Clinical Ethics Concerns of Rural Healthcare Providers

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Abstract

Purpose:
This project aimed to identify ethical concerns in rural hospitals and elicit ideas for establishing clinical ethics services to meet needs.

Methods:
Two-hundred-fifty-six rural physicians were sent an email requesting participation in an electronic survey. Data were managed in Microsoft excel.

Findings:
Seventy-four (29%) physicians responded; 59% have an ethics committee available to them. Of these ethics committees, 43% are available 24/7. Themes that emerged from the most recent ethical dilemmas were: end of life care (34.5%), vulnerable adults (21.8%), patient autonomy versus best interest (10.9%), limited resources rurally (9.1%), vulnerable children (7.3%), patient capacity (7.3%), genetic abnormalities of fetus/nonviability (7.3%), patient/family discord (7.3%), code status (5.5%), decision makers (5.5%), knowledge about family members/confidentiality (3.6%), and 14.5% unique responses, including professional ethics, transgender issues, cultural differences, double effect, a non-compliant patient, a racist patient, illegal substance use, and a personal moral dilemma in the delivery of care that went against the personal beliefs of the provider. Online group-learning was the preferred training method for ethics education. Thirty-eight percent would likely use a tele-ethics service if available.

Discussion:
Providers in rural health systems face unique and complex ethical dilemmas and would likely utilize remote support for complex bioethical situations.
Conclusions: Given these findings, the next step is to develop and pilot an ethics service that would include the three traditional roles for a clinical ethics service: policy development, education, and clinical ethics consultation services to address the identified need for expanded clinical ethics services.

Approximately 20% of the US population lives in non-metropolitan, rural areas; rural residents are often described as “older, poorer, and sicker,” and rural hospitals have fewer services than metropolitan hospitals.[1] In addition to higher rates of many common chronic health conditions, rural residents have higher rates of morbidity and mortality associated with rural occupations, including agriculture, forestry, fishing, and hunting.[2]

Like their rural patients, rural providers also often lack access to services to support their practices, such as clinical ethics services to assist when challenging ethical dilemmas arise in their clinical practice. There have been a number of papers published about the

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especially sensitive nature of mental health services, ethics, confidentiality, and dual relationships that are more common in rural settings.[3-10] Other uniquely rural ethical issues that have been identified previously include increased problems of confidentiality, resource allocation/access, and scope of practice.[11-14] The results of surveys published in 2000 and 2010 indicated that clinical ethics services are available at less than 40% of rural hospitals.[15-16] A rural healthcare ethics agenda was proposed in 2006; it included developing an understanding of rural healthcare ethics and proposing models for delivering ethics services in rural hospitals.[17] The COVID-19 crisis has brought renewed interest in addressing ethics needs in rural hospitals.[18]

There are no recent publications on the availability/accessibility of clinical ethics resources among rural hospitals. The goal of the current project is to identify ethics concerns of providers in rural Minnesota hospitals and to elicit ideas for establishing services to meet these needs. Once these unique concerns are identified, they will be used to determine how additional ethics training, consultation, or remote ethics services could be developed to support providers in rural locations.

Methods

The project was reviewed by the IRB at the University of Minnesota and determined not to be human subjects research. Emails were sent to 256 physicians across Minnesota and western Wisconsin in June 2019, requesting their participation in a survey created in surveymonkey.com, seeking their responses to questions about clinical ethical dilemmas and access to healthcare ethics services. These physicians are preceptors in the University of Minnesota Summer in Medicine (SIM) program, Rural Medical Scholars Program (RMSP), and/or Rural Physician Associate Program (RPAP). These programs are experiential rural clinical opportunities for first year (SIM), first/second year (RMSP), and third year (RPAP) medical students at the University of Minnesota, and many of the preceptors are graduates of the RPAP program.[19] One follow-up email reminder was sent two weeks after the initial email to encourage participation. The survey questions can be found in Table 1; questions three through six were open-ended. Responses from providers who practiced exclusively in urban areas were an exclusion criterion.

The survey responses were exported from Survey Monkey into a Microsoft Excel file where coding of the qualitative was completed. Rural was defined as the hospital being located in a city of 50,000 or fewer people. Qualitative analyses were performed by grouping responses into similar themes. All data were stored in password-protected files. The surveys were completed anonymously, only clinic/hospital name was collected as a potential identifier. The response categories were not mutually exclusive. The following response categories were combined into one 'likely to use in some capacity' category: utilizing service in rare/unique situations, likely to use service, and very likely to use the service. The 'unlikely' and 'very unlikely' responses were combined into an 'unlikely' category.

