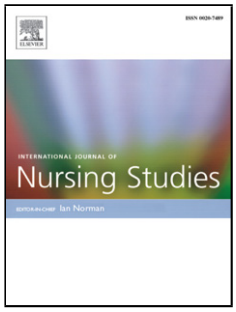

Title: Ethical elements in priority setting in nursing care – a scoping review

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Ethical elements in priority setting in nursing care – a scoping review

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Abstract

Background: Nurses are often responsible for the care of many patients at the same time and have to prioritise their daily nursing care activities. Prioritising the different assessed care needs and managing consequential conflicting expectations, challenges nurses' professional and moral values.

Objective: To explore and illustrate the key aspects of the ethical elements of the prioritisation of nursing care and its consequences for nurses.

Design, data sources and methods: A scoping review was used to analyse existing empirical research on the topics of priority setting, prioritisation and rationing in nursing care, including the related ethical issues. The selection of material was conducted in three stages: research identification using two data bases, CINAHL and MEDLINE. Out of 2024 citations 25 empirical research articles were analysed using inductive content analysis.

Results: Nurses prioritised patient care or participated in the decision-making at the bedside and at unit, organisational and at societal levels. Bedside priority setting, the main concern of nurses, focused on patients' daily care needs, prioritising work by essential tasks and participating in

priority setting for patients' access to care. Unit level priority setting focused on processes and decisions about bed allocation and fairness. Nurses participated in organisational and societal level priority setting in discussion about the priorities. Studies revealed priorities set by nurses include prioritisation between patient groups, patients having specific diseases, the severity of the patient's situation, age, and the perceived good that treatment and care brings to patients. The negative consequences of priority setting activity were nurses' moral distress, care missing, which impacts on both patient outcomes and nursing professional practice and quality of care compromise.

Conclusions: Analysis of the ethical elements, the causes, concerns and consequences of priority setting, need to be studied further to reveal the underlying causes of priority setting for nursing staff. Prioritising has been reported to be difficult for nurses. Therefore there is a need to study the elements and processes involved in order to determine what type of education and support nurses require at assist them in priority setting.

Keywords: Ethics, nurse, nursing care, priority setting, prioritisation, rationing, scoping review

What is already known about the topic?

- Nurses, being responsible for many patients at the same time, have to prioritise and sometimes ration their daily nursing care activities.
- Prioritisation of nursing time may mean that nurses are not able to carry out the provision of effective and safe care appropriate to patient need, based on a skilled clinical assessment.
- Earlier research on the topic has focused on direct care in daily clinical nursing practice, without consideration of the ethical elements or their consequences

What this paper adds

- There is a paucity of literature dealing with nurse prioritising and its consequences.
- Nurses set priorities across the levels of nursing activity including care giving at the bedside, on the ward/unit, within organisational policy and in society.
- Nurses are not necessarily well equipped to identify and articulate the ethical values and principles that underpin their responses to the prioritisation or rationing used in making nursing care decisions.

- When nurses prioritise care, and when such prioritisation involves rationing, they may also compromise the patients' right to health care, which conflicts with personal and professional values. This challenges nurses' ethical and moral value systems, ultimately resulting in consequences for both the nurses and patients.

Introduction

Nurses are responsible for managing their work and are professionally responsible for their conduct and the quality the nursing care they deliver (IOM 2001; Mitchell 2008; WHO 2006). This responsibility includes the observation and monitoring of the health status of patients, such as the measurement, monitoring and understanding of patients' vital signs. (Mitchell 2008). Working in a regulated profession, nurses are educated in the science and art of caring (see Carper 1978), and are mandated to manage care, being accountable for their acts and omissions in their care work (International Council of Nurses 2013). Despite the profession's regulatory and legislative obligations, the increasing needs of patients, cost constraints and/or austerity measures affecting health care service delivery, directly impact on nurses' capacity to complete their work satisfactorily from an ethical perspective (e.g. Borges et al. 2013; Ifanti et al. 2013; Papastavrou et al. 2014a). This impact leads to nurses prioritising and sometimes rationing their nursing care activities (Tønnessen 2011). The act of prioritisation means the nurse chooses to do something (A) instead of something else, B, at a particular time. When a nurse chooses one (A or B), prioritising the need for either A or B, the choice may or may not cause a real problem for the patient. For example, if all the work is done eventually, problems may not be significant. The biggest problems arise in situations where the nursing work force does not have the capacity to provide effective and safe care appropriate to patient need, based on a skilled clinical (as different from a financial) assessment (Harvey et al. 2016). In this situation some of the work may not be done at all leading to prioritising with a specific type of local health care rationing. Nurses have reported that they are practicing in situations with a lack of congruency between individual patients' needs and the demands of the organisation (Hart 2005). Such situations include contexts where care needs and nursing work is intensified due to the numbers and care requirement of patients (usually high) and the numbers of nursing staff available to meet the care needs (usually too low) (Scott et al. 2013). Where this incongruity occurs it produces ethically difficult situations for nurse to resolve which, in turn, has a negative impact on the morale of

practising nurses, a separate but important ethical issue. This intensification puts nurses at risk of charges of professional misconduct (Harvey et al. 2016; Tønnessen 2011).

In the United Kingdom, the Francis inquiry (Francis 2013) into the appalling standards of care in Mid Staffordshire NHS Foundation Trust, highlighted that work intensification is indicator for an environment where care may be left undone. The Francis inquiry (Francis 2013) identified and investigated the causes of the failures in care provision between the years 2005 and 2009. The report of the inquiry made 290 recommendations to improve care provision, care quality monitoring systems and public accountability in the NHS. The recommendations include the following requirements:

> "Openness, transparency and candour throughout the health care system (including a statutory duty of candour); fundamental standards for health care providers; and improved support for compassionate caring and committed care and stronger health care leadership." (The Health Foundation: https://www.health.org.uk/about-francis-inquiry.)

Other studies have described work intensification as implicit rationing of care (e.g. Kalisch et al. 2013; Papastavrou et al. 2014a; Willis et al. 2015), and point out that priority setting in such circumstances is a necessary requirement for nursing staff (Tønnessen 2011).

Hendry and Walker (2004) revealed that little is known either about the approach to priority setting that nurses adopt when deciding what bedside care they will provide, or in other priority setting activities in which nurses participate. The factors influencing this process have also not been explored. There is some earlier research on prioritisation in nursing care which focused on direct care in daily clinical nursing practice, without consideration of the ethical elements or issues in such prioritisations. Similarly, a review (Vryonides et al. 2015) of nursing care rationing in relation to the ethical perspectives of nursing, only included qualitative studies in their review. A further limited amount of literature examined the essence of justice, equality in care and in values when prioritising care, with little attention given to the ethical effects of rationing on nurses (Vryonides et al. 2015).

The aim of this scoping review was to explore and illustrate the key ethical aspects of priority setting, in the patient care context undertaken by nurses. The goal was to map and formulate an

understanding of the depth, breadth and scope of the current research focusing on ethical elements in priority setting in nursing. This current review is based on the work of RANCARE research collaboration (https://www.rancare-action.eu/).

Background

To prioritise something means to treat that something as more important than other things (Collins Cobuild Advanced Learner's English Dictionary 2004). If something is a priority, it is the most important thing you have to do or deal with before everything else you have to do. The verb "prioritise" means to determine the order for dealing with a series of items or tasks according to their relative importance. This means that all actions nurses take have some type of relative importance and prioritisation rank orders nursing activities. In nursing

> "…priority setting involves making decisions about the significance of patient problems and needs, and about the actions that should be made in response" (Hendry and Walker 2004, p. 430).

These concepts demonstrate that not all priority setting is rationing, but some forms of priority setting such as age discrimination may be associated with types of rationing.

Priority setting has been described as the most critical skill in the time management of nurses' work (Hendry and Walker 2004), for example when planning care and daily work. However, not all priority setting in nursing has an ethical dimension (Hendry and Walker 2004; Jones et al. 2015). The ethical dimension becomes important when priorities make nurses choose (Vike 2017), the most important or urgent activity bringing moral values and expectations into conflict (Fry and Johnstone 2008). The allocation and prioritisation of nursing resources may involve rationing of nursing care, without an explicit normative framework, the use of rationing principles or specific instructions provided by institutions to guide individual practitioners' decision-making (Halvorsen 2009; Tønnessen 2011, 2014). Tønnessen (2016) has argued that this type of prioritisation may lead to ethical dilemmas for nurses when their prioritising decisions involve choosing between various professional considerations and values, and when there is no satisfying solution.

In the literature, several terms have been used interchangeably with priority setting and prioritisation. The term rationing is closely linked to priorities as a special issue when resources are limited (Papastavrou et al. 2014a). Rationing is usually defined in terms of different ways to limit access to health care, such as denial, deflection, dilution, delay and deterrence (Harrison and Hunter 1994). In the nursing literature rationing has been defined as:

> "the withholding or failure to carry out necessary nursing tasks due to inadequate time, staffing level and skill mix" (Schubert et al. 2008).

Care left undone has also been called implicit rationing in the literature (Jones 2015). Care left undone is care which nurses make the decision not to provide because of time or resource constraints, as distinct from care that is explicitly rationed through cost cutting measures that are organisationally decided (Jones 2015; Schubert et al. 2008). As a result of rationing, whatever the rationale, fundamental patient needs may not be met, and human rights linked to discrimination may be affected (Papastavrou et al. 2014a).

