



CHAPTER 13

Ethics Conflicts in Rural Communities: Reproductive Health Care

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Ethics Conflicts in Rural Communities: Reproductive Health Care

Barbara Elliott, Ruth Westra

ABSTRACT

For the rural health care professional, it is essential to create a practice where community members can expect trust, respect, and safety in their patient-clinician relationships. This goal becomes critical when the practice includes reproductive health care, a specialty where providers may experience heightened ethics concerns regarding the management of clinical information. When health care is needed as a consequence of sexual activity that strays from the community's culture or norms, the clinician and clinic can be put into a difficult position. Both medical and social circumstances require appropriate care, confidentiality, truth-telling, and careful boundaries. In order to avoid such conflicts, specific and personal guidelines can be indispensable. When the professional communicates expectations up front, he or she lets patients know that they will receive appropriate care, whatever their circumstances, and that confidentiality of their personal medical information is carefully guarded. Clinician stress is reduced, and patient-clinician relationships are enhanced, when clinicians can establish and maintain clear boundaries in their clinical relationships, and take the time to examine their own views regarding birth control, abortion, and sexual liaisons. These personal efforts on the part of the clinician can assure objectivity and integrity in a practice that includes reproductive care.

CASE STUDIES

CASE 13.1 | Birth control for a minor

Dr. Bennally has been a friend of the Rosenthal family since coming to town 18 years ago as a family physician. The Rosenthal's oldest child, Sally (15 years), has come to the office to have a physical for the school's track team. Her mother has brought her to the office but, as usual, Dr. Bennally sees Sally alone. After taking the history and doing an exam, it is evident that Sally wants to talk. In response to a question about dating, she explains that she has been dating one boy for the last six months. Sally says she really likes him a lot, and although they "haven't done it yet, they have been thinking about it a lot." Sally is wondering if she could start taking birth control pills. Sally also explains that her parents do not know anything about her sexual activity. Sally says that when she tried to talk with her mother about sex, Mrs. Rosenthal just, "got weird—talking about babies having babies, and nobody having morals any more." Sally says that her mother would be very upset if she knew Sally is considering birth control, and asks that Dr. Bennally not share this information with her parents.

CASE 13.2 | Managing and treating sexually transmitted infections

Dr. Haladay, a family physician, is providing care for Joan Larson, who is 26 weeks pregnant. This is her third pregnancy; her previous two vaginal deliveries went easily and her babies were born at full term. Ms. Larson and her husband attend the same house of worship as Dr. Haladay and her family. When Ms. Larson comes to the clinic for the appointment, she complains of a "sensitive area" that "really hurts" on her perineum. The exam confirms that she has developed herpes simplex infection (HSV). Dr. Haladay explains how this may result in the possible need to plan for a C-section with the upcoming delivery. Joan Larson is horrified, and then somewhat chagrined. She admits to having had an affair with a well-known community member, who is likely the source of the infection. Ms. Larson's husband, Mr. Larson, does not know

about the extramarital relationship and she does not want him to know. She is certain that her husband is the father of the child she is carrying. Ms. Larson asks Dr. Haladay to treat the infection—and not to put the information in the chart or tell her husband.

OVERVIEW OF ETHICS ISSUES

Several ethics issues come into play regarding reproductive health issues. These issues are listed in Box 13.1.

BOX 13.1

ETHICAL DIMENSIONS OF REPRODUCTIVE HEALTH CARE

- Confidentiality
- Truth-Telling
- Boundary Issues
- Community and Personal Values
- Paying for Care
- Referrals to Distant, Specialized Providers

Confidentiality

One of the essential concerns in managing ethics tensions in rural settings is the need for confidentiality.¹ This becomes especially important for patients with reproductive health issues in rural settings, given their limited care options, unique community values, and overlapping patient-clinician relationships. Confidentiality can be difficult to maintain in a small community, where the people who work at the clinic are relatives, friends, and neighbors. However, in order to “do no harm,” confidentiality is vital. Charts and billing records need to contain information that supports continuity of care. Balancing the ethics burdens associated with confidentiality can also isolate clinicians, adding to clinician stress.^{1,2}

