

Scarcity Without Moral Abandonment: An Ethical Framework for Bedside Decisions Under Health-System Constraint

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Abstract

Health-system scarcity becomes ethically acute when a clinically relevant option is not merely expensive in the abstract but unavailable to a particular patient at a particular moment. This article develops an original normative framework for bedside decisions under such constraint. It distinguishes scarcity from allocation, patient-level constraint, and moral abandonment, and argues that justified limits on what a system can provide do not automatically extinguish duties toward the patient whose options have narrowed. The analysis integrates contemporary work on distributive justice, staffing scarcity, medicine shortages, institutional capacity, triage, moral agency, and procedural fairness. It proposes a persistent ethical floor comprising verification of the constraint, individualized clinical assessment, proportionate mitigation, consideration of clinically reasonable alternatives, transparent explanation, escalation where meaningful, documentation, maintenance of feasible care, and reassessment. The framework then organizes these duties into a branching decision sequence that tests whether the constraint is genuine and system-generated, reducible locally, replaceable by an adequate alternative, sufficiently serious to require escalation, compatible with delay, or contestable enough to warrant independent review. The proposed contribution is not a validated clinical algorithm, legal standard, or universal allocation rule. Its purpose is narrower: to prevent system scarcity from being treated as though it dissolves the therapeutic relationship. The framework remains sensitive to differences in resource type, urgency, institutional authority, jurisdiction, equity, and the practical limits of clinicians acting inside constrained systems.

Keywords: Scarcity, Resource allocation, Clinical ethics, Bedside decision-making, Moral abandonment, Health-system constraint

Introduction

When system scarcity reaches the bedside

Healthcare scarcity is usually discussed as a distributive problem: when legitimate needs exceed available capacity, which claims should receive priority? That question is unavoidable, but it does not exhaust the bedside ethical problem. Contemporary normative

analysis shows that allocation often involves several morally relevant values rather than one self-interpreting principle [1]. Once a scarce-resource decision reaches an identifiable patient, however, the problem changes form. A clinician may confront a person for whom a clinically relevant option cannot be supplied because the system lacks staff, beds, medicines, equipment, specialist access, time, or usable referral capacity. Staffing is especially revealing because personnel are not interchangeable units of supply; their skills, judgment, continuity, and relational roles make workforce scarcity ethically and operationally different from shortage of a divisible commodity [2].

Recent evidence demonstrates several pathways by which system limitation can narrow actual care.

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Oncology drug shortages can force substitutions or delays, preparedness systems differ in how priorities are structured, and nurse staffing levels are associated with clinically consequential outcomes [3-5]. These findings do not establish one uniform scarcity mechanism. They establish that scarcity can enter bedside care through materially different routes, with different possibilities for substitution, delay, mitigation, or review.

The normative gap addressed here begins after that narrowing has occurred. A system may have defensible reasons for limiting access to a resource, yet the patient still requires an answer to a different question: what remains owed when the preferred or ordinarily relevant option cannot be provided? This article proposes “scarcity without moral abandonment” as an ethical floor for that situation. The phrase does not deny scarcity, promise unavailable resources, or make clinicians personally responsible for structural deficits. It instead rejects the inference that justified constraint terminates responsibility. The central claim is that inability to provide everything clinically relevant can coexist with continuing duties to assess, explain, mitigate, escalate, care, document, and review.

Distinguishing scarcity, allocation, constraint, and abandonment

Four concepts must remain separate if the framework is to avoid moral overreach. Scarcity describes a mismatch between clinically relevant demand or need and available resources or capacity. Allocation concerns the rule, criterion, or process through which competing claims are ordered. Work translating theories of justice into triage practice illustrates that allocation is not scarcity itself; it is a normative response to scarcity, and different theories can support different criteria [6]. This distinction matters because a patient may experience restricted care even when no bedside clinician has personally made an allocation decision.

Constraint is the patient-level consequence of a system limitation. In this article, a bedside health-system constraint means a system-generated limitation, delay, restriction, or nonavailability that materially narrows clinically relevant options for an identifiable patient and cannot simply be removed by the treating clinician acting alone. This is a proposed analytic definition. It covers explicit rationing but also accommodates cases in which scarcity is expressed through closed pathways, unavailable expertise, delayed diagnostics, depleted staffing, or inaccessible institutional capacity.

