



Rural Health Care Ethics

A MANUAL FOR TRAINERS

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Funding for this project was provided
by the National Rural Health Association



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Although many of the case studies contained in the *Training Manual* are drawn from actual events, every effort has been made to disguise the identities and the organizations involved.

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Section I

INTRODUCTION

Background: What is Rural Health Care Ethics?

Approximately 62 million people, one-quarter of the United States' overall population, live in rural communities distributed over three-quarters of our country's land mass. Many rural residents have significant illness and injury-related disabilities, and they encounter tremendous obstacles when seeking needed health care. Rural Americans have limited access to clinicians, health facilities, and specialized services, and their care is hampered by geographical and climatic barriers as well as heightened social, cultural, and economic challenges. Indeed, the burden of illness for rural populations is considerable, placing great demands on a resource-poor clinical care system. Consequently, rural residents are increasingly recognized as an underserved special population. Attaining an appropriate standard of care for rural populations has emerged as a major concern in the national discussion of health disparities.¹⁻⁵

With the growing understanding of rural health care has come an emerging awareness of the special ethical considerations inherent to clinical practice in closely-knit, tightly interdependent small community settings. Therefore, what makes rural health care ethics unique is the context—how the rural environment and culture is woven into the fabric of the encountered ethics issues.

Despite regional differences between Northwest, Appalachia, Southwest, New England and other rural communities, there are many common rural health-related characteristics that influence and create ethical challenges, including those noted in the box on page 8.

Rural ethical challenges that are shaped by these contexts include obtaining informed consent, establishing a therapeutic alliance, treatment adherence, overlapping personal and professional relationships, protection of confidentiality, conflicts between the interests of individual patients and the community overall, distributing scarce resources equitably, and experiencing pressure to provide care in areas that are beyond one's usual scope of clinical competence. It is difficult, for example, to protect the privacy of rural patients when their care occurs in clinics where neighbors, friends, and relatives may work. Similarly, it is difficult to establish a professional clinician-patient relationship when the patient is the clinician's former grade school teacher or a member of the local parish. Certain ethical aspects of care appear to be especially relevant and sensitive when the health issue is stigmatizing, as is the case with mental illnesses, drug abuse disorders, and infectious diseases.

COMMON RURAL HEALTH-RELATED CHARACTERISTICS^{2, 5-13}

- Small population density
- Overlapping personal and professional relationships between health care providers and community members
- Rural isolation and long distances to urban-based tertiary medical centers
- Limited availability of health care services, specialists and providers
- Small hospitals, many of which have 25 beds or less
- Residents with close-knit, shared experiences
- Residents with a strong interdependence and self-reliance
- Shared values and culture
- Challenging economic and employment situation(s), i.e., higher rates of uninsured and lower per person income compared to non-rural settings
- Poor health care status compared to non-rural populations
- Hazardous work environment
- Limited rural ethics resources, including rural focused ethics literature, ethicists, training, and ethics committees

Because of these distinct pressures in the rural community context, the solutions that providers develop to resolve complex ethical dilemmas that arise in rural areas may differ from those derived in urban areas. Providing health care, such as mental, reproductive, or end-of-life care to a family member, friend, or neighbor may become necessary in a rural setting, whereas urban contexts—with other health care clinicians, facilities, and more diverse health resources in the immediate area—may permit greater role separation and clearer personal and professional boundaries.

Despite the unique character of rural ethics issues there are limited ethics training and resources specifically focused on assisting rural clinicians who are confronted with complex ethical dilemmas. When rural professionals seek ethics training and resources, they report that the ethics training is so urban and tertiary-care oriented that it is of minimal relevance. In a recently completed study, clinicians indicated the need and desire for ethics resources and training. A survey of NH Critical Access Hospital CEOs noted that 100% of the CEO respondents indicated a need for additional ethics training.¹⁴ Additionally, rural clinicians have expressed concerns about professional ethics codes and ethical standards of practice that are inattentive to the dilemmas that exist in small communities. Many of the standards appear most applicable to resource-enriched, less interdependent urban communities.

As a result of limited ethics committees at rural facilities, rural focused ethics publications, rural based health care ethicists, and rural resources and training, we see a significant need for increased rural health care resources and training that integrates rural culture and values into ethical reflection and decision-making. The recognition of these issues has led to the development of this Training Manual.

Manual's Purpose

The purpose of this Training Manual is to provide training guidance and resources to enhance multidisciplinary rural professionals' ability to respond effectively, in an evidence-informed and culturally competent manner, to complex ethical conflicts. The Training Manual provides practical, programmatic guidance and resources for training coordinators or facilitators interested in conducting rural health care ethics training workshops, classroom teaching, or sessions imbedded within larger conferences. It does so by providing step-by-step guidelines and resources for a workshop or conference session on rural health care ethics. Ultimately, the goal of the Training Manual is to increase awareness and understanding of rural health care ethics issues and to assist professionals in the identification or development of appropriate resources to manage ethical issues in their practice.

Manual's Target Users and Audiences: Coordinators and Facilitators

The target users of this Training Manual are:

- individuals or groups who would like to *plan and facilitate a training session* on rural health care ethics; or
- individuals or groups interested in *organizing a training session that others will facilitate* on rural health care ethics.

Examples of the primary target **USERS** for this Training Manual include:

- **Rural health care administrators, providers or coordinators**—such as directors of state offices of rural health (SORH), Area Health Education Centers (AHEC), administrators or providers at critical access hospitals, and rural providers on ethics committees. For example, ethics training at SORH conferences or meetings can be planned and implemented based on the Training Manual's guidance. Administrators or providers at critical access hospitals may also find the Training Manual useful for conducting or organizing a session on rural health care ethics.
- **Health care educators**—such as directors of nursing, medical or allied health professional school programs focused on training future rural health care professionals. The directors or faculty of such programs can use the Training Manual to provide rural ethics training to complement other aspects of their curriculum. For example, a nursing school director can use components of the Training Manual to foster rural ethics training into the training program.
- **Health care ethics educators**—whether they facilitate training for future rural health care professionals or not. The Training Manual contents can provide useful material to help students understand the nature and scope of rural ethics through presentations and cases studies.
- **Organizers of inter-professional training and development**—whether an education coordinator works within one institution or across institutions, the Training Manual contents, including the training formats and case studies, can assist in facilitating training and conversations among different professionals.

There is a wide range of potential learners who could benefit from the rural ethics training. Examples of the primary target **AUDIENCES** for this Training Manual include:

- Rural health professionals, including nurses, nurse practitioners, physician assistants, physicians, LPNs, and other members of the extended health care team, including physical therapists, social workers, pharmacists and other allied health professionals; particularly those with direct patient contact
- Rural health care administrators
- Students in various health profession training programs, especially those planning to go into rural settings
- Non-rural health professionals interested in health care ethics, but with little exposure to the rural setting.

Our overall purpose for the Training Manual is to provide concise guidelines, tools and materials to organize and conduct rural health care ethics training. We realize that some individuals interested in facilitating the training may not have experience in conducting some of the suggested activities, such as large group discussions, or may not have experience talking about rural health care ethics. Therefore, in Section III, we provide guidelines for how to facilitate large or small group discussions and a list of potential rural ethics training facilitators for those who would like some initial assistance.

Using the Manual

This Training Manual is divided into 3 sections:

- Section I—Introduction
- Section II—Training formats
- Section III—Training resources

Following the current Introduction Section, we provide three potential workshop or training formats for delivering content and skills development activities related to rural health care ethics. The formats include a 1-2 hour session, a 3-4 hour session and a full-day session. Each format description includes a suggested timeline, activities for the session, instructions for how to conduct each activity, and links to training materials (e.g., PowerPoint presentation), all of which are included in Section III of the Training Manual. Additional information and resources, including a bibliography and potential handouts, are also provided in Section III.

In providing these different session formats, we assume that training sessions will often be a component of a larger conference, training program or curriculum. For example, the 1-2 hour ethics training model could be a segment of a day long SORH conference that is addressing a variety of other topics. The 3-4 hour session may be a special Continuing Nursing Education (CNE) or Continuing Medical Education (CME) training event organized by a group of state-coordinated critical access hospitals. Alternatively, the organizer may decide that it would be better to break the day-long training down into several, shorter sessions done over a period of a year at their institution. Since we provide multiple session formats and training

materials to use, we expect that organizers will adjust the materials to suit their settings and time available.

In addition to deciding on the best formats to use, we expect that organizers will adjust the training materials used to meet the needs and experiences of their audience. For instance, we assume training participants either are rural health care professionals or have at least some experience in rural settings. If the participants have had limited exposure to rural settings, the training facilitator will need to spend more time than we have allocated presenting and discussing the rural characteristics that influence ethical challenges. They may also need to rely more on the rural health care ethics cases presented in Section III for small group discussions versus having participants use their own examples. We also assume that the participants have had limited formal training in health care ethics. If participants have already had training in health care ethics, the facilitator should adjust the content accordingly.

Each session format adheres to principles of learning that emphasize interactive activities for participants and opportunities for participants to reflect on how the material is relevant (or not) to their particular work contexts and their own experiences with ethical challenges.¹⁵ In doing so, we hope to support participants' ability to understand and recognize rural health care ethics in their own settings and to begin to identify ways to address these situations in a timely and professional manner. One implication of this design is that longer session formats will require additional session leaders or facilitators to help run small group discussions. This is largely dependent on the number of participants, so anticipating the number of participants will be very helpful for planning the session.

One note of caution—there are no easy answers to ethical dilemmas. Also, there rarely is only one “correct” response to ethical challenges. However, there generally is a range of appropriate responses, as well as range of inappropriate responses. Facilitators should be ready to acknowledge this in their training and not feel pressured to provide absolute “answers” to ethics conflicts. Two excellent publications for analyzing or preparing to discuss selected case studies are found in the American College of Physicians' Ethics Manual¹⁶ or Bernard Lo's book, *Resolving Ethical Dilemmas: A Guide for Clinicians*.¹⁷ These resources provide generally accepted ethics guidelines for a wide range of ethics conflicts. Additionally it should be noted that the law frequently informs ethics conflicts and questions. Ideally, training facilitators will be aware of case-relevant federal, state, and local laws to help inform discussions during training, but health care professionals should seek specific legal counsel and advice before offering legal advice related to health care ethics comments.

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Section II

TRAINING SESSION FORMATS

In this section we outline three training formats that could be used to conduct training on rural health care ethics. Each format includes:

1. goals and learning objectives;
2. suggested timeline for each component;
3. activities for each component, with links to the training materials provided in Section III; and
4. general instructions for conducting the session.

The suggested timelines are based on a mid-point for each format model. For example, the timeline offered for the 1-2 hour session is 1½ hours. The timelines for each format can be adjusted as needed by the user.

The session formats are similar in that the longer formats include some of the same materials and structure as the shorter formats, but each format is structured to meet the specific learning objectives. In all cases, presenters or organizers should adjust the training and materials to suit the time available for the session and the needs and background of their participants.

Accompanying Power Points

Accompanying PowerPoint material has been created to cover the different sections of the three session formats. The slide numbers for each section are noted under “Resources” for the three formats presented below. Some slides also include additional notes to assist presenters in the presentation. The notes are viewable using either the “Normal” or “Notes page” view option in PowerPoint. All slides are available electronically at <http://dms.dartmouth.edu/cfm/resources/manual/>.

1-2 HOUR TRAINING SESSION

Session Learning Objectives

The overall session goal is for participants to recognize ethical challenges that are common in rural settings and examine methods, strategies and resources for addressing such challenges. By the end of the session, participants will be able to:

- Describe how the rural context influences health care ethics
- Identify different types of ethical challenges which emerge and their potential effects
- List 8 steps of a basic approach for addressing ethical challenges
- Locate ethics resources geared towards rural health care professionals

Suggested Timeline and Training Resources for 1-2 Hour Training Session

Time	Topic	Content and Format	Resources
9:00-9:05	Introduction	<ul style="list-style-type: none">• Session purpose and objectives	<ul style="list-style-type: none">• Slides #1 and 2
9:05-9:20	Ethical challenges in rural health care settings	<ul style="list-style-type: none">• Hand out rural ethics case• Large-group discussion with listing	<ul style="list-style-type: none">• Select case from Section III. Consider 12, 13 or 14• Discussion questions on Slide # 5
9:20-9:45	Framing rural health care ethics	<ul style="list-style-type: none">• Presentation—overview of rural health care ethics; impact of ethical conflicts on health practices	<ul style="list-style-type: none">• Slides #6-31
9:45-10:10	Response to rural ethical challenges	<ul style="list-style-type: none">• Present a case for mini-discussion with two other participants. Ask participants how they might respond.• Large group discussion of mini-discussion• Presentation—8-step ethics decision-making process	<ul style="list-style-type: none">• Select case from Section III• Large group discussion guidelines• Slides #33-41 or just use #33 with 8-step handout
10:10-10:20	Anticipating rural ethics challenges	<ul style="list-style-type: none">• Presentation—importance of anticipating ethical challenges• Rural ethics resources	<ul style="list-style-type: none">• PowerPoint #43,47-49• Hand out one-page resource guide (Section III)
10:20-10:30	Conclusion	<ul style="list-style-type: none">• Answer questions• Conclude Session• Session evaluation	<ul style="list-style-type: none">• Slide #52• Evaluation form and/or learning plan (Section III)

General Instructions for How to Conduct the 1-2 Hour Training Session

This session begins with a case presentation to immediately engage participants in thinking about rural health care ethics. This leads into a large group discussion in which participants share their thoughts of the case—what are the ethics issues in the case and how are the ethics issues influenced by the rural context. The discussion should be captured by the facilitator on a whiteboard or flip chart.

The previous discussion segues into the presentation providing an overview of rural health care ethics, in which the facilitator can refer to the discussion and highlight points made during the previous, case discussion.

The second case presentation (9:45) seeks to engage participants by asking them to reflect on and share with two other participants (mini-discussion) how one might anticipate and address ethical challenges presented in rural settings. This is followed by a large group discussion and a brief presentation on basic strategies to address ethical situations, which can refer to points noted in the large group discussion. If the number of learners or location of the training does not permit mini-discussions the facilitator may create a large discussion for this section.

The next brief session (10:10) focuses on the importance of anticipating ethics conflicts. Potential rural ethics resources should then be reviewed during this session, using the handout, which can be distributed out during this session or included in participants' folders.

To conclude the 90-minute session the facilitator should review the basic points made during the training: the nature of rural health care ethics; that ethics issues are frequently encountered and can have a significant impact on health care; that thoughtful discussions about the applications of basic ethics principles and guidelines can be helpful; and the importance of health care professionals developing strategies for anticipating and decreasing ethics conflicts.

The overall timeline and format is a 90-minute session, but facilitators can expand or contract the amount of time by devoting more or less time to the individual reflection and mini-discussion sections. For instance, a facilitator could choose to present two cases for reflection and discussion during each case discussion or allow more time for questions and discussion at the session conclusion, bringing the total session time to 2 hours.

3-4 HOUR TRAINING SESSION

Session Learning Objectives

The overall session goal is for participants to become familiar with ethical challenges that are common in rural settings and learn how to address or prevent these challenges. By the end of the session, participants will be able to:

- Summarize how rural context influences health care ethics
- Identify frequently encountered ethical challenges
- Implement an 8-step process for ethical decision-making
- List strategies to anticipate and decrease ethical challenges
- Locate ethics resources for rural health care professionals

General Instructions for How to Conduct the 3-4 Hour Training Session

The opening session begins with a case presentation to immediately engage participants in thinking about rural health care ethics. This leads into a large group discussion in which participants share their thoughts of the case. Suggested questions include: What are the ethics issues in the case? How are the ethics issues influenced by the rural context? The discussion should be captured by the facilitator on a whiteboard or flip chart.

