

Dealing with Scarcity of Resources in Nursing. The Scope and Limits of Individual Responsibility

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Abstract

Empirical studies show that nursing staff are often unable to perform all the nursing tasks they consider necessary. The phenomenon of incompletely performed nursing tasks is a consequence of the scarcity of resources in patient care and represents a form of rationing of nursing care. Although nursing staff cannot be held responsible for the lack of resources, an approach that has considered ethical aspects is necessary for decisions regarding prioritisation and rationing, as well as for considerations regarding efficiency in nursing care for patients. The phenomenon of incompletely performed nursing care should be addressed not only in the context of nursing science and health economics, but also in the context of ethical interpretation. Within the latter context, it is also possible to define in broad terms the scope and limits of individual responsibility of nursing staff under conditions of scarcity.

1 Introduction

It's been a long while since I was a clinical nurse juggling competing demands on a busy medical ward. Fighting down the sense of panic, with a growing realisation that what needs doing is more than I can get done. Hoping that somehow, by luck or judgement, the amount of harm caused by what I leave undone is minimal. Leaving a shift with a nagging doubt, and finding it increasingly difficult to imagine staying in nursing.¹

Under the terms “care left undone”, “unfinished care”, “missed care”, “unmet nursing care” and “implicit rationing of care”, a particular phenomenon in professional nursing care is examined: the fact that, due to a lack of time or other resources, nurses are regularly unable to perform all the nursing tasks that are considered necessary or are unable to perform tasks to the extent intended.² The individual investigations vary in terms of focus. Some studies focus on the causes or consequences of incomplete care,³ while others focus on the decision-making processes themselves.⁴ The extent of incompletely performed nursing tasks is regarded as a possible indicator of the risk to patient safety, as well as an indication of the overburdening of nursing staff, which in turn is regarded as one of the causes of the shortage of nursing staff. This shortage is a phenomenon that is not only observed in Germany.⁵

The aforementioned studies address incompletely performed nursing care as a form of treatment error.⁶ These are errors that are due to the failure to provide nursing care, rather

¹ Ball 2017, p. 1.

² Jones et al. 2015; Papastavrou et al. 2014; Recio-Saucedo et al. 2018.

³ Ball et al. 2016; Recio-Saucedo et al. 2018; Schubert et al. 2013; Zander et al. 2014; Zúñiga et al. 2015.

⁴ Kalisch 2006.

⁵ Ball 2017, p. 25, 66; Kutschke 2014; Papastavrou et al. 2014, p. 5, 22.

⁶ Scott et al. 2019, p. 1529; Suhonen/Scott 2018, p. 549; Jones et al. 2015, p. 1122.

than the incorrect provision of nursing care or provision of the incorrect nursing care. Although it is a form of undertreatment rather than overtreatment, it is a failure that can be equally dangerous for patient safety and patient well-being.⁷ The empirical studies discuss incompletely performed nursing care primarily in the context of professional standards and their incomplete implementation in nursing practice.

As will be shown below, however, the phenomenon of incompletely performed nursing care is also associated with a number of ethical issues that are not adequately described by the inadequate implementation of professional standards. It is only against this background that questions of responsibility for incompletely performed nursing care can be addressed. The phenomenon of incompletely performed nursing care should be addressed not only—as has been the case to date—in the context of nursing science and health economics, but also in the context of ethical interpretation.

The following elaborates on the fundamental ethical issues associated with the phenomenon of incomplete nursing care. The first section provides an overview of those empirical findings that are of greatest importance to the ethical discussion. This is followed by a clarification of some of the terms used in the field of allocation ethics. In this context, it is also necessary to address the extent to which issues of rationing nursing care are typical of the increasing opening of the healthcare system to the principles of the market economy and are determined by the overarching structural conditions. Against this background it is possible to determine in broad terms the scope and limits of the individual responsibility of nursing staff in dealing with scarcity of resources in nursing.

2 The Phenomenon of Incompletely Performed Nursing Tasks in Empirical Research

There are now not only numerous empirical studies, but also several reviews and systematic reviews covering the nature and extent, as well as the causes and consequences of incompletely performed nursing tasks in professional nursing.⁸ The following will therefore not provide any further systematic overview of the empirical findings; instead it will present those aspects that are of relevance for further ethical analysis.

The majority of existing studies were conducted in acute hospitals. A few were also conducted in the field of long-term inpatient and outpatient care.⁹ Both quantitative and qualitative research methods were used.¹⁰ Most of the studies followed a methodological approach in which nursing staff were presented with a questionnaire containing a number of nursing tasks. In this questionnaire they were asked to retrospectively assess for a defined period in the past which nursing tasks they had been unable to perform and how often, despite having themselves identified these tasks as necessary. Questions were asked, where relevant, regarding work environment (e.g. nurse-to-patient ratio, workload, work atmosphere), effects

⁷ WHO 2009, p. 16, 106, 148.

⁸ Ball 2017; Jones et al. 2015; Papastavrou et al. 2014; Recio-Saucedo et al. 2018.