Moral abandonment is narrower still. It is proposed here as the failure to preserve relevant care obligations merely because a preferred or ordinarily indicated option is constrained. It is not a legal definition of abandonment and does not imply that every unavailable service is wrongful. The distinction between descriptive evidence and normative justification is important: empirical studies of public values can inform priority-setting debates without themselves determining what justice requires [7]. Likewise, proof that a resource is unavailable does not establish that explanation, advocacy, symptom control, monitoring, or reassessment are no longer owed.

The framework therefore avoids two opposite errors. One is moralizing every shortage as abandonment. The other is treating scarcity as a complete ethical answer. Scarcity can justify limits; allocation can distribute them; constraint describes how they reach the patient; abandonment concerns what happens when responsibility is allowed to disappear afterward.

Sources of bedside health-system constraint

Bedside constraint can arise from absolute shortage, but also from how institutions organize access to limited capacity. Qualitative research on scarce-resource planning shows that organizational facilitators and barriers shape whether allocation processes can be developed and used coherently [8]. At the bedside, this means that “the resource is unavailable” may conceal very different realities: true exhaustion, fragmented coordination, absent decision authority, lack of transfer capacity, inconsistent escalation routes, or a policy that renders a pathway inaccessible.

Material shortages remain central. Perinatal care, for example, illustrates scarcity involving equipment, medicines, and specialized formula, each of which creates distinct substitution and prioritization problems [9]. A missing medicine may have a therapeutically acceptable substitute; an unavailable specialist may not. A temporarily unavailable diagnostic technology may permit safe delay in one case but cause irreversible loss of treatment opportunity in another. The ethical significance of scarcity therefore depends not only on what is missing, but on what the missing resource does within the patient’s care trajectory.

The relevant sources can be grouped, without assuming they are ethically equivalent, into workforce capacity; beds and treatment locations; medicines and supplies; time and attention; specialist expertise; diagnostic or

therapeutic technology; referral and transfer pathways; and wider institutional capacity. Some constraints are transient. Others are recurrent or structurally produced. Some affect one patient; others generate competition among many patients. Some are visible and formally governed; others emerge through queueing, deferral, or informal workarounds.

This article therefore treats constraint as a mechanism that changes the feasible set of care rather than as a synonym for “shortage.” That framing creates a more precise normative question: once a particular mechanism has narrowed feasible care, which obligations remain possible, relevant, and proportionate? The answer cannot be read directly from the fact of scarcity itself.

Ethical duties that persist under scarcity

Scarcity does not make priority criteria ethically neutral. Analyses of triage systems show that apparently practical rules embody underlying distributive commitments [10]. Justice therefore remains independently relevant even when clinical systems are under severe pressure [11]. At the point of care, priority setting likewise contains ethical elements rather than functioning as pure logistics [12]. These sources support a crucial premise: constraint can change what clinicians are able to provide without eliminating the moral character of what they still do. The framework adds a second distinction between constrained agency and extinguished agency. Moral distress and moral agency should not be collapsed into

the assumption that a constrained clinician has no meaningful ethical role [13]. Yet recognizing residual agency must not become a device for shifting structural responsibility downward. A clinician cannot manufacture a medicine, create a staffed ICU bed, or open a referral pathway by moral effort alone. Continuing duties should therefore track remaining agency, not impossible control.

From the preceding analysis, five duty domains emerge. First, epistemic responsibility: establish what the constraint actually is, how certain it is, and whether it is current. Second, clinical responsibility: preserve individualized assessment and distinguish a system restriction from a judgment that an option is clinically inappropriate. Third, mitigation responsibility: identify alternatives or adjustments that remain clinically reasonable. Fourth, relational responsibility: explain the constraint, acknowledge its consequences, and maintain feasible care rather than allowing nonavailability to become disengagement. Fifth, procedural responsibility: escalate, document, and reassess when the significance of the constraint exceeds ordinary bedside authority. These domains are proposed as a persistent ethical floor, not as universally enforceable legal duties.

Table 1 translates these manuscript-derived duty domains into an analytic matrix showing what different constraints alter and what they do not, by themselves, cancel.