Truth-Telling

Overlapping relationships, community and personal values, and clinician stress all share a common core ethics issue: truth-telling. Questions, such as: how much of the truth is revealed to the patient and when; to what extent should information be placed in the medical record; and so

on, are all part of the scope of truth-telling. It is important for the clinician to establish the habit of being honest and objective about medical diagnoses and treatments when talking with patients. This can become socially and emotionally complicated, given the expectations and values of the people involved and the community. Nevertheless, in order to ensure informed consent, provide appropriate medical care, and protect the community's public health, the truth needs to be told.^{3, 4}

Boundary Issues

Tensions around boundary issues are brought into patient-clinician encounters by the clinician, the patient, and/or the patient's family.^{1, 2, 4} When working with patients regarding sexual or reproductive health diagnoses and treatment decisions, ethics tensions may be increased by differing community and personal values, and by overlapping relationships. Such conflicts can put the clinician in a difficult position regarding how he or she offers recommendations. A clinician's scientific and/or social objectivity may be limited when specific sexual liaisons are revealed, or particular sexual infections are diagnosed. Clinician stress can also be increased in these circumstances.

Community and Personal Values

Ethics tensions are heightened when personal values and the community's culture are part of the clinical decision-making process.^{4, 5} Decisions that are impacted by social and/or personal stigma increase the provider's difficulty in decision-making, and complicate patient-clinician relationships. With limited access to alternate care settings,^{2, 4} these value conflicts can undermine appropriate medical care, and can add to both the patient's and the clinician's stress.

Smaller communities frequently include less diversity in values.⁵ As a consequence, the community's norms are narrower than larger settings and there may be less tolerance for a variety of experiences.^{4, 5} For example, if community values include the traditional sexual expectation of "sex only after marriage, and then monogamy," all sexual behavior is assessed in this light. Appropriate and responsible medical care for any sexually active person includes birth control and the prevention and treatment of sexually transmitted infections. These medical interventions should be indicated, and care provided to all patients, even those who

are not meeting the community's expectations. Providing this care is made more difficult when the clinician's own values are offended by the patient's sexual activity, and patient-clinician tension is increased.

Paying for Health Care

Clinical settings are fiscally precarious, especially in rural settings where the costs associated with the care of one patient can mean being in the black or in the red.^{1,2} Third-party payers have access to the charted notes regarding care for which they are asked to pay, so billing records need to be consistent with charted care. When confidentiality is necessary because of personal and/or community values, arranging payment for rendered care must also be discrete. The business side of practice can be ethically complex and requires great care, adding to clinician stress.

Referrals to Distant, Specialized Providers

Because rural areas often have limited access to specialized clinicians and resources, referrals to distant hospitals are common.^{1,2,4} This can result in diminished resources for the local care community, and requires patients to travel far and sometimes spend extended time away from home. This travel issue raises both financial and personal ethics issues for the community, clinician, and patient.^{1,2} The ethics tensions in making these referrals add to the complexity of decisions that need to be made and add to clinician stress.

Rural Characteristics That Intensify Ethics Issues

In rural settings, the ethics concerns that are commonly involved in reproductive health care are heightened by the specific characteristics of rural settings. These characteristics are described in Box 13.2.

BOX 13.2

RURAL CHARACTERISTICS INTENSIFYING ETHICS ISSUES IN REPRODUCTIVE HEALTH CARE

- Availability and/or limited access to care and services
- Overlapping relationships between patients and clinicians
- Community and personal values
- Clinician stress

For example, rural communities offer close support and supervision of family units and sexual behaviors. When health care is needed for sexual activity that strays from the community's culture and norms, the clinician and clinic can be put into a difficult position (re: experiences with HIV and related diseases, etc). Health care that is medically appropriate, but required as a result of socially stigmatized relationships and behaviors, becomes fraught with ethics tensions.³ The resulting pressures, both from within the patient-physician relationship and without, can actually become barriers to accomplishing the needed care.

