CHAPTER 2

A Landscape View of Life and Health Care in Rural Settings

Angeline Bushy

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ABSTRACT

Compared with people living in more populated urban areas, residents in rural environments may experience greater isolation, have less access to health care, and identify with more traditional cultural beliefs about health and illness. Rural residents often seek care from a health professional who may also be an extended family member, neighbor, friend or professional colleague. The rural health care provider should consider these factors, along with other social, economic, and cultural contextual attributes, when he or she responds to ethical situations involving his or her patients' care. This chapter focuses on the rural contextual attributes that can impact ethical situations that arise for clinicians in this practice setting.[1, 2] The ethical situations include, among others, the often overlapping professional and personal roles of rural health care providers, and the threats to patient confidentiality and privacy that may occur in smaller communities. The rural context has factors that can cause or impact such situations, including geographic isolation, small population, and close social and/or kinship relationships among community members. These factors create unique ethical opportunities and challenges for rural health care providers. Clinicians and administrators should seek potential ethics resources, such as ethics programs and consultants, and the ethics literature, to help solve conflicts.

INTRODUCTION

Over the past two decades, there has been extensive publicity about ethics conflicts occurring, primarily, in large urban health care facilities. Ethics issues in rural health care settings have received less attention. For example, in small communities, the dynamics surrounding ethics conflicts often become extremely complicated because clinicians, patients and their families live and work in close proximity, with often overlapping professional and personal relationships. A rural clinician's patient care is provided within a context of broad familiarity and multiple relationships.[1, 2] Sometimes an ethics case has intense emotional aspects, especially if there is a stigma associated with a particular condition, such as substance abuse, domestic violence, mental illness, or sexually transmitted diseases.[3] It is this rural context that makes rural health care ethics unique. Some rural contextual features that contribute to ethical conflicts are listed in Box 2.1.[4, 5]

BOX 2.1

Features Encountered by the Rural Provider

- Limited health care services and resources
- Geographic barriers to health care services
- Conflicts between community values and professional guidelines
- Challenges to privacy and confidentiality
- A clinician providing care to a neighbor, a friend, or a family member
- A provider trying to deliver quality care, despite being professionally isolated, with limited access to peers and specialists
- Overlapping professional and personal boundaries
- Community expectations and professional stress

Despite the uniqueness of every rural community, there are several general characteristics that influence ethics conflicts in all rural communities. There are limited resources in the rural setting, including various health care specialties as well as experts in the field of ethics. Clinicians often work in isolated situations, away from peer colleagues. There are geographic barriers such as challenging roads, limited public

transportation, and weather conditions that may impede patients' access to health care services. Rural clinicians commonly experience the phenomenon of overlapping or dual relationships with patients. Because everyone knows each other, disease stigma is frequently encountered, especially associated with conditions like substance abuse, mental illness or sexually transmitted diseases.

Professional isolation and high demands for the clinician's services can create provider stress. In some cases a doctor or nurse is on call 24x7 with no real backup. These general contextual features regularly surround and shape the ethical issues that are encountered by rural clinicians.[3]

When ethical issues occur in small towns, they are often not easily remedied using professional guidelines that were, in many cases, developed and applied in urban-based and resource-rich health care facilities. The rural clinician's response to ethics conflict is based not only on his or her training, experience, and professional guidelines, but also on the community's values. The social, economic, and cultural characteristics of small communities reflect the values of their residents. Understanding the health care ethics conflicts that have occurred in the past in the rural community can provide insights to clinicians, enabling them to more effectively respond to ethics conflicts and anticipate potential conflicts.[1]

Defining Rural Communities

The term "rural" can be defined in many ways, depending both on who is defining it, and why he or she is defining it, which can result in sometimes confusing and conflicting statistics. In fact, the National Rural Health Association does not provide a definition of rural, but instead encourages individuals to tailor the term to meet the needs of a particular program.[6]

Population is a common way to define rurality. According to the U.S. Bureau of Census, about 60 million people live in areas defined as "rural."[7] Rural residents make up about one-fifth (20%) of the total U.S. population and are spread across four-fifths (80%) of the U.S. land area.[8]

Another common definition of rural is based on the geographic size of a community relative to population density; for example, the number of

people living in a square mile. More remote regions having fewer than six people per square mile are defined as frontier areas, although this statistic varies as well, depending on the program.[9] Of the total U.S. rural population, about 5% live in towns of 2,500 residents or less. Some definitions of rural also consider the distance to services and/or "time to access services" (e.g., greater than 30 minutes or more than 20 miles to a certain destination).[10] It is important to note that the time to access health care may also impact residents who live in inner city or suburban areas due to transportation challenges.[6]

