Ethics Conflicts in Rural Communities:
Stigma and Illness

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ABSTRACT

Stigma is defined as a negative perception that is assigned to an individual because of an attribute that, in the eyes of others, deeply discredits and diminishes him or her from a whole and usual person to one who is tainted and discounted. Stigma always occurs in a context. In rural health care settings, stigma takes on special importance because of the interdependent and overlapping relationships that exist in small communities. To be viewed negatively by others, to be avoided, and to be seen as less than a full member of the community is an extraordinary burden for a person in a rural community. Stigma comes with implications for the rural person's life and family, at the current time and in the future. This chapter discusses the implications and effects of stigma and stigmatizing illnesses in rural communities, and the related ethics conflicts. Such conflicts include ethics dilemmas pertaining to the rights to privacy and confidentiality, or to the allocation of scarce health care resources, and are exacerbated by the unique stressors in the rural health care provider's experience. These ethics conflicts can be minimized, or even avoided, by following certain practical guidelines. When dealing with patients who have stigmatizing illnesses, confidentiality and establishing trust are of paramount importance. Rural health care providers should also be their patients' advocates and be proactive in mitigating stigma by educating the general public about common stigmatizing illnesses.

CASE STUDIES

CASE 10.1 | Confidentiality, overlapping relationships, and unwillingness to seek care

Nancy Smith is a 25-year-old woman living in a small town. She works at the local grocery store that her family owns. Several months into the relationship with a man from a neighboring community, she found out that her partner was HIV-positive. Following testing at a distant family planning center, her fear is confirmed that she is HIV-positive. She realizes that she needs treatment, and talks to her primary care physician, Dr. Russell, about the situation. Ms. Smith is hesitant about seeking care at the only primary health care clinic in her town, because the main nurse of the clinic and the lab technician are both regular customers at her store, and are also friends of her family. She fears the possible stigma and discrimination that her illness may cause, and isn't sure that her diagnosis can be kept a secret from her family or the community.

CASE 10.2 | Limited access to health care resources in rural communities

Greg Becker, a Vietnam War veteran, is a prominent leader in his rural community. He is now running as an elected official in his local town. For some months, privately, he has been experiencing difficult memories from his war experiences, including intrusive thoughts, nightmares, irritability and an inability to relax. He feels depressed and has occasional thoughts of suicide. His wife has "nagged" him about drinking until he reluctantly has agreed to see Dr. Chen, the family practice physician in his town. Mr. Becker is uncomfortable discussing his wife's fears about his drinking with Dr. Chen, and he fears his disclosure may hurt his campaign. Dr. Chen recommends Prozac for depression, but Mr. Becker later develops side effects, and chooses to be non-compliant. Dr. Chen suspects alcohol issues, but does not know how to broach that topic. Dr. Chen soon feels overwhelmed by the situation and recommends referral to a psychiatrist located 100 miles away. Mr.

Becker agrees, and stops seeing Dr. Chen. However, due to his fear of being labeled a "psych patient," Mr. Becker does not see the psychiatrist.

OVERVIEW OF THE ETHICS ISSUES

Coined by the Greeks, the word 'stigma' originally referred to a mark or sign on the physical body of a person that identified the bearer as being morally flawed and thus inferior to his fellowmen—someone to be avoided, especially in public places. In an important 1963 article, sociologist Erving Goffman defined stigma as "an attribute that is deeply discrediting," where a person is diminished "from a whole and usual person to a tainted, discounted one."[1] Stigma is essentially the devaluing of an individual's social identity.

