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Recognizing and Resolving Ethical Dilemmas in Rural Medicine

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

The National Rural Bioethics Project (NRBP) has sought for nearly a decade to better understand the specific ethical problems and questions of health care in the rural context [1]. Ann Freeman Cook and Helena Hoas synthesize findings on these topics to paint a picture of the bioethics landscape in rural health care organizations.

Ethics committees are less prevalent in rural hospitals than elsewhere, they do not fulfill the typical role, and they are seldom used. By 1985, 60 percent of U.S. hospitals had ethics committees, and the bioethics literature now suggests that such entities exist in most hospitals throughout the country [2]. But only 41 percent of rural hospitals in a six-state survey reported having an ethics committee [3, 4]. The committees that do exist, Cook and Hoas report, are mainly devoted "to the education of the members," rather than "policy development or review, patient advocacy, research, evaluation, or case consultation" [5]. Seventy-six percent of rural physicians who participated in a multi-state study reported they had *never* referred a case to an ethics committee at any time during their training or career—even when they were available, there was no significant difference in their rate of use.

Health care personnel in rural areas do not see bioethics analysis as applicable to the problems they face. Most rural health care workers were familiar with landmark bioethics cases, models for ensuring ethics care (e.g., ethics committees), and standard services (e.g., case consultation), but few had any experience with them [3, 6], formal ethics training in the rural setting was limited [3], and they reported feeling "that the ethical problems they encounter seem mundane, too frequent, and too common for analysis in venues like ethics committees" [7]. Rural physicians and nurses defined the most useful ethics resources as spouses, peers, or the Ten Commandments [2].

A lack of consensus about what constitutes ethical behavior leads to hesitancy and inaction. Cook and Hoas cite a study in which physicians and nurses suggested 83 potential "combinations of actions" would be appropriate responses to "an ethically problematic situation," none of which the authors felt would be effective [5]. This lack of consensus appears to lead rural health care professionals to respond to ethical dilemmas with a kind of stubborn inaction: the authors cite another study that found

that "one in four nurses was not willing to take action when orders [for patients] were unclear," and many fewer than that were willing to take action on *any other* kind of problem, "even when the issues clearly heightened the potential for harm, compromised autonomy, inhibited disclosure, or created other ethical problems" [7].

These findings beget several questions about the role of medical ethics in rural health care. Why do rural physicians see bioethics analysis as inapplicable to the dilemmas they experience frequently? Why do bioethics committees have a different role in the rural than the nonrural context? Why is there such a lack of consensus about ethical behavior among rural health care workers? And what can be done?

Typical Dilemmas

One of the particular attributes of rural health care is the connection between health care professionals and the community; it is underscored by the obvious importance of "familiarity, trust, mutuality, and caring for one another as family" [8]. At first glance, familiarity and interconnectedness would appear to be a boon to the relationship between clinicians and their patients, but what happens when this closeness hinders the physician's ability to make responsible decisions or raises difficult ethical quandaries?

Cook and Hoas note that bioethics colleagues often suggest that the problems routinely encountered by rural health workers would be better addressed by "peer review, quality control, credentialing, or patient safety" measures rather than ethics committees [1], but the authors assert that in the rural context, the dividing line between "practical" and "ethical" is often blurred—or nonexistent.

Example 1: An 86-year-old patient with vast influence in the community wanted a surgery for incurable cancer that would not be fully covered by Medicare, and "the healthcare providers registered their concerns about risks and futility of surgery but acceded to family wishes because the old gentleman was influential, well known, and well respected in the community; there was no desire to antagonize either the patient or his family" [7]. The same hospital denied the child of a less influential family vaccination because they were unable to pay for it.

This scenario illustrates how power and prestige play into the allocation of hospital funds and hints at the calculus of which "relationships…can be honored or sacrificed" [7]. The hospital Cook and Hoas describe was willing to accrue financial burden in order to avoid causing friction with an influential family, but could not extend that same treatment to everyone in the area. "So, explained one healthcare provider…'the burden kind of falls on the professional, on being able to blend these problems of knowledge, emotion and finances'" [7]. Financial concerns are less likely to land on the shoulders of a single health care professional at a large hospital. At larger institutions in less remote areas, a bureaucracy, including ethics committees, is involved in setting priorities and making coverage decisions—the physician is not making these decisions in a vacuum, on the fly, and may be less likely to have personal relationships at stake.