The previous discussion segues into a PowerPoint presentation providing an overview of rural health care ethics, in which the facilitator can refer to the discussion and highlight points made during the previous case discussion.

The purpose of the first small group exercise (10:00–10:30) is to encourage further exploration of rural health care ethics through the use of the participants' own experiences in their rural settings. Participants are asked to describe their common recurring ethics conflicts. Additional cases provided in this Training Manual (Section III) can be used if participants do not come up with their own ethical conflicts. This discussion also provides questions that begin to explore how such situations are currently addressed in the different settings or not and leads into the next presentation on the 8-step ethics decision-making process.

The purpose of the 8-step ethics decision-making process (see Section III) is to provide a method for clarifying and addressing ethical situations. The presentation and decision-making handout (10:45–11:15) introduces the process and the following small group exercise provides an opportunity to apply the method using a different rural ethics health case in the Training Manual. The presentation and discussion provides opportunities for participants to identify questions about the process, understand its potential application and to begin to identify potential resources in their own settings for addressing situations.

Following the presentation is the second small group exercise (11:20–11:50) where participants can apply the 8-step ethics decision-making process to a case study. The case study can be one identified in the previous small group exercise or a pre-selected case, such as from Section III in the Training Manual.

Suggested Timeline and Training Resources for 3-4 Hour Training Session

Time	Topic	Content and Format	Resources
9:00-9:05	Introduction	<ul style="list-style-type: none"> • Session purpose and objectives 	<ul style="list-style-type: none"> • Slides #1 and 3
9:05-9:20	Ethical challenges in rural health care settings	<ul style="list-style-type: none"> • Hand out rural ethics case • Large-group discussion with listing 	<ul style="list-style-type: none"> • Select case from Section III. Consider 12, 13 or 14 • Discussion questions on Slide # 5
9:20-9:50	Framing rural health care ethics	<ul style="list-style-type: none"> • Presentation—overview of rural health care ethics; impact of ethical conflicts on health practices • Describe small group activity 	<ul style="list-style-type: none"> • Slides #6-31
9:50-10:00	Form small groups		
10:00-10:30	Current challenges in rural health care ethics	<ul style="list-style-type: none"> • Small group discussions, identifying common ethical challenges encountered by participants and other rural health care professionals and potential responses to these challenges 	<ul style="list-style-type: none"> • Small group facilitation guidelines, Section III • First small group instructions
10:30-10:45	Break and reconvene		
10:45-11:15	Managing ethical conflicts	<ul style="list-style-type: none"> • Large group discussion of common ethical issues • Presentation—8-step ethics decision-making process around a rural ethics situation • Describe small group exercise 	<ul style="list-style-type: none"> • Large group discussion guidelines, Section III • Slides #33-41 or just use #33 with 8-step ethics decision-making process handout
11:15-11:20	Reconvene small groups		
11:20-11:50	Application of decision-making process	<ul style="list-style-type: none"> • Small group exercise, applying 8-step process to case from Training Manual or one of participant's own case 	<ul style="list-style-type: none"> • Small group discussion guidelines, Section III • Second small group instructions
11:50-11:55	Reconvene large group		
11:55-12:20	Ethics resources	<ul style="list-style-type: none"> • Large group discussion/questions on small group exercise • Presentation—strategies for preventing ethical conflicts • Review of ethics resources 	<ul style="list-style-type: none"> • Slides #42-45 • Hand out one-page resource guide, Section III
12:20-12:30	Conclusion	<ul style="list-style-type: none"> • Conclude and summarize the session • Session evaluation 	<ul style="list-style-type: none"> • Slide #52 • Evaluation form and/or learning plan (Section III)

The small group discussion leads into the final large-group discussion regarding the application of the decision-making process (11:55–12:20). After the discussion, there is a brief (PowerPoint) presentation identifying strategies and resources to aid in addressing rural health ethic challenges.

To conclude the training the facilitator should review the basic points made during the training: the nature of rural health care ethics; that ethics issues are frequently encountered and can have a significant impact on health care; that thoughtful reflection using the decision-making process can be helpful in applying basic ethics principles and guidelines to cases; and the importance of health care professionals developing strategies for anticipating and decreasing ethics conflicts.

The timeline and format of this session is for 3.5 hours but facilitators can expand or contract the amount of time by devoting more or less time to different sections. For example, a facilitator could choose to turn one of the small group discussion times into an individual reflection and mini-discussion time (i.e., participants discuss with two other participants sitting near them), which decreases the amount of time needed for that section. To increase time, the facilitator could present two cases for reflection and discussion during small group time or allow more time for questions and discussion at the session conclusion, bringing the total session time to 4 hours.

FULL-DAY TRAINING SESSION

Session Learning Objectives

The overall session goal is for participants to become familiar with ethical challenges that are common in rural settings, and learn how to address or prevent these challenges, including development of formal ethics committees or resources. By the end of the session, participants will be able to:

- Summarize how rural context influences health care ethics
- Identify frequently encountered ethical challenges
- Implement a process for ethical decision-making
- List strategies to anticipate and decrease ethical challenges
- Describe role and functions of an ethics committee in rural hospitals
- Locate ethics resources for rural health care professionals and hospitals

General Instructions for How to Conduct the Full-day Training Session

This session begins with introductions and a chance for participants to express what they hope to gain from the session. This information provides facilitators with the opportunity to identify topics that they should emphasize or expand on depending on interest.

The next component (9:20–9:40) begins with a case presentation to immediately engage participants in thinking about rural health care ethics. This leads into a large group discussion in which participants share their thoughts of the case. Suggested questions include: What are the ethics issues in the case? How are the ethics issues influenced by the rural context? The discussion should be captured by the facilitator on a whiteboard or flip chart.

The previous discussion segues into a PowerPoint presentation providing an overview of rural health care ethics, in which the facilitator can refer to the discussion and highlights points made during the previous case discussion.

The purpose of the first small group exercise (10:20–10:50) is to encourage further exploration of rural health care ethics through the use of the participants' own experiences in their rural settings. Participants are asked to describe their common recurring ethics conflicts. Additional cases provided in this Training Manual (Section III) can be used if participants do not come up with their own ethical conflicts. This discussion also provides questions that begin to explore how such situations are currently addressed in the different settings or not and leads into the next presentation on the 8-step ethics decision-making process.

Following a break a large group discussion will be facilitated to explore the findings from the small groups. Each group will be asked to give brief presentations.

The purpose of the (11:25–12:00) 8-step decision-making process session (see Section III) is to provide a method for clarifying and addressing ethical situations. The presentation and decision-making handout introduces the process and

provides an opportunity for participants to raise questions about the process, understand its potential application.

Following lunch (12:00–1:00), the reconvened group will discuss any issues that may have arisen during lunch conversations. Following any discussion the facilitator will describe the next small group activity that provides an opportunity to apply the method using participants' own rural ethics case or one of the rural ethics cases provided in the Training Manual. The small group discussion (1:15–1:50) provides opportunities for participants to identify questions about the process, understand its potential application and to begin to identify potential resources in their own settings

Suggested Timeline and Training Resources for Full-day Training Session (Morning)

Time	Topic	Content and Format	Resources
9:00-9:20	Introductions	<ul style="list-style-type: none"> • Session purpose and objectives • Participants introduce themselves and individual goals for day 	<ul style="list-style-type: none"> • Slides #1 and 4 • Large group discussion guide
9:20-9:40	Ethical challenges in rural health care settings	<ul style="list-style-type: none"> • Hand out rural ethics case • Large group discussion with listing 	<ul style="list-style-type: none"> • Select case from Section III. Consider 12, 13 or 14 • Discussion questions on Slide #5
9:40-10:10	Framing rural health care ethics	<ul style="list-style-type: none"> • Presentation—overview of rural health care ethics; impact of ethical conflicts on health practices • Describe small group activity 	<ul style="list-style-type: none"> • Slides #6-31
10:10-10:20	Form small groups		
10:20-10:50	Current challenges in rural health care ethics	<ul style="list-style-type: none"> • Small group discussions, identifying common ethical challenges encountered by participants and other rural health care professionals and potential responses to these challenges 	<ul style="list-style-type: none"> • Small group facilitation guidelines, Section III • First small group instructions • Select case from Section III
10:50-11:05	Break and reconvene		
11:05-11:25	Common responses to rural ethics challenges	<ul style="list-style-type: none"> • Large group discussion of small group findings. Each small group presents if possible. 	<ul style="list-style-type: none"> • Large group discussion guidelines
11:25-12:00	Anticipating rural ethics challenges	<ul style="list-style-type: none"> • Presentation—8-step ethics decision-making process around a rural ethics situation 	<ul style="list-style-type: none"> • Slides #33-41 or just use #33 with 8-step ethics decision-making process handout
12:00-1:00	Lunch		

for addressing situations. These are then brought back to a large group discussion using small group presentations (1:55–2:20) to discuss questions and findings.

Following an afternoon break, the small and large group exercises then lead into a PowerPoint presentation (2:40–3:10) describing the importance of health care professionals developing strategies for anticipating and preventing ethical conflicts. The presentation will offer examples for proactively addressing ethics challenges and engage with the participants in any approaches they might be using. As done previously, the facilitator can refer to points or questions raised in the large group discussion to link strategies and resources to issues raised.

Suggested Timeline and Training Resources for Full-day Training Session (Afternoon)

Time	Topic	Content and Format	Resources
1:00-1:10	Large group	<ul style="list-style-type: none"> Respond to questions related to 8-step ethics decision-making process and introduce small group activity 	
1:10-1:15	Form small groups		
1:15-1:50	Ethics decision-making process application	<ul style="list-style-type: none"> Small group case studies applying 8-step ethics decision-making process. Can use 'real life' cases discussed by participants in prior small group exercise. 	<ul style="list-style-type: none"> Small group facilitation guidelines, Section III Second small group instructions
1:50-1:55	Reconvene large group		
1:55-2:20	Small group review	<ul style="list-style-type: none"> Large group sharing and discussion of small group exercise (questions, difficult steps, potential solutions) 	<ul style="list-style-type: none"> Large group discussion guidelines
2:20-2:40	Break and reconvene		
2:40-3:10	Preventing ethical conflicts	<ul style="list-style-type: none"> Presentation—strategies for anticipating and decreasing ethical conflicts 	<ul style="list-style-type: none"> Slides #42-45
3:10-3:40	Next steps: creating and accessing ethics resource	<ul style="list-style-type: none"> List ethics resources Presentation—potential structures for ethics committees in rural hospital 	<ul style="list-style-type: none"> Hand out one-page resource guide, Section III Slides #46-51
3:40-4:00	Wrap up and questions	<ul style="list-style-type: none"> Session summary Questions Session evaluation 	<ul style="list-style-type: none"> Slide #52 Evaluation form and/or learning plan

Following the previous presentation and discussion the facilitator should shift the focus to a presentation and discussion of ethics resources (3:10–3:40), including the potential use of facility based ethics committees. The presenter can describe the role and functions of ethics committees in small rural hospitals. Because many rural hospitals do not have such committees the facilitator can provide basic suggestions and foster a general discussion about the development of such a committee and other ethics resources that rural health care professionals might identify.

To conclude the day-long training the facilitator should review the basic points made during the training: the nature of rural health care ethics; that ethics issues are frequently encountered and can have a significant impact on health care; that thoughtful reflection using the process can be helpful applying basic ethics principles and guidelines to cases; and the importance of health care professionals developing strategies for anticipating and decreasing ethics conflicts; and the role of ethics committees a useful ethics resource.

The timeline and format of this session is for a 7-hour long session, but facilitators can expand or contract the amount of time by devoting more or less time to different sections. For instance, a facilitator could choose to turn one of the small group discussion times into an individual reflection and mini-discussion time (i.e., participants discuss with two other participants sitting near them), which decreases the amount of time needed for that section. To increase time, the facilitator could present two cases for reflection and discussion during small group time or allow more time for questions and discussion at the session conclusion



Section III

TRAINING RESOURCES

POTENTIAL RURAL ETHICS CASE STUDIES

The following rural ethics case studies are drawn from a variety of situations, both fictional and sanitized non-fictional, that bring ethical situations in rural settings to life. Cases also provide the basis from which attendees can reflect on ethical situations in their own settings. Cases are categorized by the domains (e.g., end-of-life issues) which they illustrate most directly and are offered in various styles—short brief cases as well as longer cases with multiple decisions points.

The general purpose of the cases and subsequent discussions is to help attendees reflect on two different aspects of rural health care ethics: first the identification of the ethical challenges and second, the potential responses and resources for addressing these challenges. Questions that address each of these purposes are provided below and can be used with most of the cases.

Health care professionals encounter ethics issues everyday and to great extent can use common sense, experience, ethics training, organizational policies, and/or colleagues to provide a moral compass. When decisions serve the patient's best interest and desires, are consistent with personal values, and professional ethics guidelines, a clinician or administrator usually can conclude that the decision or action is morally correct. However, there are some ethics situations where there is no clear response or committing values. In such situations it is important that clinicians or administrators can apply a thoughtful process (e.g., 8-step process) to analyze the situation and determine what response is appropriate when there is uncertainty or competing values. The use of the following cases can assist the training participant to develop this knowledge and skill.

In presenting and discussing the ethics cases, the facilitator should foster an understanding that ethics reflection is a tool to assist health care professionals in a process of recognizing an ethics conflict, reasoning or analyzing the conflict, and proposing solutions to the conflict. In many ethics cases, as noted earlier, there is no one “right” answer. In fact many cases have a range of “right” responses as well as responses that are outside that range and unethical. For example, regarding end-of-life decisions; following an informed consent process, one terminally ill patient may decide to refuse further treatment and elect to go home to live out his/her life as comfortably as possible. Another terminally ill patient may chose to accept aggressive inpatient treatment in hope that the treatment may extend their

life. Both patient-driven decisions can be morally valid based on a shared decision-making process. What would be considered morally inappropriate is if the terminally ill patient requested or even demanded that the physician actively killed them through the administration of a lethal inject and the physician willingly accepted such a request.

Good resources for analyzing ethics questions and conflicts in accordance with ethics standards are the American College of Physicians' Ethics Manual¹⁶ or Bernard Lo's book, *Resolving Ethical Dilemmas: A Guide for Clinicians*.¹⁷ These resources provide generally accepted ethics guidelines for a wide range of ethics conflicts. In presenting and discussing ethics cases several general questions are useful to guide the discussion.

General questions to elicit discussion on ethics challenges in rural settings:

1. What is the specific ethics conflict or question?
2. What are the ethics concepts or guidelines that can be applied to the case?
3. Who has the ultimate moral authority in decision-making in the situation?
4. How are those ethics concepts affected by the rural context?
5. What resources are available in your setting to help address the situation presented?
6. How would you respond to the case and why?

Patient-Provider Relationship Issues

1 Dr Webster, a family physician in a small, remote community, believes that a patient, who is a school teacher, is developing a post-partum psychosis. Post-partum psychosis is a rare and severe mental illness characterized by mood disturbances, delusions, hallucinations, and sometimes suicidal or homicidal thoughts. It can be treated with antipsychotic medications and mood stabilizers, although hospitalization may be necessary.

Dr. Webster does not feel qualified to treat the patient. He recommends she seek treatment at a distant large mental health center but she refuses to travel to the center because of the distance. He is concerned about the potential risks to both the mother and the child. Dr. Webster is unclear about his conflicting obligations to the patient, child, school, and the small community.

Should Dr. Webster treat the patient when the treatment is outside his area of competency? As a health care professional and a member of the community, should he disclose the teacher's health problems to school officials and/or other officials, if she is unwilling to receive care?