Perceptions of "rural" and the available resources within a particular region are relative in nature. For example, some communities with a population of approximately 25,000 may statistically be defined as rural, yet have features that one expects to find in a large city. Or, in a relative sense, residents in a town of fewer than 2,500 may perceive a community with a population of 10,000 as a city. Likewise, a family living in a frontier region may not feel isolated, because urban-based services are relatively easy for them to access via telecommunication and reliable transportation.[1, 11]

Rural Demographics

American rural communities have a diversity of geographical regions, population dynamics, age stratification, and other features. For instance, a higher proportion of African-Americans reside in the southeast, more elderly live in the rural Midwest, while Native Americans tend to reside on or near reservations (usually located in more remote parts of the United States). Rural communities also have diverse population trends; some have experienced a declining population in recent years, and others have had an economic revival and population growth.

Demographically, the population in rural communities sometimes is described as bipolar; rural residents tend to be under the age of 17, or over 65 years of age. This may be because many rural communities have strong schools and are safe places to retire, but lack the employment options needed to sustain groups of young and middle-aged adults. Consistent with national trends, there has been an increase in racial and ethnic minorities in rural areas, who now comprise about 17% of the overall rural population. Overall, compared to urban

residents, a greater proportion of rural residents are married, have fewer years of formal education, have lower incomes, and fewer have completed high school.[12-16]

HEALTH STATUS OF RURAL RESIDENTS

Health and illness are defined in various ways, as influenced by individuals' cultural background. Among some rural residents, health is defined as "the ability to work; to do what needs to be done," reinforcing a work ethic. Thus, a patient with such views may not seek "formal" health care until he or she becomes too ill to work. Further, the practical limitations of time and work in a rural community mean that residents may wait to seek medical care until they can combine it with other business requiring a trip to town.[11] Box 2.2 provides a brief overview of some urban-rural comparisons regarding health status.

BOX 2.2

Health Disparities of Rural Areas as Compared With Urban Areas[12-16]

- Higher infant and maternal morbidity rates
- Higher rates of chronic illnesses, such as hypertension and cardiovascular disease
- Higher rates of mental illness and stress-related diseases (especially among the rural poor)
- Lower rates of health insurance and pharmacy coverage plans
- Greater expenditures on prescription medications, associated with lack of pharmacy insurance benefits and/or more out-of-pocket costs for drugs because of lower insurance coverage
- Problems unique to rural occupations, such as machinery accidents, and skin cancer from sun exposure in farming or outdoor labor

A recent U.S. Department of Health and Human Services (HHS) report indicated that "rural residents are more likely to report fair to poor health status than urban residents, and are more likely to have experienced a limitation of activity caused by chronic conditions than urban residents."[17] Rural residents have a higher prevalence of long-

term health problems as compared to urban residents; this is primarily attributable to rural areas having a higher proportion of poor and elderly residents, as well as more accidents and trauma.

Mental health needs appear to be particularly significant in rural settings where residents struggle with significant substance dependence, mental illnesses, and psychiatric-medical co-morbidity. It has been noted that suicide rates in rural areas have surpassed urban suicide rates for over 20 years.[18]

Yet, rural residents have relatively low mortality in light of their high rate of chronic illnesses. A serious gap exists in the health-status data of vulnerable and at-risk populations like those in rural areas. Knowledge of a community's demographics is particularly important, because health status can affect health care ethics conflicts. The HHS report concludes, "a scant provider network, lack of adequate and affordable health coverage, and difficulty accessing high-quality care can lead to worse health among rural populations."[17]

RURAL CHARACTERISTICS AND LIFESTYLE

Even though each rural community is unique, the overall experience of living in a small rural town tends to be similar, characterized by certain features, a list of which is shown in Box 2.3.[1-5, 11]

It's always risky to generalize about a particular group, as this can perpetuate stereotypes. Furthermore, the belief systems of rural residents are complex, and there is wide diversity among and within communities. However, some authors describe a "rural culture" associated with local belief systems and values, including some rural residents' sense of fatalism and subjugation to nature associated with nature-oriented businesses (e.g., agriculture, mining, timber production). Weather also tends to play a prominent role in these residents' lives, because of its effect on economic activities and the ability to travel.[2, 11-14]

Conservative Values and Perspectives

Members of small and homogenous communities tend to be conservative politically and socially, with some exceptions. They tend to be "church-going," i.e., actively involved in a faith community's