Table 1. What health-system constraints change—and what ethical responsibility they leave behind

Constraint signature	What the constraint changes	What it does not by itself establish	Proposed persistent duty
Workforce scarcity	Available attention, skill mix, continuity, and task capacity	That remaining care may be depersonalized or ethically unstructured	Verify capacity, protect essential assessment, escalate serious gaps
Medicine scarcity	Feasible treatment options, timing, and substitution possibilities	That any available substitute is clinically equivalent	Compare alternatives, explain nonavailability, reassess
Institutional access constraint	Ability to activate transfer, review, or scarce-resource pathways	That a blocked pathway is clinically justified	Identify the blockage, use available escalation, document
Technology or supply constraint	Diagnostic or therapeutic capability	That delay or substitution carries acceptable clinical loss	Evaluate consequences of delay or substitution
Priority-setting constraint	Order in which competing claims are served	That the chosen criterion is ethically neutral	Preserve justice-sensitive, individualized reasoning
Time or bedside prioritization pressure	Depth and timing of attention or intervention	That communication and relational care are optional	Protect core assessment and explanation
Severe structural constraint	Clinician power to alter the underlying system	That moral agency is wholly extinguished	Maintain feasible care while locating responsibility at the proper level

Note: Constraint descriptions are evidence-informed; the distinctions between what changes, what is not established, and the persistent-duty formulations are original proposed synthesis.

The scarcity without moral abandonment framework

The framework begins from a verified bedside constraint, not from an abstract declaration that resources are scarce. Contemporary crisis-allocation guidance supports the value of explicit, structured processes when resources are insufficient [14], while work on fair critical-care allocation similarly emphasizes the importance of process rather than leaving distributive decisions to ad hoc improvisation [15]. The present framework extends that procedural insight to a narrower question: what should clinicians and organizations consider after a system limitation has materially narrowed one patient's feasible care?

The first test is epistemic: is the limitation genuine, current, and system-generated rather than merely customary, assumed, or locally convenient? If so, the second test concerns reducibility: can the care deficit be meaningfully lessened within the existing team, unit, schedule, supply chain, or pathway? A locally available workaround counts only if it preserves clinically relevant value rather than simply moving the burden out of sight. The third test asks whether a clinically reasonable alternative exists. "Reasonable" is deliberately not equivalent to "available." Ethical work on healthcare priority setting cautions against assuming that larger benefit automatically resolves every priority question

[16]. The framework therefore requires comparison of expected benefit, burden, reversibility, timing, and fit with the patient's clinical situation without converting those considerations into a numerical score.

If a material deficit remains, the fourth test is jurisdictional and organizational: does its seriousness exceed ordinary bedside authority and therefore require escalation? The fifth concerns temporality: can delay plausibly preserve meaningful benefit, or is postponement likely to become effective denial? Comparative analyses of triage recommendations show why no single answer should be presumed across healthcare systems or jurisdictions [17]. Finally, when a consequential decision remains disputed, inconsistently applied, or difficult to justify, the framework asks whether independent review is warranted.

Across these branches, one feature remains constant: scarcity changes the feasible option set, not the existence of the patient as a moral claimant. The framework therefore returns every pathway to a common ethical floor—state the constraint truthfully, preserve the care that remains possible, record the reasoning and actions taken, and trigger reassessment when circumstances change.

Figure 1 translates this manuscript-derived sequence into a branching bedside decision tree.

