

Virtual Mentor

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CLINICAL CASE

Patient Privacy and Mental Health Care in the Rural Setting

Commentary by Tom Townsend, MD

Mary was a 42-year-old mother of four children in a small town in rural Wisconsin. On this particular afternoon, she had come to see Dr. Wilson because she had been feeling tired and “out of sorts.” Dr. Wilson knew that her father had recently passed away and was aware that Mary had struggled with depression in the past. He asked his medical assistant to give her a brief questionnaire to screen for depression, performed a quick examination, and discussed Mary’s health concerns with her in order to rule out an underlying physical cause. After seeing the results of the questionnaire and talking with Mary, there was no doubt in his mind that she was suffering from depression.

“Listen, Mary,” Dr. Wilson said gently. “I know you’ve been having a hard time lately. There’s been a lot going on in your life, and it’s natural to have some difficulty with that. It might be time to address your depression.”

Mary nodded. “I know,” she said tearfully. “I feel like things are getting out of control. I just want to feel like myself again.”

Dr. Wilson paused. He didn’t want to prescribe antidepressants to Mary without concurrent cognitive therapy.

“The mental health clinic over in Lakeview has a psychiatrist in whom I have great confidence,” Dr. Wilson said. “This is her area of expertise, and the clinic also offers counseling services. It might be helpful to have somebody to talk to about everything that’s happened recently. How would you feel about that?”

Mary drew back. “No,” she said vehemently. “Absolutely not. Look, I work at the elementary school! I play organ for the church every Sunday. Everyone knows my car, and if they see it at the mental health clinic, they’ll know it’s me. I don’t want people to think I’m crazy. No one will want to trust me with their kids if they think I’m a nutcase! I don’t see why I should go somewhere like that when you could just treat me here.”

Commentary

Country doctors “do,” or see and treat, many psychiatric problems, both in terms of the number of patients and the variety of diagnoses. Primary care physicians, not mental health professionals, treat the majority of patients with symptoms of depression; in fact, it is the second most common chronic disorder they see—on

average, 12 percent of their patients have major depression [1]. In rural areas, physicians are in short supply, patients live far from health care delivery sites, and populations tend to be older, sicker, and poorer than their nonrural counterparts [2, 3].

Rural physicians fill many roles in their communities and are expected to counsel patients not only competently, but with the awareness and sensitivity that respects neighbors and their acknowledged familiarity in a small community. Rural people typically know a lot about each other. Dr. Wilson, in this case, faces several representative clinical and ethical challenges of caring for a patient with a psychiatric ailment.

Roberts and Dyer identify several concerns central to “small community” ethics: (1) overlapping relationships, conflicting roles, and altered therapeutic boundaries; (2) confidentiality concerns; (3) cultural dimensions of care; (4) limited access to clinical care, mental health care, and ethics resources; and (5) the special stresses of small-community clinicians, which are discussed below [4]. Each of these factors speaks to the particularities of delivering ethical care in the rural setting.

Overlapping, or multiple, relationships foster familiarity between doctor and patient and raise a concern about boundary conflicts. We see the result of familiarity in Dr. Wilson’s early suspicion and detection, through his brief questioning and then the questionnaire, of Mary’s clinical depression. He suspects her depression because of his knowledge of her personal life. While Mary seems to resist or initially deny the diagnosis, she realizes the special significance of their relationship. It seems that she is requesting, or perhaps demanding, that Dr. Wilson simply treat her, to keep her from having to go to Lakeview.

Professional relationships between country doctors and their patients represent to some of us an idealized long-term relationship that involves friendship and warmth as well as professional responsibility. An ethical relationship with strangers, typical of relations of the city, is different from the ethics of intimate relationships in rural communities, and this distinction is key to many differences between urban and rural health care ethics. There are fewer people in rural America, and relationships are often more intense [5]. In addition to being competent counselors, rural physicians are expected to act with the awareness and sensitivity to take into account their acknowledged familiarity in a small community.

Mary’s previous bouts of depression presumably resolved. This can offer reassurance and be incorporated into the country doctor’s frequently used and vital tool—the reassurance of having known someone for a long time and being able to truthfully offer the supportive observation like, “Well, I’ve seen you come through worse times than this.” It is the strength of the familiar relation over time that allows such observations to be utilized—when true.