BOX 2.3

Characteristics of the Rural Lifestyle and Culture

- Extensive distances between people and services
- Work and recreational activities are often cyclic and seasonal in nature
- Prominence of high-risk land-oriented occupations and activities
- Social interactions that facilitate frequent, informal, face-to-face contacts
- Close social or kinship relationships among community members
- Preference for informal support systems in times of need
- Individual and community self-reliance
- Small towns as centers of trade
- Churches and schools are centers of socialization for residents
- Importance of local health systems, especially hospital and long-term care facilities, to the local economy
- Overlapping roles and relationships for clinicians as community members

activities. Residents in rural communities are likely to adhere to traditional gender-role expectations, holding precise ideas about what constitutes "men's work" versus "women's work." Men are expected to work outside the home for money and to support their families without public assistance. Women are expected to manage the household and to nurture and support their husbands and children without monetary compensation.[11-14]

Such old-fashioned, or (what some might call) sexist expectations shape some rural people's views about medical providers. Regardless of their actual education, women tend to be viewed as the "nurses" while men are considered "doctors." Female clinicians living in a rural community may be expected to serve as a community resource, and volunteer their professional expertise. Community members may look to nurses and other clinicians to provide no-cost consultations, to respond to local emergencies, or even to provide home-care services that are otherwise unavailable.[1, 11]

Self-Reliant Behaviors

Self-reliance is another characteristic often attributed to rural residents. Historically, and today, the trait of self-reliance has helped families to survive in austere, isolated, and rugged environments. Self-reliance can help a patient through illness, with informal support from family, neighbors, or community groups; however, it can undermine healing if the patient and family avoid formal health care treatment and "tough it out." For example, a man abusing alcohol or chemical substances may avoid acknowledging his problem and from seeking much-needed professional services, due the enabling behaviors of his family. Or the community may view a woman with a mental illness as exhibiting a character flaw or weakness typical of her family, about which nothing can be done. Hence the admonition, "What happens in the family, stays in the family." To preserve family integrity, it becomes important to maintain secrecy, and not let others know about the problem (e.g., substance abuse, domestic violence, incest, rape, emotional disorders, stigma laden-illnesses, or unplanned pregnancy). Additionally, professional values and guidelines may conflict with family expectations, and coupled with community-defined standards of behavior or values, can impose stress for residents and the clinicians who care for them. Such scenarios can lead to patient-provider-family conflicts and, subsequently, ethics conflicts.[2, 11-14]

Rural Social Support Systems

The literature describes three levels of social support for patients in rural settings. The first level includes assistance volunteered by a patient's immediate and extended family, friends and neighbors. Although this type of support is not monetarily reimbursed, there is an expectation of reciprocity by those rendering the services. The second level includes support provided by a group or organization (e.g., civic organizations, homemakers' clubs, faith community, youth groups) in which members assist each other in the network during times of need (e.g., volunteering expertise, providing food, contributing financially, assisting with field work and farm chores).[2, 11-14] Essentially these levels offer an "insurance policy" should a catastrophic event occur to anyone belonging to one of these community or faith groups. These care systems are a resource for rural residents who are coping with hardships and geographical isolation; yet they also reinforce perceptions of self-reliance. The third

level of care consists of formal support, such as services provided by health departments, home health and hospice agencies, community nursing services, mental health centers, physicians, and hospitals. Financial remuneration is expected for these services, albeit in some cases on a sliding scale.[4, 5]

Urban residents often prefer the third level of support, since they may not have access to the informal care systems that characterize small towns. Rural communities, however, historically rely on the first two levels of support. In day-to-day activities, rural residents prefer to deal with someone they know ("kith and kin") rather than a stranger ("bureaucrat"), such as providing child care to a family during an illness, or preferring to receive care in the local hospital from the doctor and nurses who are neighbors, friends or relatives.[11]

Rural Economics

Rural economics can impact a sick person's care-seeking behaviors. Generally, in small towns, salaries are low; there are limited benefits, including employee health insurance benefits, which results in a high rate of uninsured and under-insured.

The 2008 *Health Disparities: A Rural-Urban Chartbook* pointed out that, "Rural residents were more likely to be uninsured than were urban residents. The proportion of uninsured persons increased as the level of rurality increased, with residents of remote rural counties having the highest rate of uninsurance."[19] The *Chartbook* further noted that, "Rural residents were more likely to report that cost had kept them from seeing a doctor than were urban residents. The proportion of adults who reported deferring care because of cost increased with the level of rurality."[20]

According to the Rural Assistance Center (RAC), "The uninsured in remote rural counties are not a peculiar sub-population of their communities: 68 percent come from families where there is at least one full-time worker; 30 percent are children; and almost two-thirds come from low-income families (less than 200 percent of the federal poverty level—less than $37,700 for a family of four). Families with two full-time workers, married couples, and the employed are also at greater risk of being uninsured if they live in a remote rural county."[21]

