethical theory according to each different case determines whether these decisions are related to the attempt to achieve as much as possible personal benefit (egoism), whether the decisions are related to an attempt to achieve the maximum benefit, for as many people as possible (utilitarianism—benevolence) or if associated with the adherence in certain commonly accepted ethical principles (deontology or principled).[25,30]

Furthermore, the theory of ethics of care as proposed by Gilligan,[31] with some of its later variations,[32,33] seems to demonstrate compatibility with the historical and philosophical tradition of nursing as it has very

good application potential in nurses' ethical decisions[34–37] and emphasize the value of care as a moral activity that occurs into a network of relationships.[38] Thus, it is considered as a moral orientation that is based on relational care, support, emotions, and sensitivity, that generally inform the relationship between the nurse and the patient[33,35,37] and from which an ethical action may be derived.[33,39]

Ethics in nursing has also been discussed around principles such as honesty, loyalty, trust and confidentiality,[25] responsibility and accountability, patient advocacy,[40] and others that are not always directly related to nursing care rationing. Moreover, since nurses are members of their professional group, they must follow certain nursing ideals and standards of professional conduct in their activities.[41] For example, central to the interest of nurses are the humanistic values, since nursing was created, developed, and evolved through the dedication and ongoing response to these values.

Several definitions of the phenomenon of nursing care rationing have been given such as, the withholding of, or failure to carry out necessary nursing tasks,[28] nursing care that has been omitted (either partially or totally) or delayed,[42] care needs not being met,[43] care not performed,[44] priority setting,[45] or care prioritization[27,46,47] that are due to inadequate nursing resources. Rationing of nursing care has been conceptually placed within the nurses' decision-making processes and the prioritization aspects of care, supporting that implicit rationing occurs when nurses lack sufficient time and resources to provide all the care they perceive that is needed by their patients.[28] Similarly, missed nursing care, as conceptualized by Kalisch et al.,[48] refers to any aspect of required patient care that is omitted or delayed and is influenced by factors in the care environment, affecting nurses' internal processes, that guide them in deciding which activity of nursing care should be missed, should be completed, or should be delayed. The current synthesis accepts all these terms as equal in meaning. However, for ease of reference, the term ''rationing'' is mostly used throughout the text, and the other terms are used when referring to their corresponding literature.

According to the theoretical model of missed nursing care[42] that guided this synthesis, omissions or delays in care 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 demands for patient care, resource allocation, and professional relationships.[46,49–51] However, the choice of nurses to complete, delay, or omit items of care is additionally influenced by internal processes such as team norms and decision-making habits, as well as values, attitudes, and beliefs that nurses perceive about their roles and responsibilities[42] and so shape their behavior. The immediate question that arises, when nurses are deciding which nursing care should be provided or not and who will receive this care and who not, is whether they violate the right to healthcare to all patients according to their needs or if recourses and care are distributed in an equitable, just, and fair manner. When resources are limited, nurses may minimize the standards of offered care,[27] increasing the risk of adverse patient outcomes[22,28,51] threatening patient safety and care quality,[51–53] and perhaps violating the concept of dignified care.[54] Moreover, the philosophy of care that refers to nurses' personal beliefs, values, and ideals and what nursing is trying to achieve[55] may also be jeopardized.

Thus, empirical evidence supports that dignity, care quality, and safety are jeopardized in contemporary nursing. Staff shortages, particularly among nurses, contribute to poor practice and substandard patient care[56] with neglect, unnecessary suffering, adverse patient outcomes, and higher mortality rates,[56,57] while nurses feel distressed when they are not able to deliver the care they believe they should provide.[58] Similarly, most studies of nursing care rationing, for example,[29,59–62] indicate that fundamental elements of care (e.g. patient feeding, patient ambulation, patient hygiene, communication, patient support, teaching and discharge planning, surveillance and care documentation, etc.) are omitted on a regular basis. Moreover, care rationing was also found to be significantly associated with negative patient outcomes like falls, nosocomial infections, pressure ulcers, increased mortality rates, and low rates of patient satisfaction.[28,63,64]

The immediate argument that arises is that nurses, in scarcity, may face difficulties in fulfilling their professional roles and balancing the needs of individual patients, the demands of their employers, their personal values, and the ethical context of the profession. Furthermore, it seems that nursing care rationing is not

merely an organizational and economical issue as it requires judgments that potentially conflict with personal and professional values. Instead, ethical elements embedded in nursing, professional education, the healthcare environment and in the nurses' code of ethics may potentially influence the moral decisions of nurses when they ration care. Certain professional challenges and the perception of nurses of their own role, within the context of rationing, may additionally affect the phenomenon of care rationing. Moreover, nurses' decisions when prioritizing care must be screened in the light of beneficence and nonmaleficence, justice, equality, and fairness—while the ethical basis of decisions to provide certain aspects of care to some patients and not others must also be examined.

Thus, there is need for a more thorough understanding of how nurses experience nursing care rationing in its ethical perspectives and ethical outcomes, and explore the deeper moral meaning in an otherwise administrative and organizational problem. By synthesizing the relative evidence base of rationing found in nursing and ethics literature, the intent was to obtain multifaceted accounts and details about underlying ethical motives, prioritizing factors and value considerations of nurses, as well as their perception of ethical concerns and ethical outcomes in relation to nursing care rationing.