Stigmatization is best understood as a 'situational threat' where one's stigma could influence how one is treated or judged. Link and Phelan state that stigma exists "when elements of labeling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows the components of stigma to unfold."[2] Thus, for stigma to occur, the stigmatized individual must have a labeled attribute that is different and distinguishable from the stigmatizer. Next, dominant cultural beliefs link such labeled persons to negative stereotypes. Thirdly, labeled persons are placed in distinct categories to accomplish separation of "us" from "them." Finally, labeled persons experience status loss and discrimination that lead to unequal outcomes. And, all of this is dependent on social, economic, and political power. It takes power to stigmatize, and being empowered (i.e., having control over the outcomes of self/others) reduces one's vulnerability to being stigmatized.[3] Stigma research[4] provides insight into an individual's experience of stigmatization. These experiences are portrayed in Box 10.1.

Stigma associated with illness, disability, and physical and mental limitations in particular, can create tremendous difficulties for rural residents as well as for the clinicians who provide their care. Certain illnesses are more stigmatizing in some communities. For instance, in some Alaskan villages, alcohol use and dependence are commonplace, and do not appear to have socially adverse consequences, whereas in

BOX 10.1

THE "STIGMA EXPERIENCE"

- Prejudice and discrimination, wherein the stigmatized person encounters barriers to employment, housing, accessibility to health care, and acceptance in social groups and/or communities
- Awareness of the devalued quality of one's social identity, such as when teenage African-Americans are aware of the prejudice against their group[5]
- Threat from a stereotype, such as the negative attitudes experienced by any person wearing a turban, who may have been assumed to be a Muslim terrorist, following the 9/11/01 attacks

other villages, stigma and alcohol are tightly linked. Link and colleagues[6] have studied how stigma may be more closely associated with other perceptions, such as how "biologically based" an illness is, as opposed to being more of a "psychological problem" or a "lack of will power." Other factors identified in the same study that increase the stigma of an illness are shown in the Box 10.2.

BOX 10.2

PERCEPTION ISSUES THAT INCREASE THE STIGMA OF AN ILLNESS

- Responsibility or blame for the illness' cause, for example, acquiring HIV by IV drug use or multiple unprotected sexual contacts, versus by blood transfusion for needed surgery
- Negative, stigmatizing labels associated with certain conditions, for example, the labels "lazy" or "stupid" associated with ADHD/ADD/Mental Retardation/Autism
- Potential for danger, most highly associated with mental illness and substance use
- Perception of "contagiousness," and, hence, a desire for distance; for example, AIDS/HIV, substance abuse, mental illnesses, other STDs are more stigmatizing than diabetes or heart disease[7]

There are certain core ethical principles and concepts that should guide every patient-provider encounter; definitions are shown in Box 10.3.

BOX 10.3

GUIDING PRINCIPLES FOR HEALTH CARE PROVIDERS

Autonomy
The right to self-rule or self-determination, closely linked to concepts of privacy and voluntarism

Respect for Persons
All persons are worthy of respect due to inherent personal worth and dignity, irrespective of race, ethnicity, socio-cultural background, sexuality, etc.

Beneficence
The obligation to "do good," "do right by patients," and to "use one's expertise to treat the ill"

Justice
Equitable distribution of power and resources

Ethical Use of Power
The use of power by a provider in an ethically directed manner, as determined by intent (i.e., to do good and to minimize harm) and by the outcome of the provider's actions

Confidentiality
A promise to not disclose personal information, linked to the concept of respect for a person's privacy

Do Your Duty
The adherence to profession and organization established standards of ethical behavior including professional codes of ethics

Nonmalefience
Seek to avoid risks and ensure that potential benefits of care outweigh burdens and harms

Veracity
Telling the truth in a clear and open manner

These principles are also discussed in detail in Chapter 3 of this *Handbook*.

The ethical principles are severely tested while dealing with stigmatizing illnesses, be it in an urban or rural setting. However, treating stigmatizing illnesses in rural areas becomes even more complicated, due to specific characteristics of the rural health care system. Some of these rural patient-provider characteristics, as enumerated in the Hastings Center report,[8] and the resultant ethics conflicts are listed in Box 10.4.

