CHAPTER 4

"Doing" Ethics in Rural Health Care Institutions

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ABSTRACT

Ethics is often a scary term for health care professionals, because it is a word that may evoke accusations of wrongdoing. But ethical values are an important part of everyday clinical decisions. The provider's ability to identify ethics issues, and to work to resolve them, is an important part of delivering quality care. Ethics issues arise for administrators and health care clinicians in both rural and urban settings. However, access to ethics resources is often limited in a rural setting. This chapter provides basic information about ethics and ethics deliberation. "Ethics" is defined and distinguished from the law. The challenges to ethics deliberation in a rural context are discussed, and three mechanisms for supporting ethics deliberation in rural settings are provided. A practical model template for ethical decision-making is provided and applied to a sample case. The template mirrors clinical-care decision-making and includes eight steps:

1. What is/are the ethics question(s) or issue(s)?
2. What is your gut reaction?
3. What are the facts?
4. What are the values at stake for all involved?
5. What could you do?
6. What should you do?
7. What is the justification for your choice?
8. Could this question or issue have been prevented?

ETHICS IS A PART OF EVERYDAY DECISION-MAKING

Every day, health care professionals make ethical decisions as an integral part of clinical decision-making. Clinical decision-making incorporates profession-grounded values. This is evident when physicians, dentists, nurse practitioners or physician assistants solicit a patient's views out of respect for his or her preferences, or recommend therapies aimed toward the patient's well-being; or when nurses or social workers raise questions about the safety of a discharge plan. Additionally, ethics discussions go on every day without necessarily being called ethics discussions. For example: the staff of a clinic is discussing whether to recruit an interventionist cardiologist, and the conversation revolves around whether they would have enough patients to keep doing procedures well, and whether the money spent on this procedure is more appropriately spent on other things. This is an ethics discussion that involves the values of beneficence (promoting well-being) and justice (fair distribution of resources.)

Unfortunately, a discussion of ethics and ethics committees makes some people nervous. When "ethics committees" are mentioned in the news these days, it is often in the context of government officials, accusations of wrongdoing, conflicts of interest, and taking the claim to an ethics board. Some people assume that to raise ethics issues at all, in the health care arena, is to accuse clinical professionals of being unethical, or in special need of ethics remediation. This *Handbook* is not intended for either of these situations; rather, it is meant to aid in ethics discussion and ethics conflict-resolution for rural health care providers.

DEFINING ETHICS AND THE NEED FOR ETHICS DELIBERATION

If ethical values are already included in day-to-day clinical decision-making, why do we need a more formal mechanism for ethics deliberation? Can't we just assume that good people will make good decisions? Yes and no. Personal values are an important factor in making reliable moral judgments and following through with them. However, many professionals may want to answer health care ethics questions or conflicts according to their personal values—which may differ from their professional values. Historically, many ethics scholars have distinguished between personal morality and ethics reasoning. Morality refers to one's personal moral choices that come from family

upbringing and traditions, culture, and/or religious beliefs—whereas ethics reasoning is a more formal conflict-analysis process. A clinician's personal values may be in conflict with his or her patient's values, professional ethics, the organization's ethical standards, or even society's common morality (do not kill, harm, deceive, do your duty, etc).[1] How does a health care provider resolve the conflict? Resolving ethics conflicts in health care requires the more formal mechanism of ethics reasoning, defined below.

ETHICS REASONING

Ethics reasoning refers to a formal process of analyzing the basis for moral judgments of ethics conflicts or uncertainty. Ethics conflicts or uncertainty occur when personal values, professional and organizational values, and society's common morality compete. Ethics reasoning provides a formal way to step back from the conflict or uncertainty and to apply this reasoning in future situations. Sometimes in health care situations, the values are in such conflict that a plan of care cannot be developed until the conflict is resolved. That's when it's important to have a more intentional way to identify and resolve the ethics issue (moral value conflict) involved.

LAW AND ETHICS DIFFERENCES

Many people turn to the law to resolve ethics issues. The law is one expression of the shared values in communities and society, and it is important to obey the law. But even though the law does have ethics content, it is a kind of minimalist expectation of obligations to others. Ethics strives to inspire the best professional behavior and the law demands only a basic minimum. For example, the law would require professionals not to abandon patients that they no longer wish to have in their practice. Ethical values would require a professional to try to work with patients until a point where it is judged that the patient would be better served in someone else's practice.