Availability and/or Limited Access to Care and Services

One ethics issue that increases providers' concerns in the reproductive health arena is the limited number of clinicians and medical facilities in rural areas.⁶ In most settings, few clinicians work in each clinic. Few options for reproductive health care are available other than the 'local clinic' (e.g., Planned Parenthood, etc). This limitation increases the likelihood that all sexual and reproductive health issues will be treated through one set of clinicians.

Overlapping Relationships Between Patients and Clinicians

The providers who work in the local clinic are also part of the community, and they have relationships beyond their clinical connections.^{1,4} All community residents have opportunities to participate in activities with one another. These overlapping relationships, whether at work, school, a place of worship, ballpark, or neighborhood, can increase the ethics tensions related to needed health care as a consequence of sexual behavior. The expectations of the community and individuals can complicate the clinician's relationships.

Health Care Provider Stress

A clinician needs to manage all circumstances that heighten tensions within the patient-clinician relationship. These circumstances often create additional stress for the clinician, who in turn needs to increase attention to his or her own personal care.^{1,4} Given so many overlapping relationships, the clinician in a smaller community is often in a position where his or her own values need to be set aside when providing care. In many cases, the characteristics of a case can isolate the clinician to the extent that he or she cannot manage the stress by

simply talking with colleagues. Instead, the provider needs to develop additional ways to cope with the stress that can arise as a result of these cases.

These characteristics of the rural health care experience especially amplify the ethics challenges related to reproductive health care. The ethics issues that arise in these circumstances are certainly observed in practices everywhere. However, they are especially poignant in rural settings, and become important considerations for rural clinicians who want to create a practice in which community members can expect trust, respect, and safety in the patient-clinician relationship.

CASE DISCUSSION

Neither case presented at the beginning of this chapter involves ethics conflicts that are focused on clinical decisions. However, the clinicians and patients differ somewhat in their view about how best to accomplish the common goal of providing appropriate care. The first patient wants her information kept private from her parents; the second patient wants information kept private from both her husband and the insurance company. These differences generate ethics conflicts for the clinicians, especially in a rural context. In rural settings, personal, professional, and community issues complicate the clinicians' abilities to deliver state-of-the-art care.

The discussion of the cases is based upon the analysis method presented in Chapter 4 of this *Handbook*.

CASE 13.1 | Birth control for a minor

In this case, the clinician's personal and professional issues are especially poignant. The ethics questions raised by Sally Rosenthal's request are highlighted in Box 13.3.

To address these questions, additional information is critical to the clinician in deciding how to proceed. The needed information is related to Sally's maturing identity and relationships, to state laws regarding confidentiality in the treatment of minors, and to the clinician's personal and professional positions on birth control. It is clear that Sally is

BOX 13.3**ETHICS QUESTIONS IN THE CASE
OF BIRTH CONTROL FOR A MINOR**

- Should Dr. Bennally keep Sally's confidence?
- Who, if anyone, should tell Sally's parents about their daughter's sexual activities?
- Should Dr. Bennally prescribe birth control for Sally?

competent and is speaking for herself when she makes the requests for contraception and for confidentiality. She is at the appropriate developmental level for her age, and does not want to tell or involve her parents in her independent activities. Various states have their own laws regarding the confidentiality of medical information generally and with respect to specific types of information, such as that related to reproductive health care. As is noted in Chapter 7, The Health Insurance Portability and Accountability Act of 1996 (HIPAA) resulted in an overlay of federal privacy regulations. It is important that rural clinicians be aware of what the law requires of them and their staff members with respect to sharing patient information, as well as what it permits.

As is the case in many states, Dr. Bennally has no right to reveal medical information in this situation—the patient can have confidential relationships with clinicians around reproductive health issues.³ Thus, neither conversations nor medical records about Sally Rosenthal's health care relating to sexual activity are available to anyone else—including her parents—without her permission. State laws on minor consent vary and can apply differently to different types of medical information, so it is important to know the law in one's state. Each clinician has her own personal feelings about prescribing birth control to anyone at any age; each of us needs to know our own heart. The boundary issues and personal values concerns related to this assumption are significant because they can directly impact patient care.