Prioritisation can happen at different levels (see for example Norheim 2003). The first level is the superordinate level (macro level) corresponding to health policy. At this macro level, justice (as fairness) and equality are significant values guiding prioritisation. Priorities are usually connected to needs, severity of illness, benefit and cost efficiency and to just (fair) allocation at a high strategic level (Hofmann 2013). Brody (2012) points out that in the current health care delivery climate, rationing is inevitable because

> "if we avoid explicit rationing, we will resort to implicit and perhaps unfair rationing methods." (Brody 2012, p. 1949)

This is something that elicits moral anxiety from health professionals working directly with patients (Batifoulier et al. 2013; Magelssen et al. 2016). The second level is the intermediate level representing the employer's or organisation level (meso level). The prioritisation of healthcare services for the individual patient should be rooted in the medical community and other healthcare personnel since the actual specific clinical priorities are made by healthcare personnel. Finally, the third level is the patients' immediate environment, the individual level (micro level). Prioritisation decisions performed by individual nurses then have much in common with clinical decision-making. However, nurses perceive that the lack of resources set limitations on their work, in particular regarding caring tasks, because they have to give priority

to the interventions driven by severity of illness or emergency situations. In prioritising in this way nurses acknowledge that and act as if caring interventions, such as comforting patients have to be rationed or de-prioritised. The hard choices are made at the "bedside", where medical treatment and nursing care in various ways need to be prioritised and rationed. These choices need to take account of resources and/or prioritisations that are made on the basis of medical and ethical considerations (Halvorsen 2009).

The dimensions of prioritisation have also been identified. For example, the second Norwegian regulation of priority setting, The Lønning II Commission (NOU 1997:18, 6), described these different dimensions of prioritisation as: 1) *Balancing* between main categories of treatment measures, for example, acute care and rehabilitation; 2) *Rationing* services, for example, delaying tasks and services, diluting the quality of services, deterring services by constructing barriers for patients' requirements and denying different services; 3) *Ranking* different interventions or services, for example, priority for diagnoses and the degree of urgency of need for treatment. (NOU 1997:18, 6 p.25-26).

To summarise, when there is a scarcity of resources (for example, low staffing levels, poor skill mix, reduced time, poor practice environments) nurses need to set priorities and prioritise nursing care and work. Having to make decisions prioritising different assessed care needs, dealing with conflicting expectations or urgency of needs, challenges nurses' professional and moral values. Nurses may face difficulties in fulfilling their professional and ethical roles in an appropriate manner. For example, nurses may delay or omit some nursing interventions, or give less priority to certain patients (Vryonides et al. 2015) leading to implicit rationing. Implicit rationing by nurses may reduce the standards of care offered (IOM 2001; Mitchell 2008; Nortvedt et al. 2008), increasing the risk of adverse patient outcomes, threatening patient safety, reducing care quality; and directly contradicting ethical codes (Papastavrou et al. 2014a; Pedersen et al. 2008; Schubert et al. 2008, 2009). Additionally, such rationing is hidden (Papastavrou et al. 2014a), so that the responsibility and related distress rests with the nurses, even though it may be the systemic cost constrained environment that is directing such decisions (e.g. Harvey et al. 2016; Willis et al. 2016).

Aim and review questions

The aim of this scoping review was to explore and illustrate the key aspects of the ethical elements in priority setting undertaken by nurses

Specific research questions were:

- How have the ethical aspects of priority setting in nursing been examined previously?
- What are the focus areas in priority setting in nursing?
- What ethical aspects are present in priority setting in nursing?
- What is prioritised in practice by nurses?
- What factors are associated with priority setting in nursing?

Methods

A scoping review was used to map the main concepts underpinning the research area, identifying the main sources and types of evidence. This scoping review was conducted to identify any need for a systematic review and determine future research (see Tricco et al. 2016), the possible research agenda for the RANCARE project on priority setting, prioritising and rationing. The review follows the stages of a scoping review (Arksey and O'Malley 2005) which uses a five-step protocol: 1) Identifying the research question(s); 2) Identifying relevant studies; 3) Study selection; 4) Charting the data; and 5) Collating, summarising and reporting the results.

Identifying relevant studies

The systematic search strategy used two electronic databases relevant to nursing science (Subirana et al. 2005), MEDLINE/PubMed (from earliest to March 2017) and the Cumulative Index of Nursing and Allied Health Literature CINAHL (from earliest to May 2017). The search was completed using the following terms and protocols: (priority setting* OR priorit* OR ration* OR decision-mak*) AND ("Nursing"[Mesh] OR "nursing" [sh] OR "Nurses"[Mesh] OR nurs*) AND (ethic* OR moral*). The results were limited to the English language and having a title with abstract. The search produced 2024 records to be analysed (MEDLINE/PubMed 1707 and CINAHL 317). (Figure 1). The search was conducted as open to include all possible citations.

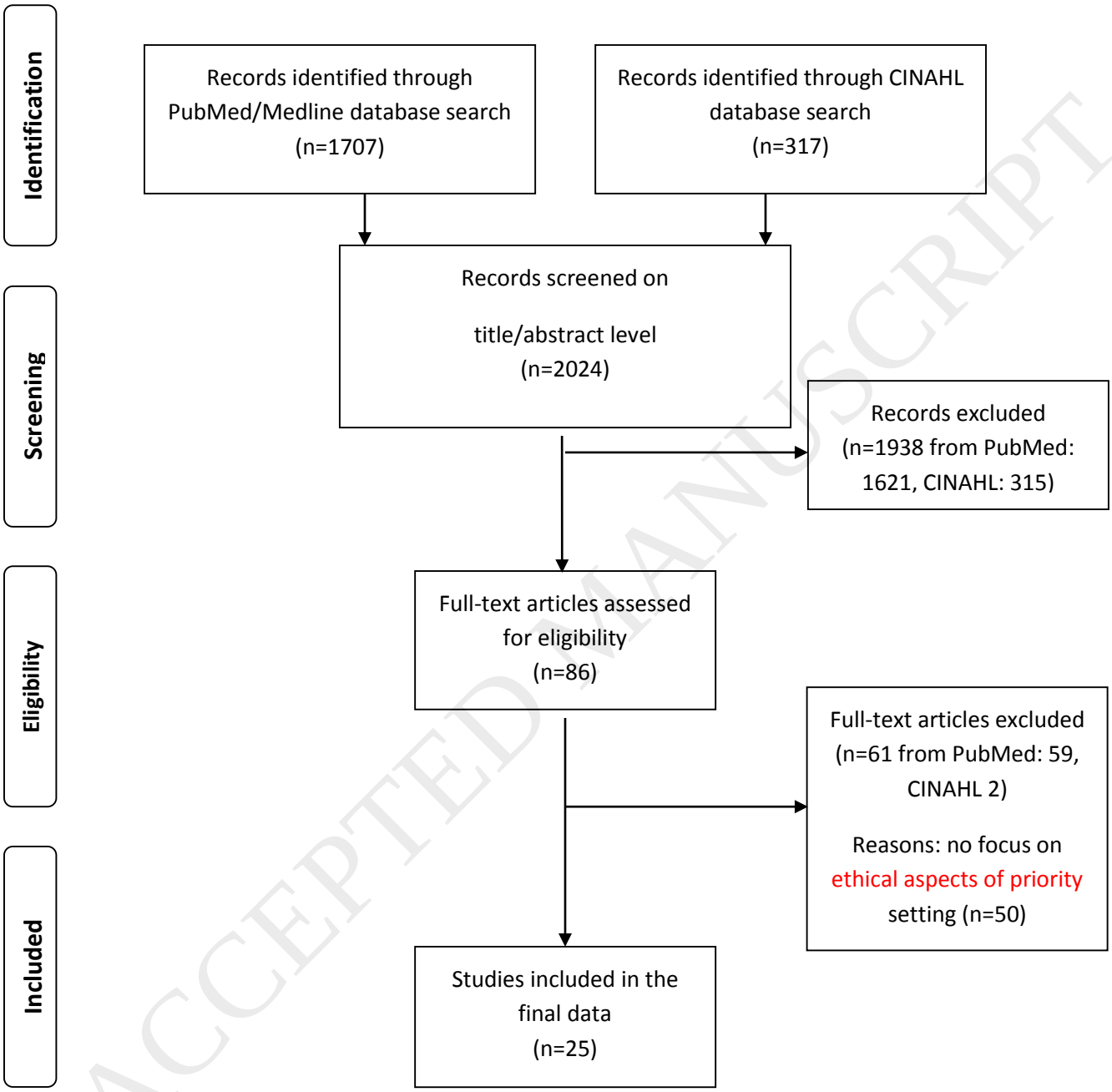

Figure 1. Flow chart of the literature search process.

Study selection

A three-stage protocol was used for study selection (Figure 1), applying inclusion and exclusion criteria. A publication was included in the review if it: 1) was an empirical peer reviewed, research article; 2) included nursing personnel, nurses as decision-makers of prioritisation; 3) was conducted in any speciality area or field of nursing practice, 4) had the main focus in priority setting, prioritisation or rationing of nursing care and work; 5) included an examination of an ethical aspect or element of ethics or ethical issues in the priority setting activity. Papers were excluded which focused on 1) students, 2) identification of research priorities; 3) non-ethical aspects or views on priority setting, such as daily work planning; and 4) were not empirical research such as case descriptions, editorials, opinions and discussions. No limits were set for the year of publication.

After identification of the citations in the electronic database search, the first screening focused on the title and abstract of all records (n=2024). Following this, pairs of researchers (n=7) (all authors, two first authors RS, MS, being the second reviewers for all) independently screened the possible records to be included in further analysis. Based on the screening, and a discussion until consensus was reached, 86 articles were chosen to be studied more thoroughly (Figure1). Using the same format, pairs of researchers considered the 86 research papers and most (n=50) did not focus on ethical aspects of priority setting or were not empirical studies (n=11). Those excluded, for example, were based on the criteria not focusing on ethical aspects of priority setting. This process identified the final 25 records to be included in the review (Figure 1).

Charting the data

Data were collected into a spreadsheet in table format using the terms and words of the original authors and included: authors, year of publication and country, aim of the study, study design, sampling method, sample size and informants, data collection and analysis methods. The following information was also collected: the priority setting decision-maker, the study context area (and how the priority setting was analysed), the focus area (how it relates to priority setting, prioritisation), the ethical aspects of the priority setting and prioritisation, and finally, factors associated with priority setting.