Physician age, preferred training method, and the last ethical dilemma the physicians had experienced were analyzed by individual physician response, regardless of how many health care systems they worked for; e.g., denominators reflect the number of physicians, not the number of clinics/hospitals. Inductive thematic analysis was used to evaluate the most recent clinical ethics dilemma reported and to group into common themes. This analytic approach does not presume themes, but instead allows themes to emerge from the data. Responses were independently coded by two of the authors, and differences were resolved by consensus between the two coders. Responses could be categorized in more than one theme, i.e., were not mutually exclusive.

RESULTS

Demographics:

Seventy-four of the 256 physicians responded to the survey (29% response rate). Seventy-one unique rural hospitals/clinics around Minnesota/Wisconsin were represented. The average number of years in practice was 15.6 years, ranging from two to 47 years, median 13.5 years.

Availability of clinical ethics services:

Fifty-three (59%) of the health systems assessed had an ethics committee. Thirty-five (39%) physicians reported that an ethics committee was not available to them, and two (2%) were unsure. Of the 53 systems with an ethics committee, 23 (43%) have 24/7 access. Sixteen (30%) of these systems do not have access to their ethics committee 24/7, six (11%) reported being unsure, and eight (15%) reported ad hoc availability.

Recent clinical ethics dilemmas:
Fifty-five of the respondents included information about the most recent ethical dilemma they had encountered. Themes that emerged from the most recent ethical dilemmas were: end of life care (34.5%), vulnerable adults (21.8%), patient autonomy versus best interest (10.9%), limited resources rurally (9.1%), vulnerable children (7.3%), patient capacity (7.3%), genetic abnormalities of fetus/nonviability (7.3%), patient/family discord (7.3%), code status (5.5%), decision makers (5.5%), knowledge about family members/confidentiality (3.6%), and 14.5% unique responses, including professional ethics, transgender issues, cultural differences, double effect, a non-compliant patient, a racist patient, illegal substance use and a personal moral dilemma in the delivery of care that went against the personal beliefs of the provider. Illustrative comments for all themes can be found in Table 2.

End of life:
“I had a patient who was still coherent, but lost his ability to speak or swallow. He had lung cancer and recurrent pneumonia. He was hospitalized on Bipap and full code. He tried to indicate that he didn't want further intervention, but it was very difficult to communicate with him. His family was torn with what to do. Ultimately, he improved enough to get off the Bipap and we were able to communicate enough to change his code status, but we were nearly in an ethical dilemma as to whether or not to continue futile care.”
“The last real ethical dilemma was a patient with mental health issues that had cardiac arrest at home and was found down and brought to the ER. The patient did not have an advanced directive and no known next of kin. We did revive her, but with the knowledge that her outcome likely would be poor”.
“Somali end of life transition. Patient brain dead, fully vented, multisystem organ failure and 3 pressors to sustain pressure, continuous dialysis and family would not consider comfort care. Additional futile services in place for 5 days.”

Vulnerable adult:
“Placing a vulnerable adult report and forcing staff at SNF to take over medication administration.”
“A parent of an adult handicapped male who was encouraged to consider "not treating" his pneumonia because it was stressful for the family when he got sick. Parent transferred hospitals due to fear of euthanasia.”

Patient autonomy versus best interest:
“One that I still battle is elderly with cognitive deficits. They live alone and have no one else and I start to worry about memory for driving and living, but they don’t want to move.”
“A patient who had three prior C-sections (some emergent) wanted to have a home birth locally, and we had to be prepared as a medical community to encourage her toward safe delivery (not at home) (at a bigger hospital).”

Limited resources rurally:
“The last clinical ethical situation I remember is a case where the family wanted the patient sent to an urban hospital for further evaluation while the patient just wanted to stay in our rural critical access hospital. The family won out and the patient ended up going to the urban center where the patient died. I'm not sure if there are clinical ethics services which would have been of help.”
“Pt needing services, declines due to distance and cost of getting services”.
“How to deal with a problem patient in a facility that is sole community provider”.

