



Health Care Ethics and Rural Life

STIGMA, PRIVACY, BOUNDARY CONFLICTS RAISE CONCERNS

BY WILLIAM A. NELSON, Ph.D.

Ethics challenges long have been recognized as a common phenomenon in health care. Less recognized is how the geographical context — especially the rural context — can influence both the presentation and the response to the challenges. Historically, the rural context has received limited attention in relation to its influence on ethical challenges and value conflicts. I'd like to review the growing awareness of this influence, and to note implications of some of the ethical challenges common to rural settings.

THREE CASES

■ **Susan, recently appointed chief executive officer** of a small, rural critical access hospital, was attending church on Sunday morning. She had previously worked at a 140-bed suburban hospital located on the outskirts of a large urban center.

The pastor of the rural church also serves as the volunteer chaplain at Susan's hospital. During the time allotted for announcements, the pastor began listing the names of people admitted to the hospital, including one person scheduled for surgery the following day. The surgeon who would be performing the operation also was in church that morning. The pastor wanted to be sure the congregation remembered both the surgeon and the patient in their prayers.

The new hospital administrator

was troubled by what appeared to be not only a serious violation of privacy, but also a breach of HIPAA privacy regulations. Concerned, she approached the pastor after the service to ask about the perceived indiscretion.

"Susan," he said, "you don't really understand, we don't have all the community visiting nurse programs and other types of health care programs you might be accustomed to in the city you moved from. We look after one another in this community. It's part of our community's values and tradition. We have to know the health needs of our neighbors in order to provide support for the community member and his or her family."

The hospital administrator paused and suggested they discuss the issue in a different setting.

■ **A family physician** recognized that Bob, a patient she was treating for a farming accident, also had a serious depression related to several family problems. When the physician raised her concern and suggested he get support from a

psychologist, Bob quickly indicated he did not want to see a psychologist in a neighboring town. People would recognize his truck parked outside the psychologist's office, Bob told her, they would think he's crazy. Bob also asked her not to put anything in his chart about the depression because a close friend worked in the medical office.

■ **Margaret, a patient with chronic lung disease**, approached her nurse practitioner at the local grocery store and apologized for several missed appointments. Margaret said her husband lost the family's insurance coverage because his logging company could no longer afford it. Margaret asked whether the nurse practitioner would still see her and offered to try to pay over time. Margaret also indicated she is more than willing to



do cleaning at the clinic or at the nurse practitioner's home in exchange for health care visits.

The ethics questions in the above cases involve confidentiality, disease stigma and the privacy of information, as well as boundary conflicts and economics — providing health care to patients lacking financial resources. They are not necessarily dramatic issues, and they can occur in any geographical setting. However, the rural context clearly influences and wraps itself around the ethics questions and responses.

SETTINGS SHAPE HEALTH CARE ETHICS

As the three situations indicate, characteristics common to rural settings influence health care ethics. Those characteristics are very real to me because I divide my life between New York City and a rural community in New Hampshire near Dartmouth Medical School.

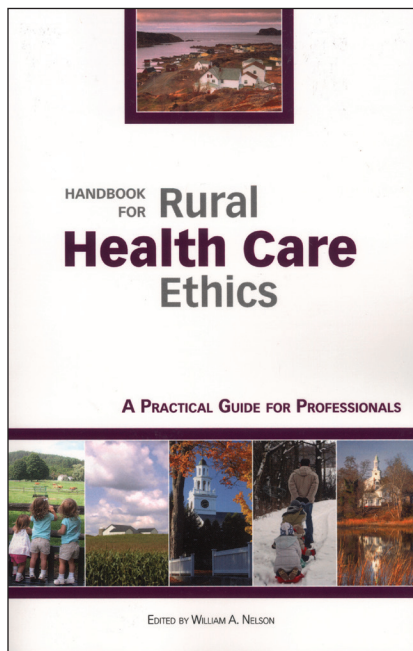
What I get to enjoy and deeply appreciate is a city life and a country life. My geographical dance gives me insight about why some people love one, some the other. I love both. The dual settings also give me a unique perspective on how each setting can shape health care ethics. In my rural life, I experience the small population density and geographical separation from a large population center. I witness a rural community's economic status and cultural values, and I see how the availability, acceptance and use of health care services differ in rural and urban areas. I also see how those differences affect the delivery of health care.

Specific differences include:

■ **Limited economic resources.**

The rural population has a lower income per capita and higher rate of poverty compared to the urban population. Rural residents are also more likely to be underinsured or uninsured, further increasing the financial hardship of interacting with the health care system, as in the situation of Margaret and her family.¹

■ **Limited availability and accessibility of health services.** Rural resi-



In light of the distinct challenges of delivering health care in rural America, William A. Nelson, author of this article, gathered a team of experts to reflect and write about medical ethics in a rural context. The result, *Handbook for Rural Health Care Ethics: A Practical Guide for Professionals*, was published in 2009 by Dartmouth College Press. Sellers include Amazon.com, and the book, or selected chapters, can be downloaded free of charge at <http://dms.dartmouth.edu/cfm/resources/ethics/>.

dents tend to have a limited scope of medical services available. A variety of health care professionals are in short supply, including nurses, social workers, dentists and home-based providers. Mental health services are especially limited for people living in rural communities.²

Rural residents generally have to travel greater distances for access to different points of the health care delivery system. The lack of public transportation, along with challenging road and weather conditions, may limit or prevent them from getting to facilities or providers.