Collating, summarising and reporting the results

Collating and summarising the results was undertaken using inductive data analysis. This included readings of the raw data from articles included in the review with this current review questions in mind, to identify concepts and frequent, dominant or significant themes. Descriptive tables were constructed summarising the study methods and the main topics. The rules of good scientific conduct of research, research integrity and publication ethics (Committee on Publication Ethics 2018) were followed in the review process and in reporting the results.

RESULTS

Study description and methods used

A total of 25 full text research articles were analysed beginning from the year 1994. Most of the studies were conducted in Nordic countries or Europe; Norway (n=7), Sweden (n=1), Finland (n=1), the Netherlands (n=1) and Cyprus (n=1). The North-American content was represented by Canada (n=7) and United States of America (n=3). Some studies were conducted in Asia, (Iran, South-Korea one in each), Australia (n=1) and Africa (Uganda n=1) (Table 1).

The majority of the articles used qualitative approaches to explore priority setting, using a mixture of methods to collect data. Interviews were most often used (n=12) with some studies combining interviews and observation (n=5), interviews and document analysis (n=2), or a combination of all of these (n=3). Surveys were also used (n=4). The sample size varied between five and 1675 participants. All the studies included nurses as decision-makers in priority setting. However, other professional stakeholders were also represented. Nurses were the only group of research informants in 13 studies, with physicians being co-research informants in 12 studies. Most of the studies were conducted in hospital settings (n=20), and a minority in primary health care (n=2) or community or home care (n=2) settings. In one study the context was not specified and referred to nurses in general.

Table 1. Description of the included studies by author information and methods

Author, year, country	Aim	Study design	Sampling method	Sample size (rr%), informants	Data collection	Data analysis	Concept	Findings
Millette 1994 USA	To examine the moral decision-making processes used by nurses.	Qualitative descriptive	Random	24 nurses	Interviews	Content analysis	Care rationing	Both the caring and the justice orientation are present in the nurses' stories. Neither orientation seemed to be more effective in assisting nurses in making moral choices. Both orientations guided nurses in the provision of quality care and towards a role in client advocacy.
Foster & McLellan 1997 USA	To assess and compare professional acceptance of some considered moral judgments in the rationing of health care resources	Exploratory-descriptive	n/a	31 social workers (69%), 69 nurses (23%), 51 physicians (23%)	Developed questionnaire	Descriptive and inferential statistics	Care rationing	Social workers and physicians were more likely than nurses to consider cost-benefit ratios, quality of life, relative strength of a patient's moral claim, and scarcity of resources in rationing decisions. The findings appear to portray social workers and physicians as being more utilitarian and nurses more egalitarian in rationing decisions.
Meslin et al. 1997 Canada	To understand the nature and frequency of the ethical issues clinical managers face as a consequence of their involvement in resource allocation decisions, and to identify mechanisms for dealing with these problems in their hospitals.	Explorative	Random, total, 3 groups: all PHMs, random sample of NUMs, total population of HPMs.	1675 (54%) clinical managers = 584 (46%) physician-managers (PHMs), 660 (50%) nurse-managers (NUMs), and 431 (71%) other managers (HPMs)	Developed questionnaire	Descriptive statistics	Ethics in resource allocation decision-making	Three most rated factors that CMs might take into account when faced with ethical issues associated with resource allocation decision were: personal beliefs/values; law/legal standards, and general clinical experience. Most frequently used organisational strategies used in hospitals for addressing ethical issues arising from resource allocation were consultation strategies with patients/families, colleagues and superiors.
Varekamp et	To explore patient selection and to reveal	Qualitative	n/a	1. site: 33 professionals	Observations;	Content	Resource allocation;	In the renal transplantation, patients are seldom considered urgent. Criteria for urgency

al. 1998 The Netherlands	underlying arguments and considerations for professionals' use of selection criteria.			(including physicians in different medical specialities, social workers, nurses, transplant coordinator, medical director); 2. site 39 persons (including physicians, social psychiatric nurses, medical adviser, social workers)	interviews	analysis	patient selection	are technical dialysis problems or the severe psychological burden due to protracted dialysis treatment. In contrast, psychogeriatric patients are often considered urgent, with the principal criterion being too heavy care load for informal carers. Both health care services show variation in assigning urgency codes. It appears that the exact meaning of urgency is not self-evident and that admission of urgent patients to nursing homes can be negotiated by professionals or informal carers. Further, professionals involved in renal transplantation raise several moral and practical arguments against giving patients priority, even if they need treatment urgently.
Martin et al. 2003 Canada	To describe the process used to decide which patients are admitted to the intensive care unit (ICU) at a hospital with special focus on access for neurosurgery patients and evaluate it using "accountability for reasonableness".	Qualitative case study	Theoretical*	13 participants (including nurse manager, physicians in different medical specialties, administrator and coordinator)	Reviewing documents; interviews; observations	Thematic analysis; Ethical framework of "accountability for reasonableness" (relevance, publicity, appeals, enforcement)	Priority setting	ICU admissions were based on the referring physician's assessment of the medical need of the patient for an ICU bed. Non-medical criteria (for example, family wishes) also influenced admission decisions. Although there was an ICU bed allocation policy, patient need always superseded the bed allocation policy. ICU admission guidelines were not used.
Mielke et al. 2003 Canada	To describe priority setting for admissions in a hospital critical care unit and to evaluate it using the ethical framework of "accountability for	Qualitative case study	Theoretical*	20 critical care unit staff members	Reviewing documents; semi-structured interviews; observations	Grounded theory	Priority setting	Decisions to admit patients involve a complex cluster of reasons. Both medical and nonmedical reasons are used, although the nonmedical reasons are less well documented and understood. Medical directors, who are the chief decision-makers, differ in their reasoning. A hospital critical care admissions

	reasonableness."							policy exists but is not used and is not known to all stakeholders.
Myllykangas et al. 2003 Finland	To investigate the acceptability of 14 prioritisation criteria from nurses', doctors', local politicians' and the general public's perspective.	n/a	Random	682 (68%) Nurses; 837 (56%) Doctors; 1,133 (52%) Polititicians; 1,178 (59%) General public	Developed questionnaire	Inferential statistics	Priority criteria	All respondents preferred treatments for poor people and children. With the exception of the doctors, the three other study groups also prioritised elderly patients. Treatment for institutionalised patients, those with self-induced disease, diseases with both poor and good prognosis, and mild disease were given low priorities
Rocker et al. 2003 Canada	To describe perceptions of the administrative procedures for seasonal bed closures and their consequences in the intensive care unit (ICU), and to critique this example of health care priority setting for legitimacy and fairness.	Qualitative case study	Purposive	19 ICU clinicians (9 bedside nurses and 5 physicians), and administrators (3 ICU managers and 2 senior hospital executives).	Reviewing documents; semi-structured interviews	Modified thematic analysis; Ethical framework of "accountability for reasonableness" (relevance, publicity, appeals, enforcement)	Priority setting; bed closure	Emerging themes concerned: (1) bed closure rationale (including arbitrary decision making, bed closure masquerading as a code for a nursing shortage, and suboptimal evidence base for implementing closures); (2) bed closure process (viewed as unclear with insufficient prior publicity and inadequate subsequent review); and (3) adverse consequences (including safety issues, negative professional working relationships, and poor morale).
Cooper et al. 2005 Canada	To describe participants' perceptions of communication during the priority-setting process in the Critical Care Unit to gain an understanding of how the fairness of our bed allocation process might be improved	Qualitative case study	Theoretical*	18 participants (3 critical care physicians, 4 clinical fellows in critical care, 4 resource nurses, 4 end-user physicians, 3 members of the administrative	Semi-structured interviews; reviewing documents	Modified thematic analysis	Priority setting; bed allocation	The critical care physician, resource nurse, critical care fellow and end-users (trauma team leader, surgeons, neurosurgeons, anesthesiologists) functioned independently in unofficial "parallel tracks" of bed allocation decision-making; this conflicted with the official designation of the critical care physician as the sole authority. Communication between key decision-makers was indirect and could exclude those affected by the decisions; notably, family members. Participants

				staff)				perceived a lack of publicity for bed allocation rationales.
Arnold et al. 2006 USA	The purpose of this evaluation is to answer critical questions about the health system CNEs' (chief nursing executives) roles and leadership priorities.	Descriptive design, grounded theory	n/a	22 (63%) chief nursing executive	Survey; interview	Findings from the survey and interview were compiled for each participant	Strategic positioning; leadership priorities	CNEs' integration strategies for coordination and leadership of nursing practice across the health system fell into similar categories: 1) Financial performance, 2) Clinical integration, 3) Quality, patient safety, and compliance, 4) Nursing practice and professionalism
Cesi 2006 Canada	To examine how the current preference for economic discourses affects case managers' practice and to consider the implications of these effects for this workforce.	Ethnographic	n/a	7 case managers	Observations; interviews	Not specified	Economic discourses affecting practice	Case managers (and their managers) find themselves with limited capacity to exercise control over their practices. A growing gap between professional and organisational priorities creates a dissonance for case managers as the political-ethical dimensions of their practices are displaced by budget "realities".
Kapiriri & Martin 2006 Uganda	To describe priority setting in a teaching hospital in Uganda and evaluate the description against an ethical framework for fair priority setting	Qualitative case study	Combination theoretical* and snowball	14 health planners; 40 doctors; 16 nurses	In-depth, individual interviews; reviewing documents	Modified thematic approach; ethical framework of "accountability for reasonableness" (relevance, publicity, appeals, enforcement).	Priority setting	Senior managers, guided by the hospital strategic plan, make the hospital budget allocation decisions. Frontline practitioners expressed lack of knowledge of the process. *Relevance*: Priority is given according to a cluster of factors including need, emergencies and patient volume and departments whose leaders "make a lot of noise" are also prioritised. *Publicity*: Decisions, but not reasons, are publicised through general meetings and circulars, but this information does not always reach the frontline practitioners. *Revisions*: There were no formal mechanisms. *Enforcement*: There were no mechanisms.