⁹ Zúñiga et al. 2015; Tønnessen et al. 2011.

¹⁰ Jones et al. 2015; Papastavrou et al. 2014.

on patient safety (negative patient outcomes such as falls, decubital ulcers, infections) and/or employee satisfaction. Some information was taken from other data sets (e.g. administrative data). Some studies have also used patient questionnaires to survey the quality of care or the extent to which nursing tasks are incompletely performed.¹¹

The individual studies show great differences in form and content, e.g. with regard to the collection and evaluation methods used, as well as the contexts in which the data were collected (e.g. surgery, internal medicine, gynaecology). This variability places certain limits on the comparability of the study results. In general, the results of the individual studies suggest that incompletely performed nursing tasks have a negative impact on patient and staff satisfaction.¹² Although several studies link the level of neglected tasks to the nurse-to-patient ratio, as well as the experience and training of the nursing staff (known as the “grade and skill mix”)¹³, they are very different in terms of results.¹⁴ Negative patient outcomes were also used to measure the effects of incompletely performed nursing tasks on patient well-being and safety. There was evidence of corresponding correlations between incompletely performed nursing tasks and the occurrence of nosocomial infections and urinary infections, falls, decubital ulcers and medication errors. An effect on patient mortality is also discussed.¹⁵ The individual studies make no explicit distinction between the concept of incompletely performed nursing care and incompletely performed nursing tasks; instead the two are sometimes used as synonyms. From a systematic perspective, the relationship between the two terms can be summarised in such a way that nursing care that is considered necessary (e.g. oral and dental care) can be divided into specific individual nursing tasks. These can vary depending on the patient and his/her health requirements. Depending on the patient, oral and dental care may require cleaning the teeth and interdental spaces with a toothbrush, or cleaning the denture in the sink. Nursing care is considered to have been incompletely performed if the nursing tasks stipulated for this purpose in the expert and care standards have not been performed in full.

The extent of incompletely performed nursing tasks identified in the studies varies greatly due to factors including the aforementioned differences in the survey and evaluation methods and the survey location. Nevertheless, it is possible to identify some similarities in dealing with time and other resource constraints using the example of two studies.¹⁶

A study¹⁷ conducted in Germany, asked 1511 nursing professionals how many of the nursing tasks listed in a questionnaire it had been necessary for them to neglect during their most recent shift. On average, this was 4.7 out of a total of 13 nursing tasks. 92.6% of the nursing

¹¹ Jones et al. 2015; Papastavrou et al. 2014; Recio-Saucedo et al. 2018.

¹² Ball et al. 2014; Jones et al. 2015; Schubert et al. 2008; Schubert et al. 2009; Papastavrou et al. 2014; Recio-Saucedo et al. 2018; Zúñiga et al. 2015.

¹³ “Grade and skill mix” refers to the specific composition of the personnel who make up the nursing team and their various levels of qualification, individual job-specific skills and specialist professional knowledge.

¹⁴ Jones et al. 2015; Papastavrou et al. 2014; Kalisch 2006.

¹⁵ Schubert et al. 2008; Schubert et al. 2009; Schubert et al. 2013, Papastavrou et al. 2014; Recio-Saucedo et al. 2018.

¹⁶ Since this paper deals with the framework conditions for nursing care in Germany, studies from Germany and neighbouring Switzerland will be used as examples.

¹⁷ Zander et al. 2014.

professionals surveyed stated that they had been unable to perform at least one of the tasks listed in the last shift. Among the most frequently mentioned nursing tasks were “time to give the patient attention/talk to the patient” (82%), “developing and updating nursing care plans/nursing care pathways” (54%), “counselling/instruction” (54%), and “planning nursing tasks” (43%). However, “patient monitoring” was also mentioned as a neglected nursing task in 37% of cases. In contrast, “treatments and procedures” (15%) were mentioned least frequently, followed by “pain management” (19%), “timely medication” (21%) and “regular repositioning” (22%).¹⁸

In a study conducted in Switzerland, Schubert and colleagues used a list of 32 nursing tasks and asked a total of 1633 nursing professionals how many of these tasks they had been unable to perform during the previous seven working days.¹⁹ In contrast to the German study mentioned above, the Swiss study specified in each case whether these tasks were “never”, “rarely”, “sometimes” or “often” neglected. A total of 98% of respondents reported that they had been unable to perform at least one of the aforementioned tasks in the previous seven working days. The items “set up care plans”, “assessment of newly admitted patient”, “emotional and psychological support” were mentioned with frequencies of 12.3%, 11.5% and 10.6% respectively in the category of “often” neglected nursing tasks. In the “sometimes” neglected category the nursing tasks mentioned most often were “emotional and psychological support” (30.8%), “mobilization” (28%), “necessary conversation” (27.3%) and “assessment of newly admitted patient” (26.6%). The most rarely neglected tasks were “change of the bed linen” (65.2%), “necessary disinfection measures” (61.7%), “partial sponge bath” (56.2%), “change of wound dressings” (54.7%), “preparation for test and therapies” (53.3%) and “continence training (insert catheter)” (52.5%).²⁰