State-of-the-art medical care for Sally indicates that Dr. Bennally should prescribe her requested contraception and should keep this care confidential. To provide this care and protect Sally from the perceived

harm of involving her parents, Dr. Bennally faces several ethics challenges. These challenges result from the clinician's overlapping roles in the rural community and the need to maintain confidentiality. The conflicts Dr. Bennally faces are described in Box 13.4.

BOX 13.4

ETHICS CONFLICTS IN THE CASE OF BIRTH CONTROL FOR A MINOR

- Personal and professional conflicts due to overlapping relationships in the community
- Professional conflict, because of concern that confidentiality may be breached in connection with payment or reimbursement for Sally's care and medications
- Anticipated conflicts related to the confidentiality of future care

Dr. Bennally's relationships with Sally, Mr. and Mrs. Rosenthal, and other relevant parties such as clinic staff, make adherence to ethical standards more difficult and add to her stress level. Her friendship with Sally's parents is based on expectations of honesty. How can Dr. Bennally maintain her friendship without sharing the confidential care she is providing for their daughter?

Confidentiality can also be strained when it comes to payment. Sally may need to pay cash for her care, or be billed directly—but not through the insurance company—in order to maintain the privacy she requests. How does Dr. Bennally maintain confidentiality when the billing system works against that process?

Finally, Sally will need to return for more injections or prescriptions in order for Dr. Bennally to provide the best possible care. Reminders about that care will also need to be handled confidentially. If Sally has medical problems as a result of the birth control or her sexual activity, Dr. Bennally may have to explain the circumstances to her parents. What would Sally want Dr. Bennally to say to her parents then? The complexity of maintaining confidentiality becomes a truth-telling issue.

CASE 13.2 | Managing and treating sexually transmitted infections

Professional and community values are especially important in the ethics issues raised by the second case. There are two ethics questions raised by Joan Larson, the wife who'd contracted herpes from an affair, and now wants her medical records not to indicate her STD so as to disguise the affair from her husband (see Box 13.5).

BOX 13.5**ETHICS QUESTIONS ABOUT MANAGING AND TREATING SEXUALLY TRANSMITTED INFECTIONS**

- Should Dr. Haladay keep Joan Larson's herpes diagnosis information out of the record?
- Who should inform Joan's husband, Mr. Larson, and her extramarital partner about the infection, if anyone?

These issues require more information that is critical in order for the provider to move forward. Dr. Haladay needs to obtain more information about Ms. Larson's medical condition and her pregnancy, and to plan for the care of the newborn. The doctor also needs to examine her own personal and professional truth-telling attitudes and skills. Ms. Larson is competent when she requests appropriate treatment for herself, the baby, and her partner, and when she requests confidentiality. She is an adult and does not want to involve her husband in this conversation. Since she is pregnant, Ms. Larson needs to be treated medically for her incident case of HSV, and will need careful monitoring until delivery.⁷ If the disease is active when she goes into labor, she will need to protect the baby from acquiring the disease by having a C-section, which will either mean a referral to the obstetrician in a regional center, or else careful planning around a local delivery if there is a local physician who performs C-sections. If a C-section occurs, it will necessitate decisions about how to explain the need for surgery to Ms. Larson's husband.

Though Ms. Larson's condition has implications for her baby, her husband, her partner, and perhaps the community at large, public health guidelines do not require reporting of HSV in most states. However, in

order to provide appropriate care, Ms. Larson's partner will need to be informed of these circumstances and be offered treatment to suppress his HSV. Ms. Larson's husband will need to protect himself from the disease by using condoms during intercourse, assuming he has not already contracted the disease.

Each clinician has his or her personal guidelines and habits regarding truth-telling in settings where there is high emotion around a socially sensitive diagnosis. Revealing bad news is a skill all clinicians develop, but certain circumstances involving sexual liaisons and overlapping relationships can be especially sensitive. This case discussion assumes that the clinician, Dr. Haladay, prefers honesty in both conversation and charting.

Given this information, appropriate care for Ms. Larson involves medications, increased monitoring of her pregnancy, and education about protecting others (her fetus and her sexual partners) from HSV. Ms. Larson has requested care and that the information regarding that care be kept confidential. This leads to several specific ethics conflicts for the clinician, as described in Box 13.6.

