CAN MEDICINE REMAIN ARS CURANDI? STRUCTURAL TENSIONS BETWEEN INDIVIDUAL RIGHTS AND HEALTHCARE SYSTEM RESILIENCE UNDER CONDITIONS OF SCARCITY

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Анотация

Силвия Капикова, Войтех Озоровски, Мария Новакова. Може ли медицината да остане Ars Curandi? Структурните напрежения между правата на личността и устойчивостта на здравната система в условията на ресурсен дефицит. В изследването се разглежда нарастващото напрежение между защитата на правата на отделния пациент и необходимостта от поддържане на устойчивостта на здравната система в условия на ресурсен дефицит. Въз основа на съвременните предизвикателства, като извънредните ситуации в здравеопазването, недостига на медицински персонал и нарастващото търсене на медицински услуги, се прави опит да се отговори на въпроса: "Може ли медицината да продължи да изпълнява традиционната си роля на ars curandi, функционирайки в условията на структурни и финансови ограничения?". Особено внимание се отделя на взаимовръзката между професионалната автономия на лекарите, достъпа до медицинска помощ и колективните интереси в ситуации, в които здравните ресурси са ограничени. Изследването допринася за научната дискусия, концептуализирайки устойчивостта на здравната система като правно-етично предизвикателство, а не просто организационен или управленски въпрос. В статията се обосновава тезата, че устойчивото управление на здравеопазването изисква внимателен баланс между зачитането на правата на личността и мерките, насочени към гарантиране на функционирането на здравната система като цяло. Актуалните събития показват, че недостигът не може да бъде напълно елиминиран, но той трябва да бъде все по-предвидим и контролиран. Качеството на законите и подзаконовите нормативни актове има решаващо значение за гарантирането на прозрачност, рационалност и справедливост при предоставянето на медицинска помощ.

Ключови думи: недостиг на здравни услуги, устойчивост на здравеопазването, права на пациентите, AAAQ система, автономия на лекарите, здравно законодателство

Анотация

Сільвія Капікова, Войтех Озоровський, Марія Новакова. Чи може медицина залишатися Ars Curandi? Структурні напруженості між правами особистості та стійкістю системи охорони здоров'я в умовах дефіциту ресурсів. У дослідженні розглядається зростаюча напруженість між захистом індивідуальних прав пацієнтів та необхідністю підтримувати стійкість систем охорони здоров'я в умовах дефіциту ресурсів. Спираючись на сучасні виклики, такі як надзвичайні ситуації в галузі охорони здоров'я, нестача робочої сили та зростаючий попит на медичні послуги, здійснюється спроба відповісти на питання: "чи може медицина продовжувати виконувати свою традиційну роль ars curandi, працюючи в межах структурних та фінансових обмежень?". Особлива увага приділяється взаємозв'язку між автономією лікарів, доступом до медичної допомоги та колективними інтересами в ситуаціях, коли ресурси охорони здоров'я обмежені. Дослідження робить внесок у дискусію, концептуалізуючи стійкість охорони здоров'я як юридичний та етичний виклик, а не просто організаційне чи управлінське питання. У ньому стверджується, що стале управління охороною здоров'я вимагає ретельного балансу між повагою до прав особистості та заходами, спрямованими на захист функціонування системи охорони здоров'я в цілому. Сучасні події свідчать про те, що дефіцит не можна повністю усунути, але його потрібно все частіше передбачати та контролювати. Якість законів та підзаконних актів має вирішальне значення для забезпечення прозорості, раціональності та справедливості у наданні медичної допомоги.

Ключові слова: дефіцит медичних послуг, стійкість охорони здоров'я, права пацієнтів, система AAAQ, автономія лікарів, законодавство про охорону здоров'я

Annotation

Silvia Capikova, Vojtech Ozorovský, Maria Nováková. Can Medicine Remain Ars Curandi? Structural Tensions Between Individual Rights and Healthcare System Resilience Under Conditions of Scarcity. The study examines the growing tension between the protection of individual rights of patient and the need to maintain the resilience of healthcare systems under conditions of resources scarcity. Drawing on contemporary challenges such as public health emergencies, workforce shortages, and increasing demands on healthcare services, it explores whether medicine can continue to fulfil its traditional role as Ars Curandi while operating within structural and financial constraints. Particular attention is paid to the relationship between physician autonomy, access to care, and collective interests in situations where healthcare resources are limited. The study contributes to the debate by conceptualizing healthcare system resilience as a legal and ethical challenge rather than merely an organizational or managerial issue. It argues that sustainable healthcare governance requires a careful balance between respect for individual rights and measures aimed at safeguarding the functioning of the healthcare system as a whole. Contemporary developments suggest that scarcity cannot be fully eliminated, but must be increasingly anticipated and managed. The quality of laws and bylaws is crucial for ensuring transparency, rationality and fairness in healthcare delivery.

Keywords: healthcare resources scarcity, healthcare system resilience, patients' rights, AAAQ framework, physicians' autonomy, health law

Recent global crises, including the COVID-19 pandemic, have exposed structural vulnerabilities in health care systems and challenged their normative foundations. While health care in many European countries, including Slovakia, is formally grounded in principles of solidarity and universal access, persistent shortages of healthcare professionals, financial and material resources and medical supplies increasingly limit the system's capacity to meet health needs even in times of continous medical innovations. Rights-based approach is of crucial importance in countries where health care is perceived as a branch of economy with jsts slightly regulated "free hand of market", too.