These examples illustrate a general trend observed in the available evidence, which is that aspects of social, psychological care and counselling, as well as tasks related to nursing planning and documentation, are most often neglected when nursing professionals are unable to perform all the nursing tasks deemed necessary due to a lack of time or other resources. The least frequently neglected tasks tend to be those in the field of treatment care, measures delegated by doctors, and assisting tasks in diagnostic and therapeutic measures. The same applies to tasks that do not take up much time (e.g. changing bedding, medication) or whose duration is easier to estimate, e.g. regular repositioning, as opposed to more time-consuming measures such as mobilisation and activating care. This raises the question of whether these trends can be used to identify an informal system that has emerged in times of resource scarcity and according to which nurses decide to neglect certain nursing tasks while others are not neglected wherever possible.²¹

This informal system could be seen as an attempt by nursing staff to neglect those nursing tasks that have a less direct influence on the health of patients and residents, i.e. those which are not expected to have negative effects in the immediate term (e.g. social and psychological care and counselling for patients and their relatives) but could tend to have negative effects

¹⁸ Zander et al. 2014, p. 731.

¹⁹ Schubert et al. 2013.

²⁰ Schubert et al. 2013, p. 235.

²¹ Jones et al. 2015, p. 1131; Schubert et al. 2013, pp. 236–37; Zander et al. 2014, p. 731.

during the later course of care, e.g. after discharge from hospital.²² These tendencies can also be seen as an expression of increasing trend towards other occupational groups determining the tasks of nursing staff, in that nursing staff seldom neglect areas of responsibility that are based on delegation by doctors or consist of direct assistance to doctors. This determination of nursing tasks by other occupational groups leads to the fact that nursing staff neglect primarily those tasks over which they themselves can decide and which are regarded as the intrinsic tasks of nursing, i.e. social and psychological care.²³ Furthermore, this could also be a sign of a changing self-image of the nursing profession, moving away from a more holistic understanding of nursing based on denominational nursing (see Section 3) to a biomedically abbreviated, but at the same time biomedically deeper understanding of professional nursing that places the social and psychological care of patients on the periphery of their professional self-image and how their profession is viewed by the public.²⁴

With regard to the available findings, it should be added that a major point of criticism is directed against the survey methods used. Almost all the studies were based on self-reporting by the nursing staff (and in some cases the patients) when collecting data on neglected nursing tasks and negative patient outcomes. In this form of retrospective survey, it is necessary to consider possible recall bias and that the concept of “necessary nursing tasks” is likely to be understood and used very differently by the individual nursing professionals (and patients). This issue of definition will be discussed later.

Due to these methodological shortcomings, the studies explicitly point out that none of the studies mentioned is, strictly speaking, capable of proving a causal relationship between neglected nursing tasks and negative patient outcomes. Nevertheless, the phenomenon of incompletely performed nursing tasks is seen as an essential component of a theoretical model that should be able to explain an aspect that has been discussed in many international studies: the connection between nurse-to-patient ratio (or “skill and grade mix”) and negative patient outcomes, which can include a higher mortality rate.²⁵ Especially, as a correlation between incompletely performed nursing tasks and negative patient outcomes has already been demonstrated in case of a small amount of neglected nursing tasks.²⁶

Irrespective of the methodological shortcomings described above, from an ethical point of view, the question arises of how nursing staff should responsibly deal with a lack of time and other resources, as well as which responsibilities are associated with the phenomenon of incompletely performed nursing tasks in the various levels of the healthcare system.

²² Jones et al. 2015, p. 1131; Schubert et al. 2013, pp. 236–37; Zander et al. 2014, p. 731.

²³ Papastavrou et al. 2014, p. 18.

²⁴ Papastavrou et al. 2014, p. 23; Suhonen/Scott 2018, p. 550.

²⁵ Ball 2017, pp. 20–22; Recio-Saucedo et al. 2018, p. 2250; Schubert et al. 2008, p. 227; Schubert et al. 2013, p. 232; Griffiths et al. 2018; Twigg et al. 2016; Aiken et al. 2012; Schwab et al. 2012.

²⁶ Schubert et al. 2009.

3 Allocation, Prioritisation, Rationing, Rationalisation and Efficiency of Healthcare Services

As previously mentioned, the literature describing the phenomenon of incompletely performed nursing care due to resource scarcity uses various terms. The term “implicit rationing of care” makes it clear that both nursing staff and doctors function as “gatekeepers” for the healthcare system and control access to healthcare services. Nursing staff carry out medical interventions delegated by doctors. As part of nursing planning, they themselves determine the need for care (e.g. in the form of nursing diagnoses) and independently initiate appropriate nursing measures. “Therefore, few care processes reach patients without first passing through the hands of nurses.”²⁷

Nurses are constantly busy allocating healthcare services²⁸, as they have to allocate the time and material resources available to them between patients and therefore decide which healthcare services should be made available to individual patients and which should not. They also have to decide when and how these services should be made available.²⁹ This is achieved in the form of prioritisation: nursing staff arrange their tasks according to the degree of importance and work through them one after the other. Prioritisation becomes rationing when, due to lack of time or other resources, it is no longer possible to fulfil certain tasks or only possible to fulfil them incompletely.