Over-lapping Relationship Issues

2 Dr. Gomez, an internist who also is a member of the town's school board, discovers during a routine examination that one of the patients, a school teacher, has missed many teaching days because of a significant alcohol problem.

*What are Dr. Gomez's professional responsibilities to the patient, the school?
What should he do if the school board members need to evaluate the teacher?*

Confidentiality and Privacy Issues

3 Nurse Practitioner Joanne Baker prescribed a partial opiate agonist to a young man, Brian, for treatment of prescription opiate dependence. Brian was outgoing and talented, and he played on the same soccer team as Joanne's son. Three weeks later, Brian was found unresponsive, requiring intubation and medical evacuation to a city three hours away. He recovered and didn't want others in the community to discover he had attempted suicide. He began to spread rumors that Joanne was incompetent and prescribed a medication she didn't know how to use. Another patient brought up these rumors during his own appointment with Joanne. She wished she could set the record straight; that Brian obtained opiates from a provider in a neighboring town and had taken these in large quantities in a suicide attempt but she was unsure about how to discuss the situation without breaching Brian's patient confidentiality.

Is there a way for Ms. Baker to protect her professional reputation from slander while still protecting the confidentiality of a vulnerable patient?

Case adapted from Davis R and Roberts LW. Ethics Conflicts in Rural Communities: Patient-Provider Relationships. In: Nelson WA, ed. Handbook for Rural Health Care Ethics. Hanover, NH: Dartmouth College; 2009. <http://dms.dartmouth.edu/cfm/resources/ethics/>

4 Dr. Joan McDougall, a family physician, has recommended additional diagnostic testing for an 80-year-old patient who may have a malignancy related to a long standing blood abnormality. The patient has recently been treated for anemia and accepted blood transfusions when becoming symptomatic. Dr. McDougall explicitly states her concerns, including possible cancer with the patient. Though the patient fully understands Dr. McDougall's concerns, she declines further assessment for financial reasons. The patient and her husband, who must live their remaining days off the income made from the sale of their farm, are still paying off the hospital bills from the previous testing and treatment. She wishes not to incur further debt at this time. Dr. McDougall treats other members of the patient's family and suspects they would want their mother evaluated and would help with financial issues. The patient refuses to give Dr. McDougall permission to discuss this matter with her family.

Was Dr. McDougall's offer to talk with the patient's family meddlesome, or appropriate under the circumstances? Now that the patient has refused, what should Dr. McDougall do? Is it appropriate for a patient to base end-of-life decisions on personal finances?

Case adapted from Niemira D. Ethics Conflicts in Rural Communities: Shared-Decision Making. In: Nelson WA, ed. Handbook for Rural Health Care Ethics. Hanover, NH: Dartmouth College; 2009. <http://dms.dartmouth.edu/cfm/resources/ethics/>

Allocation of Resources

5 Granite Hospital owns and operates a small, two-person primary care practice in a community 25 miles from its main campus. Within the remote practice, two highly regarded primary care physicians provide practically all of the primary care to the small town. The hospital has received numerous comments over the years attesting to the quality of the physicians and the secure feeling that is provided by their presence.

The hospital originally established the primary care practice in response to anticipated capitation contracts that never materialized. Granite Hospital serves a large geographical area with a small population and has received numerous accolades and awards for its efforts to meet community health needs and offer preventive services to the residents. The hospital is not strong financially, but has been able to make financial ends meet in its primary care lines of business with offsets from its acute care services.

Recently, deep Medicaid reimbursement funding cuts have negatively impacted the financial condition of the hospital and questions have been raised about the hospital's ability to continue to subsidize the distant primary care practice. Members of the administration and the Board of Trustees are distressed by the devastating impact this decision could have on the small town.

Should decisions about health care distribution be based on which services are well reimbursed? In tough economic times, do health care administrators have any other choice?

Case adapted from Gardent PB and Reeves SA. Ethics Conflicts in Rural Communities: Allocation of Scarce Resources. In: Nelson WA, ed. Handbook for Rural Health Care Ethics. Hanover, NH: Dartmouth College; 2009. <http://dms.dartmouth.edu/cfm/resources/ethics/>

Conflict of Interest

6 The CEO of a small, 30-bed rural non-profit hospital is approached by the administrator of a new imaging center who offers to provide outpatient imaging services, including MRIs, for the hospital's patients. The hospital, which faces various financial challenges, currently refers many needed diagnostic procedures to distant, larger hospitals. The administrator of the imaging center indicates that for

each referred patient, the hospital will receive \$100 that can legally be worked out. He also indicates that the amount of payment will increase after passing a certain threshold of referred patients.

Is it appropriate to establish such a financial relationship with the new Imaging Center? Will such a relationship create a conflict of interest? Will the financial arrangement increase the frequency of “needed” service from the Imaging Center?

Managing Medical Errors

7 Ms. Peters, a lean 50-year-old woman arrived as for a hysterectomy at a small Critical Access Hospital. During surgery, Dr. Harrison accidentally nicked the lower bowel. The bowel was repaired and assessed to ensure it was adequately sealed. The patient was immediately started on antibiotics to prevent any potential infection from intestinal leakage. There were no post-operative complications; however, Dr. Harrison kept Ms. Peters as an inpatient for a day longer than planned in order to watch for any infection and maintain the IV-antibiotics. Dr. Harrison prescribed oral antibiotics before discharging the patient. Ms. Peters’ insurance covered the cost of the surgery, antibiotics, and inpatient recovery time, although Ms. Peters had to make a \$300 co-pay.

*Should Dr. Harrison tell Ms. Peters about the accident?
Should he tell her insurance company?*

When Ms. Peters inquired about the extended length of stay, Dr. Harrison indicated that he wanted “to play it safe” and make sure the incision was healing properly. Following discharge Ms. Peters developed a low grade fever and chills. She saw Dr. Harrison at the post office and told him about the fever. Dr. Harrison then asked her to visit his outpatient office in the community. Dr. Harrison examined Ms. Peters’ incision site and encouraged her to continue to take the oral antibiotics.

Later that day, Dr. Harrison was at the hospital when an operating nurse asked how Ms. Peters took the news about the accidental cut.

What should Dr. Mason say to his nurse colleague?

Dr. Mason told the nurse that he did not tell Ms. Peters because “she was not harmed” and suggested that the nurse not say anything, explaining “We can’t afford to lose more patients to the large, neighboring hospital.” The nurse felt conflicted and upset because she believed the patient had the right to know the truth but also knew the surgeon was a respected member of the community.

What are the nurse’s options?

8 Dr. Bristol and Dr. Applegate are internists and both perform colonoscopies in a rural hospital. This procedure is performed to visually examine the colon and rectum in order to detect or biopsy lesions that may be indicative of colorectal

cancer, a common cancer in the United States. If found and treated at an early stage this cancer has a high rate of cure. The procedure has provided an important source of revenue for both physicians, and helps offset many health care services with inadequate reimbursement rates.

Dr. Applegate has consistently performed the procedure correctly. Dr. Bristol has been less thorough when conducting the examination and has frequently failed to reach the cecum. The nurses who assist both physicians have been aware of the discrepancy and, believing that Dr. Bristol does not perform the test correctly, repeatedly sought the intervention of the hospital administrator. The nurses have also spoken to other members of the medical staff and asked for an intervention. The administrator and the medical staff were hesitant to intervene. After two years of repeatedly lodging complaints with hospital administration and struggling with their moral obligations to provide safe care, the nurses announced they would no longer assist Dr. Bristol when he was performing the procedure. Faced with pressure from the nurses, the hospital administration agreed to study and respond to this clinical and ethical problem.

What steps should the hospital administrators take now that they can no longer ignore the issue? Hospital culture can be quite hierarchical—how does this affect the management of medical errors or questions regarding a health care worker's competence?

Case adapted from Cook A and Hoas H. Ethics Conflicts in Rural Communities: Recognizing and Disclosing Medical Errors. In: Nelson WA, ed. Handbook for Rural Health Care Ethics. Hanover, NH: Dartmouth College; 2009. <http://dms.dartmouth.edu/cfm/resources/ethics/>

Shared Decision-making

9 Dr. Boardman is a surgeon at a small rural hospital. The hospital is struggling to stay afloat in the face of competition from larger hospitals within easy driving distance and all the physicians are pressed to keep the beds full.

While in the emergency room, Dr. Boardman is faced with a complicated case that he has not seen since he was in training. He realizes the patient may receive better care at one of the larger tertiary hospitals, but that would mean lost revenue for his own facility. Faced with the choice, he elects to keep the patient in his hospital. Following the patient's admission, the patient asks her nurse, Linda Robinson, who is friend, if she ought to ask to be transferred to the large tertiary care center a hundred miles away.

How should Nurse Robinson respond? What services should a small rural hospital provide if there is a large hospital nearby whose physicians and surgeons have greater expertise?

Case adapted from Pomerantz A. Ethics Conflicts in Rural Communities: Overlapping Roles. In: Nelson WA, ed. Handbook for Rural Health Care Ethics. Hanover, NH: Dartmouth College; 2009. <http://dms.dartmouth.edu/cfm/resources/ethics/>

10 Dr. John Smith, a primary care provider, is discussing with a patient the need for a referral for semi-urgent major surgery. The surgical procedure could be done at the small, rural hospital; however, the general surgeon has limited experience with the needed procedure. The surgery is one whose outcome is statistically volume sensitive, i.e. the more procedures the surgeon and institution performs, the better the outcome. The patient does not raise the issue about where is the best location for performing the procedure but says, “Just tell me what to do, doc.” The local community hospital is struggling financially. Contributing to the problem is the number of referrals to large facilities away from the rural community. The surgeon’s experience with the particular surgery remains limited because of referrals outside the community. Dr. Smith is uncertain about how to respond to the patient.

How do the economic needs of the rural facility influence Dr. Smith’s discussion with the patient about the options and alternatives? Does the discussion change if the patient specifically asks, “Where would you have the surgery done?” Does the discussion change if the large hospital is an academic medical center with a new batch of surgery residents?

Reproduction and Sexuality Issues

11 Dr. Jones has been a friend of the Smith family since coming to town 18 years ago. The Smith’s oldest child, Sally (15 years), has come to the office to have a physical to be on the track team. Her mother has brought her to the office, but as usual, Dr. Jones sees Sally alone. After taking the history and doing an exam, it is evident that Sally wants to talk about something. In response to a question about whether she has started dating, she explains that she has been dating JJ for the last six months. She says that she really likes him a lot, and although they “haven’t done it yet, they have been thinking about it a lot.” She is wondering if she could start taking birth control pills. Sally also explains that her parents do not know anything about it. She said that when she has tried to talk with her mother, her mom just, “got weird—talking about babies having babies, and nobody having morals any more.” She says her mother would be very upset if she knew Sally was talking about it, and asks that this information not get back to her parents.

Should Dr. Jones’ friendship with Sally’s parents impact how Dr. Jones approaches the situation? Is it ethical to prescribe birth control without parental permission to a patient who is below the legal age of consent for sexual activity? What information and guidance should Dr. Jones share with Sally?

Case adapted from Elliot B and Westra R. Ethics Conflicts in Rural Communities: Reproductive Health Care. In: Nelson WA, ed. Handbook for Rural Health Care Ethics. Hanover, NH: Dartmouth College; 2009. <http://dms.dartmouth.edu/cfm/resources/ethics/>

12 Dr. Johnson is providing care for Joan Larson who is 26 weeks pregnant. This is her third pregnancy; the other two deliveries went easily and at term. She and her husband, Bob, attend the same church as Dr. Johnson and her family. When Joan comes to the clinic for this appointment, she complains of a “sensitive area” that “really hurts” on her perineum. The exam confirms that she has developed herpes infection (HSV). Dr. Johnson explains how this may result in the possible need to plan for a C-section with the upcoming delivery. Joan is horrified, and then somewhat chagrined. She admits that she has had an affair with George, a well-known community member, who is likely the source of the infection. Her husband does not know about the extra-marital relationship and she does not want him to know. She is certain her husband is the father of the child she is carrying. She asks Dr. Johnson to treat the infection for her and George, and not to put the information in the chart or tell her husband.

What measures can Dr. Johnson take to protect Joan’s confidentiality while upholding professional standards of record keeping and patient care? Should Dr. Johnson try to persuade Joan to talk to Bob? Does the answer change if Bob is Dr. Johnson’s patient as well as a friend?

Case adapted from Elliot B and Westra R. Ethics Conflicts in Rural Communities: Reproductive Health Care. In: Nelson WA, ed. Handbook for Rural Health Care Ethics. Hanover, NH: Dartmouth College; 2009. <http://dms.dartmouth.edu/cfm/resources/ethics/>

Disease Stigma

13 Dr. Smith is a family physician seeing one of his patients for a minor work related injury. The patient is very depressed and tearful but will not acknowledge his symptoms when asked. Dr. Smith believes the patient is depressed and knows that he can provide treatment for the patient’s depression. However, the patient is uncomfortable seeking treatment or having Dr. Smith document his findings in the patient’s record because of a stigmatizing effect of having a mental health disorder known in a remote community.

What steps should the physician take to address a stigmatizing illness? How could the community potentially learn about the patient’s mental health disorder? Do you think that it is likely or unlikely that the patient’s concerns about confidentiality are valid?

Caregiver Stress Issues

14 Dr. Morrison has been the only physician in his small community of 1,500 people for about 15 years and is known as the “Town Doc.” When he first moved to town, he quickly became involved in the community. The longer he practiced, the more awkward his social life became. He helped coach the baseball team for several years. But then he treated one of the boys on the team for Chlamydia and the boy stopped coming to practice. Dr. Morrison didn’t sign up to coach the following year. He began to turn down social invitations, as more

friends became patients. Eventually he began to feel burdened and overworked but unable to decrease his workload. He attended to numerous horrific farm and motor vehicle accidents, often as the only provider for multiple patients. He felt indebted to the community but also began to feel resentful. Where he once took pride in the fact that people looked to him for support, he began to feel overwhelmed and useless. He recognized that he was depressed but had no idea where to turn for help. His patients began to notice that he seemed tired and irritable. At the nearby critical access hospital, where Dr. Morrison is affiliated, the administrators were increasingly concerned about his ability to practice and feared he might even resign.

What, if anything, should the administrators say or do? What steps can rural providers take to avoid isolation and burn-out?

Case adapted from Davis R and Roberts LW. Ethics Conflicts in Rural Communities: Patient-Provider Relationships. In: Nelson WA, ed. Handbook for Rural Health Care Ethics. Hanover, NH: Dartmouth College; 2009. <http://dms.dartmouth.edu/cfm/resources/ethics/>

End-of-Life Care Issues

15 Dr. Dennis, a general internist, had recently discharged Mr. Coulter to a nursing home for permanent placement following a hospitalization for complications related to a fall. Mr. Coulter, 80-years-old, has end-stage Alzheimer's disease with a swallowing disorder worsened by his recent illness. Prior to his discharge, Dr. Dennis conducted a lengthy discussion with the Coulter family about Mr. Coulter's condition. Dr. Dennis explained that Mr. Coulter was very sick and would likely die within a year's time; and that towards the end of life, people often lose interest in food and do not feel the need to eat as often. Currently, Mr. Coulter has to be spoon-fed—which is difficult and time consuming because of Mr. Coulter's dementia and his swallowing problems. Dr. Dennis described that the alternative, a feeding tube, would make it easier to care for Mr. Coulter, but studies in other patients with severe dementia had not shown that feeding tubes extend the patient's life, improve the patient's quality of life, or prevent malnutrition and aspiration pneumonia. A feeding tube carries risks for the patient, including infection and GI problems. Patients with Alzheimer's often have to be restrained or sedated because they try to pull out feeding tubes. The feeding tube was rejected by Mrs. Coulter, Mr. Coulter's wife of 50 years and his Durable Power of Attorney for Health Care. The rest of the family supported the decision. Dr. Dennis discharged Mr. Coulter to a local nursing home.