While resource scarcity exists in all systems, war conditions and humanitarian crises expose, intensify, and make explicit the misalignment between the commitment of medicine to the individual patient and the constraints imposed by system survival. Extreme situations of armed conflict, such as those experienced in Ukraine, should not be approached as points of comparison with intact health systems, but rather as contexts in which underlying structural tensions within health care become visible in their most acute form.

This paper argues that contemporary health care must be understood as operating at the intersection of two analytically distinct levels: medicine as ars curandi, centred on the individual patient and clinical judgment, and the health system as a material and organisational infrastructure that conditions the possibility of medical practice. Under conditions of scarcity, a misalignment emerges between these two levels. While the clinical logic of medicine is oriented toward the needs of the individual patient, the system-level logic is driven by constraints of resource allocation, prioritisation, and continuity of services. By conceptualising this tension and clarifying the role of legal regulation within it, this paper contributes to a deeper understanding of how individual rights, clinical practice, and system-level imperatives can be balanced under recent challenges.

Our analysis focuses on the relationship between the human rights-based AAAQ framework (availability, accessibility, acceptability, quality) (UN Committee on Economic, Social and Cultural Rights, 2000) in one hand and the concept of health system resilience (World Health Organization, 2024) on the other. The AAAQ framework, explicitly formulated by the UN Committee on Economic, Social and Cultural Rights in 2000, expresses a normative commitment to universal and equal access to care, presupposing that health systems are capable of delivering at least a minimum standard to all. By contrast, resilience framework emphasises the capacity of the system to anticipate, absorb, and adapt to shocks, often requiring prioritisation and the allocation of limited resources. These frameworks thus operate according to different normative logics and come into structural tension when not all individual entitlements (rights) can be realised simultaneously.

Scarcity also exposes a conflict between two distinct ethical frameworks: one oriented toward the individual, and the other toward the system. While traditional medical ethics (Trizuljaková, 2017) is grounded in principles such as beneficence, non-maleficence, and respect for autonomy, these principles are primarily oriented toward the individual patient. Public health ethics (Coughlin, 2008) is focusing control over variety of determinants to maintain health. In contrast, ethical reasoning at the level of the health system increasingly relies on additional principles, such as solidarity, utility, duty to care, stewardship, and proportionality, which reflect the need to allocate limited resources and maintain system functionality. These principles do not replace classical medical ethics, but operate alongside it, often generating tension between the commitment to individual care and the demands of population-level decision-making.

Many authors had addressed the issue of equitable allocation of resources in response to an acute public health threat claiming the need to balance competing values (O'Sullivan, et al., 2022; Emanuel, Persad, 2023). Emanuel and Persad (2023) developed a general ethical framework for the allocation of scarce medical resources face to face to accute public health threats, identifying key principles such as maximizing benefits, mitigating unfair disadvantage, and ensuring equal

moral concern. Drawing on experiences from the COVID-19 pandemic, including triage protocols and allocation frameworks (O'Sullivan, et al., 2022; Emanuel, Persad, 2023; Emanuel et al., 2020), we argue that distributive justice becomes increasingly inherent to clinical practice under conditions of scarcity. Decision-making is no longer confined to determining what is medically appropriate for a particular patient but increasingly involves evaluating how limited resources should be distributed across competing claims. In this context, clinical judgment becomes inseparable from considerations of fairness, prioritisation, and system sustainability.

Within this tension, health law and legal regulation assume a crucial but often under-theorised role. Law does not eliminate the need for allocation, nor law resolves the underlying conflict between individual rights and system constraints. Rather, law structures this conflict by providing the normative and procedural framework within which allocation decisions can be made. Legal rules and principles – such as non-discrimination, proportionality, and due process – transform allocation from an ad hoc or purely clinical practice into a legitimate and accountable form of decision-making. In doing so, the law mediates between the logic of individual rights and the logic of system resilience. For law, this creates a particularly demanding task: not merely to balance competing values or principles, but to mediate between fundamentally different normative logics. This mediation role becomes particularly visible in situations where not all rights can be simultaneously realised.

At the same time, legal regulation performs a limiting and protective function: it sets boundaries to prioritisation and prevents the complete subordination of individual entitlements to system-level considerations. Thus, law simultaneously enables and constrains allocation, making visible the structural nature of the tension it seeks to govern. In conditions of legal uncertainty, this mediation function weakens, potentially leading to inconsistent or non-transparent allocation practices. Thus, quality of laws and bylaws is crucial to ensure transparency, rationality, fairness in delivering health care.

Preparedness frameworks institutionalise the expectation that scarcity must be managed through allocation, not eliminated. Crisis preparedness framework transforms scarcity from an exceptional situation into a foreseeable and governable condition of health system operation. Scenarios of scarcity must be anticipated and allocation principles must be embedded into planning and legal frameworks. As a result, allocation logic becomes integrated into the organisation of care and care delivery even before crises occur. A prominent example on an international level is the WHO Pandemic Agreement (World Health Organization, 2025).

As noted in the literature, “governments and policy makers must do all they can to prevent the scarcity of medical resources” (Emanuel, et al., 2020, p. 2054). However, it is not always possible to secure sufficient resources. Contemporary developments in health system governance suggest that scarcity cannot be fully eliminated, but must increasingly be anticipated and managed. In this sense, a tension emerges between the normative aspiration to avoid scarcity and the practical necessity of organising health care under conditions where limited resources are a persistent reality. The resulting structural tension between individual rights, material constraints, and system resilience is not a contingent failure, but a constitutive feature of contemporary health care systems. We conclude, that scarcity does not alter the fundamental aim of medicine as ars curandi, but reshapes the conditions under which this aim can be realised. Thus, need for legitimacy, transparency and legality of distributive mechanisms is of utmost importance and requires expertise overarching traditional disciplinary boundaries.

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