Although the terms “allocation”, “prioritisation”, “rationing” and “rationalisation” are closely related, they have different meanings. These are explained below using the example of incompletely performed nursing tasks.

Allocation

In the following, the term “allocation” is generally understood to mean the distribution of limited resources among various recipients (persons, institutions, tasks, etc.). The allocation can be performed on the basis of implicit or explicitly specified objectives or criteria.³⁰ For example, the German Transplantation Act explicitly stipulates that post-mortem donor organs must be distributed primarily according to the urgency and prospects of success of an organ transplant.³¹ In contrast, the allocation of nursing care on wards or in the residential sector described in the previous section is based on implicit criteria, which are therefore not explicitly formulated in the form of generally binding guidelines or directives. In this case, the criteria and allocation rules are not specified above the individual relationship between nursing staff and patient, i.e. at a higher level of the healthcare system.

²⁷ Jones et al. 2015, p. 1122.

²⁸ The terms “healthcare service” and “healthcare resource” are used in the following in a comprehensive sense and include both tangible and intangible goods. The designation of a resource or service as “healthcare” means that they are designed to protect, strengthen or restore health, or to alleviate or prevent suffering or dysfunction.

²⁹ Scott et al. 2019; Suhonen/Scott 2018.

³⁰ Marckmann 2006, p. 195–196.

³¹ German Transplantation Act § 12 para. 3.

Prioritisation

According to the proposed definition presented here, the term “prioritisation” should be understood as the classification of nursing care or the recipients of nursing care according to their degree of importance, which is determined by the application of the implicit or explicit allocation criteria.³² A frequent and ethically well-founded example of prioritisation in the healthcare system is that of prioritising patients with acute, life-threatening conditions as opposed to those with mild illnesses. In the emergency room or waiting room, for example, such patients have preference over patients who have been waiting longer (triage), as it is assumed that a longer waiting period is associated with the risk of serious health problems for these patients. This largely corresponds to the first possible interpretation of the informal prioritisation system in nursing described above, i.e. that in times of resource scarcity, nursing staff prioritise those nursing tasks for which a time delay is associated with the concrete and acute risk of serious damage to health.

The second possible interpretation of the informal prioritisation system in nursing is more questionable from an ethical point of view, i.e. that nursing staff primarily prioritise those tasks that have been delegated to them by other professional groups, especially doctors, because in this case the prioritisation is not per se based on detriment to patient health. In some cases, there may well be an overlap between these two systems of prioritisation, i.e. when tasks delegated by doctors are also those whose postponement is associated with a potential health risk. However, these overlaps are contingent and the two informal prioritisation systems must be strictly distinguished from an ethical point of view.

Rationing

The term “rationing” should only be used if patients are deprived of healthcare services that are in principle suitable for prolonging their lives or for alleviating or compensating health-related dysfunctions or preventing further health impairments.³³ Accordingly, the withholding of nursing care that is not indicated from the perspective of nursing science cannot be described as rationing of nursing services. In Germany, the guiding principles for determining the current state of nursing science are expert standards developed by the Deutsches Netzwerk für Qualitätsentwicklung in der Pflege (German Network for Quality Development in Nursing). These expert standards formulate evidence-based standards for various tasks in nursing care (decubital ulcer prophylaxis, discharge management, pain management, etc.), which serve as a benchmark for high-quality nursing care and are designed to be implemented in the individual facilities by means of nursing standards.³⁴

Rationing becomes necessary when the available resources are limited and not all potential recipients can be given access to these resources. The phenomenon of incompletely performed nursing tasks is primarily a consequence of resource scarcity. For this reason, it seems that using the term “allocation” to describe the recurrent phenomenon of incompletely performed nursing care obscures the central ethical problem and that the term “rationing” is more appropriate. In such cases, patients are at least partially denied access to nursing care

³² Marckmann 2006, pp. 193–199.

³³ Scott et al. 2019, pp. 1530–1531; Marckmann 2006, pp. 193–194.

³⁴ § 113a of the German Social Code (SGB) XI.

that is in principle suitable for alleviating health-related limitations (e.g. by providing needs-based support for personal hygiene instead of the time-saving complete assumption of personal hygiene by nursing staff), or for preventing further health impairments (e.g. by adequate patient monitoring or mobilisation). This constitutes nursing support to which patients (similar to medically indicated treatments) have a legitimate *prima facie* ethical right, especially in a publicly financed healthcare system that is based on the aforementioned expert standards.³⁵ Since patients must forego nursing care in favour of other persons, justification must always be provided for such rationing. The extent to which individual patients can actually be granted an ethical right to individual nursing care must be determined as part of nursing process planning. The current state of nursing science and the standards of care prescribed in the institutions provide the external framework within which the individual support needs of patients can be determined and planned.³⁶