Additionally, the law can be ambiguous, and it is not always clear what the law actually says about a certain question. Laws also can vary in

different jurisdictions. The law is often not capable of subtle distinctions in specific situations. For example, all states have laws about who can be held on an emergency mental health hold and what that process entails. Some states have clearer language than others about what is the specific mental health criteria for detaining or committing someone against their will, and how other conditions, like substance use disorders or dementia, are to be viewed.

The law does not address many of the issues that are important in ethics. The study of ethics is concerned not only with what a decision or action a person makes, but also with the kind of person he or she is or what kind of character he or she has. In the above example about mental health law, the law is more concerned that a professional acts in a way that does not violate another person's legal rights. Ethics is concerned that providers are also compassionate and caring, and that they communicate in an honest, clear and respectful manner. And finally, ethics is more fundamental than the law. We can always ask from an ethical standpoint, "Is this a good law? Should I conscientiously disobey the law or should I work to change it?" For example, some clinicians believe that the mental health laws in their states impede patients from receiving needed, appropriate treatment because the laws respect patient rights to refuse forced treatment. A number of clinicians are working to change state laws, to use the same process as psychiatric emergency holds to allow emergency psychiatric treatment.

When making ethics decisions, it is important to have clear and accurate information about the relevant laws. But it is also important not to stop there. If a provider involves attorneys in any ethics deliberations, everyone must be clear on his or her role. Attorneys, like other individuals and professionals, certainly bring a different and valuable viewpoint to the discussion. They can be an important resource to provide helpful information about the relevant laws. But they are only one voice among many, and subject to the same rational deliberation regarding the ethics issues. Attorneys should not be allowed to trump important ethics deliberation.

CHALLENGES TO ETHICS DELIBERATION IN A RURAL CONTEXT

Ethics deliberation is influenced by the rural context. Even though there are some contextual differences among various rural communities, rural

life in general, as noted in Chapter 2 of this *Handbook*, is characterized by the following factors: limited economic resources; reduced health status of patients and clinicians; limited availability of, and accessibility to, health care services; dual and overlapping professional-patient relationships; distinct cultural and personal values; and clinician stress.

The rural context described in Chapter 2 affects the kinds of ethics issues that are identified and discussed during the deliberative ethics analysis process. Section II of the *Handbook* (chapters 5-14) elaborates on specific issues in a rural context, including confidentiality, truth-telling, shared decision-making, boundary issues, justice, and access to quality health care services.

The rural context also affects the mechanisms by which ethics deliberation takes place. Ethics committees are an important mechanism, but they are mostly found in large, urban, tertiary care centers. A traditional ethics committee consists of different health care professionals who meet on a regular basis to address hospital policies, such as a resuscitation policy; to develop educational programs and materials; and to provide ethics case consultation. An emerging trend is to have a separate organizational ethics committee to deal with ethics issues that arise from the business decisions of a hospital.[2-4] Small rural health care facilities are less likely to have ethics committees. Survey data from 117 hospital administrators from six western states indicated that only 42% of the small hospitals had created ethics committees, or other formal mechanisms for providing ethics services. Surveys of physicians and nurses indicated that only 29% and 22% of these groups, respectively, have access to ethics resources. In another survey of 600 randomly selected rural physicians from Montana, Wyoming, and North Dakota, only 29% reported having access to any ethics-related resources, and 75% of the physicians had never referred a case to an ethics committee.[5, 6]

Nelson summarizes the obstacles for implementing more traditional ethics committees in rural settings in a 2006 article in *The Journal of Rural Health*.[7] The obstacles are listed in Box 4.1.

BOX 4.1

Obstacles to Implementing a Traditional Ethics Committee in Rural Settings

- Lack of multidisciplinary professionals
- Limited time available for a small staff with multiple responsibilities, making regular meetings difficult or impossible to conduct
- Lack of ethics knowledge and skills
- Limited opportunities for relevant ethics training
- Lack of effective training materials that focus on rural ethics conflicts
- Lack of regulatory incentive: rural hospitals are less likely to be reviewed by the Joint Commission on Accreditation of Health care Organizations, which requires an ethics "mechanism" to address ethics conflicts
- Overlapping relationships among patients, clinicians, administrators, and ethics committees; this raises challenges rarely seen in non-rural facilities

MECHANISMS FOR ETHICS DELIBERATION IN RURAL FACILITIES

In spite of the many challenges, being able to access ethics resources in rural facilities is important to administrators and to clinicians. No less than their urban counterparts, rural administrators and clinicians face ethical challenges that can negatively impact the quality of care. Therefore, the need for ethics resources as a component of providing quality care is essential in all health care settings. The important thing for providers to remember is that the ethics resources must relate and be contextually grounded in the rural setting. Because of the diversity in rural settings, it is not possible to have one rural model fit all needs for effective ethics deliberation. Several models have been suggested in Box 4.2.