The nursing home was known for its commitment to end-of-life care and understood the plan of care. The administrator did tell Dr. Dennis that a new medical director had just been employed and that he would need to review the plan of care. Several days later, Dr. Dennis received a frantic call from Mrs. Coulter who had just authorized the transfer of her husband to the hospital emergency room for evaluation. The nursing home medical director had requested the transfer because Mr. Coulter was dehydrated and probably had elevated sodium. The medical

director had also told Mrs. Coulter that she might not be able to re-admit Mr. Coulter to the nursing home unless he had a feeding tube. Mrs. Coulter was upset by this conversation and by remarks she had overheard from other nursing home staff members about her husband starving to death. She told Dr. Dennis that she wanted to reconsider her decision to withhold a feeding tube.

How should Dr. Dennis respond to Mrs. Coulter? What should Dr. Dennis do regarding the nursing home administrator and staff's thinking about the care of the patient?

Case adapted from Niemira D and Townsend T. Ethics Conflicts in Rural Communities: End-of-Life Decision-Making. In: Nelson WA, ed. Handbook for Rural Health Care Ethics. Hanover, NH: Dartmouth College; 2009. <http://dms.dartmouth.edu/cfm/resources/ethics/>

16 Dr. Townes, a family physician, returns from a week's vacation to find Frank Foote, a 72-year-old patient with multiple illnesses including heart failure and end-stage COPD, on a ventilator in intensive care. Brenda, Frank's wife of 48 years, greets Dr. Townes saying, "I'm so glad you're back. His breathing got so bad I had to call 9-1-1. Your partner put in a breathing tube and now he's been on the ventilator for six days. He has pneumonia and the antibiotics aren't working so well. Your partner told me he should go to the University Hospital because his breathing isn't getting better and he may need a tracheotomy. I'm so scared I might lose him. They say he's not responsive but he seems to calm down when I speak to him and act up when they poke him to draw blood."

A reading of the medical record confirms Brenda's story. Dr. Townes' partner, following Brenda's lead, has pursued aggressive care. The chart indicates that Frank has no advance directive, although Dr. Townes and Frank had discussed it at his last visit and Frank assured him one was complete but not yet witnessed. Two unsuccessful attempts have been made to wean Frank from the ventilator. Based on his discussions with Frank, Dr. Townes knows that continued care is not what Frank wants. However, Brenda is also his patient and she has a hard time confronting death—both her own and Frank's. Dr. Townes also knows that withdrawing Frank's ventilator will not be typical of the procedures his institution has undertaken in the past and that his institution has no policy for removing a ventilator in cases where the patient cannot breathe on his own. He is in a quandary about how to proceed.

Should Dr. Townes talk with Brenda about his discussions with Frank? If so, what should he say?

Case adapted from Niemira D and Townsend T. Ethics Conflicts in Rural Communities: End-of-Life Decision-Making. In: Nelson WA, ed. Handbook for Rural Health Care Ethics. Hanover, NH: Dartmouth College; 2009. <http://dms.dartmouth.edu/cfm/resources/ethics/>

Health Technology Issues

17 Dr. Adams, a rural general internist, is on call for his three-person group and is seeing one of the group's patients in the ER. The patient is a 57-year-old male patient whom Dr. Adam's partner had sent to an out-of-town cardiologist the previous week for evaluation of recurrent chest pain. The patient is concerned because he is still having chest pain and wants to know more about the previous tests and why he is on so many new medications. He has been feeling dizzy and nauseous and recently stopped taking his drugs because he thought one of them may have been causing his symptoms. Dr. Adams has the patient's medical record and there is no information from the cardiologist other than a brief discharge summary faxed several days ago stating that the patient has "inoperative coronary artery disease" and a list of several new medicines. The letter also indicates that the patient's electronic medical record (EMR) provides a full account of the patient's hospital stay. Dr. Adams' group uses a paper record system and the clinic has only one computer, which is at the front desk and used for billing and appointments. Though they know it would be useful, Dr. Adams' group can't afford an EMR system. If they had an EMR system he still wouldn't be able to access the patient's hospital record because his clinic is not affiliated with the cardiologist's hospital. Dr. Adams will have to call the referral hospital to get a faxed copy of the patient's record. Meanwhile, the patient is complaining of chest pain and becomes short of breath.

What should Dr. Adams do? Who is responsible for this situation? How could this problem have been prevented?

Case adapted from Fleming DA. Ethics Conflicts in Rural Communities: Health Information Technology. In: Nelson WA, ed. Handbook for Rural Health Care Ethics. Hanover, NH: Dartmouth College; 2009. <http://dms.dartmouth.edu/cfm/resources/ethics/>

18 Gina Jones is 75 years old, has multiple chronic medical conditions including severe rheumatoid arthritis, lives in a rural chronic care nursing facility, and requires a wheelchair to get around. She was recently seen by her family physician for a persistent rash. Following several failed diagnoses and treatments, her physician recommended referral to a dermatologist at university hospital sixty miles away. Both Gina and her physician did not feel she could make a trip of this kind due to her fragile condition.

Since the local hospital was part of the university's telehealth network, Gina agreed to have the dermatology consultation done remotely. Gina was not sure what to expect, and was only informed that she would, "... be seeing a skin doctor on the TV screen." When Gina arrived at the local hospital she was taken to a room near the emergency room waiting area. While talking to the dermatologist on the screen Gina felt a little uneasy, especially when he asked the nurse to disrobe her to examine the rash. The nurse was instructed to use a special camera for a closer examination of the rash on her buttocks and scrapings were taken and sent to the lab. Gina noticed that the dermatologist seemed to be talking to someone else but it wasn't until the session was almost over that she realized a student and resident

were off camera. When Gina was wheeled out of the telehealth room she felt as though the people in the ER waiting room were staring at her. She was grateful to see a skin specialist without having to travel far, but wondered why her physician hadn't given her more warning about what to expect.

What should Gina's physician say and do if Gina shares her feelings of discomfort during her next visit? What telehealth protocols might have made Gina feel more comfortable and in control?

Case adapted from Fleming DA. Ethics Conflicts in Rural Communities: Health Information Technology. In: Nelson WA, ed. Handbook for Rural Health Care Ethics. Hanover, NH: Dartmouth College; 2009. <http://dms.dartmouth.edu/cfm/resources/ethics/>

Cultural Norms and Professional Standards Conflicts

19 Susan Winship is the newly appointed CEO of a critical access hospital. While attending a Sunday church service, the pastor, who serves as a volunteer chaplain at the local hospital, listed the names of parishioners in the hospital, including asking for prayers for one of the church members because she is going to have surgery on Monday by a general surgeon member of the parish. Ms. Winship was concerned about privacy issues and spoke with the pastor following the church service about sharing the names of parishioners without permission. The pastor indicated that it was his responsibility to share such information with members of the community so they can provide support. He also noted to Ms. Winship that because home care for the sick is provided by members of the parish that they need to be aware of health issues of members of the community. He further pointed out, "that's the way we do it here, its part of our culture."

How should Ms. Winship respond to the Pastor? She wants to be respectful of the community's cultural norms but is very concerned about HIPAA regulations and patient privacy?

Case developed by WA Nelson

LONGER CASE STUDY I

Provider-Patient Relationship Issues

20 Bill is a 41-year-old patient with arthritis who lives in a rural area and has received primary care at a local clinic for his entire life. Bill sees Dr. Murphy, a family physician, and his children see Debbie, a nurse practitioner, whom Bill has known since childhood. Bill has also received care from Dr. Dunlap, who no longer works at the clinic, and Debbie, who treated him over ten years ago.

Bill likes Dr. Murphy, but feels he needs more help with his arthritis. Bill often struggles with pain and fatigue. During one visit, Dr. Murphy comments that Bill may need to reduce his work load, but then says Bill would probably get depressed if he doesn't work regularly. This statement puzzles Bill, because he has no mental health concerns.

Bill would like to see a rheumatologist, but he has no health insurance and is concerned about cost of specialty care. Bill mentions his concerns to Debbie during one of his children's appointments. Debbie considers offering to see Bill herself, but instead suggests that Dr. Collins, the new internal medicine physician at the clinic, might be able to treat Bill's arthritis. Bill decides to schedule an appointment with Dr. Collins.

At the appointment, Dr. Collins takes a complete history and performs a thorough physical exam. He orders lab work, repeating tests previously ordered by Dr. Murphy. During a follow-up visit to discuss the test results, Dr. Collins tells Bill that he should see a rheumatologist and also says that he is concerned about Bill being depressed. Bill is disappointed that Dr. Collins is unable to help him with his arthritis, and confused by the second mention of depression.

Bill asks for a copy of his charts, which he receives by mail after Dr. Collins writes a release. In the notes is an evaluation from the clinic's psychiatrist listing the diagnosis of severe depression and borderline cognitive function. Bill remembers that Dr. Dunlap, who no longer works at the clinic, had mentioned that an evaluation for another patient had accidentally been placed in Bill's charts. The other patient is an acquaintance of Bill's wife, who has the same last name and lives in a nearby town. Dr. Dunlap had promised to have the medical records staff remove the evaluation from Bill's chart, but obviously this had not happened.

Bill is very upset because he feels that the mistake has drawn attention away from his true medical problems and compromised his care. He calls Debbie at her home, tells her he is thinking about hiring a lawyer, and asks her for advice. With Bill's permission, Debbie reviews Bill's chart at the clinic and verifies that it includes a misplaced psychiatric evaluation. Debbie immediately contacts the CEO and other staff to discuss a plan of action. She then calls Bill and offers to meet with him personally to get his records clarified and do a thorough evaluation. She also offers to inform Dr. Murphy and Dr. Collins that the psych evaluation was not Bill's, and says that a re-evaluation with either doctor could be arranged.

Bill states that he does not wish to see either Dr. Murphy or Dr. Collins again, and would consider whether or not he wanted to see Debbie. He says that he is not hiding the fact, when talking with others in the community, that the clinic really “screwed up” and cost him a great deal on several levels.

What are the different ethical issues present in this story? Should the patient whose psychiatric note was mistakenly placed in Bill's chart be also be notified? How should the rural clinic as an organization, as well as the involved clinicians address the problem?

Case adapted from personal communication with Jill Cochran RN-C, FNP, Robert C. Bryd Clinic, Lewisburg, WV

LONGER CASE STUDY II

Medical Error

21 Mr. Chen is a 52-year-old male living in a rural area. He went for a routine visit to his family physician, Dr. Mason. All of Mr. Chen's family members have been going to Dr. Mason for years as do many people living in the area since he is the only physician within a 50-mile radius of their town.

During the visit, Mr. Chen is diagnosed with hypertension. After discussing various options, Dr. Mason recommends that Mr. Chen go on Tenormin to help control his hypertension, along with some dietary changes to see if these interventions could help control his hypertension. Dr. Mason had trouble locating the prescription pad, but finally found it under a magazine on the desk in the office. As he started to write the prescription, Mr. Chen asked him a question about the side effects of the medication which Dr. Mason answered before finishing the prescription. Unfortunately he ended up writing the prescription for Metformin 50mg rather than Tenormin 50mg (Metformin is a hypoglycemic used to lower blood glucose in diabetics).

Since the pharmacy was already closed for the day, Mr. Chen went the next day to have the prescription filled by the local pharmacist. Mr. Chen knows the pharmacist well since their sons play football together at the local high school. After discussing the latest football game, in which Mr. Chen's son had scored a key touchdown, the pharmacist went to fill the prescription. He noticed that Dr. Mason had made an error by writing Metformin 50mg since Metformin comes in 500mg and 1000mg dosage forms, but assumed that Dr. Mason had just left off a “0.” The pharmacist filled the prescription with Metformin 500mg, 1 tablet, up to twice daily and gives the medication to Mr. Chen.

When Mr. Chen arrived home from work that evening, he takes a pill (which very effectively lowers his blood glucose but does nothing for his blood pressure). The next morning when he wakes up he feels terrible. He takes his blood pressure to find that it is still very elevated, so he takes another pill. By mid-morning, he can barely stay awake and is extremely weak. His wife, a local school teacher, called

to see if he was feeling better. When he explained how weak he felt, she called Dr. Mason's office and was able to take him in during her lunch hour.

At the office, Dr. Mason's nurse aide takes vital signs and performs a finger-stick glucose test to find that Mr. Chen has a blood glucose level of only 32. The nurse alerts Dr. Mason, and he quickly administers an IV of D50W, and within an hour Mr. Chen begins to feel much better. During this time, Dr. Mason questioned Mr. Chen about whether he had been eating and drinking or if he had taken anything different. Mr. Chen explained that the only thing he had done differently was to take the new medication, and that he had taken two in the last 12 hours. On hearing this, Dr. Mason went to check Mr. Chen's record and found the carbon copy of the prescription. He realizes his mistake of prescribing Metformin instead of Tenormin.

Background note: several residents in the town have started going to distant specialists and the rural community population has steadily been getting smaller due to the lack of jobs. Both situations have led to a smaller practice than previously. Dr. Mason is concerned that if people knew he made an error his practice might diminish further.

What are Dr. Mason's options at this point?

After a few hours, Dr. Mason tells Mr. and Mrs. Chen that they can go home since he feels better, but to call him if Mr. Chen felt worse again. Dr. Mason decides to tell Mr. Chen and his wife that the first prescription was not working as expected for the patient and caused him to feel worse, and that he is going to change the medicine to another that should work better. He then writes a new prescription (this time for Tenormin 50mg) and sends the patient home. After Mr. and Mrs. Chen leave, Dr. Mason's nurse asks about Mr. Chen's acute situation.

What should Dr. Mason say to nurse colleague and why?

Dr. Mason tells her that he was not sure what caused the problem of a low blood glucose level, "probably something he ate." His nurse thought that was strange and decided not to question Dr. Mason.

Since the pharmacy was on the way home, Mr. and Mrs. Chen decided to stop to fill the new prescription. While waiting for the prescription to be filled, Mr. Chen tells the pharmacist what happened since the previous day. The pharmacist, seeing the new prescription for Tenormin 50mg realizes the medication error that has occurred. He also realizes that by assuming Dr. Mason meant 500mg of Metformin instead of 50mg of Tenormin, he also contributed to the medication error in by filling the prescription without checking first.

What are the pharmacist's options?

The pharmacist does not say anything about the error and fills the new prescription. Several days later Mr. Chen is talking with the pharmacist at the coffee hour after

church. Mr. Chen tells the pharmacist he is feeling better and his blood pressure seems to be fine. He then mentions to the pharmacist that he is still concerned about his strong physical reaction he had to the other medication. Mr. Chen said he looked up the first drug on the internet and said he is confused about why he was even given that medication.

What are the pharmacist's options at this point?

The pharmacist decides to explain to the patient what he believes were the sequence of events. He indicates that he contributed to the problem, apologizes, and says he will refund the cost of the first (wrong) prescription. Mr. Chen is taken back by the information—angry that this could have happened and that he is just learning about the situation. Mr. Chen calls Dr. Mason at home and leaves a message that Dr. Mason should call him right away.

Case is adapted from a personal communication with Dr. Paul Moore, past President of the National Rural Health Association

8-STEP ETHICS DECISION-MAKING PROCESS

There are several ethics decision-making processes available in the health care ethics literature. They are similar and only vary in how they break down the basic elements in an analysis. The following 8-step decision-making process and suggested questions were developed by WA Nelson* to serve as a detailed guide in exploring the ethics cases. The process starts with an often overlooked issue. What exactly is the ethics conflict? This generally should be expressed as question, for example, “is Dr. Samson ethically allowed to discontinue life-sustaining treatment without the patient’s consent?” Without having a clear sense of what is the ethics question, it is unlikely that the decision-maker(s) will be able reach an agreement in what is the appropriate response to the conflict. Throughout, the other question that needs to be continually pushed is what is the basis for your thinking? As noted earlier, the process will not always lead to one appropriate response; usually there is a range of appropriate responses. It will be the decision-maker’s choice regarding what they believe to most appropriate decision or action in their particular situation.