Like allocation, rationing, i.e. healthcare limitations, can take either an explicit or implicit form. Explicit healthcare limits are set above the individual relationship between the doctor/nurse and the patient.³⁷ Implicit rationing, on the other hand, “is not carried out according to generally binding rules, but rather by the healthcare providers in each individual case”.³⁸ This form of healthcare limitation is also known as “bedside rationing”.³⁹ From an ethical point of view, the explicit and implicit forms of rationing each have different advantages and disadvantages. Explicit healthcare limitations have the decisive advantage that they improve the transparency and consistency of allocation decisions and that patients with comparable health impairments receive the same healthcare services everywhere.⁴⁰ Explicit allocation decisions can also provide positive relief for the relationship of trust between the persons providing the healthcare and the patients, since the former do not have to decide for themselves which of their patients should have access to the scarce resource and which should not; instead this decision is made at a higher level within the healthcare system.

A decisive advantage of implicit rationing from an ethical point of view, however, is that the individual health needs and personal preferences of the patients can be addressed more flexibly. This does, however, involve the risk that this may lead to unequal treatment of patients, which from the perspective of allocation ethics should be regarded as questionable and threatens to disadvantage vulnerable patient groups in particular.⁴¹ In principle, implicit rationing has the advantage that nursing staff can react individually to an increase in workload and decide which nursing tasks to curtail or neglect.

³⁵ § 113a of the German Social Code (SGB) XI.

³⁶ This does not affect the wider ethical question of the extent to which patients should or even must be granted the right to personal attention and individual adaptation of care services to personal needs and preferences over and above the standardised care services defined in the expert and care standards. The application of expert and care standards is a minimum requirement from the point of view of the patients' needs.

³⁷ Marckmann 2006, pp. 195–196.

³⁸ Marckmann 2006, p. 196.

³⁹ Ubel/Goold 1997.

⁴⁰ Marckmann 2006, p. 196.

⁴¹ Marckmann 2006, p. 198.

Rationalisation

From an ethical point of view, rationing of healthcare services is only legitimate if all options for rationalisation, i.e. increasing efficiency, have been exhausted.⁴² In principle, options for increasing efficiency exist wherever it is possible to achieve the same goal (e.g. a specific nursing goal) with fewer resources and wherever it is possible to achieve more with the same application of resources (e.g. more patients can be cared for). Measures to increase efficiency can certainly be in the interest of patient well-being, e.g. when evidence-based care is used to offer the patient the most effective nursing measure for achieving a specific nursing goal. Rationalisation should be regarded as ethically questionable if the quality of care is reduced as a result or if it is no longer possible to offer the necessary nursing measures, e.g. as a result of the nurse-to-patient ratio being too low.⁴³

Whether restructuring can in practice be regarded as improving efficiency is sometimes disputed, since the assessment of efficiency is partly dependent on overriding principles and normative models. The organisational form of functional care has the advantage over holistic and patient-oriented care models that the individual nursing tasks can, under certain circumstances, also be carried out with a smaller number of carers. From the perspective of a principle of holistic care, however, functional care cannot simply be described as a more efficient form of organisation, as this means that the principle of holistic care is abandoned in favour of another higher-level care principle, i.e. functional care. Similarly, the complete assumption of personal hygiene by nursing staff cannot be described as efficient if this means that the actual nursing goal, i.e. that a patient receives instruction on regaining the partial ability to wash himself/herself, must be abandoned due to a shortage of staff and time. In this case, the nursing goal is no longer realised at all.

Accordingly, a more technical understanding of professional nursing – one that is oriented towards a narrow biomedical model that places the nature and quality of nursing care in the assumption of defined tasks of basic and treatment care, and assistance in medical tasks – would not necessarily define the aforementioned frequent neglect of social and psychological care as rationing of a nursing task that is necessary per se, or perhaps only would if it was possible to establish a causal connection to objectively ascertainable negative patient outcomes. Dealing with scarcity of resources and healthcare limitations in professional nursing in a manner that takes into account ethical aspects cannot therefore be separated from the overarching social ethical question of what normative ideal of professional nursing is targeted within a healthcare system and what individual patient needs a community based on the principle of mutual solidarity wishes to see fulfilled in nursing care.

Efficiency

When talking about rationalisation in the healthcare system, it is necessary, from an ethical point of view, to critically examine the meaning of the term “efficiency”. As will be argued according to the proposed definition presented here, the concept of efficiency can be framed in very different ways; either by focusing on saving resources or on the goals targeted. In the former case, care must be organised in such a way that the minimum number of nursing staff

⁴² Scott et al. 2019.

⁴³ Marckmann 2006, p. 192.

are deployed and the maximum number of patients are cared for. Although it is possible to justify such an orientation towards efficiency (especially from a utilitarian point of view), there is a danger that seriously ill and high-maintenance patients in particular will be disadvantaged. In the case of a strictly timed daily routine in the ward, older and disoriented patients in particular run the risk of not receiving the support they need, especially if there are no relatives on site to make up for the lack of personal care.