Designated Ethics Expert

The first possibility in developing a local strategy for a health care facility ethics resource is to designate a person to become the "local expert" in ethics, who could then train and support local practitioners

BOX 4.2

Mechanisms for Ethics Deliberation in Rural Settings

- A designated ethics expert to develop a facility ethics committee
- Linked institutional ethics committees through a network or academic center
- A multi-facility ethics committee (MFEC)

and members of the local ethics committees. That person would be designated and supported by their organization to attend ethics training courses, to develop relationships with helpful ethics resources available from universities and other centers, and to inform the health care facility on ethics. The development of one local expert's knowledge can be passed on members of an evolving ethics committee. This strategy might be more cost-effective for resource-strapped institutions, rather than sending an entire committee for ethics training.[7-9]

Ethics Network

A second possibility is for ethics committees to be linked through local and state-based networks. But to be maximally effective, the networks would have to be familiar with rural issues.[10] A network that only deals with the ethics issues that are seen in larger tertiary centers, focusing on highly technological treatments including transplantations or reproductive technologies, or where there are numerous ethical resources like ethics consultants, may not be equipped to deal with questions and conflicts that involve ethics issues arising in critical access hospitals or small rural clinics. See the discussion of ethics networks in Chapter 16.

Multi-Facility Ethics Committee (MFEC)

Sometimes an institutional ethics committee is just not feasible in small rural or frontier facilities. In these cases, an ethics resource can be made possible when multiple facilities share an ethics committee, known in the literature as a multi-facility ethics committee (MFEC).[7] The MFEC would provide several of the basic functions of the traditional model by overcoming many of the obstacles mentioned above. A committee shared among facilities has the potential to be both efficient

and effective, by sharing ethics expertise and financial support and by reducing possible duplication of effort.[7]

How would the MFEC work? One model is for each facility to identify one or two professionals who are well respected in their institutions, willing to participate in regular meetings, and committed to developing ethics knowledge and skills. These members would select a chair or co-chairs of the committee. Each participating institution would provide modest financial support for their representatives and for the operation of the committee. Because of geographical distances between facilities, meetings could be conducted by conference calls, or, where available, video-conferencing.

The MFEC could sponsor educational activities not only for its members, but also for staff at the participating institutions. A second function could be the proactive review of organizational practices. All too often, traditional ethics committees function in the reactive mode—consulting on individual cases as they come up. A MFEC document could be a procedure, policy, and/or educational plan. The activities of a MFEC are listed in Box 4.3.

BOX 4.3

Multi-Facility Ethics Committee Activities

- Identify and prioritize common ethics conflicts
- Study the conflicts
- Review the ethically grounded alternatives to the conflict
- Select and document the appropriate response, such as a better procedure, policy, or educational plan

Each institution would review the multi-facility ethics document for potential implementation. Such a process could promote well-reasoned ethical practices without burdening any one facility. Once the multi-facility committee is established and respected at each facility, the third function of real-time case consultation can be implemented.

The development of an MFEC requires much trust among various institutions, which are often in competition with each other. Institutions

might prefer not to air institutional "dirty laundry," and confidentiality is of particular concern. The MFEC model is particularly plausible where there is an existing relationship among institutions. My own experience in central West Virginia is that it can be done, even without such an existing relationship. I participated in an effort in which three counties worked closely together to start an ethics committee that would serve two small rural hospitals and a number of long-term care institutions. Key factors included the resources available from the Center for Health Care Ethics and Law at West Virginia University, and the willingness of the top administration at each institution to support the plan.