More specifically, the research questions guiding this qualitative synthesis are as follows:

- Is there an ethical element in nurses' decision to ration patient care in bedside nursing?
- How do nurses experience the effects arising from nursing care rationing, in relation to their personal and professional values and the ethical dimension of nursing?

Methods

The literature search, study selection, and extraction process were based on the guidelines suggested by the Joanna Briggs Institute Reviewer's manual[65] in order to minimize the likelihood of noninclusion bias. The synthesis of the data was based on thematic synthesis guidelines as suggested by Thomas and Harden.[66]

Searching

The search strategy was intended to find published studies dealing with any ethical aspects of nursing care rationing, as was apparent from their title, abstract, or stated research aims. The search was performed between May and December 2013 and refreshed in March 2014 in order to include any new studies. It was implemented in nine databases (see Table 1), without considering publishing dates.

Guided by search and keywords from the initial papers meeting the inclusion criteria, certain specific search terms were established, which were then used as the basis for the search strategy in various combinations and in each database. The search terms included a combination of index terms such as Medical Subject Heading terms and free text. Additionally, all articles obtained as full text were screened for citations of relevant studies. Grey literature, which included dissertations and theses databases, was also checked for any relevant studies and relevant citations on their reference lists.

Inclusion criteria

Studies were included if they met the following criteria: (a) Qualitative studies relevant with the research questions, (b) aims explicitly addressing rationing, (c) studies that used rationing as the main variable and related it by any means with ethical aspects of nursing care (Table 1), (d) any acute-care or chronic-care clinical setting or community setting, (e) sample included nurses at any level of duty and experience, (f) mixed samples such as physicians and nurses were additionally included, since very few relevant studies were found during the pilot search stage and in the hope to inform the review. However, only the perceptions

Table 1. Search terms for each electronic database and other sources.

Electronic databases searched	Keywords used
1. PubMed	Resource allocation + Nursing + Ethical climate Rationing + Nursing + Ethical climate Missed nursing care + Ethical climate
2. EBSCO databases: Cinahl, PsycInfo, PsycArticles, Academic Search Complete	Omissions + Nursing + Ethical climate Prioritizations + Nursing + Ethical climate Delayed nursing care + Ethical climate Priority setting + Nursing + Ethical climate
3. ScienceDirect	*Where the term Nursing and also the terms Nursing Care or Nurses used
4. ProQuest Platform Databases	*and where Ethical Climate is shown, the terms Ethical Reasoning,
5. Web of Science	Ethical Behavior, Ethical Decision Making, Moral Conflict, Moral
6. EMBASE	Distress, and Ethical Burden were used
Reference tracking from relevant articles	None found

of nurses were taken into account, as evident in their quotations. (7) Articles in English and/or Greek language only—due to the proficiency of the researchers in those languages.

Screening

Three researchers (V.S., EP., and A.P.) screened the titles and the abstracts separately, based on the inclusion criteria; any disagreements at any stage of the screening and selection process were discussed with the other two researchers (A.M. and A.C.) to reach a consensus. Studies were excluded if they did not clearly examine rationing of nursing care, or were not related in any way with the ethical aspects of nursing (Table 1). Studies were included if they included terms synonymous with care rationing. Research that focused on healthcare rationing in general, including managerial and workforce perspectives, was excluded.

Quality assessment

There is little consensus as to whether ''qualitative'' research should be assessed regarding its quality, how and who should assess it, and what should be the criteria used.[67] However, it was decided to assess the primary studies for explicitness and comprehensiveness of reporting in order to avoid drawing unreliable conclusions, but to include all studies regardless of their quality. The framework of consolidated criteria for reporting qualitative research (COREQ)[68] was used. These are 32 criteria, grouped in three main categories: (a) research team and reflexivity, (b) study design, and (c) data analysis and reporting.[68]

The intent was to provide contextual details for readers themselves to assess the trustworthiness and transferability of study findings to their own setting. E.P. and S.V. independently assessed each study, and any disagreements were resolved through discussion with A.C.

Extracting data from studies

Deciding what to extract from the studies was not easy, as it was not always clear, what counted as data and what counted as findings,[66,69] or else because findings were sometimes distinct from the data upon which they were based.[70] To bypass this difficulty, Campbell et al.[71] have extracted what they have called ''key concepts,'' but the identification of these concepts is not always, straightforward either.[66] The data in primary studies were identified as quotations from nurses themselves, but key concepts and findings were

identified with difficulty. Thus, it was decided to consider all text labeled as 'results' or 'findings' as findings, and to include all findings reported in the abstracts, in the same way as in the main text.