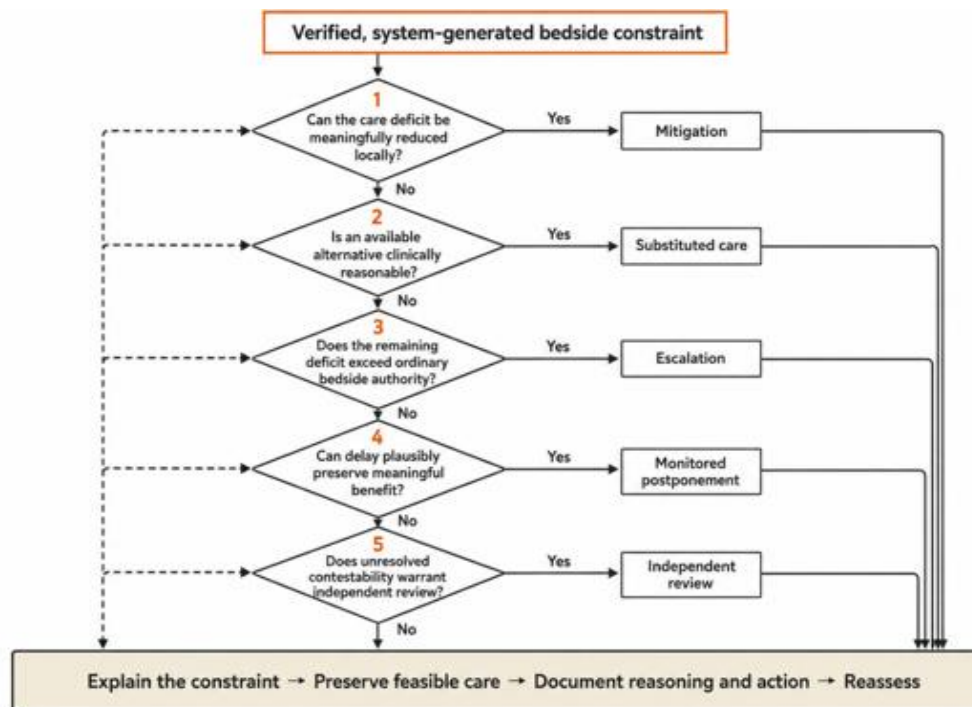


Figure 1. From verified constraint to a persistent bedside ethical floor

Maintain a predominantly top-to-bottom architecture with controlled lateral branching, sharp or subtly squared rectangles, precise decision diamonds used only for genuine questions, angular connectors, balanced spacing, and substantial negative space. Avoid connector crossings. Yes/No labels must remain readable after journal reduction.

Use professional sans-serif typography comparable to Arial, Helvetica, Source Sans, or Frutiger. Ensure the figure remains fully interpretable in grayscale through shape, wording, line style, position, and grouping rather than color alone.

Do not add percentages, scores, priorities, probabilities, urgency scales, benefit thresholds, time cut-offs, effect sizes, legal entitlements, causal claims, or validated-algorithm language. Do not imply that “clinically reasonable,” “meaningful benefit,” or “exceeds ordinary bedside authority” has a validated numerical threshold.

Do not use gradients, shadows, bevels, glow, glass effects, 3D rendering, decorative medical illustrations, clinician or patient silhouettes, hospital icons, medical crosses, logos, software-interface elements, rounded corporate cards, circular or radial architecture, funnels, pyramids, honeycombs, mind maps, generic left-to-right corporate workflows, or generic blue-teal AI infographic aesthetics.

The finished figure should resemble a carefully commissioned conceptual figure for Bioethics or a comparable Q1 medical-ethics journal: restrained, analytical, manuscript-specific, editable as vector artwork, and legible at approximately one-column to one-and-a-half-column publication width.

Proportionality, transparency, escalation, and appeal

Once a constraint has been verified and cannot be fully neutralized, the ethical question becomes how much loss, delay, substitution, or uncertainty can reasonably be imposed before a stronger procedural response is required. Proportionality is therefore not a numerical threshold in this framework. It is a disciplined comparison between the seriousness of the constraint and the burdens created by the response. Formal accounts of fairness in emergency triage emphasize publicity, accessibility, relevance, standardisability, and accountability as procedural requirements [18]. These requirements support the view that a consequential restriction should be explainable and reviewable, even though procedural quality alone cannot determine whether the underlying distribution is substantively just.

Triage theory likewise treats allocation as comparison among morally relevant claims rather than as the automatic consequence of scarcity [19]. Applied at the bedside, that insight means that a brief delay with little expected loss is ethically different from postponement that is likely to erase a treatment opportunity. A clinically reasonable substitute differs from a merely available substitute; and a local workaround differs from one that shifts serious burden onto the patient without acknowledgement. The framework therefore asks whether the remaining loss is proportionate to the constraint, not whether scarcity can be invoked in the abstract.

Transparency should identify what is constrained, what remains feasible, and which part of the decision belongs to clinical judgment rather than system limitation. Escalation becomes appropriate when the unresolved deficit exceeds ordinary bedside authority or when local mitigation cannot protect clinically important interests. Appeal or independent review is most relevant when stakes are high, criteria are disputed, application appears inconsistent, or a patient or clinician has a reasonable basis to question the allocation process. The framework does not treat appeal as a universal legal entitlement. It treats contestability as a proposed safeguard against allowing consequential system decisions to become invisible, unchallengeable, or misrepresented as purely clinical necessity.

Communicating constrained options to patients

A constrained option set changes the content of decision-making, but it does not remove the obligation to communicate in a manner that respects the patient as a participant in care. Shared decision-making has been characterized as a method of care rather than simply the act of presenting several options [20]. Under scarcity, this distinction becomes especially important because the available menu may no longer represent the clinically relevant menu. A patient can therefore be fully informed about feasible options only if the clinician also explains when and why an otherwise relevant option has been removed by system conditions.

Relational accounts of autonomy reinforce this point by locating agency within social and institutional relationships rather than treating choice as independent of context [21]. Scarcity can alter those relationships by transferring power toward institutions that determine availability, timing, eligibility, or access. Respect for autonomy cannot restore a missing resource, but it can

prevent institutional constraint from being concealed inside the language of individualized choice.

