



“Treating a Case of Rural Neglect”

By Derek Lin

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Derek Lin

Dr. Nancy Martin

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Treating a Case of Rural Neglect

One of the most prevailing issues in the contemporary United States is the question of health care coverage, yet many ignore or are unaware of the a separate crisis of rural health care. While Democratic presidential candidates tussle over health insurance and coverage in their primary debates¹, not a word is spoken about the current challenges rural regions face in not just affordability but also access and quality of medicine in these regions. It is generally accepted that the quality of health care in these areas is extremely poor. The CDC, among others, notes “rural Americans are more likely to die from heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke than their urban counterparts” (Center for Disease Control [CDC], 2019). More controversial is why this is the case. And was there anything that could have reasonably been done to alleviate the rural person’s plight? Factors such as poor terrain, infrastructure, and distance certainly play a part. However, it is much more difficult to quantify the impact of lack of patient-specialist trust, political underrepresentation, and social prejudice upon the health care of these communities. This paper will seek to evaluate the different factors involved in creating the American rural health care crisis, and attempt to gauge the extent to which political neglect stemming from societal issues contributed to the problem. Examining prior research and case studies such as Helen Ouyang’s article on health care efforts in the

¹ Washington Examiner Staff, 2019; The Fix Team, September 2019; Fix Staff, July 31, 2019; Fix Staff, July 30 2019; CQ-Roll Call, Inc, June 28 2019, CQ-Roll Call, Inc; July 26 2019

southern “black belt” and Alhaf & Goleman’s work on health care in Alaska shed light onto the different challenges communities face. Alaska and Alabama are not just physically distant, but in some ways socially-politically so. But in rural health care they are often united, including in having substantial populations of historically disregarded social groups. Looking forward, new ideas, policies and technologies have emerged, but they are not without their own limitations - which is further complicated by the role of American democracy and its reliance on political goodwill and concern. A brief examination indicates that many of these problems have long plagued the rural community. It soon becomes apparent that while natural conditions such as terrain and climate are significant, the primary cause of the rural health care crisis is an underlying neglect by the rest of society. And not only that, there is no end in sight for this political neglect that plagues the rural community.

Section I: Identifying the Problem

If there is one thing that literature on rural health care agree upon, it’s that the state of health care in rural regions is quite poor. Even examining the abstracts of many papers on rural gives a rather negative general impression. About a decade ago, in 2011, Doorenbos et al opened their paper on Telehealth with a relatively tame “healthcare providers serving rural populations face numerous barriers to accessing educational programing...providing comprehensive healthcare in the rural setting is challenging”. More recently, in 2017 Greenwood-Ericksen et al opened their paper proposing the expansion of emergency medical care in rural areas with a correspondingly more dramatic

The health of rural America is failing and our traditional approaches have proved ineffective at improving health in rural communities. Rural populations are now a health disparity population, facing higher mortality rates for the 5 leading causes of death compared with their urban counterparts. (Greenwood-Ericksen et. al, 2017)

The federal government’s Center for Disease Control and Prevention (CDC), for their part, quickly acknowledge the issue in their rural health care webpage, calmly stating “rural Americans face numerous health disparities compared with their urban counterparts... [there exists a] significant gap in health between rural and urban Americans” in their introduction to the issue. As mentioned previously, there are a few reasons why this is the case, most notably infrastructure-terrain, hospital short-staffing, economic difficulty, social tensions, and government efforts (or perhaps lack thereof) that factor into the equation. Further complicating the situation is the possibility that these factors may overlap, making identifying causes difficult. It also confounds focused, mono-faceted solutions.

Physical problems such as poor infrastructure-terrain, short-staffing, and poor institutional quality are much easier to quantify. Infrastructure and terrain are related concepts, describing roads and other concerns that may hinder efforts to transport patients to medical centers. Staffing shortages are another issue, as attracting physicians (not to mention quality physicians) and other medical staff proves difficult in many regions. An older paper by Rosenblatt & Hartt in 2000 notes that “The relative shortage of physicians in rural areas of the United States is one of the few constants in any description of the US medical care system”. Almost two decades later, this trend has not changed very much, in fact the United States in general is expected to experience a physician shortage of up to 122,000 doctors according to the non-profit Association of American Medical Colleges (Heiser, 2019). In terms of quality, rural hospitals performed worse than urban hospitals in three Medicare quality scores², often even

² Preventable hospitalizations, HbA1c monitoring, and mammography screening

after adjustment for sociodemographic and environmental characteristics such as ethnicity, poverty, and adult drinking/drug use (Henning-Smith, 2017).