In the second case, the term “efficiency” refers to the most efficient possible realisation of the specified goals, i.e. “efficiency” would be defined here primarily in terms of the nursing goals targeted. In such a case, the efficiency of care measures is determined by the actual care needs of the patients. From such a point of view, if the need for nursing support (e.g. regular walks in the hallway after orthopaedic surgery) identified by nursing staff during the course of nursing process planning cannot be met due to a lack of time or other resources,⁴⁴ this does not constitute efficient use of the “nursing resource”. Instead it constitutes a failure to fulfil *lege artis*, the patients’ right to certain nursing care services as established by nursing staff on the basis of professional standards.

4 Structural Framework and Overarching Responsibilities in Dealing with Scarcity of Resources in Nursing

Although nurses have a responsibility for how they prioritise and ration nursing tasks in direct patient care, they cannot be held equally responsible for this scarcity of resources. This scarcity of resources is determined to a far greater extent by decisions and responsibilities at higher levels of the healthcare system. Allocation decisions are made at all levels of the healthcare system and have a direct influence on allocation decisions at lower levels. Insofar as these allocation decisions at the upper levels are subject to both national differences and changes over time, it is to be expected that this will also result in differences in the understanding of what is regarded as a necessary nursing task in direct patient care and what demands must be made of nurses in dealing with resource scarcity. Using the allocation decisions at individual levels, it is possible to reconstruct the ideal of professional care within a healthcare system and how it should be ethically evaluated and implemented in direct patient care in the form of prioritisation and rationing systems.

This paper cannot provide a comprehensive systematic reconstruction; it can only provide a brief outline of the development of the structural conditions in Germany, as it is these conditions that determine the extent and handling of resource scarcity in nursing care.

The Reform of Nursing in Germany in the Post-war Period⁴⁵

⁴⁴ Kalisch 2006, p. 307.

⁴⁵ The explanations provided in this section refer to Kreuzer (2005), which is still the authoritative work on the reform of nursing in Germany after 1945. A general overview of the developments in nursing and other healthcare professions after 1945 can be found in the anthology by Hähner-Rombach and Pfüttsch (2018).

Nursing care in German hospitals was primarily characterised by denominational care until the 1950s. The sisters sent by the motherhouse understood their activity not as a profession but as a vocation, not as work but as service.⁴⁶ The sisters were expected to devote their lives entirely to the service of denominational care, i.e. to the care of the physical and spiritual well-being of the patients. This understanding of service was linked to compulsory board and lodging, i.e. the unmarried sisters lived in the hospitals, or at least in the immediate vicinity of them, which meant that the nurses were available to care for their patients virtually around the clock.⁴⁷ Accordingly, the sisters were not paid a performance-related salary; instead they received a non-monetary compensation.⁴⁸ The high availability of the nurses made it possible to design nursing primarily as holistic care, i.e. the nurses usually worked in two shifts (day and night shift), fully caring for the patients assigned to them in each shift. The hierarchisation of nursing into basic and treatment care, which is still common in Germany today, was only established with the reform of nursing into a modern, performance-related paid profession.⁴⁹ The model of holistic care was also adopted by the so-called free, i.e. non-denominational sisterhoods that emerged at the beginning of the 20th century as an alternative to the orders.⁵⁰

One major difference to the current situation of nursing professionals in Germany is that under the model of holistic care outlined above, periods of high workload were mainly absorbed by the sisters simply extending their shifts according to the amount of work required. Under the model of denominational care, this might also have been understood (to a certain extent) as a legitimate ethical requirement for the sisters in dealing with the scarce time resources. Nevertheless, even then, the nursing staff had to make allocation decisions on a daily basis. It was also necessary to prioritise nursing tasks according to their importance and to share them between several patients. Even rationing of nursing measures cannot be ruled out. Due to the declining attractiveness of the nursing profession, the motherhouses struggled with an increasing shortage of staff since the mid-1950s. It was therefore necessary to decide at the level of the motherhouses to which institutions the remaining sisters were to be sent, or which institutions it was necessary to abandon completely.⁵¹ Due to the lack of staff, however, it was not possible to provide nursing care as recommended or desired even in direct patient care. Rationing was therefore necessary in this case too⁵²—even if it was only that the sisters did not have the desired time for personal, “spiritual” care of the patients. Just as today, rationing in direct patient care probably primarily took the form of implicit rationing, i.e. without the use of guidelines for action that had been explicitly formulated or that took into account the relevant ethical aspects.

The anthology by Kreutzer and Nolte (2016) goes beyond Germany and the 20th century. The anthology by Kreutzer (2010) contains a contribution by Kreutzer on the radical changes that took place in nursing in Germany after 1960 and again takes up essential points made in Kreutzer (2005).

⁴⁶ Kreutzer 2005, p. 7.

⁴⁷ Kreutzer 2005, p. 18.

⁴⁸ Kreutzer 2005, p. 206.

⁴⁹ Kreutzer 2005, p. 18, 27.

⁵⁰ Kreutzer 2005, p. 8.