Choosing the method of synthesis

Several factors need to be considered when selecting a particular qualitative synthesis method.[72] The utilitarian, realist, and mainly aggregative nature of this synthesis was aimed to describe the phenomenon of care rationing by producing a list of its key dimensions seemed congruent with thematic synthesis.[66,73,74] By treating the findings of the synthesis as if they were isolated from the contexts, in which they occurred,[75] the intent was to produce concrete and definitive outcomes that could adequately represent an external reality,[72] and could have practical value for policy makers. Since the researchers have different clinical, academic, and research experience, combined with their general epistemological stance (which is mostly aggregative and less interpretive) led them in more structured synthesis methods, such as, is the thematic synthesis.[66,72] Moreover, considering the small number of primary studies and the large number of research contributors could permit any method without considering cost issues by sharing time and workload since all researchers work in the same region thus allowing regular meetings with no extra cost.[76]

Data analysis and synthesis

Synthesis was carried out in three stages as described by Thomas and Harden[66] that overlapped to some degree and facilitated in part using an electronic software reviewing system, "EPPI-Reviewer 4.[77] This led to coding of the findings, construction of descriptive" themes, and development of analytical themes. Thereafter, the relationships between analytical themes were discussed so as to develop a new analytical framework and to extend the findings of the primary studies. Having applied this framework to individual manuscripts during meetings, a clearer picture of the data as a whole emerged, ensuring that the developed themes have been cross-checked not only with data but also within and between primary studies so that the validity of emerging explanations was improved.

Results

Study selection

The search strategy proved to be productive and yielded 2053 potentially relevant studies for further screening. All titles were checked and duplicates excluded (n = 659) as were articles with titles irrelevant to the research subject (n = 1303). In total, 91 articles were forwarded for screening of their abstracts. The majority of these were excluded (n = 72), because abstracts proved irrelevant (n = 33) or full text was written in other language (n = 39). The full text of remaining studies (n = 19) was read, as to assess relevance to the research topic and if they met the complete set of the inclusion criteria. In this third stage, 11 studies were excluded, and so 8 studies were initially retrieved. Focused new searches that were conducted after the original search resulted in the inclusion of another study[29] and thus a total of nine studies were finally retained (Figure 1).

Characteristics of included studies

All studies (see Table 2) were published in English, from 2008 to 2014. They included samples of nurses (n = 5) or nurses and physicians (n = 4) with a total 255 participants (167 nurses and 88 physicians). Most of them were conducted in Norway (n = 7), one in New Zealand,[80] and one in Cyprus.[29] The research topic varied in each study and only two studies[53,79] appeared to focus on some ethical aspects of nursing care rationing.

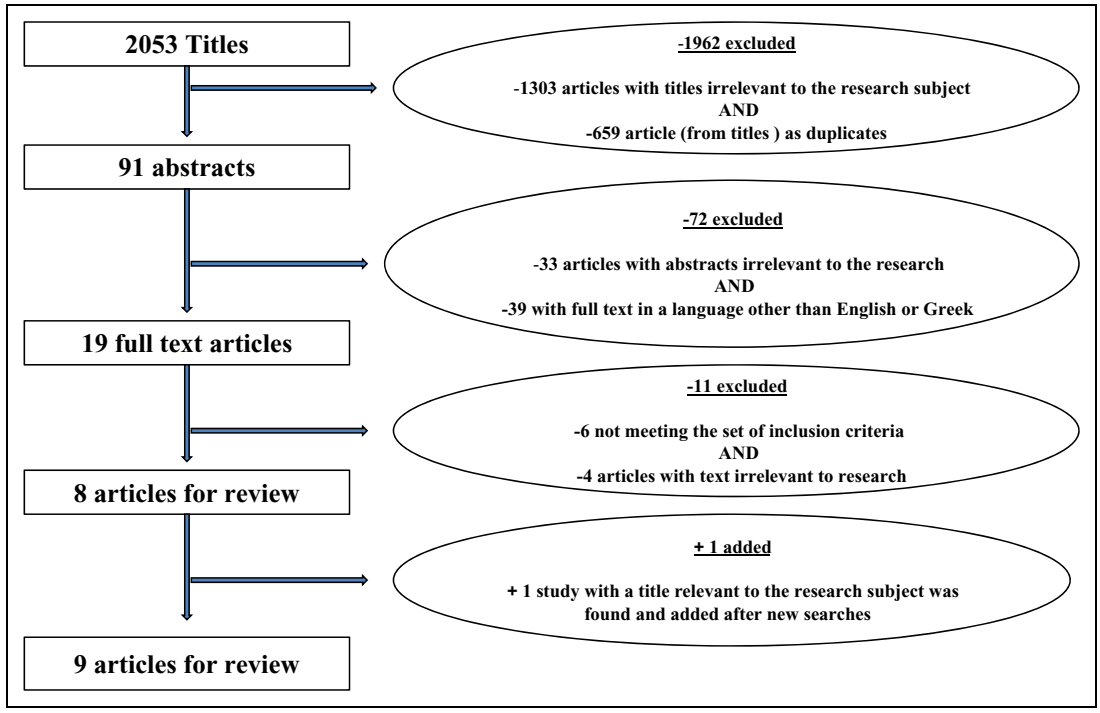

Figure 1. Flow diagram for identifying and selection of the studies of the review.