BOX 13.6

ETHICS CONFLICT ISSUES IN THE MANAGEMENT AND TREATMENT OF SEXUALLY TRANSMITTED INFECTIONS

- Maintaining the challenge of confidentiality is difficult in some cases, including potential the need to make a referral
- Billing for the care and medications will need to document the diagnosis
- Anticipating confidentiality needs for future care
- Boundary issues due to professional and personal contact with patient in the community
- Potential community health issue in the spread of infection

If Ms. Larson's request to keep the medical information confidential is honored, her medical care may be compromised, depending on how the medical and ethical issues are managed. Ms. Larson needs to be treated now for her active HSV infection. Her extramarital partner needs

to be evaluated now for suppressive therapy for his HSV infection. Ideally, her husband would also be evaluated for infection and treated as appropriate. However, if Dr. Haladay honors Ms. Larson's request for confidentiality about the infection and does not reveal it to her husband, Ms. Larson and Dr. Haladay will need to decide how to handle the billing for the necessary exams and cultures. If Ms. Larson decides to refuse the indicated tests, there may be an increased risk for harm to the fetus or need for a surgical delivery.⁸

These conflicts result from overlapping roles in the community, truth-telling, the need to maintain confidentiality while making referrals, and paying for care. When Dr. Haladay completes his charting and requests the referral (if a local C-section is unavailable), he will need to explain the reason for the consult, and written information returning from the consultant will include full discussion of the diagnosis. How can he maintain confidentiality while in contact with the obstetrician?

Confidentiality will also be put at risk when billing occurs. Either Ms. Larson will pay for her care directly, or the bill to the insurance company will need to be handled separately from any copy sent to the Larson home, as with the Rosenthal family in Case 1. How can confidentiality be maintained when the billing system works against that process?

Joan Larson may also need special care in the future. If Ms. Larson has delivery troubles or additional medical problems as a result of HSV, the clinician may need to explain the circumstances to her husband. What does Ms. Larson want Dr. Haladay to say then?

Maintaining confidentiality becomes more complicated and complex with each step. Dr. Haladay has friendships with both Larsons and the extramarital partner, outside of work. Each friendship is important, and their families' frequent interactions as members of the same house of worship extend the difficulty. Again, clinician stress is extenuated by being in a "no-win" position, and with the potential inability to discuss the tension with colleagues or at home. In addition to this, Dr. Haladay faces the potential for more infected patients if all parties are not notified and treated. How can Dr. Haladay achieve the public health goal of reducing the number of the community's sexually transmitted infections, when truth-telling does not occur?

RESPONDING TO REPRODUCTIVE HEALTH CARE ETHICS CONFLICTS

In both cases presented, the solutions to these issues are ideally negotiated within the clinical setting, based on professional guidelines that set clear expectations for care. First, clinicians should provide medical care that is evidence-based, and in accordance with professional standards to ensure the quality of patient care. Secondly, clinicians, within the context of the fiduciary patient-clinician relationship, should provide all the needed information in a confidential manner to foster a shared decision-making process. Thirdly, clinicians and their staff should ensure that they are adhering to the legal requirements, including making written information available for all patients regarding their privacy and confidentiality policies.

BOX 13.7

PROFESSIONAL GUIDELINES FOR REPRODUCTIVE HEALTH CARE

- Appropriate medical care is provided to patients seeking care
- Information exchanged at the office is confidential
- Act in in manner consistent with federal and state laws

CASE 13.1 | Birth control for a minor

Possible responses to the ethics issues presented by Sally Rosenthal's request for birth control and confidentiality depend on the relationship the clinician builds with Sally over the next months. The conflict stemming from the friendship with Sally's parents might be addressed in one of three ways. One possibility would be for Dr. Bennally to agree with Sally's request and to give her the prescription. This would respect Sally's preferences, but might upset her parents greatly in the future, when and if they learn of Sally's activities and the clinician's silence. Another option is to agree with Sally's request and give her the prescription, but encourage her to talk with her parents in the future. The third option would be to agree with Sally's request now, give her the prescription, and at her next appointment offer to play a supportive role in a conversation between her and her parents. In any case, the first option should be honored. Sally should obtain the care requested,

and her privacy should be respected. However, Dr. Bennally should also work to achieve option two or three, as they are both clinically and ethically appropriate in this social context. The family and friendship values are secondary to the medical and clinical care needs, but they are important values for the clinician and the community.