Health care facilities in rural areas generally are small, and most hospitals are designated critical access facilities offering a maximum of 25 acute-care beds and emergency care services. To help keep hospitals in rural settings available and economically solvent, Congress in 1997 created the critical access hospital designation and allowed them to seek Medicare reimbursement on a cost-basis method. As of July 2010, there are 1,305 such hospitals in rural America.³

■ **Rural Health Status.** Rural residents tend to have poorer overall health compared to non-rural residents. For example, they are more likely to have a chronic or life-threatening disease and to face significant mental health disorders. Rural populations also have higher rates of infant mortality and suicide, and they encounter a higher prevalence of environmental and occupational hazards, such as those related to farming and logging.

Rural communities have a higher proportion of residents, especially adolescents and elderly people, who require more health services.

More facts and figures comparing rural and urban health status are available on the websites of the National Rural Health Association (ruralhealthweb.org) and the Rural Assistance Center (www.raconline.org).

■ **Shared Community Values and Culture.** The cultural values, traditions and beliefs of rural residents affect health care in rural settings. Though there may not be a single all-encompassing "rural culture," most rural communities are culturally and ethnically distinct from urban settings. There usually is less ethnic diversity within a given rural community, although there can be ethnic diversity from one rural community to another, depending on its location.

Geographic factors like distance from population centers mean living in small towns or sparsely populated areas. These create unique, shared experiences for residents, especially in regard to health care. Personal and shared cultural values such as self-



reliance, self-care and a strong work ethic affect how residents perceive illness; when and from whom they seek health care; their attitudes toward and acceptance of caregivers; how they think about the decision-making process in health care; and what kinds of treatment decisions they make. They tend to define health and illness more by whether they are able to work than in medical terms.⁴

The greater the extent to which a community shares certain values, the more likely those values strongly influence health care relationships and practices. Additionally, the more pervasive community values and perceptions differ from the professional perspective and ethos of clinicians, the more likely it is that ethical conflicts will arise. This was the situation when the pastor indicated to Susan that the community's values and tradition necessitated sharing information to provide health care support.

The low population density, isolation, limited health care resources and services and the close-knit nature of rural communities affect the availability and use of public support for health-related needs. Rural residents tend to look to families and friends first, and these informal support systems are usually reciprocal, implicitly based on the understanding that the recipient of help now will later be repaid in kind. Support services provided by community or civic organizations are seen as complements to the efforts of family and friends.

■ **Overlapping Professional-Patient Relationships.** A rural community's geographical and social structure means rural health care providers commonly participate in multiple and overlapping relationships, as is the case all three ethical situations presented above. Practicing medicine in a small setting generally means living and working in the same place.

For Susan, the hospital administrator, going to church meant seeing the hospital chaplain. For Bob, going to the psychologist's office meant neighbors would see his truck and

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jump to conclusions. For the nurse practitioner, going to the grocery meant running into a patient. Everyone knows one another; everyone certainly knows the community's physician, nurse or hospital executive.

It is both common and expected that rural health care professionals will interact with patients outside the professional realm. During a focus group on boundary issues in provider-patient relationships, a pharmacist said, "Rarely do I go anywhere in town without meeting a client." A physician noted that his best friends are patients and neighbors: "We regularly go fishing together."

These multiple relationships can enhance the professional-patient relationship. The ongoing contact gives health professionals a rare opportunity to know their patients in depth, as well as to understand their values and perspectives.

However, it also can complicate patient care or, as in Susan's example, create potential boundary ethics conflicts for hospital management.⁵

■ **Caregiver Isolation and Stress.** The combination of professional isolation, overlapping relationships, immense clinical responsibilities and emotional and physical exhaustion

commonly lead to significant stress for health care professionals in rural communities. As in the example of the nurse practitioner whose patient offered cleaning services in exchange for health care visits, it is difficult to deny care to a patient, friend or neighbor, yet alternative financial arrangements can deny the professional a source of needed revenue. Rural providers, especially in isolated communities, tend to have limited resources in the way of colleagues to help them cope, and the rural value of self-reliance leads many providers to just stoically accept the stress — or burn out.⁶

LIMITED RURAL ETHICS RESOURCES

Despite the extent of ethical conflicts arising in rural health care, ethics resources specific to the characteristics of rural settings are limited. Historically, the ethics literature has scarcely addressed rural issues. Rural clinicians have commented that professional codes of ethics and guidelines are inattentive to the conflicts that exist in small communities. Furthermore, rural practitioners attending ethics training have indicated the training had such an urban bias that it provided little assistance.⁷

Few health care ethicists work or live in rural communities, compared to urban areas, and there are significantly fewer professional ethics resources available, including ethics committees. Where rural facilities do have ethics committees, many obstacles undermine their effectiveness, including the lack of a professionally diversified membership, members' competing commitments, the inability to meet regularly and the unavailability or inaccessibility of adequate ethics training.