The most frequent method of data collection was semi-structured interviews (n = 8), while two studies used additionally participant observation.[78,79] Only one study[29] used focus group interviews. Data in most studies (n = 6) were analyzed using hermeneutical interpretation, two of which additionally used content analysis,[27,53] one study used manifest content analysis,[47] one a general inductive approach,[80] and one an inductive thematic analysis.[29] Four studies used purposive sampling, but none of the studies used a probability sample based on the information provided. No information is provided for justifications of their sample size; some studies focusing on nurses had relatively small samples.[47,80]

However, samples were well described, regarding nurses age (range 24–59), gender, and years of working experience (range 1–35), with only one study[80] failing to provide this information. The work setting of nurses varied from intensive care unit (ICU),[78,79] home-based care[46,50] nursing home,[47] adult acute-care hospital,[80] and public general hospitals[29] to public hospitals and nursing homes.[27,53] However, three articles appeared to draw from similar sample and setting, but it is not clear whether these are different papers of the same study.

Comprehensiveness of reporting

The comprehensiveness of reporting varied across studies (Table 3). The researchers that conducted the interview or focus group were identified in 6 out of 9 studies (i.e. in 66.6% of the studies), their credentials were reported in all of the studies, and their occupations in 77% of the studies. The participants' knowledge of the researchers (assumptions and reasons for performing the research) was poorly reported (11.1%–22.2%). All studies reported use of theory and methodological orientation. Sampling description was adequate regarding participant approach, selection, and sample size. However, only three studies reported numbers and reasons for nonparticipation. The research setting was

Table 2. Summarized characteristics of the included studies.

(Study) Country	Sample (n) sampling method	Nurses (Y) age range	Working setting	Nurses (Y) working experience	Data collection method	Data analysis	Research topic
Halvorsen et al.,[78] Norway*1	Physicians (n = 21) ICU nurses (n = 25)	28–57	ICU	1–26	Participant observation and semi-structured interviews	Hermeneutical interpretation	To explore how limited resources influence nursing and medical treatment in intensive care
Nortvedt et al.,[27] Norway *2	Physicians (n = 20) Nurses (n = 25)	26–59	Public hospitals and nursing homes	1–34	Semi-structured interviews	Hermeneutical and content analysis	To explore how clinicians understand their professional role in clinical prioritizations for older patients
Pedersen et al.,[53] Norway*2	Physicians (n = 20) Nurses (n = 25)	26–59	Public hospitals and nursing homes	1–34	Semi-structured interviews	Hermeneutical and content analysis	To explore what kind of criteria, values, and other relevant considerations are important in clinical prioritizations in healthcare services for older patients
Halvorsen et al.,[79] Norway*1	Physicians (n = 21) ICU nurses (n = 25)	28–57	ICU	1–26	Semi-structured interviews and participant observation	Hermeneutical interpretation	To examine how significant others (e.g. family) may affect the principles of justice in the medical treatment and nursing care of ICU patients
Tønnessen et al.,[46] Norway*3	Nurses (n = 17) Purposive	25–55	Home-based care	1½–35	Semi-structured interviews	Interpretive hermeneutic methodology	To investigate nurses' priority decisions and the provision of home-based nursing care services

(continued)

Table 2. (continued)

(Study) Country	Sample (n) sampling method	Nurses (Y) age range	Working setting	Nurses (Y) working experience	Data collection method	Data analysis	Research topic
Slettebø et al.,[47] Norway	Physicians (n = 6) Nurses (n = 5)	38–59	Nursing homes	10–34	Semi-structured interviews	Manifest content analysis	To describe nurses' and physicians' experiences of prioritization factors in nursing homes
Tønnessen et al.,[50] Norway*3	Nurses (n = 17) Purposive	25–55	Home-based care	1½–35	Semi-structured interviews	Interpretive hermeneutic methodology	To investigate nurses' decisions about priorities in home-based nursing care
Winters and Neville,[80] New Zealand	Nurses (n = 5) Purposive	NR	Adult acute-care hospital	NR	Semi-structured interviews	Using a general inductive approach	To explore the concept of "missed care" using a qualitative descriptive approach
Papastavrou et al.,[29] Cyprus	Nurses (n = 23) Purposive 4 groups	24-48	Three public general hospitals	2–25	Focus groups interviews (n = 4) (A: n = 7; B: n = 4; C: n = 6; D: n = 6)	Inductive thematic analysis	To explore nurses' experiences and perceptions about prioritizations, omissions, and rationing of bedside nursing care through focus groups

ICU: intensive care unit; NR: not reported; Y: years; n: number. *1: possibly the same participants were enrolled, *2: Also; *3: Also.
Numbers in bracket above country = number of the study in the reference list.

Table 3. Quality assessment of included studies using the COREQ framework of reporting criteria.