BOX 10.4

ETHICS CONFLICTS INHERENT IN THE RURAL PATIENT-PROVIDER RELATIONSHIP

- Overlapping relationships and conflicting roles
- Challenges in preserving confidentiality
- Respect for cultural values in relation to professional standards
- Limited access to health care resources in rural communities
- Issues of clinical competence
- Exceptional stresses on caregivers in rural settings

Overlapping Relationships and Conflicting Roles

In rural health care settings, stigma takes on special importance because of the interdependent and overlapping relationships that exist in small, closed communities.[8-10] In rural and frontier communities, health care providers routinely interact with patients in non-medical roles. Among physicians practicing in communities with fewer than 5,000 inhabitants, Paul Ullom-Minnich and Ken Kallail[11] found that two-thirds of physicians or their staff interacted on a non-medical basis with more than 5% of their patients. Nearly half of the physicians reported that more than 5% of their patients were friends or family. In such situations, ethics conflicts pertaining to principles of autonomy, ethical use of power, confidentiality, and right to treatment may arise. Consider an example in which the physician is the patient's uncle. The patient's (niece's) sense of autonomy may be undermined by the physician's role in her personal life. The physician-uncle wields significant power that should be used to be of beneficence to the

patient-niece. Constructive approaches to this dilemma include, but are not limited to, separating personal and professional roles to the extent possible; making it feasible for members of the clinical team to excuse themselves gracefully from especially sensitive cases; discussing the awkwardness of overlapping relationships with patients; seeking collaboration, supervision, and/or consultation when a provider's personal feelings predominate in a clinical case; and referring patients to neighboring communities when overlapping roles create conflicts of interest.

The conflicts related to overlapping relationships are also shown in the example of a physician who has diagnosed alcoholism in his friend/patient. The stigma of alcoholism may prevent the friend from seeking care, or being compliant with his physician/friend's treatment. A physician's anonymity is sometimes helpful in treating people with stigmatizing conditions. The physician in this type of situation has the option of referring his friend to a neighboring health care provider; referring the friend to local mental health professionals or clergy for counseling; or continuing to treat his friend, by separating personal and professional roles to the extent possible. Separating personal and professional roles can be accomplished by maintaining a professional demeanor while in the clinic, including addressing patients more formally, openly discussing the awkwardness of the dual relationship, and assuring patients that you and your staff follow confidentiality procedures as a matter of routine. Ensuring that both staff and patients understand confidentiality policies will help the provider to mitigate the effects of stigmatizing illnesses.

Challenges in Preserving Confidentiality
Respect for a patient's privacy is central to quality health care, and is especially important in the care of patients with stigmatizing illnesses. Maintaining confidentiality helps in establishing trust in the patient-provider relationship, but is very difficult in a small community where many people know each other, and many people talk or gossip about others' business. Also, for providers, being the town's "carriers of secrets" exacts a heavy toll. If confidentiality were breached by anyone on the health care team, this could result in a lack of patient trust in the provider and the team, and might form a barrier to needed, ongoing care. For example, a patient

diagnosed with HIV might forego necessary labs and medication to avoid being "found out," as in the case of Nancy Smith.

Heightened Cultural Dimensions of Health Care

Cultural values and beliefs can influence patients' illness perception, care seeking, and acceptance of caregivers. For example, an urban-trained physician in a rural setting has to understand cultural differences, because lack of awareness may lead to patient mistrust. Some conditions may be especially stigmatizing in a particular ethno-cultural group while not viewed that way in other groups, and such acceptance or lack thereof may be entirely different from the physician's own cultural beliefs and understanding of that particular illness' stigma. For the rural provider, enhancing his or her knowledge of a community's culture, history, and current concerns, and becoming attuned to individual patient's cultural experiences, will be helpful in mitigating any potential cultural ethics conflicts.