8-STEP PROCESS

Step 1: *Clarify the Ethical Conflict or Question*

- What is the specific ethics question or conflict?
- What if the question or conflict is not an ethical question?

Step 2: *Identify All the Affected Stakeholders and Their Values*

- Who are the individuals or programs affected by the ethics question?
- What are the values and perspectives of all the affected stakeholders?

Step 3: *Understand the Circumstances Surrounding the Ethical Conflict*

- Why has the ethical conflict arisen?
- What are the facts surrounding and related to the ethical conflict or question?

Step 4: *Identify the Ethical Perspectives Relevant to the Conflict*

- What are the ethical concepts or principles related to the conflict or question?
- Does your organization’s mission, value statement, and/or policies address the conflict?
- Are their ethical guidelines concerning the ethical conflict, such as AMA Code of Ethics or in the medical or nursing ethics literature?

Step 5: *Identify Different Options for Action*

- What are the possible options for responding to the ethical conflict or question?

- What are the potential benefits or outcomes, as well as the potential harms of each option?
- What is the ethical reasoning for each option?

Step 6: *Select from the Various Options*

- Have you systematically and quantitatively evaluated each option?
- Is the option practical? Does it have a clear ethical foundation?
- Does one ethical concept or stakeholder value appear to be stronger than the others?
- Is there assessment plan to evaluate the decision?

Step 7: *Share and Implement the Decision*

- What method will be used to share and implement the decision?
- Was the assessment plan implemented?

Step 8: *Review the Decision to Ensure it Achieved the Desired Goal*

- What was the outcome of the decision?
- Do you need to revise the decision?

* Nelson W. *An Organizational Ethics Decision-Making Process*. 2005
Healthcare Executive. 20(4):9-14

LARGE GROUP FACILITATION GUIDELINES

The primary purpose of large group facilitation is to increase engagement of participants during large group sessions and presentations. Cases are presented and time allowed for participants to respond to the cases and share their own experiences. During these discussions, presenters will be able to better facilitate the discussion if the following are in place:

- Someone to help keep a list of the main ideas, using either a flip chart (if everyone can see) or an audiovisual tool that can be enlarged for all to see (e.g., an empty PowerPoint slide to type responses)
- Microphones so that everyone can hear each individual's input particularly in large groups or rooms with poor acoustics

Facilitators should encourage as many participants to contribute as possible, but need to pay attention to the time allotted for the discussion so that the session remains on track. Additional tips include:

- Asking individuals to raise their hands
- Asking if someone has a different perspective on a discussion
- Reserving 2-3 minutes at the end to summarize the discussion, highlight questions and continue to the next segment of the session

SMALL GROUP FACILITATION GUIDELINES

Facilitating small group discussions is a rewarding experience, but requires preparation. The following are provided as guidelines to ensure consistency across small groups and to allow time for attendees to learn and reflect.

Role of facilitator:

The goal of the small group is for participants to own the group. To that end, please strive for the following:

- Do not be a participant. This will help you focus on the larger discussion/reflections/summary
- Establish balance between leading/guiding and allowing participants to share
- As much as possible, ask participants to answer each other's questions; express ideas

Logistics:

- Group sizes should be kept to 6-8 attendees
- If possible, pre-assign attendees to small groups to facilitate the formation and movement of groups. Participants can be pre-assigned based on their roles (e.g., have a mix of different work roles in each group) or other criteria
- If small groups are being moved to other areas or rooms, have small group facilitators present to lead attendees to break-out rooms or areas
- Handouts should be in each participants' workshop folder or given to each small group facilitator to hand out

First Small Group:

The goal of this small group is for participants to:

1. Describe personal experiences or knowledge of ethical situations in their own settings
2. Recognize differences and similarities of ethical situations in different contexts
3. Begin to identify types of ethical situations and potential causes of these situations

FORMAT FOR FIRST SMALL GROUP

- Introduce self, review session goals and facilitate brief introductions by each participant—5 minutes
- Ask participants to relate ethical situations that they have heard about or have been involved in. Encourage them or other participants to focus on their ethical question and what type of ethical challenge it presents
- If no one wants to share or participants seem to be uncomfortable sharing, introduce a case from Section III and discuss questions at the end of the case.
- (using flip chart) Ask question: *What does this tell us about rural health care ethics?* (Facilitate discussion)

Second Small Group:

The goal of this session is to provide participants with a chance to apply the 8-step Ethics Decision-making Process to a case—either one from the group or one from Section III of the Training Manual. If using a case from the Training Manual, we recommend that you consider one of the longer cases, #21 or 22. Each participant should have a copy of the 8-step Ethics Decision-making Process provided during the large group presentation for reference during this discussion.

FORMAT FOR SECOND SMALL GROUP

- Ask if participants would like to use a situation discussed during the first small group discussion or one provided by the facilitator
- Use the case and go through the Ethics Decision-making Process steps as a group, recording observations or questions as necessary

RURAL HEALTH CARE ETHICS HANDOUTS

The following two documents can be used as handouts for the rural ethics training programs. The first is a 3-page handout that includes an overview of rural health care ethics and other material addressed in the suggested training sessions. The second handout is a brief, 1-page handout that identifies selected rural ethics resources for training participants. Each handout can be adapted for local use, such as adding the names of rural focused ethicists, institutions, ethics committees, and/or rural ethics networks within the user region.

RURAL HEALTH CARE ETHICS

Background

Approximately 62 million people, one-quarter of the United States' overall population, live in rural communities distributed over three-quarters of our country's land mass. Rural Americans have limited access to clinicians, health facilities, and specialized services, and their care is hampered by geographical and climatic barriers as well as heightened social, cultural, and economic challenges. The burden of illness for rural populations is considerable, placing great demands on a resource-poor clinical care system. Consequently, rural people are increasingly recognized as an underserved special population. Attaining an appropriate standard of care for the rural population has emerged as a major concern in the national discussion of health disparities.

Along with the growing understanding of concerns related to rural health care is an emerging awareness of the special ethical considerations inherent to clinical practice in closely-knit, isolated, tightly interdependent, small rural community settings. This interactive session will provide a forum to discuss how common rural contextual characteristics, such as over-lapping relationships, limited availability and access to services, confidentiality, community values, and disease stigma shape ethical issues encountered in rural health care. Because most ethics guidelines appear more applicable to resource-enriched, less interdependent urban communities the need for culturally-attuned, evidence based practical rural ethics guidelines will be discussed.

Rural Health Care Ethics

To focus reflection on health care ethical uncertainty or conflicts occurring in the distinct context of the rural setting

Rural Characteristics Influencing Ethics Issues

- Small population and geographic isolation
- Limited economic resources
- Reduced health status
- Limited availability and accessibility of health care services
- Community values and culture in relation professional standards
- Dual and overlapping professional-patient relationships
- Caregiver stress
- Limited ethics resources

Common Rural Ethics Issues

- Confidentiality and privacy
- Shared decision-making
- Boundary issues and professional-patient relationship
- Allocation of resources
- Cultural and personal values in relationship to professional standards
- Patient's inability to pay for care
- Disease stigma
- Access to care

Case Studies

CASE 1 | Availability to health care services

A family physician in a small, remote community assesses a patient, who is school teacher, as developing a post-partum psychosis. He feels he lacks adequate training or experience to manage her care. He recommends she seek treatment at a distant large mental health center but she refuses to travel to the center because of the distance. He feels uncertain about caring for the patient when the treatment is outside his area of competency? As a health care professional and a member of the community, should he discuss the teacher's health problems to school officials, if she is unwilling to do so?

CASE 2 | Overlapping relationships

During a routine physical examine, one of your teenage patients shares that he has seen another teenage patient using cocaine at your neighbor's house. What are your ethical responsibilities as a physician? What are your ethical obligations to your neighbor, the law? What if those roles are in conflict?

CASE 3 | Confidentiality and privacy

Joanne Baker, NP prescribed a partial opiate agonist to a young man, Brian, for treatment of prescription opiate dependence. Brian is talented and plays on the same soccer team as Joanne's son. Three weeks later, Brian was found

unresponsive, requiring intubation and medical evacuation to a city three hours away. He recovered and didn't want others in the community to discover he had attempted suicide. He began to spread rumors that Joanne was incompetent and prescribed a medication she didn't know how to use. Another patient brought up these rumors during his own appointment with Joanne. She wished she could set the record straight; that Brian obtained opiates from a provider in a neighboring city and had taken these in large quantities in a suicide attempt. She was unsure about how to discuss the situation without breaching Brian's patient confidentiality.

CASE 4 | Community values

A patient you have treated for COPD for several years missed her last two appointments. When you speak with her after church, she indicated that her husband lost his job as a logger and no longer has family health insurance. She refuses to accept charity but does indicate she will do cleaning at your home and office as 'payment' for your health care services. Should a physician or nurse accept bartering as payment?

CASE 5 | Disease stigma

A patient has been followed by you, his family physician for various medical issues and is being seen for a minor work related injury. The patient is very depressed and tearful but will not acknowledge his symptoms when asked. You believe the patient is depressed and you know you can provide treatment for the patient's depression. However, the patient is uncomfortable seeking treatment or having you document your findings in the patient's record because of a stigmatizing effect of having a mental health disorder known in remote community. What steps should the physician take to address a stigmatizing illness?

CASE 6 | Professional role

A rural psychiatrist, who also is a member of the town's school board, discovers during a family counseling that one of the patients, a school teacher has missed many teaching days because of a significant alcohol problem. What is the physician's professional responsibility to the patient, school?

Ethical Conflict Decision-making Process

1. What is the specific ethical question(s) or value conflict(s)?
2. What are values and perspectives of the stakeholders (decision-makers)?
3. What are the relevant ethical facts?
4. What are the relevant ethical concepts or principles?
5. What are your options?
6. What options would you select and what is the ethical basis for your thinking?
7. How would you implement your decision?
8. What strategies might you employ to anticipate or decrease the ethical conflict in the future?

Selected Resources

Cook AF, Hoas H, Joyner JC. No secrets on Main Street. *Am J Nurs* 2001;101:67,69-71.

Cook AF, Hoas H. Ethics and rural healthcare: what really happens? What might help? *Am J Bioeth.* Apr 2008;8(4):52-56.

Nelson W. Addressing rural ethics issues. The characteristics of rural health care settings pose unique ethical challenges. *Healthc Exec* 2004;19:36-7.

Nelson WA, Schmidek JM. Rural healthcare ethics. In: Singer PA, Viens AM, eds. *The Cambridge Textbook of Bioethics*. New York, NY: Cambridge University Press; 2008:289-298.

Nelson WA. Ethics programs in small rural hospitals. Ethics committees are essential all healthcare facilities, not just large ones. *Healthc Exec.* Nov-Dec 2007;22(6):30, 32-33.

Nelson W, Pomerantz A, Howard K, Bushy A. A proposed rural healthcare ethics agenda. *J Med Ethics.* Mar 2007;33(3):136-139.

Purtilo RB. Rural health care: the forgotten quarter of medical ethics. *Second Opin.* Nov 1987(6):10-33.

Roberts LW, Battaglia J, Epstein RS. Frontier ethics: mental health care needs and ethical dilemmas in rural communities. *Psychiatr Serv* 1999;50:497-503.

Roberts LW, Battaglia J, Smithpeter M, et al. An office on main street: health care dilemmas in small communities. *Hastings Cent Rep* 1999;29:28-37.

NOTE: Contact local Hospital Ethics Committees and State or Regional Ethics Network for additional resources and information

RURAL HEALTH CARE SELECTED ETHICS RESOURCES

Selected Articles and Books

- Cook AF, Hoas H, Joyner JC. No secrets on Main Street. *Am J Nurs* 2001;101:67,69-71.
- Cook AF, Hoas H. Ethics and rural healthcare: what really happens? What might help? *Am J Bioeth.* Apr 2008;8(4):52-56.
- Nelson WA, Schmidek JM. Rural healthcare ethics. In: Singer PA, Viens AM, eds. *The Cambridge Textbook of Bioethics*. New York, NY: Cambridge University Press; 2008:289-298.
- Roberts LW, Battaglia J, Smithpeter M, et al. An office on main street: health care dilemmas in small communities. *Hastings Cent Rep* 1999;29:28-37.
- Klugman CM, Dalinis PM, eds. *Ethical Issues in Rural Health Care*. Baltimore, MD: Johns Hopkins University Press; 2008.
- Nelson WA. The challenges of rural health care. In: Klugman CM, Dalinis PM, eds. *Ethical Issues in Rural Health Care*. Baltimore: Johns Hopkins University Press; 2008:34-59.
- Lo B. *Resolving Ethical Dilemmas: A Guide for Clinicians*. 4th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2008.

Selected Web sites

- Rural Assistance Center (RAC)
<http://www.raconline.org/>
- The National Rural Bioethics Project
<http://www.umt.edu/bioethics/>
- American Medical Association: Medical Ethics
<http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics.shtml>
- Applied Ethics Resources on WWW
<http://www.ethicsweb.ca/resources/bioethics/>
- AMA Code of Medical Ethics
<http://www.ama-assn.org/ama/pub/category/2498.html>
- Handbook for Rural Health Care Ethics: A Practical Guide for Professionals
<http://dms.dartmouth.edu/cfm/resources/rhc>

SESSION EVALUATION FORM TEMPLATE

The following evaluation form template is provided to facilitate feedback from participants on rural health care ethics sessions. Organizers or presenters should modify the questions to best suit the content delivered during their session.

HEALTH CARE ETHICS SESSION EVALUATION

Please assess the Rural Health Care Ethics session using the scale below:

	strongly disagree	disagree	neutral	agree	strongly agree
a. The objectives of the session were clear	1	2	3	4	5
b. The objectives of the session were met	1	2	3	4	5
c. There was adequate time for questions	1	2	3	4	5
d. I am more knowledgeable about rural health care ethics than I was before this session	1	2	3	4	5
e. My ability to identify potential health care ethics situations has improved	1	2	3	4	5
f. My ability to address health care ethics situations has improved	1	2	3	4	5
g. I will share information learned from this session with other colleagues	1	2	3	4	5

h. Overall assessment of this session: poor fair average good excellent

i. The most beneficial part of this session was...

j. The session would have been better if...

SESSION LEARNING PLAN FORM

Continuing education guidelines for nursing and medicine are changing to include further assessments of outcomes following educational sessions, such as those presented in this Training Manual. One method to assess outcomes after the conference is to ask participants to fill out a plan for how they will use the information presented in their own workplace settings. The following Personal Learning Plan© can serve as a way to capture participants' plans for what they will do as a result of the conference in their own settings. If conference organizers or presenters wish to follow-up with participants after the conference to see how they did on their learning goals, the plan should be placed on a form that produces a carbon copy for conference organizers to keep, filled out electronically, or copied so that both the participants and the conference organizers have a copy. Conference organizers can then use this form to follow up with participants 3-6 months after the session to assess outcomes resulting from the educational session.

Name _____

E-mail address _____

PERSONAL LEARNING PLAN®

©Center for Continuing Education in the Health Sciences and the Office of
Community-based Education and Research at Dartmouth

1. **Learning Goal:** Write a statement that describes what you want to learn or change related to a topic covered in this session or conference. Aim for a goal that is actionable, measurable, relevant and achievable within a reasonable time frame (e.g., 3-4 months).