Reporting criteria	No. (%)	Studies reporting each criterion	Reporting criteria	No. (%)	Studies reporting each criterion
Characteristics of research team			Data analysis		
Interviewer or facilitator identified	6/9 (66.6)	[29, 46, 47, 50, 78, 79]	Number of data coders	3/9 (33.3)	[29, 46, 80]
Credentials	9/9 (100.0)	[27, 29, 46, 47, 50, 53, 78–80]	Description of the coding tree	0/9 (0.0)	
Occupation	7/9 (77.7)	[27, 29, 47, 50, 53, 78, 79]	Derivation of themes	6/9 (66.6)	[29, 46, 47, 78–80]
Sex	0/9 (00.0)		Software	0/9 (0.0)	
Experience and training	5/9 (55.5)	[27, 29, 50, 53, 79]	Participant checking	0/9 (0.0)	
Relationship with participants			Reporting		
Relationship established	1/9 (11.1)	[79]	Quotations presented	9/9 (100.0)	[27, 29, 46, 47, 50, 53, 78–80]
Participant knowledge of the interviewer	2/9 (22.2)	[29, 79]	Data and findings consistent	9/9 (100.0)	[27, 29, 46, 47, 50, 53, 78–80]
Interviewer characteristics	2/9 (22.2)	[29, 79]	Clarity of major themes	9/9 (100.0)	[27, 29, 46, 47, 50, 53, 78–80]
Theoretical framework			Clarity of minor themes	3/9 (33.3)	[29, 78, 79]
Methodological orientation and theory	9/9 (100.0)	[27, 29, 46,47, 50, 53, 78–80]			
Participant selection			Data collection		
Sampling	8/9 (88.8)	[29, 46, 47, 50, 53, 78–80]	Interview guide	6/9 (66.6)	[27, 29, 46, 47, 50, 53]
Method of approach	4/9 (44.4)	[29, 47, 79, 80]	Repeat interviews	0/9 (00.0)	
Sample size	9/9 (100.0)	[4, 7, 27, 29, 46, 50, 53, 78–80]	Audio/visual recording	8/9 (88.8)	[27, 29, 46, 50, 53, 78–80]
Nonparticipation	3/9 (33.3)	[29, 47, 80]	Field notes	2/9 (22.2)	[78, 79]
Setting			Duration	5/9 (55.5)	[29, 46, 47, 50, 80]
Setting of data collection	4/9 (44.4)	[27, 29, 53, 78]	Data saturation	2/9 (22.2)	[29, 46]
Presence of nonparticipants	0/9 (00.0)		Transcripts returned	1/9 (11.1)	[29]
Description of sample	7/9 (77.7)	[27, 29, 46, 47, 50, 53, 78]			

COREQ: consolidated criteria for reporting qualitative research.

described in 44.4% and adequate description of the characteristics of the sample was given in 77.7%, although no information given if anyone else was present (besides the participants and researchers), during data collection. Details of the interview guide were given in 66.6%, the use of audiovisual recording reported in 88.8%, and the duration of the interviews in 55.5%. The use of field notes and discussion of saturation were reported in only two studies, but no information was given regarding return of transcripts to participants for comments or corrections. The process of derivation of the themes was reported in 66.6% and the number of data coders in 33.3%, but any description of the coding tree was not given. All reports gave adequate quotations from participants, showed consistency in data findings and reporting, and demonstrated clarity in reporting the major themes.

Synthesis

All extracted quotes and interpretations were entered verbatim into the software by S.V. and then each line of text was given a code, according to its meaning and content (First stage—free line-by-line coding). Each new study was either coded under an existing code, thereby enabling the translation of codes from one study to another,[66] or additional codes were developed when necessary. This coding was then discussed with E.P. and P.A., who had reviewed the articles independently and simultaneously but manually, in order to check consistency of interpretation and to see if additional codes were needed. This process resulted in 35 preliminary codes, agreed through discussion. The team then examined the codes analytically and hierarchically to identify similarities and differences in order to create groups of themes that could capture the meaning of the corresponding codes. This inductive process resulted in 14 agreed descriptive themes (second stage—construction of descriptive themes).

The third stage of this synthesis "went beyond" the content of the original studies to develop analytical themes,[66] or "third order interpretations."[71] This was carried out by using the judgment and insights of all the five researchers independently, and through this discussion, more abstract or analytical themes emerged. This cyclical process was repeated until new themes were sufficiently abstract to explain all descriptive themes. Altogether, four analytical themes have been generated, three of which were associated with elements that impart a moral dimension to care rationing (professional challenges and moral dilemmas, dominating considerations when prioritizing perception of professional and moral role), thereby addressing the first question of this thematic synthesis and one that associated with the experiences of nurses of the moral effects arising from it (experiences of the ethical effects of rationing), which could address the second question of this synthesis. A summary of all analytical themes organized by the descriptive themes from which these were produced is presented in Table 4.

Is there an ethical element of nursing care rationing?

The ethical element of nursing care rationing can be inferred in three analytic themes (i.e. professional challenges and moral dilemmas, dominating considerations when prioritizing, and perception of professional and moral role) generated in this synthesis, each of which has been produced by a number of descriptive themes. For example, professional challenges and moral dilemmas were produced by three descriptive themes, namely, the challenges in securing adequate and comprehensive care, the challenges in securing equal access to care and challenges in securing ethical care.

Professional challenges and moral dilemmas

The inability to provide all the care patients need may lead nurses to face certain professional challenges or moral dilemmas related to securing adequate and comprehensive care, securing equal access to care, and

Table 4. Summary of main analytic themes, descriptive themes, and illustrative quotations across studies (N = 9).