The framework therefore proposes four communicative tasks. First, distinguish clinical recommendation from system nonavailability: “not recommended” and “not available here now” are ethically different statements. Second, explain whether an alternative is clinically comparable, clinically reasonable but non-equivalent, or merely technically possible. Third, identify what remains uncertain, including whether delay, substitution, or transfer could change expected benefit. Fourth, state what the team or organization will do next—mitigate, escalate, monitor, seek review, or reassess.

This communicative structure is not claimed to improve outcomes or trust. Its normative purpose is more basic: it preserves the patient’s ability to understand what has happened to the feasible care set and prevents scarcity from being translated into a misleading narrative of clinical preference or patient choice.

Application to bedside scenarios

Medicine shortages illustrate the framework’s distinction between unavailability and abandonment particularly clearly. Oncology guidance treats drug shortages as requiring explicit ethical management of alternatives and competing claims rather than silent substitution [22]. In the proposed framework, the relevant questions are whether the shortage is verified, whether an alternative is clinically reasonable, what benefit or burden may change with substitution, and whether a materially inferior option should trigger escalation or review.

Delayed treatment introduces a temporal problem. Qualitative work with oncology professionals suggests that “urgency” is context-sensitive rather than a self-executing priority label [23]. A delay should therefore be assessed in relation to the patient’s disease trajectory, reversibility, expected opportunity for benefit, and available interim care. The framework deliberately avoids converting urgency into a universal time threshold.

Scarcity also extends beyond intensive care. Ethical analysis of access to high-demand medicines shows that distributive questions can arise in routine therapeutic markets as well as declared crises [24]. Conversely, qualitative evidence of covert ICU rationing shows that restrictions may occur without a transparent formal triage process [25]. Together, these cases support attention not only to what is scarce, but also to whether the decision is visible, governed, and contestable.

The framework can also be applied, more tentatively, to limited rehabilitation, unavailable specialist care, delayed diagnostics, and constrained referral. The approved evidence does not validate these applications directly. They are proposed extensions of the same normative structure: verify the pathway limitation, identify what clinically relevant opportunity is endangered, determine whether mitigation or an alternative is adequate, escalate when the remaining deficit exceeds bedside authority, and maintain feasible care while the constraint persists.

Table 2 summarizes the application logic that emerges from these scenarios rather than treating all forms of scarcity as interchangeable.

Table 2. How the proposed ethical floor changes across bedside scarcity scenarios

Bedside scenario	Ethical feature that becomes decisive	Manuscript-derived question	Proposed response if the deficit remains
Delayed treatment	Temporality and reversibility	Could postponement erase meaningful benefit?	Escalate time-sensitive loss; monitor and reassess
Restricted ICU access	Competing claims and decision authority	Which criteria and process produced nonaccess?	Maintain interim care; seek review when contestable
Limited rehabilitation	Recoverability over time	Will reduced intensity or delay narrow recovery opportunity?	Preserve feasible support; reassess trajectory
Medicine shortage	Clinical substitutability	Is the available alternative genuinely reasonable?	Explain non-equivalence; seek alternatives or escalation
Unavailable specialist care	Expertise dependency	Can present care safely continue without required expertise?	Seek alternative expertise; retain interim responsibility
Delayed diagnostics	Decision-dependent uncertainty	Could delayed information materially alter treatment opportunity?	Safety-net, explain uncertainty, review timing

Constrained referral	Pathway failure	Is another route capable of preserving the relevant benefit?	Escalate blockage; continue care pending transfer
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Note: Direct evidence informing ICU, oncology, and medicine-shortage applications derives respectively from [14, 22, 25]. Rehabilitation, specialist, diagnostic, and referral rows are original proposed extensions of the framework.

Organizational duties beyond individual clinicians

A framework intended to prevent abandonment would be self-defeating if it converted every institutional failure into an additional moral burden for individual clinicians. Qualitative evidence from physicians working within health-system transformation shows that ethical tensions can be generated by policy and structural conditions rather than by isolated bedside choices [26]. Scarcity therefore requires a distribution of responsibility that mirrors the distribution of control.