A MODEL PROCESS FOR ETHICS DELIBERATION

Even though ethics is part of everyday clinical decision-making, sometimes a more formal mechanism for ethics deliberation is necessary. In a model ethics deliberation process, the provider steps back from the situation and applies a decision template to determine and review the various stakeholders' values that may be competing with one another. The process also pushes the decision-maker to carefully identify and review all potential options for addressing the ethics conflict. The goals of this deliberative ethics process are to make sure that all ethics issues are adequately articulated and understood; that the perspectives of all relevant stakeholders are heard; and that ultimately, a course of action that is ethically justifiable is chosen. Several models for ethics decision-making are available in the literature, but all share some of the basic components or steps that are highlighted below:[11-14]

Process for Ethics Decision-Making

Step 1: What are the ethics questions? (These are the "should" questions)

Step 2: What is your first reaction to this case? What is your "gut" telling you to do on an emotive level? Why do you think you are reacting this way?

Step 3: What are the relevant facts, including both the facts that you know currently, and the facts that you need to gather?

Step 4: What are the values at stake for all the relevant parties? What is/are the conflict(s) among values?

Step 5: What can you do to address the ethics question; what are your options?

Step 6: What should you do? Make a choice. Include a discussion of the implementation process; describe how it actually would be done.

Step 7: Justify your choice. Give the reasons to support your choice—referring to the values in Step 4. Anticipate and respond to objections to your reasons. Are there any options that shouldn't be done? What are the relevant ethical guidelines, like relevant code(s) of ethics that speak to this issue?

Step 8: How could this ethics issue have been prevented? Would any policies/guidelines/practices be useful in changing any systemic problems?

APPLYING THE MODEL PROCESS TO A CASE

Case Summary 4.1

Balancing Professional and Patient Values[15]

Dr. Olsen is a primary care physician who has been taking care of the O'Mara family since coming to a rural community five years ago. Mr. O'Mara is a rancher who presents to Dr. Olsen with symptoms of coronary artery disease. Mr. O'Mara doesn't want to go to a large, distant medical center for further assessment and tests, and without savings or medical insurance, Mr. O'Mara does not want to 'ransom his place' and possibly leave his family destitute to pay for medical care, when he may die anyway. Mr. O'Mara wants Dr. Olsen to keep the information only between the two of them.

Note: This case is adapted from reference #15, but the following discussion was uniquely developed and written by this chapter's author.

The O'Mara family has ranched in the Sweetwater Valley since the 1850s. "It's what my grandfather left us," says Sam O'Mara, "and I don't plan to let him down." There's nothing easy about this life—too much snow in the winter, not enough rain in the summer. On eight sections of land, Mr. O'Mara and his sons put their cattle out to graze, grow hay, and if they're lucky and get the moisture, harvest some wheat. "In a good year, we make a buck, and in a bad year, we lose two, but

we're here and we're not going anywhere else," says Mr. O'Mara. The little hilltop cemetery on the edge of his property quietly underscores his statement. Fenced with barbed wire, it's the resting place for Mr. O'Mara's grandparents, his parents, his uncles and others who worked this land during the past one hundred and fifty years.

When Dr. Olsen moved to this ranching community about five years ago, Sam O'Mara was one of the first people he met. Since then, Dr. Olsen has provided medical care to Mr. O'Mara and his wife and sons. He attended the festivities at the ranch when Sam O'Mara's son was married, and just last year, he delivered the rancher's first grandchild.

When Mr. O'Mara arrives for his appointment, he admits to "being a little slow this spring." But it's been a cold spring, he explains, and long hours have been spent protecting the new calves. He'd be grateful, though, if he could get something for his chest pain and his shortness of breath. The "funny, sick feeling" he's had for the past few weeks doesn't seem to be passing.

Dr. Olsen examines Mr. O'Mara and is frankly concerned. He suspects coronary artery disease, and explains to the rancher the need for more tests. "You need to go to the city," says Dr. Olsen. He carefully explains the tests that will be conducted, and the procedures that might be done. "I've heard of those by-passes," says Sam O'Mara. "And I know Pete, my neighbor, had an angioplasty; that was the beginning of his troubles. He died anyway, but not before he had more surgery and a lot more bills." Mr. O'Mara says he'll go home and think about the whole situation. He and his wife don't have health insurance, and there's nothing they can sell right now to pay for a lot of medical care. "The boys can take care of the ranch," he says. "And they'll take care of their mother and she'll have a home. My grandson can grow up knowing he has a place. But if I ransom this place to pay for a heart, well, there won't be much left for anyone to live for."