Limited Access to Health Care Resources in Rural Communities

The case of Greg Becker, the troubled Vietnam Vet who is trying to hide his problems because he is running for town office, highlights the problem of limited resources and access to needed health care, which has become a major source of health care disparity in rural communities.[12, 13] In *Health Status and Access to Care*, Braden and Beauregard[14] reported that one out of every seventeen rural counties in the United States had no physician providing patient care. Although health care needs of rural patients do not differ significantly from their urban counterparts, rural patients have to contend with limited resources and, sometimes, inadequate care. Rural health care providers are called upon to work long hours and are sometimes at risk of exhaustion and burnout. They are asked to make difficult ethics decisions regarding the allocation of scarce resources, and to provide services clearly beyond their levels of expertise, which bring forth ethics dilemmas pertaining to competence of care. A system-level solution needs to be implemented to resolve these myriad issues. Health care providers need to become advocates for rural health care funding. Local and nationwide involvement of consumer groups; professional organizations, such as the National Rural Health Association; and community leaders may help with bringing funds to

address rural health care needs. Finally, when faced with difficult ethics questions, consultation with colleagues or community leaders may provide helpful support.

Issues of Clinical Competence

The case of Greg Becker (Case 2) also illustrates the ethics issue of clinical competence, and of clinicians being called upon to provide services beyond their training and expertise. This ethics problem appears to arise directly from issues of scarce resources. Rural providers (physicians, nurses, nursing assistants, social workers, and "deputized" local citizens) are called upon to make health care decisions clearly beyond their scope of training or practice. This often happens as rural patients are faced with a lack of family support, lack of transportation, or financial limitations that do not allow them to pursue needed care in far-off urban centers. As mentioned previously, a system-based solution needs to be implemented to increase funds to rural clinics.

Exceptional Stresses on Caregivers in Rural Settings

Based upon the special characteristics of rural practice, it is clear that rural clinicians face unique clinical and ethical challenges. The stressors specific to rural caregivers are listed in Box 10.5.

BOX 10.5

STRESSORS SPECIFIC TO RURAL CAREGIVERS

- Personal and professional isolation, especially in their role as the town's "carrier of secrets"
- Cynicism associated with exhaustion and burnout
- Increased patient risk when rural clinicians are called to work extreme overtime to the point of fatigue, to make decisions beyond their level of expertise, and/or to cope with limited resources

These factors place exceptional stress on rural caregivers. How does the rural clinician balance the patient's need for confidential care with the need for public health concerns in the community? How does

the clinician, who is also a family member, friend, and/or neighbor, navigate the challenges of caring for the patient? How does the clinician protect the patient's dignity and privacy when "everyone knows everyone and everything?" How does the clinician deal with the absence of adequate health care resources, or (perhaps an even more difficult task) allocate a fraction of already scarce resources to an individual who may be disliked or devalued by others in the community (who may include some of the clinician's patients, family, friends, and neighbors)?

CASE DISCUSSION

The following cases were explored using the analysis method presented in Chapter 4 of this *Handbook*.

CASE 10.1 │ Confidentiality, overlapping relationships, and unwillingness to seek care

Stigma and the related fear of potential discrimination interfere with individuals' willingness to seek needed care.[15, 16] Nancy Smith's case exemplifies the general problem of disease stigma in small rural communities. Her reluctance to seek treatment stems from fear of the stigma and discrimination of having a sexually transmitted disease. This fear has clearly undermined her autonomy, making her choose to forgo treatment even though she knows it is needed. If Ms. Smith were living in an urban setting, she might be able to go to a different clinic where she could maintain anonymity. However, in rural settings, overlapping relationships and limited resources in the community create health care disparities rarely seen in urban settings.[12, 13] Ms. Smith is also lacking in trust that her diagnosis will be kept confidential by the nurse or the technician, especially since both know her family well.

There are several ethics issues that Ms. Smith's primary care provider, Dr. Russell, will need to address to foster quality health care for her, including Ms. Smith's diminished autonomy due to the disease stigma, the patient's expectation of a respectful encounter without prejudice or chastising, and the patient's concerns about maintaining confidentiality.