Descriptive themes	Quotations
Professional challenges and moral dilemmas (analytic theme 1)	
Challenges in securing adequate and comprehensive care (risks for mishaps and neglect)	*the interpersonal concern and care, this is what suffers.*[78] *the things that aren't about life and death, they have to be postponed.*[27] *something of a medical nature, we pay attention.*[47] *I think they're not getting the care that they could be getting.*[80] "Patients want nurses to talk to them, they need to feel safe."[29]
Challenges in securing equal access to care	*We have to give priority to those who haven't been outside for a long time.*[47] *It is unfair treatment, simply because a person is so strong that he may appear threatening.*[46]
Challenges in securing ethical care	*patients sometimes have to be sedated a little longer, In order to handle the rest of the unit, which I consider unethical.*[78]
Dominating considerations when prioritizing (analytic theme 2)	
Time constraints	*I feel that the responsibility is taken away from us because of too many tasks.*[78] *They organize the time—how long we are to spend with each patient.*[50] *There are many who want contact, but you can't. That does something to you*,[53] "*You work like a robot.*"[29]
Organizational schedule and support (unsupported feeling)	*I get a working list estimated on time.*[50] *foremost we are obliged to the assigned tasks.*[50] *the duty manager said*, '*Oh you'll just have to manage*' *and I just burst into tears.*[80] "it is not up to me to set priorities, it depends mainly on the manager."[29]
Model of care	*the most acute first. I give high priority to medical treatment*[47] *We meet physical needs. Medicines, nutrition, purely practical tasks.*[50] "we will check the vital signs, give the medication."[29]
Professional values and ethical principles	*they are ill and don't want to come, but they have to.*[53] *We do not give some patients a shower twice a week while other gets one once a week.*[46]
Patients' and families' status and position	*If he'd had a stronger family around.*[79] *if they have families who are persistent are active, get involved. Obviously they get more.*[79] *These two get help regardless, at the expense of the others*, [46] *The ones who complain of course will be given more priority.*[46] *The nice service user suffers.*[46]
Perception of professional and moral role (analytic theme 3)	
Need for holistic, individualistic, and comprehensive care	*I feel that we do not prioritize social needs.*[47] *I don't prioritize the relational aspect of care.*[27] *I'm talking about quality time, where you can see that they enjoy having us there.*[50] *It's more a matter of adapting the job to the individual.*[46]
Need for equal care based on fairness and justice	*to give priority to those who haven't been outside.*[47] *It should be more like offering almost equal help to those in almost the same situation.*[46]
Patients' advocacy	*Then there is no one who stand in the breach for these people . . . ends up at the bottom of the priority list*[27]
Disclaimer of responsibility in rationing	*the duty manager said*[80] *obliged to keep to the assigned tasks.*[50] "it is not up to me to set priorities, it depends on the manager."[29]
Experience of the ethical effects of rationing (analytic theme 4)	
Professional and moral conflicts	*There is so much to do, so you feel behind all the time.*[80] *and it is difficult to say that I don't have time to help you. It's about ethics and morals.*[27] "you wonder if you did all the things you could have done."[29]
Moral strain, feelings of quilt, and moral distress	*That does something to you.*[53] *You really feel guilty.*[27] *and I just burst into tears*[80] *I think about it all the way home, I haven't done my job properly and then I worry.*[80] "I woke up in the middle of the night because I remembered things that I left undone my mistakes and my inappropriate behavior."[29]

Italicized quotations are from study participants. Only Quotations from nurses were used for the purpose of this synthesis (number near quotation) = study reference.

securing ethically correct care. Participants in six studies[27,29,47,50,78,80] have expressed inability to fulfill appropriately their professional role, holistically and comprehensively, and therefore feel that they are betraying professional ideals and expectations.[27] Nurses reported that they feel the provided care is governed "by the clock" rather than by individual patient needs. Thus, they often feel forced into choosing between differing but equally important needs of their patient, resulting in giving lower priority to communicational, social, psychological, and relational needs[27,47,78] and higher to essential medical and physiological needs.[29,47] However, losing the human aspects of care causes nurses to feel distress, because they are unable to fulfill appropriately their holistic role[29,80] while they additionally express concern with regard to the potential for mishaps and neglect.[27,50] Moreover, participants in two studies[46,47] have clearly expressed their desire to ensure fairness and equality in their work; however, it is clear from some of their narratives[46,47] that nurses are not always able to achieve this goal. Hence, they feel that they are being forced to be unfair, predjudiced,[46] and even unethical[78] in practice by putting their patient's health at risk. In one study,[78] respondents gave a very disappointing example in that sometimes an anxious patient's sedation is increased in order to gain the time to deal with the rest of the patients in a busy ICU. Another important issue expressed[46,79] was that some patients are given more priority just because they or their relatives are more demanding or threatening than others.

Dominating considerations when prioritizing

The participants' considerations, when prioritizing care, can be described in five themes: time constraints, organizational schedule and support, the model of care, professional values and ethical principles, and patients and families status. Time constraints have been expressed in five studies,[27,29,50,53,78] as a reason for prioritizing care due to pressure of work,[29,50,78] and as an excuse for not giving priority to certain aspects of care or certain patients,[27,50,53] and as a form of personal disclaimer of responsibility in rationing.[50,78] Only in one study[53] has it been described as a source of stress for nurses. Organizational schedule and administrative decisions have been described by participants in three studies[29,50,80] as a consideration when prioritizing care, again being used as a disclaimer of personal responsibility[29,50] and transferring the responsibility of care rationing to managers, while feeling that they—the nurses—are not being supported.[29,80] Some authors claim that professional values and ethical principles such as beneficence and nonmaleficence, justice, and fairness are taken into account by nurses when prioritizing care while they deeply value the holistic care. However, these arguments have not always been supported from participants' narratives. Only quotations from one study[53] have supported value of beneficence and nonmaleficence, and one[46] gave support to fairness and equality as a guiding principle when rationing. Instead, narratives were far removed from the holistic approach of care, admitting prioritization according to biomedical model of care,[27,29,47,78] the medical requirements and the physical needs,[29,50] or even to being guided by doctors' wishes.[29] Moreover, extracts from two studies[46,79] supported an inequality and unfairness in providing care—with demanding patients and families that complain and insist on certain standards of care, or else have higher social status and knowledge, or even patients with an interesting diagnosis receiving a higher priority in care than patients and families that are helpful and understanding towards staff.