The RAC also reports: "Remote rural residents are less likely to be offered health benefits through their employment: approximately 59% of workers in rural non-adjacent counties are offered employer-sponsored health insurance, compared to 69% of urban workers, and less than half of workers in rural nonadjacent counties are covered by their employers (compared to nearly 60% of urban workers)."[21]

In addition to the economic issues that impact individual residents' use of health care services, rural health care facilities are a main economic driver in small communities. In most rural communities, the largest employers are the school system and the health care facilities. Because rural health businesses may experience frequent financial challenges, these financial issues are passed on and can significantly impact the broader community. For example, the closure of one rural hospital can create a dramatic ripple effect on the economic status of the community, many of whom may have had jobs there.

RURAL HEALTH CARE

Even in the most remote rural areas, communities have some health care system that includes formal organizations and providers, as well as informal support systems. Rural health care professionals work in a variety of settings, including those listed below.

- ***Federally-Qualified Rural Health Centers (FQHC, also known as Community Health Centers):*** FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population.
- ***Critical Access Hospitals (CAH):*** These are small (25 beds or less) federally designated facilities. CAHs provide essential services to a community and are reimbursed by Medicare on a "reasonable cost basis" for services provided to Medicare patients.
- ***Rural Health Clinics:*** These must be rural and in a designated shortage area, eligible for cost-based reimbursement. The Rural Health Clinics (RHCs) program is intended to increase primary-care services for Medicaid and Medicare patients in rural communities. RHCs can be public, private, or non-profit. The main advantage of RHC status is enhanced reimbursement rates for providing Medicaid and Medicare services in rural areas. RHCs must

be located in rural, underserved areas and must use midlevel practitioners, such as a nurse practitioner (NP) and physician's assistant (PA).

- ***Community Mental Health Centers:*** Federally enabled centers providing a safety net for mental health care in underserved areas.
- ***Private Practice Settings Clinics:*** Private clinics, providing primary care. Some private clinics are affiliated with CAHs.

Despite federal assistance, many of these various health care mechanisms continue to struggle economically. Low population density often means there is not a critical mass of consumers for a particular health care service; thus, rural facilities and services often are challenged financially due to the lack of a specialized-care revenue stream.[12-15, 22]

Although there have been hospital closures nationwide in recent years, the rate of closure has been higher among rural hospitals.[12-15] Rural closures have been related to the lack of physicians in a small community, coupled with tenuous finances. For instance, if the small town's only physician leaves the community, it could mean the local hospital must close - even if there are other health professionals, particularly nurses, in the area. Of note is the federal designation Health Professional Shortage Areas (HPSAs) characterized by insufficient numbers of providers in a geographical area.[15, 22] With this federal designation, a community is given priority in seeking a health care provider replacement.

The contextual realities at these various health care settings have implications for health care professionals in rural areas. Clinicians in the rural context often are expected to function as generalists, because they care for individuals of all ages with a wide variety of health problems. For example, in one day at a rural hospital, a primary-care clinician may care for an obstetrical family (mother and newborn infant); a patient with postoperative complications from recent surgery; and an elderly person, who has a life-threatening chronic health problem.[1, 3, 11] Such diversity in a practice can be perceived as a positive benefit by many rural health care professionals, just as it can produce caregiver stress. To manage the inherent stress and ethics situations in rural settings, clinicians must be aware of both the formal and informal resources that make up the

local health care system, as well as how the two interface, and what it takes to connect with these services.

Availability of Health Care Services

Availability refers to the existence of services and the presence of sufficient personnel to provide those services. Rural areas have fewer physicians and clinicians, nurse practitioners, and specialists; especially obstetricians, pediatricians, psychiatrists, and social-service professionals.[12-15, 22] Economically, a sparse population limits the number and array of services in a given region, as the cost of providing services to a few people may be prohibitive.

Access to Health Care Services

Accessibility refers to whether a person has the means to obtain and afford needed services, or is impaired by certain barriers to accessing health care. It has been noted that, "rural residents were more likely to report that cost had kept them from seeing a doctor than were urban residents. The proportion of adults who reported deferring care because of cost increased with the level of rurality."[20] A person in need of health care can encounter various barriers ranging from economic to transportation barriers; some of these are shown in Box 2.4.[12-15, 22]

BOX 2.4

Barriers to Accessing Health Care

- Long travel distances
- Lack of public transportation
- Limited telephone and Internet services
- Shortage of health care providers
- Limited economic resources—income and insurance
- Challenging roles and unpredictable weather conditions
- Inability to seek or obtain entitlements

Two other barriers which, like economic barriers, can limit access to health care include geographical and physical barriers. Consider the case of a rancher with a high income, who lives in a medically underserved frontier area, and who suddenly suffers a heart attack.