CASE 10.2 | Limited access to health care
resources in rural communities

In the case involving Mr. Becker, the ethical principles of justice and ethical use of power are sorely tested. Justice in this case relates to the lack of mental health resources in Mr. Becker's community. The ethical use of power and professional responsibility relate to Dr. Chen's maintaining the confidentiality of sensitive information within the context of the provider-patient relationship. Mr. Becker is reluctant to discuss his mental health issues and substance abuse, because he fears the information could sabotage his campaign. Dr. Chen also faces ethics challenges, because he is under pressure to provide mental health care services to Mr. Becker that are beyond his training and expertise.

In both vignettes, the principles of confidentiality, professional responsibility, and respect for people are also put into question. Physicians are people as well, whose inherent values, morals, and judgment systems may clash with those of certain patients depending on what the problems and diagnosis may be. For instance, Dr. Chen may have an inherent sense of disgust toward alcoholics and drug abusers, possibly from his own experiences with an alcoholic father. This may undermine Dr. Chen's ability to respect and be compassionate toward Mr. Becker. In addition, clinicians dealing with patient problems are also faced with the dilemma of beneficence toward an individual versus toward society. For instance, should a doctor disclose a school bus driver's struggle with alcoholism to the school authorities?

RESPONDING TO STIGMATIZING ILLNESS ETHICS CONFLICTS

In general, the clinician's decision-making in resolving ethics conflicts should be guided by clinical-illness factors, ethical principles, legal mandates governing the situation, collateral and corroborative information, and conscientiousness to pursue the least restrictive/ intrusive intervention, and thorough documentation of the decision-making process. The provider should approach ethics conflict situations on a case-by-case basis. Ethical principles are not mandates, but can provide fundamental guidelines to help approach and solve ethics dilemmas. Box 10.6 lists basic ethics skills that are useful to clinicians. Rural health care providers should be trained in these ethics skills, or be

able to access research material, such as this *Handbook*, that will help them identify ethics issues and inform their practice.[17-19]

BOX 10.6

FUNDAMENTAL ETHICS SKILLS[20]

- The ability to identify the ethical features of a patient's care
- The ability of a provider to see how his or her own life experiences, attitudes, personal values, and knowledge may influence his or her patient care.

  For example: In the treatment of stigmatizing illnesses, recognizing one's attitudes to such illnesses is paramount. Research has shown that there is sometimes a marked discrepancy between expressed attitudes and behavior towards stigmatized persons. Awareness of a person's stigmatized status may activate unconscious negative stereotypes, which will in turn influence subsequent behavior with the stigmatized person.

- The ability to identify one's areas of clinical expertise (i.e., scope of clinical competence) and to work within those boundaries
- The ability to anticipate situations that are ethically risky or problematic
- The ability to gather additional information, and to seek consultation and additional expertise in order to clarify and, ideally, resolve the conflict
- The ability to build additional ethical safeguards into the patient-care situation

CASE 10.1 | Confidentiality, overlapping relationships, and unwillingness to seek care

In this case, there are a number of ways in which the rural physician, Dr. Russell, and his staff can respectfully support Ms. Smith and her autonomy, and also ensure confidentiality of her records. The physician and his staff may conduct public discussion forums to educate the public about common diseases, including stigmatizing illnesses. One hopes that knowledge and awareness might at least partly mitigate stigma.

Dr. Russell and his staff should also practice respectful encounters as a "routine" with all their patients. They should be aware of diseases that are stigmatizing; be mindful of their personal values and feelings towards patients; take steps to prevent these values/feelings from affecting patient interactions; and be mindful of the potential for stigma to affect or cause certain illness behaviors, including reluctance to seek care.