Example 2: A pharmacist corrects a medication dosage that could have been lethal for a patient, without asking the physician or making the physician aware of the error, because "the physician's behavior is not likely to change; in fact there is a quiet understanding that his orders often have to be adjusted and the pharmacist and nurses are expected to be 'on the lookout....One pharmacist explained: 'I went ahead and fixed it because I wasn't going to take no for an answer anyway. So why ask" [7].

Should the pharmacist have changed the order without consulting the physician? Given the closeness of the rural community, relationships must be carefully fostered and maintained. Most would agree that the moral obligation in this case is to protect the patient. One might argue that if the patient receives the correct dosage, then the route by which he or she gets it is of little importance. Others might claim that consultation with a physician prior to changing orders is paramount to the effective treatment of a patient.

In addition to the correction of the order, the physician's error should be brought up—but by whom and to whom? Who has, or should have, the authority to do this? The hospital in this example lacks a system for identifying, noting, and remedying both medication errors and the kind of "incompetent" prescribing that occurs in this scenario, creating a situation in which a physician can just dig in his or her heels and refuse the correction of dangerous errors. Cook and Hoas quote a nurse who bluntly stated that "resources are limited and you have to think about what to do or say…if you want to be here until you retire" [9]. Though this may be considered a patient safety concern, it is easy to see how a lack of safety resources turns this into an ethical dilemma for the individual health care worker.

Example 3: A physician performs some procedures incorrectly. Hospital administrators and other physicians are aware of the problem, but "if limits are placed on a physician's ability to perform certain tasks, he may leave the community or he may stop referring patients to the hospital.... The other physicians…also note that he is a call partner, there are times they have to depend on him, and he performs some procedures very well" [7].

Though it may seem that immediate intervention is the only appropriate recourse, would that benefit the patient or community? One thing to consider is that antagonizing the physician may hurt the community. It is well known that there are not enough physicians serving rural America; the need for physicians—some might argue, regardless of competency—is urgent. Wouldn't patients benefit more from substandard care than no care at all?

Taken together, these 3 examples paint a picture of the considerations specific to rural care. The power structures and relationships in rural health care affect allocation of resources, hierarchy, care quality, and other everyday aspects of health care "pose formidable barriers that inhibit recognition and resolution of ethical problems" [9]. Cook and Hoas report that the stresses of trying to balance all these

competing factors without institutional support saps health care workers' professional satisfaction and resolve, driving many physicians away from their positions after very short periods of time [9].

Potential Remedies

In order to better attend to ethical issues in rural medicine, Cook and Hoas have undertaken a three-step approach:

(1) Work to make rural professionals more willing to take action about ethics problems and make use of ethics frameworks and resources. Cook and Hoas say they are working to "broaden our understanding of what issues merit ethical scrutiny [even when they] do not meet the 'ethical litmus test'" [9], an informal standard set by nonrural bioethicists, and provide appropriately tailored resources.
(2) This means creating interactive, interprofessional, practical materials that take what one respondent called a "not-for-experts-only approach" [9]. Cook and Hoas have developed such materials as "case studies, bookmarks, readers' theater scripts, fact sheets, booklets, and various web-based tools" that suggest language with which health care workers can talk about these issues [9].
(3) Cook and Hoas also underscore the "need to identify the system-level interventions that facilitate a sense of institutional support for ethical behavior" [10]. They seem to believe the most effective way to do this is to gently challenge the behavioral norms that encourage hierarchical, uncommunicative "traditional" interprofessional relationships.

Ethics education should be instituted in rural communities. Since "only 41 percent of nurses and 33 percent of physicians who participated in that study said previous coursework in ethics was helpful when trying to resolve the problems they encounter" [4], it seems that many rural physicians lack experience in bringing cases for consultation and may be unaware of how effective that process can be. The key is showing health care professionals the value of *applied* medical ethics. Emphasizing the importance of ethics committees and institutional efforts to foster dialogue about ethical issues may help reduce hesitancy about using such services.

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