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Rural and Remote Communities: Unique Ethical Issues in the COVID-19 Pandemic

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SUMMARY

We expand on the article “Ethical Challenges Arising in the COVID-19 Pandemic: An Overview from the Association of Bioethics Program Directors (ABPD) Task Force” to consider the ways in which rural and remote communities pose unique ethical questions in the current COVID-19 pandemic.

KEY ISSUES

Rural communities have poorer populations as compared to urban and suburban areas (Symens and Trevelyan 2019) and they have more underlying medical conditions and are more likely to die from chronic respiratory illnesses, heart disease, and other problems that put people more at risk for COVID-19 (Associated Press 2020). Because of these health vulnerabilities, US insurance providers such as Medicare and Medicaid play an outsized role in connecting individuals to testing and treatment for COVID-19 (Artiga et al. 2020). Unfortunately, most rural states tend to be those where the expansion of Medicare was most resisted (KFF 2020). In Canada, historical mistrust of government has similarly created barriers to health care.

Rural and remote communities are also home to many marginalized populations who lack integration into sources of societal power such as money and expert knowledge. Examples of these marginalized communities include Amish, (Staff 2020) immigrant refugees, Native American tribes (Sepkowitz 2020), and Indigenous people living in rural and remote communities in Canada’s north (Indigenous Services

Canada 2020). Telemedicine may be helpful but many rural communities do not have access to computers and other technologies that allow for telemedicine, including phone use that may not be utilized among Old Order Amish (Kornegay 2020).

Mental illness poses a significant challenge to rural healthcare. Rural communities experience unique problems in these patient populations, such as overlapping and conflicting patient-provider relationships and altered therapeutic boundaries that challenge the preservation of patient privacy. Increases in domestic violence and other crimes, and exacerbated risk of addiction and suicide seems inevitable as people are being forced to shelter at home where few resources may exist (Snuggs 2020).

Fewer health care professionals and hospital beds per capita mean that residents of rural communities have few sources of healthcare and rely on the ethical behavior of their providers with little recourse. Fewer resources in rural areas mean a risk of hospital closure, and potentially a lack of adequate care. In Washington, 13 rural hospitals have less than 45 days of cash on hand, according to a letter (WSHA 2020) from the state hospital association to Washington Governor Jay Inslee. Rural hospitals in Texas that have survived so far do not have funding to prepare for COVID-19 (Walters 2020).

Rural healthcare systems view ethics committees as primarily educational and commonly underutilize this resource (Shih and Goldman 2011). Rural physicians and nurses are often unfamiliar with bioethics analysis and instead turn to spouses, peers, the Ten Commandments, or the Medicine Wheel for ethical

guidance. Oftentimes, nurses see a questioning of ethical issues as a challenge to the hierarchy of rural medicine and fear often retaliation (Cook and Hoas 2008). In conditions of scarcity, bioethics can be seen as unnecessary in conditions where unequal distribution of the healthcare workforce is the true illness producing these symptoms (Morley and Beatty 2008). Not only do rural systems/hospitals lack or underutilize their ethics committees, but the lack of timely and appropriate ethical guidance or expertise is compounded during a pandemic as smaller systems are at greater risk of using all of their resources faster, without the financial or political means of larger institutions.

KEY QUESTIONS

How can bioethics engage and support rural healthcare during the COVID pandemic? To answer this question we note that Jonsen has described bioethics as “a systematic study necessarily is carried out by *scholars* dedicated to thinking, writing, and teaching about a subject” (Jonsen 1998). Here, it is important to recognize the paradoxical role of bioethicists as “other” to the clinical care team. It is through that very other-ness that we can offer questions that may otherwise not be asked, and suggest helpful frameworks that may otherwise be overlooked in the rush of pandemic care.

Second, how can policies and procedures being shared by urban and suburban institutions be adapted to use in rural and remote healthcare settings? Each rural and remote healthcare system is unique. Misinformation or simply the public fear of being identified as a person having COVID-19 is of critical concern in rural communities, and especially among undocumented persons. Because each community is best known by local healthcare systems, this is a question that must be asked by each institution, with bioethicists, leadership, and clinical care members as a team.

Third, how can rural healthcare institutions strengthen their ethical commitments to quality patient care during the pandemic while respecting traditional beliefs? Policies and processes used by larger institutions during a pandemic can be shared across institutions, but often the smaller rural clinical sites and agencies that are treating the most vulnerable of populations who are not well-informed, typically do not have a presence during deliberations about best practices and “shared” policies, and the socio-cultural aspects of rural populations are often ignored in which communication is limited. Institutions may

avail themselves of many recommendations, but these must be implemented locally in every case.