There may not be a clear line between what is learned in the grocery store or at a place of worship or at a ball game and what is expressly reserved for the exam room. Familiarity is quite normal and unavoidable in rural life and could actually create clinical and ethical benefits for Dr. Wilson and Mary. Their relationship is different than if they were to only see each other in the professional realm—the doctor knows not only of the pharmacologic successes and disappointments during previous bouts of depression, but also where she got the major family or social support she relied on in stressful times.

Maintaining confidentiality in rural communities is sometimes not merely challenging, but actually impossible, as Mary has pointed out: everyone recognizes her car and will know that she's at the mental health clinic. As peculiar as this may seem to some urban audiences, this particular aspect of multiple relationships in small communities can serve as an ordinary, but significant, form of networking. Some rural populations maintain a culturally important belief that sharing information between neighbors is usually beneficial and customarily outweighs any potential harmful outcomes [6]. This sharing of "small" knowledge of others' comings and goings is critical to understanding the difference between rural and urban ethical concerns and outcomes.

Experiences in rural practices often confirm these benefits, and neighbors seldom find it awkward to suggest that sharing of health-related information can be beneficial to patient care. The downside of having so much outside-the-clinic information is that country doctors, just like anyone else, can make inaccurate assumptions and misunderstand what is worrying a patient. Some of my most distressing mistakes with patients have been related to a seemingly innocuous reassurance—"Oh, that's nothing to worry about"—when in fact their concern is of the highest importance [7].

Because of persistent American cultural attitudes, Mary is right that risking public knowledge of a mental illness diagnosis may lead to her being stigmatized, particularly if her community equates mental illness with instability or violence or doesn't make distinctions between different diagnoses. Being seen as an incapacitated or absent member of her community may result in Mary's and perhaps her family's being isolated or stigmatized. In more populous, and therefore more anonymous, settings, this risk may be less pronounced—mental health care may be easier to seek discreetly.

Mary may also be reluctant to utilize precious mental health resources more appropriate for others—maybe those more financially challenged, but also those more psychiatrically or psychologically challenged. This particular cultural issue is very important for rural communities, whose residents may harbor both the belief that using more than their "fair share" of resources is wasting them and also a competing belief that it is their responsibility to keep a local practice afloat by using a local doctor or hospital even when their interests would best be served by transfer to a larger facility [8, 9].

It would be ideal to house mental health and clinical services in the same clinic so that access could be ensured, stigma reduced, and consultation between the family doctor and mental health specialists encouraged. Telepsychiatry is another possible alternative. The technology is now more widely available and affordable to rural practitioners, and it has found a niche in many states where it is often paid for through state-funded health coverage for the poor.

Roberts and Dyer also mention the stress of the rural clinician. Is physician stress the reason Dr. Wilson suggests Mary see a psychiatrist, rather than taking on her care himself? He must understand how significantly stigma can distress a patient, particularly one already struggling emotionally. Not only should Dr. Wilson recognize the stigmatization, perhaps he should realize the inadvisability of taking the referral route any further. And clinicians who understand this important tenet of rural practice can go on to help diminish the stigma of mental illness by working at the community level to increase awareness and perhaps identify resources for further help.

Maybe Dr. Wilson believes he won't be able to treat Mary as effectively as the psychiatrist in Lakeview could. But I think that a perceptive country doctor with a close relationship to the patient would offer not just adequate care, but probably the best care to someone like Mary. Experience with the community, its culture, and its health care system can contribute to excellent psychiatric treatment. A specialist would be able to offer Mary pharmacologic agents and psychiatric resources, but he or she would not have the relationship or commonalities with Mary that Dr. Wilson has.

David Loxterkamp, practicing family medicine in Maine, once reported on a hectic day in his clinic during which a number of people came to see him for a variety of nonclinical ailments. After one beleaguered woman had talked to him about her unhappy childhood, he asked her why she had come in that day, with no particular clinical complaint. She replied that the priest was out of town and she felt that "somebody needed to know" the story she'd told him. The general practitioner can offer understanding and a simple act of kindness; Loxterkamp reminds us that patients will put their trust in those who shoulder the suffering and uncertainty of illness, the grief of painful life events [10]. His tale is a common one in rural practice and suggests possible clinical outcomes influenced by this relationship that may beneficially overlap some boundaries. Dr. Wilson's management of Mary's case should remind us of that.

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Further Reading

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