Walton et al. 2007 Canada	To describe priority setting in cardiac surgery and evaluate it using an ethical framework, "accountability for reasonableness".	Qualitative case study	Universal, theoretical*, convenience	23 participants (including cardiac surgeons, cardiologists, and triage nurses)	Reviewing documents; interviews; observations	Grounded theory Ethical framework of "accountability for reasonableness" (relevance, publicity, appeals, enforcement)	Priority setting	*Relevance*: While decisions may appear to be based strictly upon clinical criteria; non-clinical criteria also have an impact upon decision-making. Participants stated that these factors influence their decision-making and can result in unfair and inconsistent decisions. *Publicity*: Non-clinical reasons are not publicly accessible, nor are they clearly acknowledged in discussions between cardiac clinicians. *Appeals*: There are mechanisms for challenging decisions however without access to the non-clinical reasons. *Enforcement*: Little departmental or institutional support to engage in fairer priority setting.
Halvorsen et al. 2008 Norway	To explore how limited resources influence nursing care and medical treatment in intensive care, and to explore whether intensive care unit clinicians use national prioritisation criteria in clinical deliberations.	Qualitative	n/a	21 physicians; 25 nurses	Observations; in-depth interviews	Thematic structuring; hermeneutical interpretation	Care rationing	Scarcity of resources regularly led to suboptimal professional standards of medical treatment and nursing care. The clinicians experienced a rising dilemma in that very ill patients with a low likelihood of survival were given advanced and expensive treatment. The clinicians rarely referred to national priority criteria as a rationale for bedside priorities.
Milton-Wildey & O'Brien 2010 Australia	To investigate the nursing care of older hospitalised patients and how the nurses providing care understood the clinical decision-making around this care	Qualitative, constructivist paradigm	Purposive	27 nurses	Observations; interviews; patient records	Thematic analysis (Lincoln & Guba)	Clinical decision-making	Three major themes: knowing about care; optionalising care; and blaming. Knowledgeable participants optionalised care by making decisions about which patients to care for and how much care should be provided. Participants rationalised these decisions through laying blame on the hospital organisation, needing social time with colleagues and preferring medically oriented

								technical interventions.
Langeland & Sørlie 2011 Norway	To illuminate nurses' experiences of being in ethically difficult situations in an emergency ward	Qualitative	Purposive	5 RNs	Interviews	Interpretative, phenomenological hermeneutical	Ethically challenging situations	The enormous difficulty associated with the prioritisation of tasks and the attendant sense of responsibility which this entailed, particularly in the case of nurses in charge. The narratives reveal the vulnerability of the nurses in ethically challenging situations
Tønnessen et al. 2011 Norway	To investigate nurses' decisions about priorities in home-based nursing care	Qualitative	Purposive	17 nurses	Interviews	Interpretative, hermeneutic	Care rationing; care prioritisation	Nurses describe clinical priorities in home-based care as rationing care to reduce the gap between an extensive workload and staff shortages. Legal norms set boundaries for clinical priority decisions, resulting in marginalised care. Hence, rationing care jeopardises important values in the nurse-patient relationship, in particular the value of individualised and inclusive nursing care.
Lillemoen & Pedersen 2012 Norway	This article presents the results from a study on ethical challenges and the need for ethics support, in which all types of employees working in various types of primary health-care services in a Norwegian municipality participated with their own opinions and experiences	Survey	Total by site	323 (49%) (health-care workers, nursing assistants, auxiliary nurses, care workers, laundry workers, doctors, kitchen staff, mercantile staff, nurses, physiotherapists, service managers, social educators, social workers, unit managers.)	Developed questionnaire, closed- and open-ended questions	Descriptive statistics; qualitative content analysis	Ethical challenges; ethical support	Ethical challenges seem to be prominent and common. The participants experienced ethical challenges related to scarce resources and lack of knowledge and skills, communication and decision-making.
Bentzen et al.	To examine how nurses experience ethical	Qualitative	Convenienc	20 nurses	Focus group	Content	Ethical values in	Two main themes: (1) values and reflection are important for the nurses; (2) time pressure

2013 Norway	values as they are expressed in daily practice in a Norwegian hospital		e		interviews	analysis	daily practice, prioritisation between patient groups	and nursing frustrations in daily work. The nurses reported the ethical values are often repressed in daily practice. This results in feeling of frustration, fatigue, and a guilty conscience for the nurses.
Papastavrou et al. 2014b Cyprus	To explore nurses' experiences and perceptions about prioritisations, omissions, and rationing of bedside nursing care.	Qualitative	n/a	23 nurses	Semi-structured focus group interviews	Inductive thematic analysis	Prioritisation; omission; and rationing of nursing care.	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.
Skirbekk & Nortvedt 2014	To study ethical considerations of care among health professionals when treating and setting priorities for elderly patients	Qualitative	n/a	21 health professionals (11 doctors, 10 nurses)	In-depth interviews; focus group interviews	Descriptive, explanatory, constant comparison	Priority setting	Both doctors and nurses treated elderly patients different from younger patients, and often they were given lower priorities. Too little or too much treatment. This was explained in terms of elderly patients not tolerating the same treatment as younger patients, and questions were raised about the quality of life of many elderly patients after treatment. Other explanations had little to do with medically sound decisions. These often included deep frustration with executive guideline and budget constraints.
Sundin et al. 2014 Sweden	To illuminate the meanings of RNs' lived experiences of priorities in surgery care	Phenomeno-logical-hermeneutic study	n/a	10 RNs	Narrative interviews	Interpretation, phenomenological-hermeneutic approach (Lindseth & Norberg)	Priorities	Three themes: making a conscious allocation and priorities of care, doing unreflected good, and being qualified to determine. The RNs did not comprehend their actions as prioritising, but as obvious. In situations of ethical difficulty, the RNs reflected upon their priority and actions.

Choe et al. 2015 South Korea	To explore and understand moral distress from the perspective of and as experienced by critical care nurses in Korea	Phenomeno-logical	Purposive	14 critical care nurses	In-depth interviews (twice with each participant)	Phenomenological methodology (Giorgi)	Moral distress	Five main themes of moral distress emerged: (1) ambivalence towards treatment and care (notably prioritising work tasks over human dignity, unnecessary medical treatments and the compulsory application of restraints); (2) suffering resulting from a lack of ethical sensitivity; (3) dilemmas resulting from nurses' limited autonomy in treatments; (4) conflicts with physicians; and (5) conflicts with institutional policy.
Rooddehghan et al. 2016 Iran	To explore aspects of rationing nursing care in Iran	Qualitative	Purposive	15 nurses	In-depth, unstructured, face-to-face interviews, open-ended questions.	Content analysis	Nursing care rationing	Rationing of nursing care consisted of two categories: causes of rationing and consequences of rationing. The first category comprised three subcategories, namely, patient needs and demands, routinism, and VIP patients. The three subcategories forming the second category were missed nursing care, patient dissatisfaction, and nurses' feeling of guilt.
Skirbekk et al. 2017 Norway	To explore how healthcare professionals prioritise their care; to compare different ways of setting priorities; to explore how moral dilemmas are balanced and reconciled.	Qualitative	n/a	48 healthcare professionals (nurses, doctors, psychologists, therapists)	Individual in-depth interviews; focus groups; observations	Analysis proceeding as 'bricolage', moving freely back and forth through the material.	Priority setting	A widening gap between the views of clinicians on one hand and managers on the other. Clinicians experienced a threat to their autonomy, to their professional ideals and to their desire to perform their job in a professional way. Prioritisations were a cause of constant concern and problematic decisions. The ideals of patient flow and keeping budgets balanced were perceived as more important

* Theoretical sampling: prior knowledge of the setting is used to focus on those documents, individuals, and observational settings that may provide information relevant to the emerging findings

Table 2 Description of the decision-makers, contexts, focus areas and ethical aspects of studies included in the review

Authors	Decision-maker	Context	Focus area	Ethical aspect
Millette 1994	Nurses	Not mentioned	Care rationing	Moral decision-making
Foster & McLella 1997	Nurses, social workers, physicians	Teaching hospital	Rationing care	Moral judgement
Meslin et al. 1997	Clinical managers	Hospital	Resource allocation	Ethical decision-making
Varekamp et al. 1998	Doctors, nurses	Transplantation care; Psychogeriatric nursing home care	Resource allocation; patient selection	Practice of waiting list, respect of urgency
Martin et al. 2003	Nurse manager, physicians, administrator and coordinator	Health care in general hospital (study involved following: ICU, critical care medicine, neurosurgery, internal medicine, emergency medicine, cardiology, administration, nursing)	Priority setting	To describe the process used to decide which patients are admitted to the intensive care unit and evaluate it using an ethical framework.
Mielke et al. 2003	Critical care unit staff members	Medical-surgical intensive care	Priority setting	Description of priority setting and its evaluation against an ethical framework
Myllykangas et al. 2003	Nurses, doctors, politicians, general public	Health care in general	Priority criteria	To investigate the acceptability of 14 prioritisation criteria from participants' perspectives
Rocker et al. 2003	Nurses, physicians, administrators	Intensive care	Priority setting; bed closure	Decision-making process and consequences
Cooper et al. 2005	Physicians, nurses, members of the administrative staff	Medical-surgical critical care	Priority setting; bed allocation	Role of communication when making priority setting decisions
Arnold et al. 2006	Chief nursing executive	Hospital	Strategic positioning;	To answer critical questions about the health system CNEs'