He may not have access to the most basic emergency care because of his geographic distance from the hospital, even though he has comprehensive medical insurance.

In addition to economic and physical barriers to health care, there are cultural and educational barriers that result when rural individuals lack a particular skill or element of education. Perhaps a small clinic is seeking a grant to access funding to implement a health program. However, the staff is hampered because they lack grant-writing skills. Or there may be a community perspective that opposes the use of federal or state welfare programs. Rural-based clinicians must recognize the stigma attached to the use of some types of services, and then adapt delivery approaches to try and assure anonymity and confidentiality within a rural context where people tend to be acquainted or related.[12-15, 22]

Acceptability of Health Care Services

Acceptability refers to whether a particular service is offered in a manner that agrees with the values of a target population. With the wide diversity among rural residents, acceptability of available services, like community nursing services, can be hampered by any of several factors, as described in Box 2.5.[5, 12-14]

BOX 2.5

Barriers to Accepting Health Care Services

- Self-reliance leads to self-care for health issues (e.g., patients preferring to self-treat with over-the-counter medications, exercise, rest, or prayer)
- Beliefs about the cause of an illness and the appropriate healer for it (e.g., patients prefer to see a “medicine man/woman,” curandero, shaman, or clergyperson)
- Community values about illness (e.g., patients being stoic and suffering in silence rather than seeking care)
- Lack of knowledge about a physical or emotional disorder, or of the importance of formal services for prevention and treatment
- Difficulty in maintaining confidentiality and anonymity in a setting where most residents are acquainted

Geographic, demographic, social, and economic factors will impact a clinician's practice as well as the health status in a particular rural community. In turn, ethics conflicts in rural settings generally are associated with these characteristics.

ETHICS ISSUES AND THE RURAL CONTEXT

The features of rural lifestyle (geography, population density, cultural values, and health care systems and services) influence the ethics situations that rural clinicians encounter.[1-5, 11] Many of the previously described rural characteristics that influence ethics conflicts are listed in Box 2.6.

BOX 2.6

Rural Contextual Features That Influence Health Care Ethical Situations

- Community values and beliefs that differ from professional standards
- Overlapping personal and professional roles within the community
- Threats to confidentiality and privacy
- Real and perceived geographic and professional isolation
- Limited access to, and availability of, health care services and providers
- Economic limitations, such as low income and lack of adequate insurance
- Clinician stress associated with community expectations, professional workload, and isolation
- Reliance on informal, non-professional community health care support networks
- Limited ethics resources

Overlapping Professional and Personal Roles

Probably the most common part of the rural context that can foster ethics conflict is the role of overlapping relationships between clinicians and patients. Due to the geographical and social structure of rural communities, rural health care providers commonly interact with members of the community in more than one relationship—i.e., a nurse

may serve on a school committee which also has one of her patients on the board; a doctor's children may play with the children of his patient; a psychiatrist may attend a house of worship where some of her patients also go. Generally, rural providers live and work in the same place, and everyone knows one another. Everyone knows the community's physician and/or nurse, and it is difficult to escape that role. Rural health care professionals frequently interact outside the office with community members. These multiple relationships can enhance and complicate the patient-clinician relationship.

This regular contact allows rural clinicians to have a knowledge of their patients that is unlikely in more urban settings. Rural clinicians have the unique opportunity to understand their patients in depth, including the patient's personal values and perspectives. The patient-provider relationship is formed and cultivated in both the examining room and in the general store. This can be very beneficial for treatment; however, ethics issues can also arise in maintaining professional boundaries with patients. Almost every rural ethics issue encountered is influenced and shaped by provider familiarity and overlapping roles. Patient-provider relationships and overlapping roles are discussed in more detail in Chapters 5 and 6, respectively.

Community Values Can Differ From Professional Practices

Authors have noted that rural residents from various cultures hold different views of pain, the etiologic explanations for sickness, tolerance of illness, and the use of folk healers. When the pervasive community values about illness differ from the traditional practice and ethos of clinicians, it is more likely that ethics conflicts will arise. Ethics conflicts may occur if providers show insufficient respect for cultural and community values. Recognizing community values and openly communicating with patients about how those values and beliefs differ from traditional health care clinical and ethics practices are key to the provider in addressing potential conflicts. Clinicians should also consider approaches to patient care that apply community values to their professional standards of practice. For example, a community value may be that an individual nearing death is allowed to remain in his or her home, with family, friends and neighbors supporting the family during this life transition.