Thus, Dr. Bennally should offer Sally the requested birth control and related education, but she should also open the conversation with Sally about talking with her parents. Dr. Bennally should encourage, either at this or a later appointment, discussions about loving relationships, responsible sexual behaviors, and family values. The clinician should also express her willingness to be a part of the discussions because of their importance. The primary relationship between Sally and Dr. Bennally is to obtain the needed birth control while the secondary or larger relationship invites the additional discussion. (In fact, Sally's boyfriend may also be invited to be part of the discussions, depending on how the options unfold.)

The second ethics conflict in Sally's case has to do with billing. Billing is a clinical-systems issue that each clinic needs to address specifically. The clinician does need to be aware of the institution's billing practice, including whether the information included on third-party billing documentation can be controlled. These confidentiality and privacy issues may result in only one alternative—that the patient pays cash for the services rendered and for any medication as well.

The third conflict refers to what the clinician might say if complications were to arise. This issue requires a conversation at this same appointment with Sally. Just as Sally has taken responsibility for her sexual actions with the request for birth control, Dr. Bennally should discuss with Sally the potential consequences of pregnancy or sexually transmitted infections.

CASE 13.2 | Managing and treating sexually transmitted infections

Possible solutions to the conflicts presented in Joan Larson's case depend on how open she becomes to her circumstances in the next months. For the conflict involving a referral to an obstetrician, two

options may be possible, depending on the specific circumstances in the rural setting. Ms. Larson has requested that nothing be written in the chart. However this increases the risk of limiting the care Ms. Larson receives from the consultant, both now and in the future. If there is no written recording of the care needed or rendered now, then when Ms. Larson needs additional care in the future, the consultant and her partners will not be able build on previous information, or offer what may be appropriate urgent care at the time of delivery. Thus, it is important to do the proper charting⁹ and reassure Ms. Larson that the referral and related paperwork will be protected by the confidentiality of the medical records system. Certainly to do this requires careful and continuing work with the clinic staff. There are civil and criminal penalties for HIPAA violations which can include firing staff who do not maintain the ethical obligation of confidentiality.

In terms of billing, payment will need to be managed by the billing portion of the clinical system (as described previously). Any options for future care require ongoing and evolving conversations with Ms. Larson as the pregnancy develops and her relationships evolve. Dr. Haladay has reason to believe that there may be a need for further interventions because of the HSV, and Ms. Larson is likely to need to explain the circumstances to her husband eventually. Ms. Larson can participate by either having that conversation herself, or by stating what she would like Dr. Haladay to say.

Dr. Haladay's overlapping relationships in this case can lead to clinician stress and require that he find ways to manage the stress while maintaining confidentiality. This stress is amplified by his concern that maintaining confidentiality could risk the community's overall health by increasing sexually transmitted infections. Deciding to pursue the goal of reducing community sexually transmitted infections (STIs) results in the need to confront the community stigmatization of the condition and the behaviors that spread it—in truth-telling at a more extensive level.

To confront this issue at the community level, the clinician can schedule public forums at the clinic, and provide handouts, posters, and clinic Web site information. In addition, the clinician can offer to provide health education classes in the local high school to discuss STIs and related issues.

In these ways, the truth-telling is in revealing that the disease(s) are active in the community, while protecting individuals' confidence and privacy.

ANTICIPATING REPRODUCTIVE HEALTH CARE ETHICS CONFLICTS

Relationships between clinicians and patients are complex, and when they occur in rural settings they are not anonymous. In smaller communities, everyone knows one another and there are multiple overlapping relationships.⁴ This is the reality within which rural practitioners establish their clinics and work with patients and families. Drawing guidelines is therefore helpful; some suggestions are offered in Box 13.8.