			leadership priorities	(chief nursing executives) roles and leadership priorities.
Cesi 2006	Case managers	Home care	Economic discourses affecting practice	Ethical dilemma between professionals and organisations/society.
Kapiriri & Martin 2006	Health planners, doctors, nurses	Teaching hospital	Priority setting	Description of priority setting and its evaluation against an ethical framework
Walton et al. 2006	Physicians, triage nurses	Heart surgery care	Priority setting	Description of priority setting and its evaluation against an ethical framework
Halvorsen et al. 2008	Nurses, physicians	Intensive care	Care rationing	to explore how limited resources influence nursing care and medical treatment in intensive care, and to explore whether intensive care unit clinicians use national prioritisation criteria in clinical deliberations
Milton-Wildey & O'Brien 2010	Nurses	Hospital	Hospitalised older people nursing care; clinical decision-making	to investigate the nursing care of older hospitalised patients and how the nurses providing care understood the clinical decision-making around this care
Langeland & Sørlie 2011	Nurses	Emergency care	Ethically challenging situations related to prioritisation of tasks	Nurses' experiences of being in ethically difficult situations
Tønnessen et al. 2011	Nurses	Home-based nursing care	Care rationing; care prioritisation	Nurses' decision-making
Lillemoen & Pedersen 2012	Health-care workers, different level nurses, doctors, physiotherapists, social workers, different managers	Primary healthcare	Ethical challenges, need for ethics support	Participants' opinions and experiences of ethical challenges and need for ethics support
Bentzen et al. 2013	Nurses	Somatic and psychiatric bed units in hospital	Ethical values in daily practice	Nurses' experiences how ethical values are expressed in their daily practice
Papastavrou et al. 2014b	Nurses	General public hospitals	Prioritisation; omission; and rationing of nursing	Participants' views and experiences of prioritisation, omission

			care.	and rationing of nursing care.
Skirbekk & Nortvedt 2014	Nurses, doctors	Emergency ward, three internal medicine wards, and three general practices	Priority setting	Setting priorities for elderly patients vs. younger patients
Sundin et al. 2014	Nurses	Surgery care	Priorities	Meanings of RNs' lived experiences of priorities in surgery care
Choe et al. 2015	Nurses	Critical care	Moral distress	Moral distress caused by prioritising work tasks over human dignity
Rooddehghan et al. 2016	Nurses	Hospital	Rationing of nursing care	Ethics of rationing nursing care
Skirbekk et al. 2017	Nurses, doctors, psychologists, therapists	Somatic medical and mental health wards in hospital	Priority setting	Moral issues

Focus areas in priority setting

Around half of the studies focused on priority setting (n=13), followed by rationing of care (n=4), resource allocation (n=3) and ethical questions (n=5). The ethical issues were moral distress as a consequence of priority setting, ethically challenging situations, clinical decision making including priority setting and strategic level priority setting. (Table 2.)

Ethical aspects present in priority setting in nursing

Nurses and other healthcare professionals either made prioritisation decisions or participated in this activity at several levels, including at the bedside, at unit level, organisational level and at societal level (Table 2).

Ethical elements in **priority setting at the bedside** included identifying the reasons for and basic values driving priority setting at the bedside: 1) patients' care needs on a daily basis, 2) nurses' prioritisation of their nursing work by tasks, and 3) participating in priority setting in patients' access to care.

Firstly, prioritising was understood as some form of ranking to share available resources on the basis of individual patient needs (Sundin et al. 2014), especially according to the urgency of the need (Papastavrou et al. 2014b; Sundin et al. 2014; Varekamp et al. 1998). Priority setting has been performed as a means of rationing care, to serve as many as possible (Tonnessen et al. 2011). However, nurses reported lack of time with the reality of individualised nursing care limited by, for example predefined task-based administrative decisions in home care nursing, driven by the purchaser-provider model (Tonnessen et al. 2011). Conflict concerning nurses' ability to provide individualised care based on an inclusive approach or not because of prioritisation, has implications for the nurses' role and responsibility in clinical practice (Tonnessen et al. 2011). Nurses reported being ethically challenged by the prioritisation of administrative tasks over those that preserve human dignity (Choe et al. 2015). For example, nurses felt forced to document post-death procedures contemporaneously, in the case of a patient designated as 'do not resuscitate' instead of spending the time with the dying patient. In this instance indirect patient care duties conflicted with the perceived need for direct patient care. Furthermore, nurses reported ethical challenges in prioritising interventions vitally important to life or and health of others and experienced an inner conflict in terms of their own expectations

and aspirations of being a good nurse (Langeland and Sorlie 2011, p. 2067). Nurses also described having difficulties in prioritising patients' needs in an emergency care situation, where many patients are seriously ill, requiring many nurses to complete some practical tasks simultaneously.

Secondly, nurses prioritise their work in order to ensure that essential tasks, such as responding to the patients' most vital medical needs, medication, helping in doctors' rounds are completed first (Papastavrou et al. 2014). Studies suggest that these decisions are seldom made transparently (e.g. Sundin et al. 2014). Some nurses aimed at conscious, explicit prioritisation, but felt abandoned in their quest for ethical care (Sundin et al. 2014). For professional nurses especially, care rationing becomes a challenging ethical issue when potential conflicts exist between personal and professional values (Rooddehghan et al. 2016). These situations require nurses to make "informed choices based on logical principles and fair methods" (p. 2). Rooddehghan et al. (2016) pointed out that causes of rationing lead to ethically difficult situations for nurses especially for charge nurses (Langeland and Sorlie 2011) as decision-makers. Types of rationing discussed included patients' demands for care in addition to their assessed care needs, in-direct daily tasks and additional care requirements of some patients who are given VIP (very important persons; a person who, due to their status or importance, is accorded special privileges) status (see Alfandre et al. 2016).

Caring and a justice orientation were strongly present in nurses' narratives of moral decision-making concerned with care rationing (Millette 1994). Ethical conflicts often appeared between the differing views of professionals, including nurses, working at the bedside and executive managers (Skirbekk et al. 2014). In this situation, professionals reported that the conflicts in priority setting were a threat to professional autonomy and their ideals and desire to perform their care in a professional way. Dilemmas regarding moral decision-making and the inability to handle ethical conflicts have been found to have an adverse effect on nurses' retention at work. Nurses working in organisations with a justice orientation are more likely to remain in their positions (Millette 1994).

Thirdly, studies reported that the need for daily priority setting of work had implications for patients' access to care. For example, patients' access to surgical procedures (e.g. the cardiac surgery) operative waiting list was managed by physicians and nurses. Decisions about the

prioritisation on the cardiac surgery waiting list were based on medical, clinical and non-clinical criteria (Walton et al. 2006). Some decisions, especially those based on non-medical factors, such as patient characteristics or controversial patient-related reasons, the type of surgical practice and departmental constraints on resource use, contain personal value judgements which influence decision-making and result in unfair or inconsistent decisions on patient care (Walton et al. 2006).

Unit level priority setting in the reviewed papers focused on processes and decisions about bed allocation (admission priorities) in intensive care units (Cooper et al. 2005; Martin et al. 2003; Mielke et al. 2003), and considerations about fairness. Decisions about admissions were made in complex communications between multiple participants (Cooper et al. 2005), with admission decisions usually being explained to referring staff, but seldom to patients and families (Mielke et al. 2003). Both medical and non-medical (for example, family reasons criteria were used to justify these decisions (Martin et al. 2003; Mielke et al. 2003), although non-medical reasons seldom surfaced (Mielke et al. 2003) making the decision opaque to some. However, bed allocation was mostly done according to the patient needs (Martin et al. 2003).

Varekamp et al. (1998) revealed that when priority setting, the criteria for assessing urgency differed between units. For example, the criteria for decisions about urgency in renal transplantation units were either medical or psychosocial, and were patient-centred. The criteria for similar decisions in a psychogeriatric nursing home placement, were psychosocial were not patient-centred, but rather focused on the chance of over-burdening the informal caregivers such as family members. One study (Varekamp et al. 1998) suggested that waiting a long time for access to care involved moral considerations which challenge distributive justice. However, this is likely more accurately expressed as such lengthy waits for access to care involves moral considerations which challenges distributive justice with vertical equity, which requires equal treatment of patients with equal need and thus implies unequal treatment of patients – as they are treated on the basis of need and needs are not equal. Another unit level priority setting issue was bed closure due to lack of resources, for example, lack of nurses during holidays, even though the demands for care still existed. Discussions of fairness and legitimacy of bed closure included bed closure rationale, organisational processes and estimation of future consequences, including safety and morale (Rocker et al. 2003).

Organisation level priority setting, in which nurses also participated, was described in some studies. These studies revealed ethical issues that nurses, especially those in leadership roles, encounter. Particularly challenging was the evaluation of the normative priority setting in hospital. At an organisational level, priority was usually given based on need, emergencies and patient volume (Kapiriri and Martin 2006). However, frontline practitioners believed that they were not involved in the priority setting process of the hospital, and they frequently disagreed with the decisions (Kapiriri and Martin 2006), which they felt reflected a lack of fairness. Kapiriri and Martin (2006) argued that decisions are communicated to bed-side health professionals, but not the reasons for the decisions, especially in the case where these decisions impacted on their daily work.

Ethical issues were also encountered in resource allocation by clinician-managers. Decisions about resource allocation can be categorised as follows: decisions about patient groups accessing treatment; reduced length-of-stay; the use of substitute staff with less-training; limiting the use of resources for the terminally ill; admitting elective patients over other groups of patients; limiting access for resource-intensive patients; using standardised treatment protocols for the patients where it is perceived they have similar health issues; closing beds; limiting access for patients who may not benefit as much as other patients; and limiting expensive treatments (Meslin et al. 1997). It was noted that nurses in clinical manager roles wanted to achieve resolutions to these issues that were ethically justified (Meslin et al. 1997).

Priority setting at **societal level**, which included nurses' points of view, was also found in the literature reviewed. One study (Myllykangas et al. 2003) concerned the prioritisation criteria, from different stakeholders' (nurses, doctors, politicians, general public) perceptions regarding the importance of treatment for differing patient groups being subsidised by the community. All stakeholders favoured poor people and children if the treatment is expensive, if the disease is severe, and if the prognosis is poor. With the exception of doctors, all others also prioritised elderly people (Myllykangas et al. 2003). Treatment for a rich or institutionalised patient, those having diseases of a self-induced nature or mild disease and negligent behaviour were given a lower priority.