⁵¹ Kreutzer 2005, pp. 22–25.

⁵² Kreutzer 2005, p. 22.

A major difference, however, is that under the concept of holistic care it was not necessary to coordinate allocation decisions equally across different areas of nursing and nursing staff. While the nurses in Germany at that time were still granted a great deal of autonomy in planning and coordinating the nursing care of their patients, the nursing care to be provided today also include nursing measures that are based on doctors' orders and delegation (e.g. wound care, administration of medication, blood pressure and blood sugar measurement, etc.). As constituent parts of "treatment care", these are still often separated from "basic care" in Germany. The reform of nursing has also created new allocation conflicts, insofar as nursing staff must decide how to divide the scarce resource of time between these two areas.⁵³ As seen above, one suspected consequence of the more hierarchical relationship between doctors and nurses is that in current nursing care, tasks delegated by doctors are generally prioritised to the disadvantage of nursing measures that are more heavily geared towards personal care for patients or are separate from care by a doctor.

Insofar as patients are cared for by several nurses at the same time, there is a need today for far greater coordination and communication of allocation and rationing decisions among nurses. This represents an additional challenge within patient care. The associated need for teamwork, communication and coordination is one of the factors identified by nursing staff as partly responsible for the neglect of nursing tasks.⁵⁴

The Restructuring of the German Healthcare System since the 1990s

The reform of nursing into a modern and performance-related paid profession laid the foundation for subjecting nursing to considerations of economic efficiency to a previously unknown extent. Since the 1990s, several restructuring measures (e.g. increasing privatisation, introduction of the G-DRG system⁵⁵, creation of competitive structures) in Germany have left healthcare providers in the healthcare system increasingly exposed to cost pressure, i.e. being forced to provide care for their patients as cost-effectively as possible.⁵⁶ The opening up of patient care to the principles of the market economy was primarily intended to increase the efficiency of the healthcare system. One of the aims of this was to prevent "overcare" for patients (e.g. unnecessarily long stays, unnecessary diagnostic or therapeutic measures) and to reduce the presumed overcapacity of staff. The aim was to reduce consumption of human, material and time resources without reducing quality of care.⁵⁷ Considerations of efficiency in nursing care should not be regarded as ethically questionable, provided that efficiency is defined by nursing goals, as mentioned above. If, however, considerations of efficiency are paired with the economic interests of profit maximisation, they run the risk of becoming strategies of overall benefit maximisation, so that the patient's need for nursing care as identified in the context of nursing process planning is

⁵³ Zander et al. 2017, pp. 135–136.

⁵⁴ Papastavrou et al. 2014, p. 21.

⁵⁵ German diagnostic related groups. The G-DRG system is a pricing system for hospitals that uses an algorithm to determine more or less fixed prices for medical procedures and inpatient care. The algorithm is updated on an annual basis and uses different diagnostic groups to calculate the prices of inpatient care.

⁵⁶ Mohan 2019, pp. 160–165, pp. 197–209; Slotala/Bauer 2009, pp. 55–56.

⁵⁷ Slotala/Bauer 2009, p. 59.

no longer at the forefront of staff and nursing care planning, or, as the empirical findings show, it is no longer possible to perform appropriate nursing care planning at all. Increases in efficiency should be regarded as ethically questionable if the reduction of overcare threatens to become undercare for individual patients.

In professional care, which today covers areas as diverse as hospital care, outpatient care and long-term inpatient care, there has been an increasing concentration of nursing work. Between 1990 and 2010, patients' length of stay in general hospitals fell from 14.7 to 7.3 days. In the same period, the number of hospitalisations increased from 14,080,589 to 17,485,806. According to the study, around a fifth more patients are treated in hospital in half the time than around 20 years ago. This alone has more than doubled the workload of hospital nursing staff. This does not take into account the additional burden of assuming additional tasks usually performed by doctors, instruction of service and auxiliary staff and greater bureaucratic expenditure.⁵⁸

Not only are there more patients that need to be treated, as a result of the established German legal principle of outpatient before inpatient care, those patients on the ward and in long-term inpatient care are mainly patients with severe physical and cognitive impairments, who require increased care. From an ethical point of view, it would be necessary to adjust the nurse-to-patient ratio accordingly in order to meet the patients' need for professional nursing care. In contrast to this, the number of nursing staff has been reduced in various sectors (as was originally intended) with the result that today fewer nursing staff tend to provide care for a larger number of patients with a greater need for care.⁵⁹ It should be emphasised that in the hospital sector, the number of doctors has been continuously increased at the same time as the number of nurses has been reduced. This suggests that the reduction in nursing staff as a result of the switch to the G-DRG system is not only due to the reduction of overcapacity in the nursing sector, but also to a redistribution of financial resources within the hospital in favour of doctors.⁶⁰ If we look at the ratio of nurses to patients to be cared for (nurse-to-patient ratio), Germany occupies one of the last places in an international comparison.⁶¹ It is assumed that this is one of the reasons for the frequent rationing of care tasks that are considered necessary.