Cultural insensitivity can also exacerbate a mistrust of clinicians. More specifically, a clinician's attitude can impact the long-term health status of a patient who may be embarrassed about his or her health problem(s). Embarrassment may be evidenced in certain ethnic or cultural groups, who may minimize symptoms of illness, not acknowledge self-care practices, or not seek care when it is needed. In such groups, health care is sought only for an acute illness or an emergency.

To diminish ethics issues related to cultural and community values, it would be beneficial for all health professional programs (medical training, nursing schools, technologist training, etc) to expose students to the rural environment and the cultural perspectives that they will encounter. For example, a rural-focused elective course could promote cultural competency in relationship to health care issues. Rural-based experiences and cultural understanding could go a long way to create a climate of mutual sensitivity and trust between clinicians and rural patients that could prevent health care ethics situations from occurring.[5, 12-14]

Threats to Confidentiality and Privacy

Closely related to overlapping relationships are threats to confidentiality and privacy. Breaches in confidentiality and privacy can be both intentional and unintentional, due to the close-knit nature of rural settings. It is not unusual for rural residents to report that even though they are well acquainted with most residents in the community, they feel there is no one they can trust, or with whom they can discuss personal problems. This experience is in part attributable to small town residents' genuine interest in the lives of neighbors, friends and relatives.[1-5]

Regardless of the setting, it can be devastating for those involved if their personal problems become public knowledge. Informal social structures, such as a church or extended family, in turn, can impose restrictions for those who desire to seek professional help for issues with moral overtones, such as drug and alcohol dependency, an unplanned pregnancy, sexuality issues, conflicts in personal relationships, or behaviors associated with mental illness. Further complicating the issues is the reluctance of some rural patients to access urban-based outreach services provided by professionals who are strangers, while services provided by the parish nurse may be openly welcomed.

A threat to confidentiality and privacy is a concern for rural residents, even for those who enjoy being personally acquainted with others in the community. As with all facets of professional life, familiarity has advantages and disadvantages. One provider's positive experience is described in this statement:

> *"Personally knowing a client and his or her family's lifestyle helps me to provide total care. After I provide care, I'm also able to keep track of the person's progress from direct reports by the person when I meet him or her in the store or on the street. Or, if the client is home-bound, I get word of mouth reports from his or her family, friends, neighbors, or other members of his or her church."*[1]

Personally knowing a patient creates some concerns and frustrations for clinicians, as well, as illustrated by the following comment:

> *"Sometimes knowing your patients well allows you to make assumptions without a really valid evaluation…You can miss something that should actually have been caught…I just think other emotions can get in the way when you know someone well."*[23]

Maintaining confidentiality is often difficult, particularly when the clinic or agency is located in a public facility, such as the county courthouse. Often the waiting room may be in a common hallway or an area where patients are likely to be recognized. Moreover, announcements of "specialty services" such as prenatal or family planning clinics, HIV testing, Women, Infants and Children programs and immunization clinics often are publicized in the local media (newspaper, church bulletins, radio, television) and sometimes posted in public places such as grocery stores, service stations, and grain elevators. People in small towns often are recognized by the car they drive and thus, even parking lots can jeopardize confidentiality. If a family planning clinic is held on Friday mornings, for example, assumptions may be made about anyone seen parking in front of the building—even if it is not to attend the clinic. Leaks in confidentiality can result from such chance encounters and quickly become public knowledge through the local rumor mill.

Maintaining confidentiality must always be a consideration in the rural context. For example, prenatal or family planning clinics could be scheduled to coincide with an immunization clinic, and STD clinics and HIV testing could be offered on a walk-in basis. Innovative approaches are required on the part of clinicians in rural practice to address the community's concerns surrounding anonymity and confidentiality.[1-5]

Limited Access to Health Services

The limited availability, accessibility, and acceptability of health care services can foster ethics challenges that are regularly encountered in rural settings. The lack of services and specialists, such as mental health professionals, creates situations where the general practitioner may need to provide specialized mental health care. Other health care professionals, including nurses and social workers, may become the *de facto* primary-care provider in settings with limited resources. Many rural communities have no hospitals; yet travel to the large, distant medical centers can create burdens on both the patients and the rural providers. For example, a patient may need to travel long distances over challenging roads to find needed emergency care. Or a patient may need specialized cancer treatment at the distant medical center, but opts out of the care because of the distance and lack of support. Such situations place a great burden on rural primary-care clinicians who may be forced to provide care outside their areas of expertise.