Priorities in practice by nurses

Studies revealed priorities set by nurses include prioritisation between 1) patient groups, 2) patients having specific diseases, 3) severity of the patient's situation, 4) age, and 5) the perceived good that treatment and care might bring for patients in different clinical settings.

In acute care settings, there was prioritisation of different patient groups. For example, surgical patients were prioritised over patients with chronic illnesses such as cancer or patients needing long-term wound care (Bentzen et al. 2013; Skirbekk and Nortvedt 2014). Similarly, patients with acute diseases were prioritised over elderly patients (Skirbekk et al. 2014). Patients' vital signs, severity of illness and high-risk patients were also prioritised (Rooddehghan et al. 2016). There were also some indications that demanding patients were also prioritised and patients designated VIPs were reported to be perceived as more important than others (Rooddehghan et al. 2016). Severity and acuteness of the disease/ illness were seen as the most important criteria for setting priorities by both doctors and nurses (Skirbekk and Nortvedt 2014). Patients with the most urgent medical needs had initial priority regardless of the expected effect of the treatment which sometimes compromised basic care (Halvorsen et al. 2008).

Discussion regarding discrimination also appeared in the literature reviewed. Skirbekk and Nortved (2014) reported a qualitative interview study of nurses and physicians about ethical considerations of care among health professionals when treating and setting priorities for elderly patients highlighting issues of age and ageism in care delivery. In these interviews age, ageism and elderly patients were frequently mentioned by the interviewees. Even if this was not declared, the actions of nurses towards these patients showed clear discrimination (Skirbekk and Nortvedt 2014). They found that elderly patients, who could not hope for a cure by medical treatment, were also frequently given low priority for basic nursing care. In another study, participants suggested that too much may be done for the oldest and sickest, as they are sometimes given aggressive medical treatment (Halvorsen et al. 2008). In addition, costs of treatment are also reasons for prioritisations. Halvorsen et al. (2008) highlighted the dilemma that very ill patients with a low likelihood of survival were given advanced and expensive treatment – so called futile treatment.

Moreover, priority setting was seen in nurses' work tasks. Nurses are known to prioritise routine tasks, such as documentation and checking the equipment over patients' needs, if patients were

not at risk (Rooddehghan et al. 2016). In addition, prioritisation of care was done according to the perceived patients' medical requirements (Papastavrou et al. 2014b), not necessarily based on nursing care requirements. It was also found that the time which could be made available to take care of older patients' holistic needs was substituted for time for social interaction with colleagues (Milton-Wildey and O'Brien 2010).

Factors associated with priority setting in nursing

From the scoping review, an emerging theme was the consequences of priority setting for nurses and patients. Nurses who were required to set priorities reported moral distress (Choi et al. 2015) and described ethical challenges in meeting patients' primary needs (Lillemoen and Pedersen 2012). Nurses reported feelings of inadequacy (Sundin et al. 2014), frustration and powerlessness (Cesi 2006) as a consequence of priority setting. Reduced time allocations were also reported by nurses resulting in feelings of guilt, due to a lack of time to provide emotional care for patients (Bentzen et al. 2013; Rooddehghan et al. 2016). Nurses also reported ambivalence in prioritising nursing tasks over preserving human dignity (Choe et al. 2015), in their attempts to balance indirect with direct patient care. Nurses tried to justify these difficult situations which resulted in having to set priorities, making decisions about which patients to care for and how much care should be provided (Milton-Wildey and O'Brien 2010). Nurses blamed the healthcare organisation where they worked as they optionalised care, requirement for social time with colleagues and preference for medically orientated technical interventions (Milton-Wildey and O'Brien, 2010).

The consequences of prioritisation for patients were dissatisfaction (Papastvarou et al. 2014; Rooddehghan et al. 2016), missed care (Rooddehghan et al. 2016), loss of confidence or trust in nurses (Papastvarou et al. 2014) and/or reduced nursing care quality (Halvorsen et al. 2008). (Table 3.)

Table 3. Consequences of the prioritisation of nursing care

For patients	**Author**
Missed nursing care	Rooddehghan et al. 2016
Dissatisfaction	Rooddehghan et al. 2016; Papastvarou et al. 2014

Lost confidence/trust in nursing staff	Papastvarou et al. 2014
Nursing care of reduced quality: • Premature discharge and delayed admission in ICU • Threshold of monitoring patients in ICU • Forgoing life-prolonging treatment • Impaired communication with patients and relatives • Suboptimal standards of basic care • Dignified end-of-life care	Halvorsen et al. 2008
Superficial nursing care	Bentzen et al. 2013
Violation of human dignity	Choe et al. 2015
For staff	
Moral distress	Choe et al. 2015
Ethical challenges in meeting patients' primary needs	Lillemoen & Pedersen 2012
Feeling of guilt, guilty conscience	Rooddehghan et al. 2016; Bentzen et al. 2013
Prioritising nursing tasks over human dignity	Choe et al. 2015
Feelings of inadequacy	Sundin et al. 2014
Frustration and powerlessness	Cesi 2006
For the healthcare organisation	
Preferring medically oriented technical interventions	Milton-Wildey and O'Brien 2010

Some studies revealed organisational issues in relation to priority setting. Nurse executives were required to use the principles of distributive justice to guide priority setting and decision-making. Strategies for prioritisation were identified as follows: financial performance; clinical integration of nursing care; quality; patient safety and compliance; nursing practice; and professionalism (Arnold et al. 2006). The highest priorities for chief nursing executives focused on quality, nursing resource management, patient care delivery models, nursing leadership development, and professional practice (Arnold et al. 2006). Nurses felt that organisational systems and financial limitations were the main reasons for the need for priority setting, and that ethical values are not considered much when setting priorities (Bentzen et al. 2013). Budget constraints

were considered to be an increasingly influential element in determining responses to difficult client situations (Cesi 2006). Case managers identified gaps between professionally important priorities and organisational priorities, creating a dissonance for case managers as the political-ethical dimensions of the practice were displaced by budget issues (Cesi 2006)

DISCUSSION

Although a limited amount of literature was found about the topic of priority setting in nursing care, the priority setting performed by nurses was found across the levels of care and care giving. These levels were: at the bedside, on the ward/unit, within organisational policy and in society itself, confirming earlier theoretical literature that priority setting in health care transcends all levels of health care authority (Norheim 2003). Bedside priority setting, the main concern of nurses, focused on patients' basic daily care needs. Nurses' work by prioritising essential tasks, as well as participating in priority setting for patients' access to care. Studies included in the review focused on nurses as decision-makers and as contributors to health care prioritisation.

It was found, however, that nurses attempt to prioritise nursing care, based on a desire to satisfy all the needs of their patients, in a holistic and comprehensive manner. However, when resources are low and with environmental constraints, nurses face difficulties in fulfilling their professional ethical roles whilst simultaneously balancing the needs of individual patients with the demands of their organisation. In this context they may feel that the provision of holistic and individualised nursing care to all patients is not a realistic goal, and thus may develop different standards of care by using their clinical judgment to prioritise patients' needs and nurses' interventions. This judgment is mostly influenced by the urgency of the patients' clinical condition, the satisfaction of the biomedical needs of their patients and working towards achieving, first the visible clinical tasks, and later the non-visible elements of nursing care that deal with the relational, social and emotional needs of the patients (Halvorsen et al. 2008; Slettebø et al. 2010; Tønnessen et al. 2009, 2011). The findings of this review underscore the strategic need for ethics courses at all levels of nursing education to identify and articulate the ethical values and principles that may/should underpin their prioritisation-as-rationing-of-nursing care decisions. In addition, in the interdisciplinary setting and also at a societal level, priority setting in nursing has the potential to shape the perception of nurses' work in traditional,

stereotypical ways. When medical tasks have to be done first, caring might be seen as dispensable add-on, and curing is seen as main focus in health care.

Nevertheless, some conflicting choices and the consequent decisions regarding prioritisation of nursing care may be extremely difficult for nurses, because they have the potential to jeopardise professional and ethical values and undermine nurses' philosophy of care (Schubert et al. 2009; Hendry and Walker 2004). Thus, when nurses are prioritising care they may also compromise the patients' right to health care, which conflicts with personal and professional values (Carse 2013). This challenges nurses' ethical and moral value systems, ultimately resulting in role conflict, guilt, ethical dilemmas, moral strain and moral distress (Andela et al. 2017).

Prioritisation in daily nursing care and work appeared in a number of contexts: between patient groups; among patients having specific diseases, depending on the severity of the patient's situation; age; and the perceived benefit of treatment for patients in different clinical settings. Most importantly, the review revealed prioritisation based on age namely ageism or discrimination by age, jeopardising nurses' ethical and professional values (Skirbekk and Nortvedt 2014). This discrimination may be enshrined in law and policy statements in some countries limiting the provision of treatments to people over a certain age (São José et al. 2017).

In cases where nurses' views of the older adult or those prescribed perceived futile treatment were negative, nurses experience emotional dissonance (Andela et al. 2017; Glasberg et al 2007). This dissonance may lead to compassion fatigue where nurses can no longer deal with the stress of work intensification and the consistent emotional demands of patients. Consequently, the results of this review sheds light on nurses' difficulties with and understanding of, prioritisation and rationing of nursing care by identifying when, how and why they are making implicit or explicit decisions to ration care (see Caplan 1992). Most importantly, this review has revealed that nurses and patients are affected by prioritising care. These effects include: the experience of moral distress (Choe et al. 2015); the care being missed - which impacts on both patient outcomes and nursing professional practice (Judd et al. 2017; Rooddehghan et al. 2016); and the quality of care being compromised, which in some cases also leads to long term morbidity (Bail and Grealish 2016; Halvorsen et al. 2008). Given the possible severe consequences there is need for studies to assess the prioritisation activities, processes and decision-making of nurses to

understand the phenomenon and hidden ethical elements in it. Therefore, valid and reliable instruments are also needed.