Vulnerable child:
“I had a pediatric patient who was a victim of Munchausen by proxy. Later his family asked to have this diagnosis stricken from his record because they believe it to be false. They want to blame the situation on mother's diagnosis of post-partum depression, but it was no question a case of Munchausen. I do not feel it is right to take that off his record. The outcome is still undecided.”

Genetic abnormality of fetus and non-viability: "Patient requested an induction of 24 wk fetus that had fatal fetal malformations, in order to potentially have time with him before dying in utero."

Possibility for tele-ethics to meet the needs of rural providers

Responses were received from providers at 83 systems for the question of whether they would use a tele-ethics service if one were available. Seventeen (21%) reported they would use this service on rare or unique cases, ten (12%) reported they are very likely to utilize this service, seven (8%) reported they are likely to use this service, twelve (15%) said they were unsure, 28 (34%) reported being unlikely to use the service, four (5%) are very unlikely to use the service, and five (6%) described their usage as dependent upon the service itself.

The answers deemed as 'service dependent' included a variety of caveats for using a tele-ethics service: not cost prohibitive for the organization, training of the bioethicist, ease of access, appropriate training in its usage, and supported if the hospital system did not prohibit the use of an outside resource. Of the 16 responses where a reason was provided for why they would not use a service, 14 (88%) stated they already had adequate resources.

Thirty-four (41%) respondents reported they would likely use this service in some capacity. Thirty-two (39%) stated they were unlikely to use this service.

Physicians in hospital systems without an ethics committee or without 24/7 access are more likely to utilize a telemedicine ethics consultation service. Thirty-seven of the respondents who had an ethics committee available to them stated that they were likely or unlikely to utilize a tele-ethics service. Physicians from 22 (60.5%) systems with an ethics committee reported they were unlikely to utilize this service. Fifteen (40.5%) physicians with access to an ethics committee reported they were likely to use this service. Nineteen of the 29 respondents without an ethics committee (65.5%) stated they were likely to use this service.

Physicians at 18 systems reported having 24/7 access and being likely or unlikely to use the service; 15 of them (83%) were unlikely to use a tele-ethics service. Of the 15 physicians who had ethics service available, but lacked 24/7 access to their ethics committees, 11 (73%) stated they were likely to use a tele-ethics service. Providers at 12 health systems reported being unsure if they had ethics committees available to them, and five reported being unaware of their availability. At the 44 systems without 24/7 access, 30 physicians (68%).

DISCUSSION

Slightly more than half of physicians in this rural Minnesota sample reported having an ethics committee available to them, but less than half of those services were available 24/7. This is similar to what was reported previously in 2000 and 2010.[16-17]

There is a potential market for using a tele-ethics consult service for: 1) systems without an ethics committee, 2) systems with an ethics committee, but lacking 24/7 access, and 3) a specialist service for systems facing complex situations requiring a trained academic bioethicist. Tele-ethics services have been shown previously to be successful, especially through video platforms.[20] The service could include the three traditional roles for a clinical ethics service: policy development, education, and clinical ethics consultation services.

The themes of recent ethical dilemmas encountered by the rural providers in the present study were similar to what has been reported in other studies of ethical dilemmas encountered by rural providers,[3-14] many of which are also seen in urban settings. Unique to the rural setting is the scarcity of resources for patients. The reported fear of euthanasia if transferred to another hospital was unexpected and is a potential area for further research. Minnesota is not a state that currently has legislation to allow medical aid in dying.

CONCLUSIONS

We identified a need for clinical ethics support in rural Minnesota. The next step will be to develop and pilot an ethics service to support our rural clinical teaching partners. A tele-ethics service is the most practical.

Issues of privacy and confidentiality have been worked out for emergency access provisions for COVID-19. Case studies involving ethical situations with resolutions delivered online by a trained bioethicist could be an appropriate educational method to meet the needs of rural providers. Project ECHO provides a model for this case-based education.[21] Offering continuing medical education credit could enhance interest and attendance at these sessions. There is also the possibility of enlisting experienced rural providers to teach medical students on rural clinical rotations, a model that has been shown to be effective in rural Australia.[22]
In conclusion, these data provide compelling evidence to take the next step to meet the identified need for expanded clinical ethics services in rural Minnesota.