BOX 13.8

PROFESSIONAL AND PERSONAL GUIDELINES IN THE MANAGEMENT OF REPRODUCTIVE ISSUES

- Provide appropriate medical care
- Assure confidentiality of clinical information
- Maintain clear boundaries in professional relationships
- Be aware of the law and institutional policies and procedures
- Define and examine one's own personal values

Professional and personal guidelines can be indispensable in creating a practice in which both patients and clinicians know what to expect, particularly when facing the consequences of sexual and reproductive relationships.

Provide Appropriate Medical Care

Two professional health care goals are essential to the structure and function of a clinic in anticipating ethics issues that relate to reproductive health care. First, it is crucial to always extend the best and most appropriate medical care available to all patients.³ When a patient raises sexual or reproductive health concerns, the patient care available should not be dependent on, nor diminished by, any personal shame or community stigma. Patients may choose not to follow a clinician's recommendation, but state-of-the-art care should always be available and offered. For example, Ms. Larson may never be honest with her

husband about her illness, but she still deserves to be given the best available treatments, and her pregnancy needs to be protected.

Assuring Confidentiality of Clinical Information

Information exchanged at the office must be confidential, whether spoken, written, or electronically recorded. Confidentiality must be a prime concern in a rural clinic—and reinforced through hiring, firing, and in-service education. Although confidentiality can be very difficult to maintain in a small community, it is one of the prime ways in which patients (and clinicians) are harmed within the medical setting.^{1,2,4} As referenced in both cases, charting and billing records are essential in maintaining confidentiality, too.

Maintain Clear Boundaries in Professional Relationships

It is essential for rural clinicians to establish clear boundaries between professional and personal relationships within the community.^{1,4} Personal relationships outside of the office can take many forms, but professional relationships within the clinic need to be strictly defined—and the expectations of confidentiality, responsibilities and obligations may need to be repeatedly stated and discussed with some patients and staff members. Over time, community members will come to know what they can expect and how they will be treated in each relationship setting. For example, if Sally Rosenthal and her parents see Dr. Bennally at a community function, Sally can feel secure about her health information remaining confidential even though she is not at the clinic.

Recognize and Clarify One's Own Personal Values

A personal guideline is also critical for rural clinicians who care for patients with reproductive health issues. It is important for clinicians to take the time to know themselves and to be reflective about their personal views.^{1,8} Knowing and being able to state personal positions on birth control, abortion, and sexual liaisons, are the provider's first steps to objectivity and integrity in a practice including reproductive health care. They are also essential to truth-telling and managing clinician stress. Personal positions and insights can be supported through local or distant colleagues, and awareness of professional standards of practice. For particular concerns, consultation with local or regional ethics resources can also be helpful. This is especially true in

the case of Dr. Haladay, who faces stress due to concerns not only for his patient with HSV, but also for the community. He can help to relieve some of that stress by confiding in a distant colleague or ethics network.

CONCLUSION

For the rural health care professional, it is essential to create a health care practice where community members can expect trust, respect, and safety in their patient-clinician relationships. This goal becomes critical when the practice includes reproductive health care, a specialty where providers may experience heightened ethics concerns regarding the management of clinical information. When health care is needed as a consequence of sexual activity that differs from the majority's culture or norms, the clinician and clinic can be put into a difficult position. Both the medical and social circumstances require appropriate care, confidentiality, truth-telling, and carefully defined boundaries.

To avoid conflicts that often arise in reproductive health care, the clinician may find that adhering to particular professional and personal guidelines can be indispensable. When the clinician establishes professional expectations, the patient will know and trust that he or she will receive appropriate care, whatever the circumstances, and that confidentiality of his or her clinical information will be carefully guarded. Clinician stress and patient-clinician relationships are also easier to manage when clinicians establish and maintain clear boundaries in their clinical relationships, take time to know their own views regarding sexual issues, and maintain supportive professional relationships with colleagues and ethics resources. These professional efforts on the part of the clinician can assure objectivity and integrity in a practice that includes reproductive care.

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