AREAS OF CONSENSUS

Rural health systems are an indispensable part of our obligation to care for all persons during the current pandemic and beyond. The answer to this question is particularly vexing in systems where scholars are not seen as offering pragmatic solutions to on the ground problems. Italy has answered this call by embedding ethics into the clinical care even during the COVID-19 pandemic, defining the role of the bioethicist as “*a figure able to promote dialogue*” (Nicoli and Gasparetto 2020).

Rural communities have unique socio-economic qualities that require an adaptive response from the clinical team. Bioethics is an essential element to equip healthcare providers and other decision-makers with the tools they need during this pandemic (Cohen et al. 2020; Warren 2020). It is essential for leadership in rural academic and clinical centers to provide accurate, clear information that could be immediately translated appropriately and delivered in ways that best meet the needs of that population.

It is important to have patient advocates, persons within communities who can translate, and experts at the table when there are discussions about innovative uses of technology, triaging efforts, policy development/implementation, and to be sure to connect with community leaders (e.g., elders, leaders of a refugee community) to address some of the fears, baseline knowledge, and best practices for communication.

AREAS OF DISAGREEMENT

In the USA where healthcare is privatized, should Medicare/Medicaid be expanded to help those rural areas where the population is vulnerable or marginalized? While many say yes, in the case of the *National Federation of Independent Business v Sebelius* (2012) seven justices declared the mandatory Medicaid eligibility expansion unconstitutional. States are left to decide whether to expand Medicaid to their residents, and 14 states have declined to adopt (KFF 2020). Rural populations may differ vastly due to the differences between states that have adopted and those that have not.

What are the best ways to support rural healthcare systems financially during normal times and during a crisis such as the current pandemic? Is it enough to provide direct funding from the just enacted stimulus

bill? The 2020 CARES Act (116th Congress 2020) appropriates \$1.32 billion, for the purposes of detecting, preventing, diagnosing, and treating COVID-19. Not everyone is convinced the bill provides enough relief.

Rural healthcare must overcome misinformation and fear among rural residents. Reliance on larger clinical and academic institutions can be both valuable and ethically challenging. While policies and processes during a pandemic can be shared across institutions, often the smaller rural clinical sites and agencies that are treating the most vulnerable of populations are not well-informed, typically do not have a collaborative presence during deliberations about best practices and shared policies, and the socio-cultural aspects of rural populations are often ignored.

POLICY AND PRACTICE STRATEGIES AND IMPLICATIONS

1. **Support close relationships and understanding through transparent and frequent communication.** Because of the lack of broad community knowledge and understanding of COVID-19 specific practices, there may be a misunderstanding of why these policies are in place to separate families and others from infected patients. Academic medical centers need to have clear communication policies and structures in place to assure timely access to information in a format that is understandable to the populations served.
2. **Identify gaps/lack of clarity in policies and procedures that are being shared from urban/sub-urban institutions, and create applicable policies, guidelines, and resources that consider the rural populations' sociocultural aspects.** The use of virtue ethics as a framework for the development of policies for close-knit rural healthcare may be an effective use of ethical understanding applied in a pragmatic manner.
3. **Ensure that rural healthcare systems identify the ethical responsibilities of the institution, focusing on the core domains of the healthcare system's mission.** The overall ethics environment should facilitate and support ethical practices and support from the highest levels to equalize the power differential between physicians and others on the healthcare team (Morley and Beatty 2008; Vernillo 2008). Affirmative efforts must be taken to overcome these barriers and promote a climate of open communication without fear of retaliation or exclusion.
4. **Facilitate the means for rural systems to utilize the work done by other groups to promote shared decision making with patients and providers.** These can be utilizing decision aids and educational materials (Vernillo 2008), and integrate principles of distributive justice with the pragmatic considerations of rural practice and virtue ethics attentive to the multiple relationships and perspective of rural communities (Klugman 2008).

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Preserving the Reproductive Rights of Girls and Women in the Era of COVID-19: The Need for a Least Restrictive Solution

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INTRODUCTION

Fairchild and colleagues assert that while “equal” on the surface, the rapidly implemented, society-wide public health restrictions enacted in response to the COVID-19 pandemic veil harsh inequities (Fairchild et al. 2020). These inequities are particularly apparent in the deep erosion of sexual and reproductive health rights for women and girls.

The Human Right to Reproductive Health

Human rights are fundamental, and affirm the dignity and worth of all human beings. Everyone is entitled to these rights, without discrimination, and these rights must be universally protected. All individuals

have a basic human right to the highest attainable health, including sexual and reproductive health (UN Committee on the Elimination of Discrimination against Women (CEDAW) 1979). For women and girls, this includes the rights to choose a partner, control their fertility, and birth safely, and the access to the necessary information and tools to do so without coercion (UN Committee on the Elimination of Discrimination against Women (CEDAW) 1979). States have an obligation to provide for these rights, especially in times when these rights are at risk. Rights to sexual and reproductive health extend to minor adolescents, and include the rights to access sexual and reproductive health information and services, to determine and consent to one's own care, and to have that care provided in a confidential

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