"I expect that we can keep this between us," says Sam O'Mara. "My wife is just glad I made the appointment. I'm not going to have her choose between life for me or life for her boys." The rancher does not indicate exactly what he will tell his wife, their sons, and his friends. Dr.

Olsen is pretty sure that Mr. O'Mara will just attribute his difficulties to hard work—and nothing that a little rest can't cure. Mr O'Mara expects that Dr. Olsen will go along with the story .

Step 1: What are the ethics questions?

> What are Dr. Olsen's ethical obligations to Mr. O'Mara? What should he tell him? What are Dr. Olsen's obligations to Mr. O'Mara's family? If they ask Dr. Olsen, what should he tell them? What are Dr. Olsen's obligations to the community?

Step 2: What is your gut reaction as a provider?

> "Gut" reactions range from wanting to get Mr. O'Mara the tests and possible treatment (access to health care just like anyone else) to wanting to respect his courage to spare his wife and family a choice between his health and his family's financial security.

Step 3: What are the relevant facts?

> Sam O'Mara's ranch has been in his family since the 1850s; Dr. Olsen moved to this ranching community about five years ago; Mr. O'Mara was one of Dr. Olsen's first patients; Mr. O'Mara's wife and sons are also Dr. Olsen's patients; Mr. O'Mara has been experiencing chest pain and shortness of breath since the spring; Dr. Olsen suspects coronary artery disease after the rancher's physical examination; Dr. Olsen recommends that Mr. O'Mara "go to the city" for more tests; Dr. Olsen carefully explains the tests and possible procedures; Mr. O'Mara says that he will go home "and think about the whole situation;" He and his wife don't have health insurance; there is nothing that they can sell to pay for medical care; Mr. O'Mara's friend had angioplasty and "that was the beginning of his troubles. He died anyway…. with more surgery and a lot more bills;" Mr. O'Mara asks Dr. Olsen to keep this information between them—not to tell his wife; The rancher is concerned that his wife not have to choose between "life for her husband or life for the boys;" Mr.

O'Mara doesn't say exactly what he will tell his wife, sons and friends; Dr. Olsen suspects that the rancher will attribute his difficulties to hard work—"nothing that a little rest can't cure."

The facts that need to be gathered: How long has Mr. O'Mara been experiencing his symptoms? How urgent is his need for further evaluation and treatment? How far away is "the city?" Are there any alternative clinics where he could get tests at reduced costs? What does Mr. O'Mara expect Dr. Olsen to say if his family asks about his health status? How does this family usually make tough decisions that impact everyone in the family? Are there other sources of support, i.e., other relatives, neighbors, and/or a faith community?

Step 4: What are the values at stake for all the relevant parties?

Mr. O'Mara's values center around his family's well-being—he wants to preserve the family ranch and not incur large medical bills that could put the financial viability of the ranch at risk for his wife, sons and grandchildren. He is concerned enough about his health to visit the doctor. But perhaps he is more concerned about his relationship with his wife—because he has come to see the doctor at her request. Sam O'Mara also values privacy—even from his family. He wants Dr. Olsen to keep their conversation confidential.

Dr. Olsen's professional values include promoting Mr. O'Mara's well-being by offering him the standard of care in pursuing further evaluation and treatment of his suspected coronary artery disease. Other values include truth-telling—making sure that Mr. O'Mara has enough information to make a reasoned decision to refuse further testing—and not lying to Mr. O'Mara's family if he is asked direct questions. It may also be a form of lying by omission if he accepts Mr. O'Mara telling his family something that is not true, and Dr. Olsen does not correct the misinformation. Trust is at stake for the doctor's relationship with Mr. O'Mara, but also for his relationship with the rancher's family—who are also his patients. Dr. Olsen wants to respect

Mr. O'Mara's decisions (respect his autonomy), but not at the expense of being untruthful and unfair to his family. Mr. O'Mara will need a lot of support during his illness, if he seeks treatment, but especially if he doesn't. It is not guaranteed that Mr. O'Mara will die suddenly of a heart attack. Is that what the rancher is assuming? Dr. Olsen should discuss alternative futures with Mr. O'Mara so he clearly understands what's at stake by refusing further testing. He may have a progressive decline, and if so, may need a lot of supportive care. Is it fair to his family to keep them uninformed and unable to prepare to help Mr. O'Mara? The rancher is sparing his wife a decision that he thinks she shouldn't have to make. But is that fair to her? Also at stake is the trust of this rural community. If people believe that Dr. Olsen failed to diagnose Mr. O'Mara's problems, will they still trust Dr. Olsen to provide their care? Justice is also a value of Dr. Olsen's. He is treating Mr. O'Mara, even though the rancher doesn't have insurance, and the doctor wants to offer the same level of care to Mr. O'Mara as to his other patients who do have insurance. The doctor has compassion for Mr. O'Mara and his predicament—he wants to be able to get Mr. O'Mara any needed services without sacrificing the family ranch.