Taken together, these factors (limited availability, accessibility, and acceptability) conspire so that small communities may have few health care services, lesser expertise, tremendous professional shortages, heightened ethical binds, and greater risk for errors and quality issues.

Community Economic Limitations

The economic status of rural residents can influence their use of health care services. A community member's willingness to accept needed care may be restricted by his or her economic situation. For example, patients requiring care may be underinsured or uninsured. Ethical questions can arise as a result of these situations. Rural health care professionals regularly encounter situations where they must decide whether to provide needed care with little or no reimbursement, which may potentially jeopardize both their patients' health and their own

overall practice and standing within the community. Not providing needed services is a difficult decision, because it may be contrary to community values and the perceived role of the clinician. Because everyone in the community knows the physician, such decisions can never be made in a confidential manner. Resource allocation and access to health care are areas of great ethical challenge for rural physicians.

Clinician Stress

Clinicians tend to be held in high esteem by residents in small towns, but this can make it difficult to have a life outside of work. A nurse offers these insights about her practice:

> *"In an urban setting, when you leave work and drive your car out of the parking lot, you are just one more person in a city of a million people. In a rural area when you move your car out of the parking lot… you are the same person as when you were in the parking lot. Everywhere you go you are seen as [a nurse]…This affects how you conduct yourself when you are downtown, too."*[23]

Another component of health care provider stress is professional isolation. Geographic isolation poses challenges to rural clinicians because patients probably do not live nearby, as described in the following:

> *"We had a situation…where we had a man coming home from the hospital after having a CVA-stroke. He was completely paralyzed on his left side. He came home one evening, and a nurse went out to the ranch the next morning to start services. We thought physical therapy and nursing and some aide services would be appropriate.*
>
> *When she got there (at) about 10 o'clock in the morning, and was taking the history and assessment, she found out that the man had driven into [the nearest town] the afternoon before. She asked him how he had driven with [his] left side completely paralyzed. He said when he got home he realized that unless they drove that pickup, they were stranded. There wasn't anybody around for miles and miles.*

So he thought it over, and he got a couple of his leather belts and put them together, climbed into his pickup, which was a feat in itself, and got it into first gear, got out on the road, slipped the belt around his left foot and when he was ready to change gears he just reached over with his right hand, pulled his foot up with the belt, dropped it on the clutch, put it in second, and went down the road.

Right away that precludes him from meeting the home bound criteria for Medicare. All (of) those services were not available to him. We provided services (in) some other ways, but we were not able to get any Medicare benefits for him."[23]

Although this account does not reveal the reason why the patient went into town, the account does suggest a degree of self-sufficiency and autonomy as a way of coping with the isolation. Self-sufficiency in this case, however, cost the patient his Medicare benefits. Knowing the patient could have used those benefits likely caused stress to the clinician, who could not provide all the care that might have been necessary. Rural providers might also feel stress in these situations because they are isolated, and urban-based health care workers do not understand the unique rural patient or provider experience.

Isolation for a rural health care professional also assumes not having an immediately accessible network of peers who can provide support and consultation on a particular concern. Professional, and sometimes social, isolation may be associated with geographic isolation. Isolation can be perceived by the clinician as positive, negative, or a combination of the two. Some rural clinicians appreciate the opportunity for developing professional autonomy and creativity, while others find the expectations and responsibilities in rural practice to be stressful and overwhelming. Likewise, the lack of immediately available opportunities for establishing relationships with other professionals, or not having the central office nearby, can reinforce feelings of isolation.

Perceived professional isolation requires the clinician to evaluate and prioritize needs and types of services that can be provided to the local population. The clinician can experience considerable professional

strain and stress from the lack of geographic access to other specialist providers, as well as the lack of continuing education, current telecommunications, and medical technology. Individuals who are uncomfortable when working alone, or who lack the confidence to make independent clinical decisions, probably would not fare well in a remote rural area. These individuals would likely be more comfortable in a less isolated setting with more support.[1-5, 11]

Limited Ethics Resources

Unlike their urban counterparts, many rural facilities and health care professionals have limited access to ethics resources (see Box 2.7) to help them address ethics conflicts, including rurally focused ethics literature, ethics committees, and health care ethicists. As Nelson has noted, this further supports the viewpoint that rural America is underserved.[24, 25]

BOX 2.7

Limitations in Rural Ethics Resources

- Rural-focused ethics literature
- Rural ethics committees
- Rural-based health care ethicists
- Rural-focused ethics training