2. Consider factors that may affect the likelihood of your success.

- a. How *important* is it for you to achieve your goal on a scale from 1-10? (1=least important; 10=most important)

1 2 3 4 5 6 7 8 9 10

- b. How *confident* are you that you can achieve your goal (or make progress towards your goal) on a scale from 1-10?

1 2 3 4 5 6 7 8 9 10

If you rated either question as a 6 or below, consider revising your goal or choosing a different goal.

3. **Learning activities/strategies to accomplish the goal:** What will you do? Aim to define two specific and measurable strategies e.g., “locate and read three recent reviews on treatment of diabetes” versus “read updates on diabetes.”

a.

b.

4. **Timeline:** Define a timeline for your strategy. When do you plan to start, assess, and finish process?

a. Start Process date: _____ b. Assess Process date: _____ c. Finish Process date: _____

5. **Measures to know if the goal is accomplished:** How will you know that you’ve reached your goal? What will you measure and how will you measure it? (e.g., monitor 20 statin prescriptions given during a two week period).

a. What will you measure?

b. How will you measure it?

6. **Resources to help accomplish your goal:** What resources do you have or need to achieve the above? Are there staff who could help collect measures? Could you arrange with another participant or colleague to review your progress?

a. Resources I have: 1 _____ 2 _____

b. Resources I need: 1 _____ 2 _____

POTENTIAL REGIONAL RURAL HEALTH CARE ETHICS TRAINERS

The following is a list of rural health care trainers that have agreed to have their names listed as potential trainers for education programs. The multi-disciplinary group of health care professionals includes physicians, nurses, administrators, and ethicists who possess a broad range of experiences related to rural health care ethics. You are invited to contact anyone of these outstanding educators as a possible rural ethics trainer for your education program. To help you understand each professional's background, we asked them to provide a few sentences describing their rural ethics activities.

Lisa Anderson-Shaw, DrPH, MA, MSN—Director, Clinical Ethics Consult Service; Assistant Clinical Professor, University of Illinois Medical Center

Dr. Anderson-Shaw launched the Illinois Healthcare Ethics Committee Forum in 2003 to assist small and rural health care institutions in the state of Illinois with a way to discuss issues, share ideas, and network with like institutions. She is active in the American Society of Bioethics and Humanities Rural Ethics Affinity group and has worked to have the rural ethics agenda noted in this national program.

Contact: Lisa Anderson-Shaw, DrPH, MA, MSN
University of Illinois Medical Center
1740 W. Taylor Suite 1400, UIH m/c 693
Chicago, IL 60612
Phone: 312-413-3805
E-mail: lkas@uic.edu

Angeline Bushy, PhD, RN, FAAN—Professor and Bert Fish Endowed Chair, University of Central Florida-School of Nursing

Dr. Bushy has an extensive background in rural settings and rural health care; and, the subsequent implications for ethical situations that can arise in the rural environment.

Contact: Angeline Bushy, PhD, RN, FAAN
Daytona Beach Regional Campus
University of Central Florida
College of Nursing
1200 Speedway Blvd.
Daytona Beach, FL 32114
Phone: 386-506-4056
E-mail: abushy@mail.ucf.edu

Ann Cook, PhD—Director, National Rural Bioethics Project; Research Professor, Department of Psychology, University of Montana

Dr. Cook has formal interdisciplinary training in bioethics and more than 30 years of project management experience in developing and presenting interactive ethics resources, approaches, and interventions for interdisciplinary ethics committees and for health care providers who work in rural health care settings and communities.

Contact: Ann Freeman Cook, PhD
Department of Psychology—Corbin 341
The University of Montana
Missoula, MT 59812-7397
Phone: 406-243-2467
E-mail: ann.cook@mso.umt.edu
<http://www.umt.edu/bioethics>

Rachel A. Davis, MD—Psychiatrist, Southeast Mental Health Services and Denver Health Medical Center Psychiatric Emergency Services, Instructor, University of Colorado, Denver, Colorado

Dr. Davis has served on the American Psychiatric Association Ethics Committee, currently serves on the Colorado Psychiatric Society Ethics Committee, and has co-authored a chapter in the Rural Ethics Handbook. She grew up in rural Southeastern Colorado and has contracted with Southeast Mental Health Services to provide psychiatric services to those in rural Colorado.

Contact: Rachel Davis, MD
8158 East 5th Ave, Suite 200
Denver, CO 80230
Phone: 303-344-0455
E-mail: rachel.davis@dhha.org

Barbara Elliott, PhD—Professor and Director, Clinical Research, Department of Family Medicine and Community Health, Duluth, University of Minnesota

Dr. Elliott's work has always focused on rural health and related issues, including preparing practitioners to address ethical issues in their rural settings. Her research and scholarship has focused on access to care for groups living in rural settings (elders, victims of violence and abuse, those with dementia, adolescents, Native Americans, etc). In addition, she is an active participant in ethics committees and provides ethics consultations in local and regional hospitals.

Contact: Barbara A. Elliott, PhD
Department of Family Medicine and Community Health
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For more than 15 years, Dr. Reeves was a leader at one of the few rural academic medical centers in the country. In that time, she worked with many health care and other community-based organizations to improve access to health services in underserved areas of the region. She now also serves at a small, rural, private college as an academic department chairperson. She has taught biomedical ethics to undergraduate students and presently serves as an Ethics Committee member and resource for the Lake Sunapee Regional Visiting Nurses Association.

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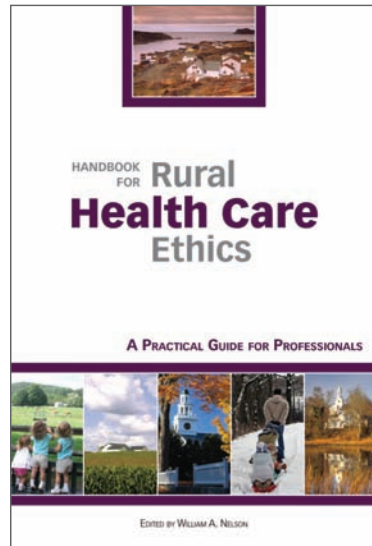
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HANDBOOK FOR RURAL HEALTH CARE ETHICS



Health care delivered in a rural context—in closely-knit, tightly interdependent small community settings—poses unique ethics considerations for clinical practitioners. A provider in a resource-poor rural setting may be faced with treating a family member, friend, business associate or neighbor, since the role separation between clinician and patient that predominates in the urban setting is less likely to occur in a small town. It is difficult for a provider to protect patients' privacy when their care occurs in clinics where neighbors, friends, and relatives work. Similarly, it is difficult to establish a professional relationship when the patient is the doctor's former grade school teacher, or a member of the nurse's local parish.

Ethical aspects of care are especially relevant and sensitive when the patient's health problem is stigmatizing, such as mental illnesses or infectious diseases. Because of the unique rural context, the solutions that health care providers develop to resolve complex ethics dilemmas may differ from solutions derived in urban areas.

The Handbook for Rural Health Care Ethics: A Practical Guide for Professionals is designed to fulfill that purpose, and contains a case-based approach to analyzing, solving and anticipating health care ethics dilemmas. The *Handbook*, edited by William Nelson, is authored by physicians, nurses, health-care ethicists, and hospital administrators who all had scholarship or expertise in rural ethics, and was funded by a grant from the National Institutes of Health (NIH) National Library of Medicine. The Handbook is an on-line e-book available free on Dartmouth Medical School's Community and Family Medicine Web site:

<http://dms.dartmouth.edu/cfm/resources/rhc>

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SELECTED ANNOTATED RURAL HEALTH CARE ETHICS RESOURCES

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.

Cook and Hoas describe how hospitals in rural America currently deal with ethical issues, and discuss ways to encourage a more systematic approach to organizational and clinical ethics. Rural nurses and physicians tend to lack formal resources for dealing with ethical conflicts, and tend to rely instead upon personal values and judgment. Hospital ethics committees are far less common in rural areas than in urban areas, and the rural hospital ethics committees that do exist tend to meet less frequently and serve a more limited role, with little or no case consultations or policy development. Many nurses and physicians report a desire for more ethics resources, particularly interactive sessions about practical issues such as: breaking bad news, decision making, billing practices, and protocols for denial of care. Rural health care providers are often skeptical of standard ethics resources, such as ethics committees and case studies, because they feel these resources are time consuming and do little to improve patient care. Cook and Hoas conclude that there is a need for ethics resources that are developed with an understanding of the interwoven nature of rural communities and target the concerns of rural health practitioners.

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.

This general commentary explores how the rural American cultural context leads to ethical challenges in clinical health care that differ from those encountered in urban areas. Cook and Hoas illustrate this point using the fictional story of an urban doctor, Dr. Philadelphia, who relocates to a small town but is not truly accepted by the community because he does not understand their values and rules, and does not fulfill their expectations for integration into the community. Dr. Philadelphia is a composite character based on research in a 12-state area that drew on the perspectives of rural physicians, nurses, patients, and other community members. Based on their research, Cook and Hoas argue that there is a paucity of bioethics resources in rural areas and a need to develop new bioethics resources that address rural cultural issues.

Cook AF, Hoas H. Bioethics Activities in Rural Hospitals. *Cambridge Quarterly of Healthcare Ethics*. 2000; 9: 230-238.

Cook and Hoas present selected results of a survey concerning bioethics committees and services, which was sent to 216 acute care hospitals in rural Montana, North Dakota, South Dakota, Alaska, eastern Washington, and northwest Minnesota. 117 surveys (54.16%) were returned. The respondents included hospital administrators (67%), directors of nursing (13%), and members of ethics committees (9.2%). They represented hospitals with 25 or fewer beds (45%), 26-50 beds (25.9%), 51-150 beds (22.1%) and over 150 beds (7%). 41.2% of the

responding hospitals had a bioethics committee or its equivalent, and 34.1% of responding hospitals had JCAHO accreditation. The researchers found a statistically significant correlation between the size of the hospital and the likelihood that the hospital had a bioethics committee and JCAHO accreditation. Ethics committees in larger hospitals tended to have more members and were more likely to include a lawyer and handle case consultation. For hospitals with ethics committees, just 29 (59.2%) met on a monthly basis, while the rest met irregularly. 73% of responding ethics committees conducted staff education, 33.5% had some role in formulating policy, and 28.6% did formal case consultation. Of the hospitals without bioethics committees, 69% said that their institution did not need a bioethics committee, but 72.9% said their hospital might be interested in participating in a bioethics training program. The authors conclude that new models need to be developed that meet the unique ethics needs of rural hospitals.

Cook AF, Hoas H. Ethics and rural healthcare: what really happens? What might help? *Am J Bioeth.* Apr 2008;8(4):52-56.

Drawing on nine years of research in a multistate area, the authors discuss the types of ethical issues impacting health care delivery in rural America and the types of resources which are needed in order to meet the needs of rural health care providers. Cook and Hoas give a qualitative description of the results of multi-method research (surveys, interviews, and focus groups conducted with rural physicians, nurses, pharmacists, hospital administrators, patients, and other community members), but do not give the details of their research methodology in this publication.

Cook AF, Hoas H, Joyner JC. No secrets on Main Street: challenges to ethically sound care in the rural setting. *Am J Nurs.* Aug 2001;101(8):67, 69-71.

Nurses working in rural areas regularly encounter ethically complex situations, but they often lack the vocabulary, training, and institutional support needed to identify and address ethical conflicts. Drawing on their research, the authors discuss the lack of ethics resources in many rural settings and describe cost-effective resources that they are pilot testing.

Klugman CM, Dalinis PM, eds. *Ethical Issues in Rural Health Care*. Baltimore, MD: Johns Hopkins University Press; 2008.

This reference is a collection of twelve essays that examine ethical issues in rural health care. It provides readers with a broad overview of the field of rural medical ethics, and a close-up analysis (from a rural perspective) of the following issues: end-of-life care, medical errors, resource allocation, health care quality, bioethics networks, welfare programs, geriatric care, and supports for the rural physician. The essay collection also includes three personal reflections on providing rural care, written by a primary care provider, a pediatrician, and a clinical psychologist.

Nelson W., Pomerantz A, Howard K, Bushy A. A proposed rural healthcare ethics agenda. *J Med Ethics.* 2007; 33: 136-139.

The Coalition for Rural Health Care Ethics—with members from medicine, nursing, religious studies, and philosophy backgrounds—developed a proposed rural health

care ethics agenda at their first meeting. The group agreed that the health care providers in rural areas face contextual challenges that add a layer of complexity to common bioethical issues. They also concluded that there was little research devoted to rural bioethics, and few ethics resources targeted to the needs of rural clinicians and administrators. The Coalition resolved to increase the awareness and understanding of rural health care ethics among clinicians, administrators, policy makers, and members of the ethics community. They resolved to research rural bioethics and, in partnership with rural health care providers, to develop guidelines for dealing with common ethical conflicts.

Nelson W, Lushkov G, Pomerantz A, Weeks WB. Rural health care ethics: is there a literature? *Am J Bioeth.* Mar-Apr 2006;6(2):44-50.

This systematic literature review quantifies and categorizes the publications that focus on ethics issues in rural American health care. The review is limited to literature available via searchable databases and published between 1966 and 2004. 55 publications were identified: 7 (13%) were original research, 12 (22%) were descriptive summaries of research and 36 (65%) were general commentaries. 55% of the publications focused on clinical ethics, while 27% addressed organizational ethics and 18% addressed ethical ramifications of rural health care policy at a national or community level. The authors conclude that there is a need for more extensive scholarship focusing on rural health care ethics, particularly formal quantitative research.

Nelson WA. Ethics programs in small rural hospitals. Ethics committees are essential in all healthcare facilities, not just large ones. *Healthc Exec.* Nov-Dec 2007;22(6):30, 32-33.

In this column, ethicist William Nelson advises a CEO on how to develop an ethics committee at a rural critical access hospital. Ethics committees are typically multidisciplinary teams (including a trained ethics expert) that meet regularly and serve an institution by providing case consultation, ethics education, and policy review. Approximately half of rural hospitals have some form of ethics program—a smaller percentage than urban hospitals, which have a larger pool of qualified candidates for an ethics committee and are more likely than rural institutions to seek JCAHO accreditation, which requires an ethics program. Smaller institutions can develop an ethics committee with strong administrative support. Particularly important is ethics training for the committee's chairman, since there are fewer candidates with prior ethics training in rural areas. In addition, rural ethics committees should network with state ethics committees, academic-based ethics centers, and ethicists focused on rural health care. Multifacility ethics committees (MFECS) are also an option for institutions that wish to share the costs and responsibilities of an ethics committee.

Nelson WA. The challenges of rural health care. In: Klugman CM, Dalinis PM, eds. *Ethical Issues in Rural Health Care* Baltimore: Johns Hopkins University Press; 2008:34-59.

This book chapter provides an informative and concise overview of rural health care challenges. It describes the impact of geographic, economic, and cultural factors

on rural health services. Ethical issues—including confidentiality, conflict of interest, reimbursement, disease stigma, and professional competency—are illustrated and analyzed via case studies. The article also discusses rural ethics committees, which are less common than urban ones, and face challenges such as limited personnel and ethics resources. Building multi-facility ethics committees and state-wide ethics networks are two practical ways to overcome these challenges. Other suggested strategies for improving rural health care ethics are included at the chapter's conclusion.

Nelson WA, Schmidek JM. Rural healthcare ethics. In: Singer PA, Viens AM, eds. *The Cambridge Textbook of Bioethics*. New York, NY: Cambridge University Press; 2008:289-298.