We can assume that Mr. O'Mara's wife values her husband's health and well-being. She is the one encouraging her husband to see Dr. Olsen. We don't know anything about how this family makes important decisions, but it doesn't seem like shared decision-making and openness are priorities—at least for Mr. O'Mara, since he is asking to make this decision alone and wants to keep the information from his wife. But learning how this family usually makes tough decisions would be important information to aid the professional in solving the ethics issues.

The conflict arises between the clinician's desire for truth-telling among the family, and promoting the well-being of Mr. O'Mara by securing further tests and possible treatment—versus respecting Mr. O'Mara's desire to make this decision alone (autonomy/privacy/confidentiality) and to not spend money on tests (to protect the family's financial well-being).

Step 5: What can a provider do to address the ethics question; what are the options?

1. Dr. Olsen could do as Mr. O'Mara requests, but with one caveat: he could tell Mr. O'Mara that if his family asks, he will direct them to talk with Mr. O'Mara. Dr. Olsen will not lie to Mr. O'Mara's family.
2. The doctor could call Mr. O'Mara's wife and recruit her to help convince Mr. O'Mara to pursue the tests.
3. Dr. Olsen could try to try to persuade Mr. O'Mara to allow a discussion about options between the doctor, Mr. O'Mara and Mr. O'Mara's wife.
4. Dr. Olsen could try to coerce Mr. O'Mara into getting further tests by means other than recruiting Mr. O'Mara's wife.
5. Dr. Olsen could discharge Mr. O'Mara from his practice, if the patient is not willing to get more tests.

Step 6: What should the provider do?

Dr. Olsen should try to persuade Mr. O'Mara to allow a discussion about his situation and various options with Mr. O'Mara and his wife (option 3). Then, Dr. Olsen could do as Mr. O'Mara requests on one condition: he could tell Mr. O'Mara that if his family asks questions about his health situation, he will direct them to talk with Mr. O'Mara. Dr. Olsen will not lie to Mr. O'Mara's family (option 1).

Step 7: The provider justifying his or her choice

Unless Dr. Olsen knew Mr. O'Mara and his family very well, options 2 and 4 are unacceptable violations of Mr. O'Mara's trust, and could result in more harm than good. Option 3 is much better, because it honors Mr. O'Mara's wishes and also tries to help Mr. O'Mara bring his family in for assistance. This option maximizes trust, openness, truthfulness, and a shared understanding of everyone's well-being. But if Mr. O'Mara cannot be persuaded to have his wife join a discussion of options with Dr. Olsen, option 1 seems like the next best

course of action. Option 5 seems out of the bounds of moral acceptability, as it both violates Dr. Olsen's obligations to provide care, and the trust that he has built with Mr. O'Mara, the patient's family and the community. Where would Mr. O'Mara find care if Dr. Olsen did not provide it? Although Dr. Olsen does not have an unqualified obligation to provide care, this disagreement about care would not seem an adequate justification for risking the abandonment of Mr. O'Mara, given the rural difficulties in finding other health care providers. With option 1, Dr. Olsen could set some limits around what he's not willing to do (i.e., not willing to lie to Mr. O'Mara's family) and still honor Mr. O'Mara's preferences for care. This seems like a better balance of obligations.

The major difficulty with option 1 is that it potentially leaves Dr. Olsen providing less than the standard of care, and also potentially deceives Mr. O'Mara's family (if they never ask for more information). It would be very hard for Dr. Olsen to see Mr. O'Mara and his family at appointments, and otherwise around town, with this secret between them. But rather than taking matters into his own hands, and approaching the family independently of Mr. O'Mara, Dr. Olsen could keep asking Mr. O'Mara to involve the rest of the family or maybe a trusted spiritual leader. Maybe over time, Mr. O'Mara would be willing to see the possible benefits of being more open with his family—and the harms associated with keeping the current secrets.

Step 8: How could this ethics issue have been prevented?