Using an established methodology for conducting literature searches, Nelson *et al.* identified only 55 publications between 1966 and 2004 that specifically and substantively addressed rural health care ethics. The majority of publications, 30 (55%), were clinically focused; 15 (27%) addressed organizational ethics; and 10 (18%) addressed ethical ramifications of policy at a national or community level. Only seven (13%) of the publications were original research publications.[26]

A survey of hospitals in six western states by Cook *et al.* found that out of 117 respondents, 59% did not have ethics committees or other formal models for ethics services.[27] For hospitals with 25 or fewer beds, 85% lacked an ethics committee. The data also suggested a predictive association among the size of the hospital, the presence of an ethics committee, and Joint Commission accreditation. The study also

revealed that only 59% of those with committees met regularly; most of these committees engaged primarily in educational efforts, with the skill and knowledge development of their own committee members as their central focus. Having *et al.*[28] reported that only 37% of the rural health facilities among their sample of 79 health care facilities listed on the Illinois Department of Public Health Web site had formal ethics committees. Where rural committees existed, the literature emphasized the lack of basic ethics training and expertise for committee members. When rural providers did seek training or consulted the ethics literature about clinical conflicts, the training and material had such an urban focus that it proved to be unhelpful.[29, 30]

A study by Nelson and Weeks[31] suggests that there are a limited number of bioethicists working or living in rural communities. This study used the American Society for Bioethics and Humanities (ASBH) membership as a representative cross-section of professional health care ethicists, to determine how members are distributed along the rural-urban continuum. The results note that, "while 91% of ASBH members live or work in urban settings, only 66% of the U.S. population did so. In contrast, 2% of ASBH members live or work in rural settings compared to 13% of the population. ASBH members were 10.7 times (95%) more likely to be represented in urban as compared to rural settings when compared to the general population, 25.6 times (95%) more so when compared to hospital facilities, and 6.9 times (95%) more so when compared to hospital beds. Using various comparisons, the authors consistently found that ASBH members are under-represented in rural, as compared to urban settings."[31] Even though not all health care ethicists are ASBH members, the authors' findings suggest that the availability of professional ethics resources is limited in rural America.

As a result of limited ethics committees at rural facilities, and limited rurally focused ethics publications, rurally based bioethicists, and rural resources and training, there is a need for increased rural health care resources and training that integrates rural culture and values into ethical reflection and decision-making.

To address these limitations, several strategies may help the rural clinician to identify rural ethics resources (see Box 2.8). Often the local

health care facility is part of a larger network that has an ethics committee, an ethics consultant, and continuing education opportunities for participating members. Rural clinicians should ask and become informed about what is available to system members. Other small communities within a given geographical setting have combined resources and developed their own health care ethics committees and educational resources. In some cases, health care providers in small communities have partnered with institutions of higher learning to educate local health professionals about ethical principles and decision-making. It is important that rural health care providers consider, though, that educational programs for health professionals generally are located in urban areas, and most clinical experiences occur there. In turn, students are not necessarily exposed to rural patients and rural health care systems. In these cases, rural clinicians must become proactive and educate urban-based educators about rural contextual features that can impact ethical situations occurring in more austere and remote environments.[2]

BOX 2.8

Potential Ethics Resources

- Local health care facility's ethics committee
- State network of ethics committees
- Multi-facility ethics committee
- Academic medical center ethics program
- University or college ethics department
- On-line resources offered by health professional organizations

CONCLUSION

Health care ethics or bioethics has evolved historically from many wide-ranging areas of focus. The *Encyclopedia of Bioethics* has indicated that there are several areas of inquiry which make up the discipline of bioethics—theoretical, clinical, regulatory and policy, and cultural.[32] *Theoretical health care ethics* deals with the foundations of moral reasoning that are applied to a variety of health care issues. *Clinical ethics* refers to challenges in individual patient care. *Regulatory and policy health care ethics* is the organizational and legal reflection of health-care-related ethics questions. *Cultural health care ethics* refers

to an effort to systematically relate health care ethics issues to the cultural and social context in which ethics conflicts arise. One of the important cultural subgroups of inquiry is the rural setting; specifically, how the rural environment influences the ethics conflicts encountered in rural America.

In sum, living and working as a health professional in a rural environment is unique, and most would describe it as a highly rewarding personal and professional experience. Compared to people in more populated settings, rural American residents often experience greater isolation; have less access to health care; espouse traditional cultural beliefs related to health and illness; and may need to obtain care that is provided by a clinician who could be a neighbor, family member, friend or professional colleague. These and other contextual features significantly influence the health care ethics challenges, and the manner in which health care professionals respond to those challenges.[1, 2, 11]

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