This textbook chapter gives an overview of rural health care ethics, with a focus on rural settings in the United States, Canada, and the United Kingdom. Health disparities in rural versus urban areas are discussed, as are ethical issues commonly encountered in the rural community. This textbook chapter includes a review of empirical studies in rural bioethics, practical advice for rural clinicians dealing with bioethical issues, and a review of three case studies.

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

In this perspective article, Denise Niemira, MD, gives advice for the development of rural ethics committees by analyzing the development of two ethics committees in rural hospitals in Vermont, the state in which she practices. Both ethics committees began as small medical staff committees, led by full-time primary care physicians who sought out training in medical ethics via independent study and regional training sessions. Once all ethics committee members had become knowledgeable in ethical principles and methodology, the ethics committees began to review policy for their hospitals and conduct formal case consultations. A central component of the ethics committees' success was regional networking, including: involvement in a statewide ethics education initiative for community members; participation by the committee chairmen in the Vermont Medical Society's Committee on Medical Ethics; and partnerships with a well-established ethics committee at an academic referral center as well as other newly developed ethics committees.

Niemira DA, Orr RD, Culver CM. Ethics committees in small hospitals. *J Rural Health*. Jan 1989;5(1):19-32.

Establishing an ethics committee in a small hospital can be challenging due to limited resources and a lack of local expertise. Still, it is possible for small hospitals to establish ethics that lead ethics education, develop and review hospitals policies, and conduct formal case consultations. This article examines the first three years of two successful IECs: one in Brattleboro Memorial Hospital, a 60-bed facility in Brattleboro, VT, and the other in North Country Hospital, an 80-bed facility in Newport, VT. It compares and contrasts how the two ethics committees were established, and analyzes what factors helped them gain the acceptance and support of hospital staff.

Purtilo R, Sorrell J. The ethical dilemmas of a rural physician. *Hastings Cent Rep.* Aug 1986;16(4):24-28.

This overview of ethical dilemmas in rural health care is based on a literature review and 125 personal or telephone interviews with rural physicians. Included are two vignettes that illustrate the ethical issues of confidentiality and quality-of-life decisions in a rural setting. The authors conclude that rural physicians grapple with similar ethical issues as do their urban counterparts, but the rural context adds another dimension to these issues and influences the type of solutions that rural providers choose.

Purtilo RB. Rural health care: the forgotten quarter of medical ethics. *Second Opin.* Nov 1987(6):10-33.

This overview of rural medical ethics, written by a Nebraskan author, emphasizes the physician's role in promoting not only the wellbeing of individual patients, but the health of the community as a whole. Rural life can be far from idyllic, with multiple health hazards due to industrialized agriculture, environmental pollution, poverty, and a lack of health care resources. This article includes three vignettes, from the perspective of a family practice physician, an elderly patient, and a farmer/rancher who had to sell much of his land. Three case studies in rural medical ethics, with commentary, are also included.

Roberts LW, Battaglia J, Epstein RS. Frontier ethics: mental health care needs and ethical dilemmas in rural communities. *Psychiatr Serv.* Apr 1999;50(4):497-503.

62 million U.S. residents live in rural areas, and 15 million of them have mental health or substance abuse problems. Mental health care providers who practice in remote areas with few resources face many ethical challenges. The authors explore these issues in this article, using vignettes from rural practices in New Mexico and Alaska. Dual-relationships and the close-knit nature of rural communities can make it hard to maintain therapeutic boundaries and patient confidentiality. Providing culturally sensitive care to Native Americans can be challenging for providers from other backgrounds. Furthermore, mental health care in rural areas is often provided by generalists with little support from psychiatric specialists. The heavy responsibilities and lack of support can contribute to stress and burnout for rural caregivers. Unlike their urban counterparts, rural mental health providers have fewer ethics committees and other ethics resources to deal with these issues. The authors suggest developing networks for both clinical and ethics support.

Roberts LW, Battaglia J, Smithpeter M, Epstein RS. An office on Main Street: health care dilemmas in small communities. *Hastings Cent Rep.* Jul-Aug 1999;29(4):28-37.

This paper gives an overview of health care needs in rural America and the ethical issues impacting health care delivery. The authors point out that roughly one quarter of the U.S. population lives in rural or frontier areas, and they often have poorer health than their metropolitan counterparts. The overall age-adjusted rate of death is higher in rural versus urban areas. Rural residents also have higher rates of chronic illnesses, life-threatening conditions, exposure to environmental

hazards, domestic and occupational injuries, mental health concerns, and alcohol disorders. Providing health care in rural areas can be ethically challenging due to: dual relationships, difficulty maintaining patient confidentiality, cultural issues, limited resources, and heavy burdens on health care providers. The authors also acknowledge that the close-knit nature of small communities can be an “ethical strength,” because rural clinicians often have a fuller understanding of their patient’s lives and may feel a sense of satisfaction from their connection with and service to the community.

Roberts LW. Johnson ME. Brems C. Warner TD. Ethical disparities: challenges encountered by multidisciplinary providers in fulfilling ethical standards in the care of rural and minority people. *J Rural Health*. Fall 2007;23(supplement):89-97.

The survey study seeks to determine whether providers report greater difficulty in providing care for rural than urban residents in general in 4 practice areas of ethical relevance: attaining treatment adherence, assuring confidentiality, establishing therapeutic alliance, and informed consent. Based on responses from 1,558 multidisciplinary health professionals from New Mexico and Alaska, the researchers report that difficulties are greater for providers in rural than in non-rural areas. The research findings indicate “clear evidence of disparity for people residing in rural compared to non-rural areas of 2 states with large rural populations.”

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RURAL HEALTH CARE ETHICS WEB SITES

National Rural Health Association (NRHA)

<http://www.ruralhealthweb.org/>

The NRHA Web site provides information about rural health care and its unique challenges and opportunities. It includes a helpful chart differentiating rural from urban health care. The site offers useful links to related publications, policy initiatives, networking opportunities, and NRHA programs.

Rural Assistance Center (RAC)

<http://www.raconline.org/>

The RAC Web site provides a broad range of health and human services information, including funding information, rural health care research, news, and events. The site also offers information guides, maps, state and regional resources, and a directory of experts and organizations that have an interest in rural health.

The National Rural Bioethics Project

<http://www.umn.edu/bioethics/>

The National Rural Bioethics Project Web site offers results from rural health care research, a helpful resources section, and applicable patient safety information. In addition, the site provides a variety of practical tools that are appropriate for health care providers and staff, patients, and even community members.

National Organization of State Office of Rural Health (NOSORH)

<http://www.nosorh.org/>

The NOSORH site provides a listing of regional and state Office of Rural Health representatives from throughout the United States. Committees are listed that address issues from finance to health information technology, and contact information for each. The site provides a mentoring program and resources for members and non-members.

Veterans Affairs National Center for Ethics in Health Care

<http://www.ethics.va.gov/>

This Web site provides tools to health care professionals for addressing ethics questions. The site also offers numerous links to VA ethics resources, including material for the Integrated Ethics Program, the National Ethics Committee, and ethical issues like pandemic flu preparedness and response, among others.

University of Pennsylvania Center for Bioethics

<http://www.bioethics.net>

This Web site details the University of Pennsylvania's Bioethics program, including outreach and public service information and Center resources, such as the journal, The American Journal of Bioethics. The site covers a broad range of bioethics topics and provides general ethics guidance that is applicable to a variety of bioethics discussions.

American Medical Association: Medical Ethics

<http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics.shtml>

This Web site provides the AMA's Code of Medical Ethics for reference, the declaration of professional responsibility, as well as a virtual medical ethics mentor. The site also includes the AMA's Council on Ethical and Judicial Affairs, the Ethics Resource Center, and the Institute for Ethics.

Applied Ethics Resources on WWW

<http://www.ethicsweb.ca/resources/bioethics/>

This site contains a basic but thorough listing of ethics related resources including ethics institute and organizations, ethics publications, topics and issues, and other relevant organizations. Noted topics cross a broad range of health care issues.

The American College of Healthcare Executives

www.ACHE.org

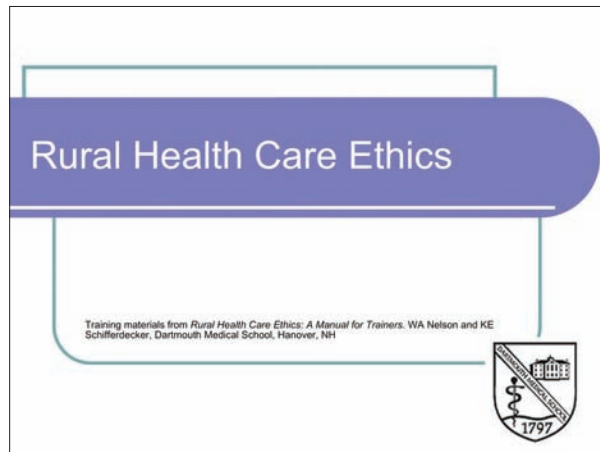
The ACHE site provides a variety of services to members, as well as helpful ethics resources that are available to non-members. The resources are very user-friendly and include an ethics toolkit, code of ethics, policy statements, and self-assessments.

AMA Code of Medical Ethics

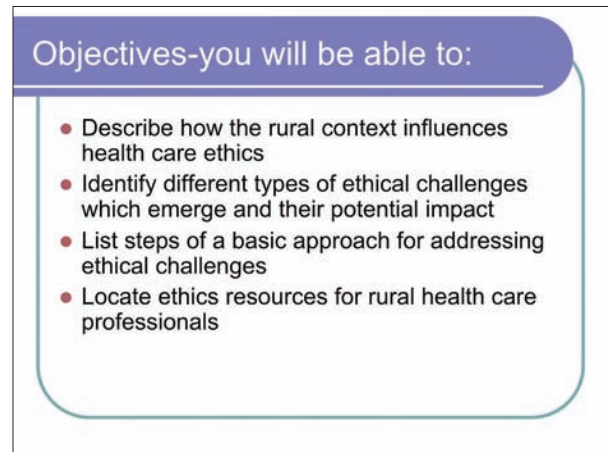
<http://www.ama-assn.org/ama/pub/category/2498.html>

This Web site provides ethics guidelines for physicians for a wide-range of ethics issues.

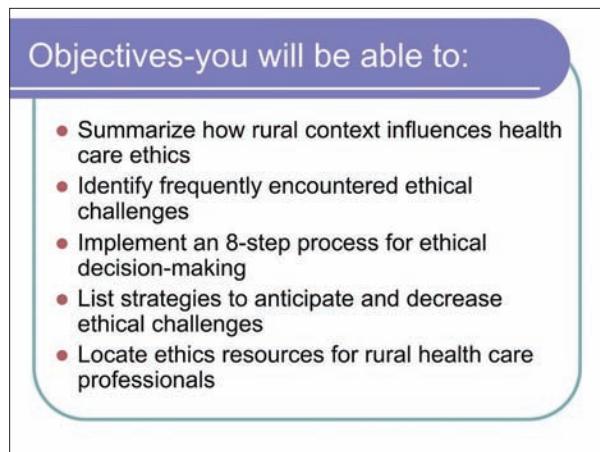
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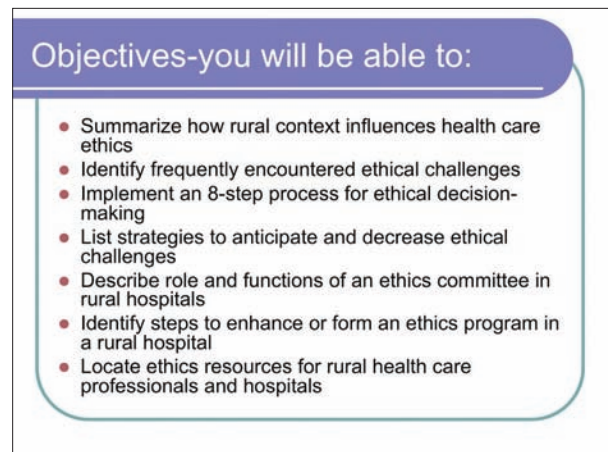
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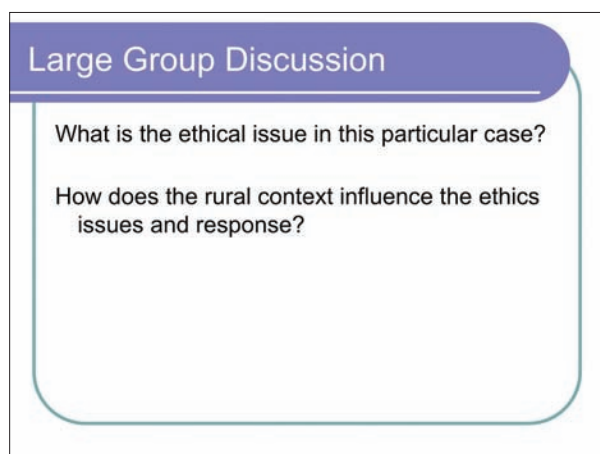
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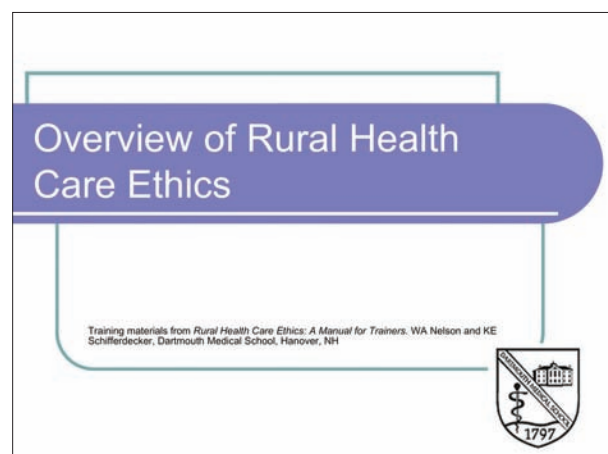
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Slide 4



Slide 5



Slide 6

Training materials from *Rural Health Care Ethics: A Manual for Trainers* written by William A. Nelson and Karen E. Schifferdecker. PowerPoint files may be found at <http://dms.dartmouth.edu/cfm/resources/manual/>.



Slide 7

Ethical Conflicts

- Occur when there is uncertainty, a question, or a conflict regarding competing ethical principles, personal values, or professional and organizational ethical standards of practice.
- Or when one considers violating an ethical principle, personal value, or ethical standard of practice

Slide 8

Components of Health Care Ethics

- Theoretical – foundations of moral reasoning
- Clinical – conflicts involving individual patients
- Organizational – business practices, policies and regulation
- Research – design, implementation, and dissemination
- Cultural – ethnic, social and geographical context

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Rural Health Care Ethics

- Focuses on how the rural context influences the presentation of ethical challenges and the response to those challenges.
- Rural health care ethics is the reflection of ethical issues encountered in the unique environment of rural settings.