One possible prevention strategy is for providers to have conversations with all patients about the scope and limits of confidentiality, including between family members. It might be easier for Dr. Olsen to keep Mr. O'Mara's wishes private if he had previously had a conversation with Mr. O'Mara's wife, and she had understood that sometimes Dr. Olsen would not share things with her about Mr. O'Mara's care.

CONSENSUS AND CONSCIENCE IN ETHICS DELIBERATION

Providers and administrators reading this discussion may disagree with my analysis of this case. Such disagreement is not a bad thing. In fact, it is a necessary part of ethics analysis. Confronting counter-arguments and responding to them makes an accepted reasoning stronger. Good reasoning is based on sound information, and is supported by respect for differing values, the ranking of competing values, and/or by the least infringement of key values. It is important to identify the possible sources of disagreement. Disagreement about how to balance differing values is the most difficult issue to resolve. Resolution requires the skills of respectful attention, patience, and open inquiry.

Although a comprehensive and careful process of ethical decision-making usually results in consensus, deep disagreement can still exist. A provider's responsibility is to be thorough and clear-thinking, to challenge assumptions, to figure out where disagreements lie, and to strive to resolve them.

CONCLUSION

Ethical values are a part of everyday clinical decision-making, whether they occur in small clinic practices or critical access hospitals. But sometimes value conflicts arise, and need to be resolved before a plan of care can go forward. It is important for rural administrators and health care professionals to be able to identify ethics issues and work to resolve them. Using a deliberative process to address ethics conflicts, such as the one I have proposed, can be a useful tool to ensure that there is good reasoning and thoughtful consideration of all competing values. The facility's ethics committee or other ethics mechanism can employ such a deliberative process. Even though such a process can be used by any person or group of health care professionals, having an effective and competent ethics committee or mechanism available is a valuable resource to clinicians and facility administrators, because disagreement is part of the moral life.

REFERENCES

1. Gert B. *Common Morality: Deciding What to Do.* New York, NY: Oxford University Press; 2004.

2. Ross JW, Glaser JW, Rasinski-Gregory D, Gibson JM, Bayley C. *Health Care Ethics Committees: The Next Generation.* Chicago, IL: American Hospital Publisher; 1993.

3. Ethics committees and ethics consultation. University of Washington School of Medicine. http://depts.washington.edu/bioethx/topics/ethics.html. Accessed Feb. 5, 2009.

4. Mills AE, Rorty MV, Spencer EM. Introduction: ethics committees and failure to thrive. *HEC Forum*. Dec 2006;18(4):279-286.

5. Cook AF, Hoas H, Guttmannova K. Bioethics activities in rural hospitals. *Camb Q Healthc Ethics*. Spring 2000;9(2):230-238.

6. Cook AF, Hoas H. Where the rubber hits the road: implications for organizational and clinical ethics in rural healthcare settings. *HEC Forum*. Dec 2000;12(4):331-340.

7. Nelson W. Where is the evidence: a need to assess rural ethics committee models. *J Rural Health*. Summer 2006;22(3):193-195.

8. Niemira DA. Grassroots grappling: ethics committees at rural hospitals. *Ann Intern Med*. Dec 15 1988;109(12):981-983.

9. Niemira DA, Meece KS, Reiquam CW. Multi-institutional ethics committees. *HEC Forum.* 1989;1(2):77-81.

10. Cook AF, Hoas H. Voices from the margins: a context for developing bioethics-related resources in rural areas. *Am J Bioeth.* Fall 2001;1(4):W12.

11. Purtilo R. *Ethical Dimensions in the Health Professions.* 4th ed. Philadelphia, PA: Saunders; 2005:15-16.

12. Lo B. *Resolving Ethical Dilemmas: A Guide for Clinicians.* 2nd ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2000.

13. Jonsen AR, Siegler M, Winslade WJ. *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine.* New York, NY: McGraw Hill, Medical Pub. Division; 2002.

14. Glover JJ. Ethical decision-making guidelines and tools. In: Harman LB, ed. *Ethical Challenges in the Management of Health Information.* 2nd ed. Sudbury, MA: Jones and Bartlett; 2006.

15. Decisions and obligations: “It’s a matter of priorities”. National Rural Bioethics Project, University of Montana. http://www.umt.edu/bioethics/health care/resources/educational/casestudies/ruralfocus/decisions.aspx. Accessed July 2, 2009.