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Table 1. Survey questions

1. What facility(ies) (clinic and/or hospital) do you work at?
2. How many years have you been in practice?
3. Are there clinical ethics services available at your facility? If so, are they available 24/7?
4. Describe the last clinical ethical dilemma you encountered as a rural physician. What was the outcome? What resources could have aided you throughout this experience? Please do not include any identifying patient information.
5. If we were to develop educational opportunities for rural providers related to clinical ethics, how would you want to participate?
6. We are considering the possibility of developing a remote clinical ethics service that could be accessed via secure audio and/or video hook-up. How likely are you to use such a service if it was available to you? Do you have suggestions for us to consider?

Table 2. Illustrative quotes from recent clinical ethics dilemmas experienced by rural physicians

Theme	**Illustrative Quotes**
End of Life	"I had a patient who was still coherent, but lost his ability to speak or swallow. He had lung cancer and recurrent pneumonia. He was hospitalized on Bipap and full code. He tried to indicate that he didn't want further intervention, but it was very difficult to communicate with him. His family was torn with what to do. Ultimately, he improved enough to get off the Bipap and we were able to communicate enough to change his code status, but we were nearly in an ethical dilemma as to whether or not to continue futile care." "The last real ethical dilemma was a patient with mental health issues that had cardiac arrest at home and was found down and brought to the ER. The patient did not have an advanced directive and no known next of kin. We did revive her, but with the knowledge that her outcome likely would be poor". "Somali end of life transition. Patient brain dead, fully vented, multisystem organ failure and 3 pressors to sustain pressure, continuous dialysis and family would not consider comfort care. Additional futile services in place for 5 days."
Vulnerable adult	"Placing a vulnerable adult report and forcing staff at SNF to take over medication administration." "A parent of an adult handicapped male who was encouraged to consider "not treating" his pneumonia because it was stressful for the family when he got sick. Parent transferred hospitals due to fear of euthanasia."
Patient autonomy vs best interest	"One that I still battle is elderly with cognitive deficits. They live alone and have no one else and I start to worry about memory for driving and living, but they don't want to move." "A patient who had three prior C-sections (some emergent) wanted to have a home birth locally, and we had to be prepared as a medical community to encourage her toward safe delivery (not at home) (at a bigger hospital)." "Patient wants to turn off her defibrillator when she is 95 but otherwise healthy."
Limited resources rurally	"The last clinical ethical situation I remember is a case where the family wanted the patient sent to an urban hospital for further evaluation while the patient just wanted to stay in our rural critical access hospital. The family won out and the patient ended up going to the urban center where the patient died. I'm not sure if there are clinical ethics services which would have been of help." "Pt needing services, declines due to distance and cost of getting services". "How to deal with a problem patient in a facility that is sole community provider".

Theme	Illustrative Quotes
Vulnerable child	"I had a pediatric patient who was a victim of Munchausen by proxy. Later his family asked to have this diagnosis stricken from his record because they believe it to be false. They want to blame the situation on mother's diagnosis of post-partum depression, but it was no question a case of Munchausen. I do not feel it is right to take that off his record. The outcome is still undecided."
Patient capacity	"Did patient have capacity to fill out POLST"
Genetic abnormalities of fetus and non-viability	"Patient requested an induction of 24 wk fetus that had fatal fetal malformations, in order to potentially have time with him before dying in utero."
Patient/family discord	"The last clinical ethical situation I remember is a case where the family wanted the patient sent to an urban hospital for further evaluation while the patient just wanted to stay in our rural critical access hospital. The family won out and the patient ended up going to the urban center where the patient died. I'm not sure if there are cues which would have been of help."
Code status	"Determining "CODE" status on a patient with memory impairment based on conflicting prior records." "I had a patient who was still coherent but lost his ability to speak or swallow. He had lung cancer and recurrent pneumonia. He was hospitalized on Bipap and full code. He tried to indicate that he didn't want further intervention, but it was very difficult to communicate with him. His family was torn with what to do. Ultimately, he improved enough to get off the Bipap and we were able to communicate enough to change his code status."
Decision maker	"The most common ethical decisions revolve around end of life care and who is the decision maker when a patient is unable to make their own choices"
Knowledge about family member/confidentiality	"A parent contacted me about her 25 yr old son who is an alcoholic and she shared a lot of information about his current drinking and recent DUI but didn't want me to say anything to him because she didn't want him to know she had said anything to me about him. I met with him the following day and had to ask very directed questions that did lead him to share a lot of information with me without divulging the info him mother gave me."