5 Summary and Outlook

As a look at the structural conditions and the changes therein makes clear, nursing professionals cannot be held responsible for conditions of scarcity. Nevertheless, in the context of professional ethical requirements, nursing professionals must be expected to deal with scarcity of resources in a responsible manner. Dealing with scarcity of resources takes place primarily in the form of implicit rationing, which creates the risk that the criteria applied in this case may not have been specifically considered by nursing staff. Integrating the

⁵⁸ Kutschke 2014, p. 55.

⁵⁹ Kutschke 2014, p. 55.

⁶⁰ Simon 2009.

⁶¹ Zander/Busse 2017, pp. 132–133; Aiken et al. 2012.

consideration of allocation ethics in the rationing of nursing care into training and practice allows nursing staff to act with greater certainty in dealing with scarcity of resources. It also ensures that the patients' right to nursing care that meets their needs is dealt with as responsibly as possible.⁶² The explanation of terms developed in Section 3 provides an important basis for further ethical consideration of dealing with scarcity of resources in nursing care.

Today, professional nursing care takes place in very different areas. Ethical requirements for nursing staff should be determined in each case by the specific nursing needs of the patients they care for, so that it is only possible to outline general principles for handling scarcity of resources in nursing care that are ethically informed. As seen above, the term "rationing" refers to the withholding of nursing care services that are of inherent necessity. Which nursing care services are considered necessary should ideally be determined with reference to evidence-based expert and nursing standards as part of nursing process planning. From an ethical point of view, the concept of necessity should not be interpreted in a narrow sense in this case. In a narrower sense, nursing care services would only be considered necessary if withholding them entailed the risk of acute deterioration in the health of the patients to be cared for. The concept of the indication of nursing care services, which refers to the suitability of a nursing task to achieve a specific nursing goal (e.g. independent personal hygiene), seems more appropriate in this case. Accordingly, expert and nursing standards constitute tools for making such nursing indications.

If, due to scarcity of time or other resources, it is not possible to provide all the nursing care services designated as indicated, preference should be given to those nursing tasks whose postponement is associated with the risk of serious damage to health. This largely corresponds to the first possible interpretation of the informal prioritisation system in nursing described above, i.e. that in times of resource scarcity, nursing staff prioritise those nursing tasks for which a time delay is associated with the concrete and acute risk of serious damage to health. One methodological problem in dealing with resource scarcity in nursing is that ethically informed prioritisation and rationing of nursing care require professional assessment and evaluation of nursing needs, but nursing planning is now precisely one of those tasks that, as seen above, is most frequently rationed. An approach to the scarcity of resources in nursing care that has considered ethical aspects is only possible if we are aware of the individual nursing needs and the short- and long-term effects of neglected nursing tasks on patient health.

However, even an approach to rationing decisions in patient care that has considered ethical aspects can only provide management of (rather than a solution to) the scarcity of resources, which is partly determined by the structural conditions in the higher-level areas of responsibility within the healthcare system. In response to the observed discrepancy between patients' right to nursing care and the identified scarcity of resources in direct nursing care, a series of regulations have been introduced in Germany to counteract the phenomenon of incompletely performed nursing tasks.

⁶² Jones et al. 2015, p. 1134.

The Minimum Staffing Limits for Nursing Staff Ordinance (Pflegepersonaluntergrenzen-Verordnung), for example, sets a minimum limit for the number of nursing staff (specialist nursing staff and nursing assistants) in “care-sensitive areas”, such as intensive care, geriatric, cardiology and accident surgery units. This regulation came into force in Germany in January 2019. Another piece of legislation relevant to the hospital care sector is the Improved Working Conditions for Nursing Staff Act (Pflegepersonal-Stärkungsgesetz), which was passed in November 2018. One of its provisions is the separation of staff costs from the G-DRG system. In Germany, the G-DRG system regulates the remuneration of healthcare services provided in hospitals. This change in the law was the German legislature’s reaction to the long-standing criticism that the G-DRGs do not adequately reflect individual nursing care needs. Nursing care provided in hospitals were previously considered to be included in the doctoral diagnosis, without taking sufficient account of the fact that the same doctoral diagnosis can be associated with very different nursing care requirements and nursing care levels depending on the patient’s general condition. With regard to the field of long-term care, mention should be made of the introduction of the levels of care (Pflegegrade) concept in Germany in 2017. This, together with the concept of need for care (Pflegebedürftigkeit), outline the essential tasks of long-term care as well as the scope and limits of legitimate patient rights in Germany.

Academics in the field of nursing science and nursing professionals in the various levels of the healthcare system must be involved in the relevant allocation decisions in order to ensure adequate nursing care. The reference to the methodological shortcomings of the studies as regards the effects of the nurse-to-patient ratio and the “grade and skill mix” on patient safety must be countered by financing corresponding studies. It is not the responsibility of the patient to prove that his/her right to needs-based nursing care cannot currently be realised in an adequate manner. This creates a further obligation for nursing staff to submit to their superiors an official notification of overload (Überlastungsanzeige) if they cannot guarantee patient safety.

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