While it is true that professionals

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in large urban facilities also have multiple responsibilities, small rural hospitals tend to have a limited number of professionals on staff, so these problems are exacerbated. Rural staff members may hesitate to use ethics committees because these health care professionals do not see many everyday problems as ethics issues. They also tend to favor informal supports, such as spouses or peers, rather than formal ethics committees.⁸

GROWING RECOGNITION

The past decade has brought a growing recognition and understanding of the unique ethical challenges in the delivery of health care in rural America.⁹ There has been significant growth in the number of rural ethics publications, many based on quantitative and qualitative research. There appear to be increasing numbers of rural hospitals with ethics committees. More ethicists are focusing on rural ethics issues, and this kind of recognition is important. As I noted in the *Handbook for Rural Health Care Ethics: A Practical Guide for Professionals* (see box, page 52), the next step should be for professional schools to expand their focus in rural health care ethics education and training. Ethics and other educators should:

- Increase their understanding of the rural contextual impact on health care delivery

- Build opportunities into the curriculum for students to learn about rural ethical issues

- Use rural-focused case studies and articles in teaching

- Use rural-based faculty for presentations and discussions

National discussions and debate over delivering high quality health care to all citizens have helped focus attention on the health care disparities between rural and non-rural settings. Examples include:

- The National Rural Health Association and other groups have advocated for increased federal and state funding for rural hospitals, clinics and health

care professionals, and they have developed strategies for increasing the number of health care professionals choosing to work in rural settings

- The U.S. Congressional Rural Caucus has lobbied for greater funding to enhance rural health care

- The Department of Veterans Affairs has established the Office of Rural Health (www.ruralhealth.va.gov/ruralhealth/index.asp) to “improve access and quality of care for enrolled rural and highly rural veterans by developing evidence-based policies and innovative practices to support the unique needs of enrolled veterans residing in geographically remote areas”

When I return from small-town New Hampshire to the city, I begin the search for that uncommon commodity, a parking spot. As I drive around my neighborhood looking for a rare space, I may pass as many as three large, tertiary hospitals — the kinds of facilities that aren’t part of the highway scenery along with open landscapes, white church steeples, deer and moose crossing zones and other unique characteristics of rural New England.

I quickly realize I am back to a world of high-tech, specialized medicine bringing the kinds of ethical challenges routinely discussed in the medical ethics literature and courses.

The contrast is striking. However, I am encouraged that rural health care and more specifically, rural ethics are gaining recognition as a special area of focus. Understanding health care disparities and their specific ethical issues is an important step that can contribute to ultimately moving us forward in providing quality of care for all residents, including rural America.

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Author’s note: My rural ethics work is supported in part by the Veterans Rural Resource Center, White River Junction, Vt. The views expressed in this article do not necessarily represent the views of the Department of Veterans Affairs or of the United States government.

NOTES

1. Kevin J. Bennett, Bankole Olatosi and Janice C. Probst, *Health Disparities: A Rural-Urban Chartbook* (Columbia, S.C.: South Carolina Research Center, 2008).
2. Larry D. Gamm et al., eds., *Rural Healthy People 2010: A Companion Document to Healthy People 2010* vol. 1 (College Station, Texas: The Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center, 2003).
3. Rural Assistance Center, “Critical Access Hospitals,” http://www.raconline.org/info_guides/hospitals/cah.php
4. Angeline Bushy, “Nursing in Rural and Frontier Areas: Issues, Challenges and Opportunities,” *Harvard Health Policy Review* 2006; 7(1): 17-27.
5. William A. Nelson, “Boundary Issues in Rural America,” *Healthcare Executive* 2010; 25(2): 54-57.
6. Laura Roberts et al., “An Office on Main Street: Health Care Dilemmas in Small Communities,” *Hastings Center Report* 29, no.4 (1999):28-37.
7. William A. Nelson, “The Challenges of Rural Health Care,” in: *Ethical Issues in Rural Health Care*, ed. Craig M. Klugman and Pamela M. Dalinis (Baltimore: Johns Hopkins University Press, 2008): 34-59.
8. Ann Freeman Cook and Helena Hoas, “Re-framing the Question: What Do We Really Want to Know About Rural Healthcare Ethics?” *American Journal of Bioethics* 6, no. 2 (2006): 51-53.
9. William A. Nelson, Mary Ann Greene and Alan West, “Rural Health Care Ethics: No Longer the Forgotten Quarter,” *Cambridge Quarterly of Healthcare Ethics* 19, no. 4 (forthcoming).

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

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Reprinted from *Health Progress*, September-October 2010
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