Due to a dearth of empirical literature exploring priority setting in nursing from an ethical perspective, there is need for further studies focused on priority setting, its consequences and the related ethical dimensions, such as the violation of patients' rights. Priority setting by nurse managers in organisations has the potential to create ethical conflicts along two dimensions. These dimensions are the ethical problems evolving from priority setting *per se* for example, setting norms and justifying them, and in questions of sound professional and ethical leadership when nurses at the bedside who have to implement the decisions, are not involved in the decision-making process.

Skirbekk and Nortvedt (2014) concluded that if patients' concrete and individual needs for humane care are not considered part of health professionals' ethos of treatment, they might be overlooked. This is significant when discussing the role of caring principles in the healthcare settings. Serious consideration needs to be given to the possible undermining of nursing care, when shaped by rationing or prioritisation, rather than by a model of individualised, holistic care based on a comprehensive nursing assessment (e.g. International Council of Nursing 2012; IOM 2001).

Strengths and limitations

Some limitations need to be taken into account. Although identification of the literature was managed using electronic data bases and established search processes, relevant studies in the area of ethics and priority setting in nursing care may have been missed. Although 'priority setting' and 'prioritisation' were the main terms used, rationing and decision-making were included to widen the literature search. Rationing can be considered as a special type of priority setting in the case of limited resources and having consequences for patients. Based on dictionary definitions 'priority setting' and 'prioritisation' includes the action of decision-making. Thus, the inclusion of decision-making to the search criteria was necessary. Only English language publications and the two most common databases (Subirana et al. 2005) were included. Additional databases may have produced more literature.

In the review retrieval process, two independent reviewers selected the abstracts and full texts to be included, supporting the validity of the inclusion of the material. A five-stage review protocol was followed, without the optional consultation phase (Arksey and O'Malley 2005) as the use of the whole author group in screening the material for inclusion can be considered a consultation. Tricco and colleagues (2016) suggested the use of an iterative team approach for both the study selection and data extraction. In this review data extraction was done by three researchers. Also, the review was done by part of an international network of researchers in the area of nursing ethics. Quality evaluation of the articles using checklists was not included for this scoping review. No consensus exists yet whether or not to include a quality analysis of the studies while using the scoping review method (Tricco et al. 2016).

A total of 50 full texts were deleted from the review as they did not focus on ethical aspects or elements in priority setting and prioritisation. This may mean that the nurse respondents in the studies were ethically aware or that they were "ethically blind". Ethical elements and aspects are the most problematic when they are hidden (Papastavrou et al. 2014). Although ethical awareness may lead to ethical conflict (Pavlish et al. 2011) the situation becomes worse if ethics are not recognised as every nursing activity includes an ethical dimension (Levine 1977). Levine stated that

> " … [ethical behavior is the] day-to-day expression of one's commitment to other persons and the ways in which human beings relate to one another in their daily interactions." (Levine 1977, p.845).

The aim of our scoping review was to identify those articles with the clear focus on these ethical issues. However, many studies were deleted because the ethical aspects were not studied. This reduced the number of ethical studies available and highlighted that further studies should focus on analysing the priority setting and its processes by nurses with ethical awareness.

This scoping review identified the breath and scope of the existing research, and research questions for more robust reviews (Tricco et al. 2016). In the future, analysis of the ethical elements, and consequences, of priority setting needs to be studied further to reveal the underlying drivers of priority setting for nursing staff. As prioritising has been reported to be difficult for nurses (e.g. Langeland and Sorlie 2011; Milton-Wildey and O'Brien 2010) any

methods and activities used to help nurses become more ethically aware in priority setting need to be explored further.

Conclusions

This review examined priority setting in nursing care; its aim to explore and illustrate the key aspects that relate to the ethical elements of priority setting in care undertaken by nurses. The review revealed that nurses are involved in the prioritisation of care at all levels of the healthcare system, from deciding on who is allocated care, what resources are provided to care to how this care is given. Work intensification has occurred which is associated with an increase in the care needed without the necessary increase of resources, human, material and time. Importantly, this intensification has led to situations where the care that nurses are employed to give is consistently the focus of a type of prioritisation where nurses may be (and at least on occasion are) forced to make decisions about what care to give, and what care to leave out. Thus, work intensification leads to emotional fatigue and emotional dissonance where nurses are literally too emotionally and physically tired.

Although priority setting itself is already an ethical issue, the consequences of priority setting produce many dilemmas with ethical features. Priority setting in nursing is an important issue as it has an impact on the development of the nursing profession, quality of care and on patient outcomes. Additionally, working in conditions that contribute to nurses feelings of guilt, inadequacy, frustration and powerlessness is likely to contribute to burnout, sickness poor nurse retention and nursing shortage. Whilst the need to contain the ever-increasing costs of health care is acknowledged, the nursing service, which is central to any health care organisation, could be the biggest casualty in the quest for economic efficiencies. Now more than ever before, research is needed to see exactly what impact prioritisation is having on care delivery. Whilst the economic fallout of care *not* provided is not a focus of attention, the fact that care delivery is being compromised in the face of not only a tired nursing workforce, but an ageing one too (Kagan and Melendez-Torres 2015), suggests that research is not only essential, but urgent. The research required is an analysis of the ethical elements, causes, concerns and consequences of priority setting to reveal the underlying causes of priority setting for nursing staff. Additionally, since prioritising care has been reported to be difficult for nurses, there is a need to study the

elements and processes involved in a way that will determine what type of education and support nurses require to assist them in priority setting.

References

* Articles included in the review

Alfandre, D., Clever, S., Farber, N.J., et al. 2016. Caring for 'Very Important Patients'--Ethical Dilemmas and Suggestions for Practical Management. Am J Med. 129, 143–147.

Andela, M., Truchot, D., 2017. Emotional Dissonance and Burnout: The Moderating Role of Team Reflexivity and Re- Evaluation. Stress Health. 33, 179–189.

Arksey, H., O'Malley, L., 2005. Scoping studies: towards a methodological framework. Int. J. Soc. Res. Methodol. 8, 19–32.

*Arnold, L., Drenkard, K., Ela, S., et al., 2006. Strategic positioning for nursing excellence in health systems: insights from chief nursing executives. Nurs. Administ. Quarter. 30, 11–20.

Bail, K., Grealish, L., 2016. 'Failure to Maintain': A theoretical proposition for a new quality indicator of nurse care rationing for complex older people in hospital. Int. J. Nurs. Stud. 63, 146–161.

Batifoulier, P., Braddock, L., Latsis, J., 2013. Priority setting in health care: from arbitrariness to societal values. J. Inst. Econ. 9, 61–80.

*Bentzen, G., Harsvik, A., Brinchmann, B.S., 2013. "Values that vanish into thin air": nurses' experience of ethical values in their daily work. Nurs. Res. Pract. 2013: 939153. doi: 10.1155/2013/939153.

Borges, W., Clarke, H. D., Stewart, M. C., et al., 2013. The emerging political economy of austerity in Britain. Elector. Stud. 32, 396-403.

Brody, H., 2012. From an ethics of rationing to an ethics of waste avoidance. N. Engl. J. Med. 355, 1949–1950.

Caplan, A.L., 1992. If I were a rich man could I buy a pancreas? And other essays in the ethics of health care. Indiana University Press, Indiana.

Carper, B., 1978. Fundamental patterns of knowing in nursing. ANS Adv Nurs Sci. 1, 13–23.

Carse, A., 2013. Moral Distress and Moral Disempowerment. Narrat. Inq. Bioeth. 3, 147–151.

*Ceci, C., 2006. Impoverishment of practice: analysis of effects of economic discourses in home care case management practice. Nurs. Leadersh. 19, 56–68.

*Choe, K., Kang, Y., Park, Y., 2015. Moral distress in critical care nurses: a phenomenological study. J. Adv. Nurs. 71, 1684–1693.

Collins Cobuild Advanced Learner's English Dictionary, 2004. Harper Collins Publishers, William Clowes Ltd, Beccles.

*Cooper, A.B., Joglekar, A.S., Gibson, J., 2005. Communication of bed allocation decisions in a critical care unit and accountability for reasonableness. BMC Health Serv. Res. 2005 5:67. doi: 10.1186/1472-6963-5-6.

Committee on Publication Ethics, 2018. Promoting integrity in research and its publication. https://publicationethics.org/ (accessed 3 July 2018)

*Foster, L.W., McLellan, L.J., 1997. Moral judgments in the rationing of health care resources: a comparative study of clinical health professionals. Soc. Work Health Care. 25(4),13–36.

Francis R., 2013. The Mid Staffordshire NHS Foundation Trust Public Inquiry. Retrieved from: http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/report (Accessed 12 February 2018)

Fry, S., Johnstone, M-J., 2008. Ethics in nursing practice – A guide to ethical decision-making. 3rd edition. Wiley-Blackwell Publishing.

Glasberg, A. L., Eriksson, S., Norberg, A., 2007. Burnout and 'stress of conscience' among healthcare personnel. J. Adv. Nurs. 57, 392–403.

Halvorsen, K.,2009. The Ethics of bedside priorities in intensive care- value choices and considerations. PhD thesis at the University of Oslo, Faculty of Medicine, 2009. https://www.duo.uio.no/handle/10852/59086 (Accessed 12 February 2018)

*Halvorsen, K., Førde, R., Nortvedt, P., 2008. Professional challenges of bedside rationing in intensive care. Nurs. Ethics. 15, 715–728.

Harrison, S., Hunter, D. J., 1994. Rationing health care. Institute for Public Policy Research, London.

Hart, S.E., 2005. Hospital ethical climates and registered nurses' turnover intentions. J Nurs Scholars. 37, 173–177.

Harvey, C., Willis, E., Henderson, J., et al., 2016. Priced to care: Factors underpinning missed care. J. Indust. Relat. 58, 510–526.

Hendry, C., Walker, A., 2004. Priority setting in clinical nursing practice: literature review. J. Adv. Nurs. 47, 427–436.