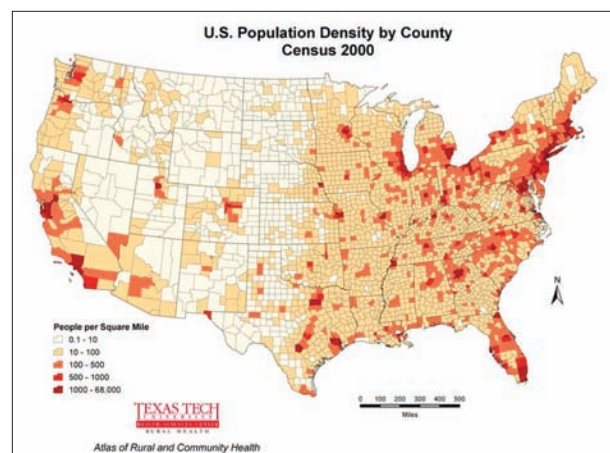
Slide 10

Rural Demographics

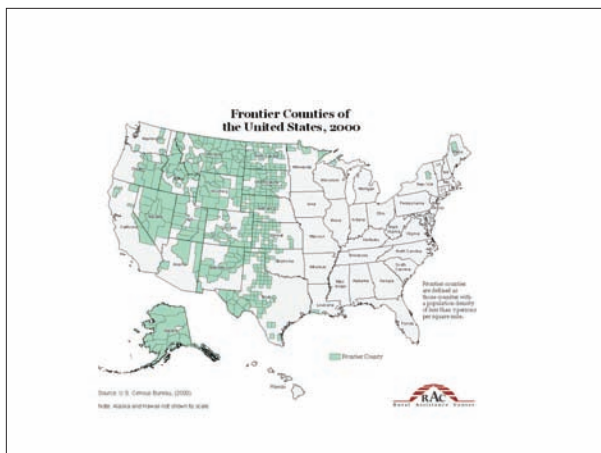
- 21-24% of population
- 60-62 million rural residents
- 3 million veterans
- ¾ quarters of land mass
- Distance to urban settings



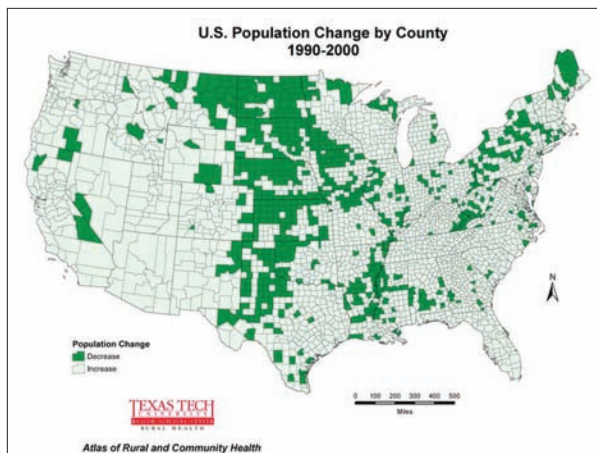
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Slide 13



Slide 14

US Hospitals

- Hospitals in US – 5,764
- Rural hospitals – 2,166
 - 1,294 are Critical Access Hospitals- 25 beds or less*
 - 29 are rural VAMCs**



* American Hospital Association
** VA designated

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Rural Health Snapshot

	Rural	Urban
US population	22%	78%
US physicians	11%	89%
Primary care physicians	54%	38%
Aged 65 or older	18%	15%
Below poverty	14%	11%
Per capita income	19K	26K

Source: Table 1, Commentary: Rural Health Can Help Lead the Way. Wisconsin Medical Journal. 2002;101:10

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Rural Health Snapshot (continued)

	Rural	Urban
Adults describing health status as fair or poor	28%	21%
Obese men	22%	18%
Adolescents who smoke	19%	11%
Male/female death rate per 100,000 (ages 1-24)	80/40	60/30
Population who are white	83%	69%

Source: Table 1, Commentary: Rural Health Can Help Lead the Way. Wisconsin Medical Journal. 2002;101:10.

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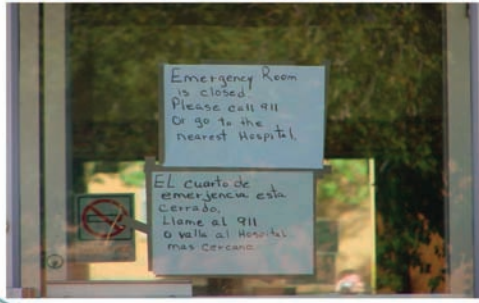
Rural Health Snapshot (continued)

	Rural	Urban
Private insurance	64%	69%
Medicare beneficiaries	23%	20%
Medicare w/o drug coverage	45%	31%
Medicare spends per capita to US average	85%	106%
Medicare hospital payment-to cost ratio	90%	100%
Poor covered by Medicaid	45%	49%

Source: Table 1, Commentary: Rural Health Can Help Lead the Way. Wisconsin Medical Journal. 2002;101:10.

Slide 18

The reality...



Slide 19

Rural Context Impacting on Health Care Ethical Challenges

- Limited availability of health care services
- Health status of population
- Economic constraints of residents
- Geographic barriers to health care services
- Community and personal values
- Professional isolation
- Overlapping professional and personal relationships
- Community expectations
- Limited ethics resources

Slide 20

Rural Health Care Ethics Literature

- Limited ethics literature focusing on rural health care ethics
- Only 55 publications between 1996-2004 specifically and substantively addressed rural health care ethics

Nelson, Lushkov, Pomerantz, Weeks, Rural Healthcare Ethics: Is There a Literature? *American Journal of Bioethics* 2006;6(2):193-195.

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Limited Rural "Ethicists"

- Limited number of ethicists living and/or working in rural America
 - 98% of American Society of Bioethics and Humanities (ASBH) members live/work in non-rural settings
 - Ratio ASBH members to non-rural hospitals: 1 to 3
 - Ratio ASBH members to rural hospitals: 1 to 100

Nelson, Lushkov, Weeks, Rural/Non-Rural Differences in American Society of Bioethics and Humanities Membership. *Journal of Medical Ethics* 2006;32:411-413.

Slide 22

Limited Rural Ethics Focus

- Health care ethics, has historically been dominated by an academic, high-technology, large facility, and urban oriented focus
- The result is limited rural specific ethics resources, including – literature, ethicists, ethics committees, and training

Slide 23

Coming Back to the Rural Context

- Limited availability of health care services
- Health status of population
- Economic constraints of residents
- Geographic barriers to health care services
- Shared community culture and personal values
- Professional isolation
- Overlapping professional and personal relationships
- Community expectations
- Limited ethics resources

What might be common ethical challenges that result from the rural context?

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Common Rural Ethical Challenges

- Professional-personal boundary conflicts
- Privacy and confidentiality
- Caregiver stress
- Community values and professional guidelines
- Allocation of resources
- Access to needed care
- Disease stigma

Training materials from *Rural Health Care Ethics: A Manual for Trainers*. WA Nelson and KE Schifferdecker, Dartmouth Medical School, Hanover, NH

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Example – Overlapping Relationships

- Dr. Gomez, a family physician in a rural setting is a member of the town's 3-person school board. He discovers during a routine examination that one of his patients, who is a school teacher, has missed many teaching days because of a significant alcohol problem. Dr. Gomez is also aware that the teacher has applied for the vacant principal position at the school.

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Example – Disease Stigma

- A patient living in a remote, rural community drives 2 hours to University Hospital for care related to a STD. When asked about not going to the primary care clinic in her community, she replies, "My sister-in-law works at the clinic by our house, that would be bad for the whole family."

Because of the burden of the long drive she becomes non-compliant for subsequent follow-up.

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Example – Privacy and Confidentiality

- NP J. Baker prescribed a partial opiate agonist to a young man, Brian, for treatment of prescription opiate dependence. Three weeks later, Brian was found unresponsive, requiring intubation and medical evacuation to a city. He recovered and didn't want others to know he had attempted suicide. He spread rumors that Joan incorrectly prescribed a medication and was incompetent.

Another patient brought up these rumors during an appointment with Joan. She wished she could set the record straight; that Brian obtained opiates from a provider in a neighboring city and had taken these in large quantities in a suicide attempt.

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Impact of Ethical Challenges

- What do you think is the potential impact of these ethical challenges on rural health care settings?

Training materials from *Rural Health Care Ethics: A Manual for Trainers*. WA Nelson and KE Schifferdecker, Dartmouth Medical School, Hanover, NH

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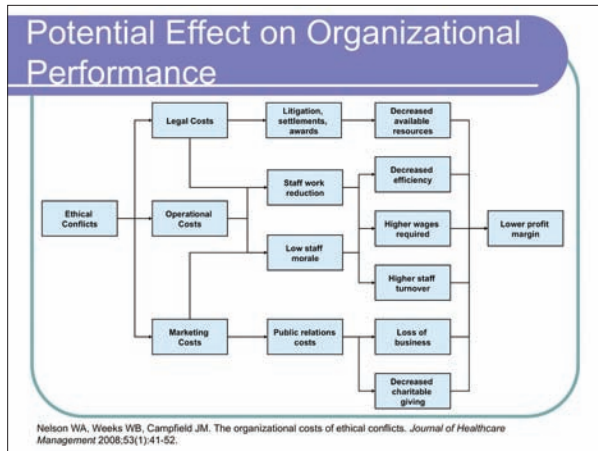
Impact of Ethical Challenges

- Staff – caregiver stress, morale, job turnover, diverted staff time,
- Patients – patient satisfaction, self-referrals
- Organizations' culture – professionalism, quality of care
- Relationship with community – public image and relations, giving
- Regulations – Joint Commission standards
- Organizations' bottom line – cost of ethics conflicts*

Nelson WA, Weeks WB, Campfield JM. The organizational costs of ethical conflicts. *Journal of Healthcare Management* 2008;53(1):41-52.

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Training materials from *Rural Health Care Ethics: A Manual for Trainers* written by William A. Nelson and Karen E. Schifferdecker. PowerPoint files may be found at <http://dms.dartmouth.edu/cfm/resources/manual/>.



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Addressing Ethics Conflicts

- Recognizing and addressing is essential for quality health care

Training materials from *Rural Health Care Ethics: A Manual for Trainers*. WA Nelson and KE Schifferdecker, Dartmouth Medical School, Hanover, NH

Slide 32

Addressing Ethics Conflicts

- Using an 8-step ethics-decision making process

Nelson W. An Organizational Ethics Decision-Making Process. *Healthcare Executive* 2005;20(4):8-14.

Slide 33

1. Clarify the Ethical Conflict

- What is the specific ethics question or conflict?
- What if the question or conflict is not an ethical question?

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2. Identify All the Affected Stakeholders and Their Values

- Who are the individuals or programs affected by the ethics question?
- What are the values and perspectives of all the affected stakeholders?

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3. Understand the Circumstances Surrounding the Ethical Conflict

- Why has the ethical conflict arisen?
- What are the facts surrounding and related to the ethical conflict or question?

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4. Identify Ethical Perspectives Relevant to the Conflict

- What are the ethical concepts or principles related to the conflict or question?
- Does your organization's mission, value statement, and/or policies address the conflict?
- Are their ethical guidelines concerning the ethical conflict, such as the AMA or Nursing professional standards?

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5. Identify Different Options for Action

- What are the possible options for responding to the ethical conflict or question?
- What are the potential benefits or outcomes, as well as the potential harms of each option?
- What is the ethical reasoning for each option?

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6. Select Among the Options

- Have you systematically and quantitatively evaluated each option?
- Is the option practical? Does it have a clear ethical foundation?
- Does one ethical concept or stakeholder value appear to be stronger than the others?
- Is there assessment plan to evaluate for the decision?

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7. Share and Implement the Decision

- What method will be used to share and implement the decision?
- Was the assessment plan implemented?

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8. Review the Decision to Ensure it Achieved the Desired Goal

- What was the outcome of the decision?
- Do you need to revise the decision?

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Anticipating Ethics Conflicts

- Most ethics conflicts are recurring, that is, the basic ethics issue is recurring, such as end-of-life conflicts or boundary conflicts

Training materials from *Rural Health Care Ethics: A Manual for Trainers*. WA Nelson and KE Schifferdecker, Dartmouth Medical School, Hanover, NH

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Anticipating Ethics Conflicts

- Because ethics conflicts
 - are frequently recurring conflicts
 - And have significant negative impact on the organizations, staff and patients
- Rural professionals should develop strategies to anticipate and potentially reduce the impact of ethics conflicts

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Interventions to Decrease Ethical Conflicts

- Facilitate a root cause analysis following ethics conflicts
 - Identify cause of conflict
 - Consider and embrace corrective actions
- Develop a proactive approach to ethics to address recurring ethical conflicts
 - Identify ethical challenges throughout the organization or clinic
 - Develop and propagate ethical practice guidelines to decrease their impact

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Apply a Proactive Approach to Ethics Conflicts

- Use quality improvement approaches
- Establish clinical and organizational ethical practice guidelines
- Direct activities to enhance the quality of care and the practice's overall culture

Slide 45

Ethics Committees in Rural Health Care Facilities

- Ethics committees can serve as a useful resource to clinicians and administrators for addressing challenging ethics questions
- The purpose of an ethics committee is to enhance the quality of care by providing a forum to discuss ethics questions with a multi-disciplinary group of professionals with knowledge and skills in health care ethics

Training materials from *Rural Health Care Ethics: A Manual for Trainers*. WA Nelson and KE Schifferdecker, Dartmouth Medical School, Hanover, NH

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The Basic Functions of Ethics Committees

- *Establish* ethical health care practices throughout the facility
- *Educate* staff regarding ethical health care practices
- *Clarify* ethical health care practices when needed
- *Evaluate* ethical health care practices

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Benefits of an Effective Ethics Program

- Enhanced patient satisfaction
- Increased employee morale and loyalty
- Improved public relations
- Fewer wasteful/unwanted treatments

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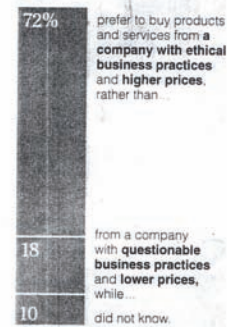
Benefits of an Effective Ethics Program (continued)

- Less diverted staff time
- Enhanced professionalism
- Fewer law suits
- Meet Joint Commission ethics standards

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Conscience Spending

In a telephone survey of 2,000 adults in December 2005,



Source: LRN

The New York Times

Slide 50

Creating or Enhancing Ethics Programs Session

- General reactions or questions to the presentation
- Do you have an ethics program? How effective is the program?
- If not, what do think about initiating an ethics program?

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Summary

- **Take home points**
 - Clinical and organizational ethical conflicts occur frequently
 - Ethical conflicts affect patient care, staff, organizational culture, and costs
 - Responding to ethics challenges requires thoughtful, systematic reflection – applying ethics concepts and standards to the unique rural environment
 - Strategies to anticipate and decrease the occurrence of ethics conflicts should be considered
 - Identifying and using ethics resources can be useful
- Any additional questions, comments or feedback?

Training based on materials from *Rural Health Care Ethics: A Manual for Trainers*. WA Nelson and KE Schifferdecker, Dartmouth Medical School, Hanover, NH

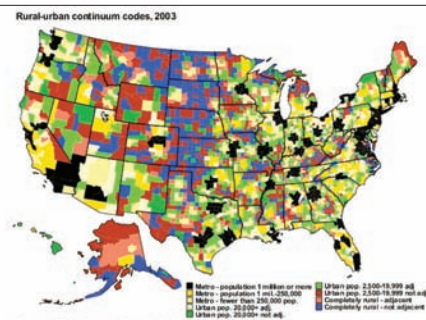
Slide 52

What is rural?

- U.S. government uses 3 separate definitions
- U.S. Census Bureau defines rural as anything that is not urban—a densely populated core area of 1,000 per square mile plus surrounding territory of at least 500 people per square mile, all with at least 50,000 people
 - 21% of US population (59.1 million)
- Office of Management & Budget defines rural as any non-metropolitan statistical area—a city of 50,000 or more residents surrounding a metropolitan area of at least 100,000 residents (75,000 in New England)
 - 7.9 % of US population (20 million)
- U.S. Department of Agriculture defines rural as “open country and settlements with fewer than 2,500 residents.”
 - 17% of US population (50 million)



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94.6% of all U.S. land is designated as rural open space
Includes natural open space, agriculture, and low density populations

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Training materials from *Rural Health Care Ethics: A Manual for Trainers* written by William A. Nelson and Karen E. Schifferdecker. PowerPoint files may be found at <http://dms.dartmouth.edu/cfm/resources/manual/>.



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