The staff should practice confidentiality in all patient scenarios. They should constantly evaluate confidentiality leaks, and take steps to prevent them. There could be collaborative teamwork among the clinic staff to evaluate and provide constructive criticism and feedback regarding each other's patient interactions, confidentiality practices, and the effect of personal moral/value judgment systems on patient interactions. The clinic may spread its message of confidentiality and respect for all people through its actions, thus supporting patients with stigmatizing illnesses, like Ms. Smith, to seek services at the clinic. The clinic should be open to feedback; should have a formal system of receiving feedback from patients, such as comment cards placed in a box in the office; and should implement changes in response to this feedback. Additionally, the patient should be made an equal collaborator in her care, thus enhancing her autonomy.

If Ms. Smith refuses treatment of her HIV, should the physician respect her right for autonomy or, in view of beneficence to society, report this illness to health agencies? Such a situation needs to be handled with compassion and respect, with the provider educating the patient about the illness, its treatment, and its prognosis with and without treatment. The provider will thus ensure that the patient is making informed decisions as an engaged collaborator in treatment. If Ms. Smith is adamant about not pursuing ongoing HIV treatment and support from Dr. Russell and others at the clinic, he should strongly encourage her to seek and obtain the needed treatment and care in a location where she would be more comfortable. Additionally, Dr. Russell should reassure Ms. Smith that if she changes her mind about where to receive care, she would be welcome to return to see him and others on the staff.

In situations where the physician is mandated to report an illness to an agency, the physician should first discuss the issue with the patient. The information provided in such a discussion is highlighted in Box 10.7.

BOX 10.7

INFORMING PATIENTS ABOUT MANDATORY REPORTING—INFORMATION THE CLINICIAN SHOULD COMMUNICATE WITH THE PATIENT PRIOR TO MAKING ANY REPORT

- The name of the agency requesting the report
- Who will complete the report
- In what form the reporting will be completed (fax, e-mail, regular mail, etc.)
- What information about the patient will be disclosed (name, age, gender, work details, address, etc.)
- Who will have access to this information
- The purpose for reporting each item of information mentioned above
- What measures are taken to ensure confidentiality, and to make sure that the information reaches only those for whom it is intended

Furthermore, when patients are fully informed about their right to confidentiality, and the practices that have been implemented to ensure confidentiality, they are more likely to cooperate fully and, perhaps, will be more likely to seek treatment even in those cases when reporting might be mandated. Maintaining confidentiality in these cases might be enhanced by using the measures listed in Box 10.8.

These steps will help patients to receive appropriate treatment, without giving up their right to confidential care. Such steps also can help to reduce the overall stigma associated with certain illnesses.

CASE 10.2 | Limited access to health care resources in rural communities

Due to a lack of mental health providers in his community, Mr. Becker turns to Dr. Chen. But Dr. Chen is not trained to deal with Mr. Becker's psychiatric problems, beyond simple attempts to diagnose or try antidepressants. Dr. Chen may also be responding to his unconscious feelings towards alcoholics, and thus not following through with Mr.

BOX 10.8

MEASURES TO ENHANCE CONFIDENTIALITY

- Be mindful of confidentiality's importance to patients
- Discuss with the patient the strategies for maintaining confidentiality
- Direct patients to a mail-order pharmacy where medications can be obtained
- Educate colleagues and staff about confidentiality in effective patient care, making it routine practice with every patient and following up on any "leaks"
- Keep records out of public view and/or keep sensitive records separate from other health care documents
- Have collaborative clinics where all kinds of care, such as treatment of medical, psychiatric, HIV, and substance abuse conditions, are given under one roof, thus making stigmatizing conditions less obvious
- Conduct community forums to educate the public about stigmatizing illnesses and dispelling related myths
- Maintain a collaborative network with neighboring health care clinics and providers where patients can be referred to support anonymity

Becker. Ideally in such scenarios, clinicians need to be aware of their unconscious negative feelings toward patients with stigmatizing illnesses and take steps to understand how these feelings impact patient interactions. There could be a discrepancy between how clinicians and their patients view illnesses. For instance, some conditions may not be considered stigmatizing by a clinician but may be potentially stigmatizing to patients. If unaware of such discrepancies, patients may perceive a lack of sensitivity. Health care providers should routinely evaluate their patients' illness experiences and associated feelings.