Hofmann, B., 2013. Priority setting in health care: trends and models from Scandinavian experiences. Med. Health Care Philos. 16, 349–356.

Ifanti, A., Argyriou, A., Kalofonou, F., et al., 2013. Financial crisis and austerity measures in Greece: Their impact on health promotion policies and public health care. Health Pol. 113, 8–12.

International Council of Nurses, 2012. The ICN code of ethics for nurses. International Council of Nurses, Geneva; Switzerland.

IOM, Institute of Medicine. 2001. Crossing The Quality Chasm: A New Health System for the 21st Century. National Academy Press, Washington DC.

Jones, T. L., 2015. A Descriptive Analysis of Implicit Rationing of Nursing Care: Frequency and Patterns in Texas. Nurs. Econom. 33, 144–154.

Judd, M. J., Dorozenko, K. P., Breen, L. J., 2017. Workplace stress, burnout and coping: a qualitative study of the experiences of Australian disability support workers. Health Soc. Care Commun. 25, 1109–1117.

Kagan, S.H., Melendez-Torres, G.J., 2015. Ageism in nursing. J Nurs Manag. 23, 644–650.

Kalisch, B., Doumit, M., Lee, K., et al., 2013. Missed nursing care, levels of staffing, and job satisfaction: Lebanon versus the United States. J. Nurs. Adm. 43, 1509–1517.

*Kapiriri, L., Martin, D.K., 2006. Priority setting in developing countries health care institutions: the case of a Ugandan hospital. BMC Health Serv. Res. 2006 6:127. https://doi.org/10.1186/1472-6963-6-127

*Langeland, K., Sørlie, V., 2011. Ethical challenges in nursing emergency practice. J. Clin. Nurs. 20, 2064–2070.

Levine, M. 1977. Nursing ethics and ethical nurse. Am J Nurs. 77, 845–849.

*Lillemoen, L., Pedersen, R., 2013. Ethical challenges and how to develop ethics support in primary health care. Nurs. Ethics. 20, 96–108.

*Martin, D.K., Singer, P.A., Bernstein, M., 2003. Access to intensive care unit beds for neurosurgery patients: a qualitative case study. J. Neurol. Neurosurg. Psychiatry. 74, 1299–1303.

*Meslin, E.M., Lemieux-Charles, L., Wortley, J.T., 1997. An ethics framework for assisting clinician-managers in resource allocation decision making. Hosp. Health Serv. Adm. 42, 33–48.

*Mielke, J., Martin, D.K., Singer, P.A., 2003. Priority setting in a hospital critical care unit: qualitative case study. Crit. Care Med. 31, 2764–2768.

*Millette, B.E., 1994. Using Gilligan's framework to analyze nurses' stories of moral choices. West. J. Nurs. Res. 16, 660–674.

*Milton-Wildey, K., O'Brien, L., 2010. Care of acutely ill older patients in hospital: clinical decision-making. J. Clin. Nurs. 19, 1252–1260.

Mitchell, P.H., 2008. Defining Patient Safety and Quality Care, in Hughes, R.G., (Ed) Patient Safety and Quality: An Evidence-Based Handbook for Nurses. The Agency for Healthcare Research and Quality (AHRQ) and the Robert Wood Johnson, pp. 1-5.

*Myllykangas, M., Ryynänen, O.P., Lammintakanen, J. et al., 2003. Clinical management and prioritization criteria. Finnish experiences. J. Health Org. Manage. 17, 338–348.

Norheim, O.F. 2003. Norway. Reasonable Rationing: International Experience of Priority Setting in Health Care, in Ham, C., Robert, G. (eds). Open University Press, Philadelphia.

Nortvedt, P., Pedersen, R., Grøthe, K., et al., 2008. Clinical prioritisations of health care for the aged - Professional roles. J. Med. Ethics. 34, 332–335.

NOU, 1997. Norges Offentlige Utredninger 18/1997. https://www.regjeringen.no/no/dokumenter/nou-1997-18/id140956/?q=NOU%201997:%2018 (Accessed 12 February 2018)

Papastavrou, E., Andreou, P., Efstathiou, G., 2014a. Rationing of nursing care and nurse–patient outcomes: a systematic review of quantitative studies. Int. J. Health Plan. Manage. 29, 3–25.

*Papastavrou, E., Andreou, P., Vryonides, S., 2014b. The hidden ethical element of nursing care rationing. Nurs. Ethics. 21, 583–593.

Pavlish, C., Brown-Saltzman, K., Hersh, M. et al., 2011. Nursing priorities, actions, and regrets for ethical situations in clinical practice. J Nurs Scholarsh. 43, 385–395.

Pedersen, R., Nortvedt, P., Nordhaug, M., et al., 2008. 'In quest of justice? Clinical prioritisation in healthcare for the aged.', J. Med. Ethics. 34, 230–235.

*Rocker, G.M., Cook, D.J., Martin, D.K., et al., 2003. Seasonal bed closures in an intensive care unit: a qualitative study. J. Crit. Care. 18, 25–30.

*Rooddehghan, Z., Yekta, Z.P., Nasrabadi, A.N., 2016. Ethics of rationing of nursing care. Nurs. Ethics. 2016 doi: 10.1177/0969733016664973. [Epub ahead of print]

São José, J.M.S., Amado, C.A.F., Ilinca, S., et al. 2017. Ageism in Health Care: A Systematic Review of Operational Definitions and Inductive Conceptualizations. Gerontologist. 2017 May 16. doi: 10.1093/geront/gnx020

Schubert, M., Glass, T. R., Clarke, S. P., et al., 2008. Rationing of nursing care and its relationship to patient outcomes: the Swiss extension of the International Hospital Outcomes Study. Int. J. Qual. Health. Care. 20, 227–237.

Schubert, M., Clarke, S.P., Glass, T.R., et al., 2009. '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. 46, 884–893.

Scott, P.A.**,** Kirwan, M., Matthews, A., et al., 2013. Report of the Irish RN4CAST Study 2009-2011: A nursing workforce under strain. Dublin City University, Dublin,

http://doras.dcu.ie/19344/1/RN4CAST_FINAL_report_18_April_2013_DORAS.pdf (2013, Accessed 5 June 2017).

*Skirbekk, H., Hem, M.H., Nortvedt, P., 2017. Prioritising patient care. Nurs. Ethics. 2017 doi:10.1177/0969733016664977. [Epub ahead of print]

*Skirbekk, H., Nortvedt, P., 2014. Inadequate treatment for elderly patients: professional norms and tight budgets could cause "ageism" in hospitals. Health Care Anal. 22, 192–201.

Slettebø, A., Kirkevold, M., Andersen, B., et al., 2010. 'Clinical prioritizations and contextual constraints in nursing homes-a qualitative study. Scand. J. Caring. Sci. 24, 533–540.

Subirana, M., Solá, I., Garcia, J.M., et al., 2005. A nursing qualitative systematic review required MEDLINE and CINAHL for study identification. J. Clin. Epidemiol. 58, 20–25.

*Sundin, K., Fahlen, U., Lundgren, M., et al., 2014. Registered nurses' experiences of priorities in surgery care. Clin. Nurs. Res. 23, 153–170.

Tønnessen, S., 2011. The Challenge To Provide Sound Services and Diligent Care a qualitative study of nurses prioritization and patients experiences of the home nursing service, doctoral thesis, Oslo, Unipub.

Tønnessen, S, 2014. Priorities in home health care – suggestions of some criterias for priorities in nursing care. [Prioriteringer i hjemmesykepleien – mot prioriteringskriterier i pleie- og omsorgstjenestene?] In Kassah, Tingvoll og Kassah (ed.): The Coordination reform; quality, organization and power in community care [*Samhandlingsreformen under lupen. Kvalitet, organisering og makt i helse- og omsorgstjenestene]*. Oslo: Fagbokforlag.

Tønnessen, S., 2016. Priorities in nursing care [Prioriteringer i sykepleie]. In Brinchmann, B. (ed..): Nursing ethics [*Etikk i sykepleien]*. Gyldendal Forlag, Oslo.

Tønnessen, S., Førde, R., Nortvedt, P., 2009. 'Fair nursing care when resources are limited: the role of patients and family members in Norwegian home-based services.' Policy. Poli. Nurs. Pract. 10, 276–284.

*Tønnessen, S., Nortvedt, P., Førde, R., 2011. Rationing home-based nursing care: professional ethical implications. Nurs. Ethics. 18, 386–396.

Tricco, A.C., Lillie, E., Zarin, W., 2016. A scoping review on the conduct and reporting of scoping reviews. BMC Med Res Methodol. 16:15. doi: 10.1186/s12874-016-0116-4.

*Varekamp, I., Meiland, F.J., Hoos, A.M., et al., 1998. Wendte JF, de Haes JC & Krol LJ. The meaning of urgency in the allocation of scarce health care resources; a comparison between renal transplantation and psychogeriatric nursing home care. Health Policy. 44, 135–148.

Vike, H., 2017. Politics and bureaucracy in the Norwegian welfare state. Palgrave MacMillian.

Vryonides, S., Papastavrou, E., Charalambous, A., et al., 2015. 'The ethical dimension of nursing care rationing: A thematic synthesis of qualitative studies.' Nurs. Ethics. 22, 881–900.

*Walton, N.A., Martin, D.K., Peter, E.H., et al., 2007. Priority setting and cardiac surgery: a qualitative case study. Health Policy. 80, 444–458.

WHO, 2006. Quality of care. A process for making strategic choices in health systems. Publications of the World Health Organisation, France. www.who.int/management/quality/assurance/QualityCare_B.Def.pdf (Accessed 12 February 2018)

Willis, E., Henderson, J., Hamilton, P., et al., 2015. Work intensification as missed care. Labour. Indust. J. Soc. Econ. Relat. Work. 25, 118–133.

Willis, E., Toffoli, L., Henderson, J., et al., 2016. Rounding, work intensification and new public management. Nurs. Inq. 23, 158–168.