Perception of professional and moral role

One can infer the desire of nurses to possess an ideal of a moral role in relation to rationing as can be described by the four descriptive themes (see Table 4). This has been expressed in four studies[27,46,47,50] as a desire to give emphasis to the provision of holistic, individualistic, and comprehensive care to patients; and in two studies,[46,47] as a desire for maintaining equality, fairness, and justice in care. In one study,[27]

participants have expressed the need of patients to have someone to speak for them, inferring an advocacy role that according to the narrative has been given to doctors, supporting again a form of disclaiming responsibility, as discussed earlier.[29,46,50,80]

How do nurses experience the ethical effects of nursing care rationing?

As expressed by participants in some studies,[53,78] if they were not able to fulfill their professional role, then they felt they were unfaithful to professional ideals and expectations. This may be perceived as a struggle between the things they wish to do and believe they should be doing, and those things that they are actually doing. In turn, this may lead to moral conflicts between their work responsibilities and ethical demands, which is expressed in guilt and frustration as it was revealed in some narratives[27,29,80] or a sense of moral strain and moral distress, as expressed in some other narratives.[29,80]

Developing a thematic framework

Discussion and identification of relationships between themes revealed a thematic framework in understanding the ethical dimension of nursing care rationing. The main purpose of this effort was to address the questions of this thematic synthesis, thereby finding out if there is an ethical element in nurses' decisions to ration care and what constitute this element and also clarifying how do nurses experience the ethical effects of nursing care rationing. This was achieved by using judgments, inferences, and insights from all the reviewers on the themes that emerged from the analysis, as well as their ability to answer the review questions. Moreover, an attempt was then made to identify relationships between these themes and among the insights. Each reviewer first did these independently and then they discussed their insights as a group. Through this discussion, a thematic analytic schema was revealed, extending the findings of primary studies.

As shown in Figure 2, nurses, in allocating scarce resources, are faced with certain professional challenges and moral dilemmas which in turn influence their considerations of prioritizing care as well as their perception, regarding their professional and moral role in relation to rationing. However, they may perceive their role in two distinct ways.

On one hand, they desire a morally ideal role—wishing to offer to patients holistic, individualized, and comprehensive care based on equality, fairness, and justice while accepting a responsibility to act as a patient advocate. Thus, by being faithful to professional ideals and expectations, nurses wish to fulfill their role in the allocation of any resources in an ethical and professional manner, regardless of any other competing considerations. This ethical approach to care obviously leads to positive patient outcomes and to professional satisfaction for nurses. On the other hand, nurses may not be able to accept a role in rationing of nursing care, disassociating themselves from such a responsibility. This may lead to an inability to fulfill an ethical role in rationing. In this case, any failure to perform within an ethical framework when prioritizing care is justified based on external factors, such as the dominating considerations, thereby providing various excuses for the nurse. However, inability to accept such a role may inevitably lead to unfair and unethical distribution of nursing resources or unacceptable practices. This, in turn, will affect their perceptions regarding professional and moral roles, as well as their personal role, within the healthcare context in which they work and in relation to nursing care rationing. Thus, if they feel that they are able to deal with professional challenges and moral dilemmas in securing appropriate care for their patients, they will provide this care and will feel professionally satisfied. Otherwise, they will experience the negative consequences that rationing may have on them in relation to the ethical aspects of nursing, expressing moral strain, moral conflicts, or moral distress.