Clinicians retain responsibility for what remains within their professional agency: accurate assessment, truthful communication, clinically appropriate interim care, documentation, and use of available escalation routes. Organizations hold different responsibilities because they control capacities that bedside professionals often do not. The framework proposes that institutions make recurrent constraints visible, define allocation authority, maintain workable escalation and review pathways, communicate significant shortages, support cross-unit or cross-site mitigation where feasible, and examine patterns in which “temporary” workarounds repeatedly substitute for adequate capacity.

Who possesses authority over microallocation is itself a normative question. Democratic analysis of healthcare allocation challenges the assumption that professional or administrative authority is self-justifying [27]. Expertise may be indispensable to judging prognosis, therapeutic comparability, or urgency, while governance arrangements determine who may convert those judgments into access rules. Patients and publics may also have legitimate interests in the principles and processes by which scarce resources are distributed.

The practical implication is a two-level responsibility model. Bedside clinicians should not be permitted to disclaim all responsibility because scarcity is structural; organizations should not be permitted to discharge their responsibility by instructing clinicians to “use judgment” without providing authority, information, or review mechanisms. Escalation without a destination is not a meaningful safeguard. Documentation without institutional learning merely records recurrent failure. Scarcity without moral abandonment therefore requires organizations to treat repeated bedside constraints as

signals about governance and capacity, not only as isolated clinical inconveniences.

Objections and non-ideal conditions

The strongest objection is that an ethical framework for practicing under scarcity could make scarcity more tolerable and thereby normalize preventable undercapacity. A system might become better at explaining restrictions while leaving their causes untouched. The framework must therefore distinguish adaptation from justification: maintaining duties under scarcity does not make the scarcity itself acceptable, efficient, or just. Recurrent constraints should remain objects of organizational scrutiny rather than being absorbed into bedside professionalism.

A second objection concerns structural inequality. Formally neutral criteria can reproduce racial or socioeconomic disadvantage, while disability-sensitive analysis shows that seemingly straightforward triage criteria may conflict with requirements of equal respect and disability justice [28, 29]. Procedural consistency is therefore not sufficient evidence of fairness. The framework’s verification, mitigation, escalation, and review steps should include attention to whether apparently uniform decisions place systematically different burdens on patients because of prior structural disadvantage. These ethical concerns do not establish identical legal requirements across jurisdictions.

A third objection is feasibility. Emergencies may leave no time for sequential deliberation; alternatives may truly be absent; escalation may fail; and independent review may arrive too late. The framework does not require impossible process. Under severe non-ideal conditions, its minimum claim is that whatever agency remains should not be surrendered unnecessarily. When the system cannot restore the missing option, clinicians and institutions can still avoid deception, unexplained disengagement, and withdrawal of feasible care.

Limitations

This is a normative framework assembled from literatures with different purposes, populations, and levels of analysis. Much of the strongest evidence concerns intensive care, pandemic triage, oncology,

nursing, or particular health systems. Extension to rehabilitation, diagnostics, specialist access, referral pathways, and routine chronic scarcity is therefore conceptual and requires testing rather than assumption. The framework is also intentionally bedside-centered. Resource-allocation ethics can include obligations concerning intertemporal sustainability and the effects of present allocation on future patients and system capacity [30]. Those macroethical questions are not resolved by a framework whose primary concern is what remains owed to a currently affected patient.

Finally, conceptual coherence does not demonstrate feasibility, acceptability, equity, or clinical benefit. Public perspectives on triage are context-dependent, cautioning against assuming that one allocation process will be regarded as legitimate across populations or jurisdictions [31]. Future research should test whether clinicians, patients, ethicists, administrators, and affected communities can reliably distinguish the framework's concepts; whether escalation and review are equitably accessible; and whether some proposed duties create unintended burden, delay, or conflict. Such findings could refine, reorganize, or reject parts of the framework.

Conclusion

Scarcity can legitimately restrict access to clinically relevant care, but restriction and abandonment are not equivalent. The proposed Scarcity Without Moral Abandonment Framework identifies a persistent ethical floor after system constraint reaches an individual patient. It asks whether the constraint is genuine, reducible, clinically substitutable, beyond bedside authority, temporally tolerable, or sufficiently contestable to require review, while preserving explanation, feasible care, documentation, and reassessment across pathways.

The framework neither promises unavailable resources nor turns clinicians into guarantors of system adequacy. It is not a legal standard, validated algorithm, implementation protocol, or universal allocation theory. Its contribution is a normative distinction: health systems may sometimes be unable to provide what would otherwise be clinically relevant, yet that inability does not by itself erase responsibilities toward the person who bears the loss. Whether the proposed ethical floor is useful, equitable, and workable across settings remains an empirical and normative question.

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