Dr. Chen may, with sensitively and compassion, broach the topic of Mr. Becker's potential war-related PTSD symptoms, including the excessive use of alcohol. He may educate Mr. Becker that alcohol dependence is a medical condition that requires specialized treatment with therapy and

medications, and acknowledge that he (Dr. Chen) lacks such training. Since their community has no mental health providers, Dr. Chen and his team may establish a collaborative and complementary network of services with neighboring health care clinics and providers, as some services may be better provided in Dr. Chen's clinic while others may be best provided in other neighboring clinics. Dr. Chen should be aware of the services and location of Veterans Hospitals, and the many Community Based Outpatient Clinics to which Mr. Becker can be referred. In such an endeavor, a system of transportation may be established which can be used by patients to travel between clinics. This requires funding for which the support of local politicians may be enlisted, as well as the cooperation among local health care agencies. The rural health care provider thus has to wear the mantle of activist for the welfare of his patients—a skill that is, unfortunately, not taught in medical school.

ANTICIPATING STIGMATIZING ILLNESS ETHICS CONFLICTS

Following the old adage, "prevention is better than cure," rural clinicians may take steps early on to recognize ethics conflicts that stem from stigmatizing illness, and prevent them from occurring. Rural clinicians have the advantage of being aware of their community's pulse; however, an individual patient's perception of his or her illness may still vary from the norm. Hence, clinicians should approach each situation on a case-by-case basis, and be aware of the patient's feelings, perceptions and understanding of his or her own illness as well as community-wide myths and beliefs. Such awareness could positively change the interaction between patient and clinician in both of the cases presented. Asking patients like Nancy Smith and Greg Becker about their feelings and ideas would educate their clinicians about what they can expect in a given situation. All patient interactions must be conducted in a sensitive, compassionate, and respectful manner, and these interactions, including clinical practice, must be ethics-directed. Having all interactions be ethics-directed will mitigate ethical mistakes, including those in cases where patients have stigmatizing illnesses. Because confidentiality is of paramount importance with regard to potentially stigmatizing illnesses, clinicians need to ensure that confidentiality is maintained. By preserving confidentiality as a routine practice, providers can encourage other people with stigmatizing illnesses to seek necessary care.

In addition, community-wide education programs can be useful in decreasing the negative impact of stigmatizing diseases. For example, community forums can be facilitated in collaboration with neighboring clinics and/or small rural hospitals, to improve the community's understanding and diminish misperceptions regarding diseases that all too often carry stigma. The development and implementation of community-wide programs can be further enhanced if such programs are planned in collaboration with respected community officials or leaders, such as police officers or clergy.

CONCLUSION

Disease stigma combines with the special characteristics of the rural provider-patient relationship to cause further dilemmas in the ethical practice of health care. Rural clinicians are faced with such challenges on a continual basis. Rural health care practice, despite its limitations, must be guided by ethical principles to the greatest extent possible. Education and training in ethics skills, and training in handling sensitive or stigma-related conditions, are essential for rural providers to undergo so as to enhance their ethical practices. Education of the general public, through community "forums" about various stigmatizing illnesses, may help to dispel associated myths. Such education may mitigate stigma, mobilize financial resources, invite public participation, and help in providing care for the stigmatized group. Policy-makers at the local, state, and federal levels must be made aware of this problem in rural communities, so that more funding and research is made available to help individuals with stigmatized illnesses. Providers should work as advocates for their patients, and be active participants in local policy-making and resource allocation. Such involvement can be enhanced through establishing collaborative networks of health care with neighboring providers. Collaborative relationships can be effective for fostering patient referrals and working with the county, state, or national agencies to advocate for financial resources to enhance rural health care delivery systems. Finally, compassion and respect for individuals must be essential features of all provider-patient interactions.

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