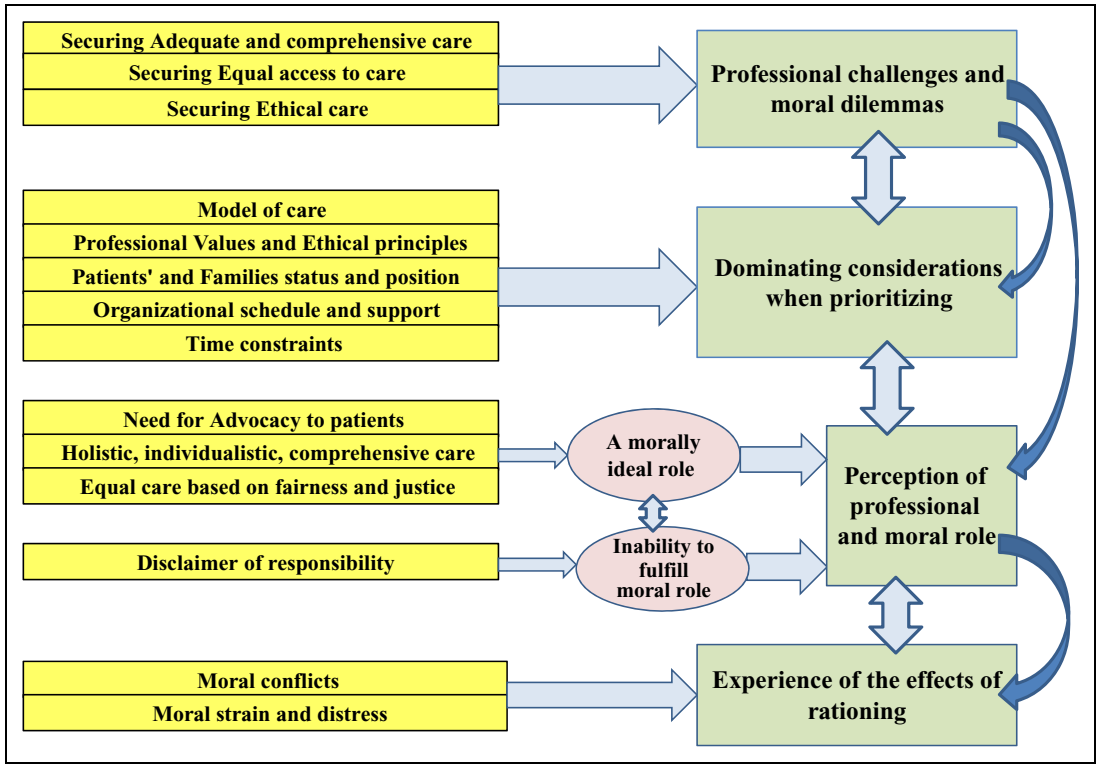

Figure 2. Thematic analytic schema of the ethical dimension of nursing care rationing.

Discussion

This thematic synthesis identified four themes to describe the ethical dimension in nursing care rationing. The majority of the synthesized studies, support that nurses may feel that the holistic and humanistic care, although desirable, is not a realistic goal, within the limitations of the scarcity of resources. Thus, they develop their own care standards that are heavily influenced by a biomedical ethos, biomedical needs, and visible clinical tasks, while they neglect basic human needs[62] and essential elements of care[50,61] such as empathetic listening and communication.[46,47,78]

However, difficult decisions in relation to rationing may jeopardize professional values—leading to role conflict, guilt, and moral dilemmas. These dilemmas are posed when nurses experience indecision because of conflicting choices. As revealed from nurses' narratives in some studies,[29,53,80] despite the fact that they knew what was "the right thing to do," certain organizational obstacles made them feel unable to implement this course of action. The result of this inability is expressed either as moral strain and conflict[50,78] or moral distress.[53,80] Therefore, one could agree that moral distress could be partially alleviated by an increase in resources,[81] thus allowing nurses to provide the standard of care they wish. However, very few studies examine nursing care rationing from an ethical perspective, and therefore more evidence is needed regarding its relationship to the moral element either as regards care choices or care outcomes on patients and nurses. Certain professional challenges together with the perceptions of nurses about their own role within the context of care rationing (as well as other aspects associated with the ethical climate[82] in healthcare organizations) may affect this phenomenon, but evidence for such a relationship is limited.

Nevertheless, an inability to provide all of the care that is perceived as needed may jeopardize nurses' philosophy of care.[22] This philosophy can be influenced by education and training, the working environment, a professional code of ethics, and the profession as a whole. However, these issues as well as themes like justice, equality, and fairness, when prioritizing nursing care, need to be examined from different perspectives between countries, across cultures, and in a variety of healthcare systems.

Study limitations

The synthesis relied only on studies in English and Greek—studies in other languages may reveal different findings. Most of the studies were conducted in Norway, one in New Zealand, and one in Cyprus. Participants' perceptions from other countries may be different. The research topic varied, and only two studies focused on ethical aspects of nursing care rationing. In these nine studies, three pairs of studies appeared to be drawn from similar samples and settings. Therefore, the findings of this synthesis must be interpreted with caution.

Conclusion

The literature related with the moral dimension of nursing care rationing is limited, tending mainly to describe this issue through its philosophical orientation. Although it seems that there is an ethical element in nursing care rationing as can be inferred from three of the analytic themes generated in this synthesis, further research is needed for this evidence, as well as, to examine relationships between these themes. Nevertheless, it seems that nursing care rationing is not merely an organizational and economical issue as it requires ethical judgments that potentially conflict with personal and professional values and the ethical context of the profession.

Moreover, the perception of nurses of their own role, within the context of rationing, may additionally affect the phenomenon of nursing care rationing. The few studies found, highlighted that the principles of justice and equality in care as well as the personal values, must be taken into account during the process of making decisions, on the allocation of the care. The ethical considerations that guide nurses in their decisions on how to allocate nursing care as well as the moral conflicts and moral distress experienced by nurses, as an ethical outcome of rationing, were rarely reported in the studies that were reviewed. However, in scarcity, nurses may face difficulties in fulfilling their professional roles and balancing the needs of individual patients, the demands of their employers, their personal values, and the ethical context of the profession. Further research on the ethical dimension of rationing of nursing care is expected to illuminate some important aspects of this phenomenon.

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Conflict of interest

The authors declare that there is no conflict of interest.

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