Another set of problems cited by those examining the reasons for poor health care in rural America are those involving societal issues such as economic challenges and social barriers. Economic difficulties reflect monetary barriers to receiving health care; patients cannot afford or feel as if they cannot afford the price of health care. Rural areas are often poor, with the Department of Agriculture noting that the Census found “higher incidence of nonmetro poverty relative to metro poverty has existed since the 1960s when poverty rates were first officially recorded” (US Department of Agriculture [USDA], 2019). This may block prospective patients from seeking health care, fearing further poverty and debt from potentially expensive operations. The National Public Radio, a nonprofit established by Congress in the 1970s, reported that 26% of rural residents responded to a survey (n=1405) with the answer “Yes, needed health care but did not get it”, and of those 26% close to half (45%) stated their reasoning as “Could not afford health care” (Siegler, 2019). Thus, for many money is a major concern in healthcare, and these economic factors may hamper efforts to improve rural healthcare systems.

Meanwhile, America is not free of social tensions, with lingering issues of racial injustice that often corresponds with economic plight. Indeed, the medical community is hardly guiltless in mistreating black populations - the Tuskegee syphilis experiment for example resulted in a 1997 apology by President Bill Clinton “for the loss, for the years of hurt... that [the] federal government orchestrated a study so clearly racist.” (Office of the Press Secretary [OPS], 1997). The Tuskegee Study of Untreated Syphilis in the Negro Male had researchers based in Tuskegee Alabama failing to obtain informed consent, knowingly failing to adequately treat patients for the

disease, and refusal even after the discovery of effective treatment to inform or offer patients an effective drug (penicillin). It was finally stopped after four decades and a very public scandal (CDC, 2015). Abuse by the medical community against marginalized groups can diminish trust between patient and medical provider. The Tuskegee study was an egregious example of abuse of power by the federal government and the medical community, and one of the more famous ones. However even if an individual does not know of the Tuskegee experiment in particular, a general mistrust of the medical community may linger on, a product of multiple and longstanding failures, real and perceived, to build bridges between the medical and minority communities. A paper published in 2000 by LaVeist et al, close to Clinton's apology, found that blacks and whites had very different views on the medical system. These was shown in responses for "[did the doctors do a good job] treating you with dignity and respect?" (65.6% vs 77.7%³), "Doctors treat African American and white people the same" (67.5% vs 86.8%), and perhaps tellingly "Hospitals have sometimes done harmful experiments on patients without their knowledge" (50.6% vs 26.0%⁴). A later study by Armstrong et al in 2007 found that blacks and hispanics have a much higher rate of physician distrust (Armstrong et al, 2007) across the nation.

Of course, these societal factors often overlap. A 2017 study found that "compared with rural non-Hispanic whites, rural racial/ethnic minorities tended to be younger, to have less income, and to have lower levels of educational attainment" while also having a lower rate of health care coverage (James et al, 2017). Poverty and racial issues often go hand in hand, and in rural regions both stifle efforts to combat low quality of healthcare.

³ Reporting Good or Excellent Care

⁴ Reporting Agree or Strongly Agree

Section II: Case Studies

So how do these factors interact with one another in the “real world”? The complex interplay of various facets comprising of the problem becomes more evident and boundaries less distinct when examining case studies from around the country. In their paper Rural Bioethics: The Alaska Context, Fritz Allhoff and Luke Golemon attempt to examine the situation in rural Alaska. A central theme of the paper is that, though there is a considerable amount of obstacles, more can still be done to help the people living in rural, isolated areas in Alaska. Taking a relatively straightforward, academic approach the paper is able to highlight the combination of many elements that cause health care challenges in Alaska. About halfway through, the authors make an interesting observation:

The main driver of these problems is largely environmental. The massive size and kind of terrain found in much of Alaska and the small population size combine to form an infrastructural nightmare. This is complicated by the fact that many of those affected belong to indigenous peoples, who are historically ignored and oppressed by the very institution purporting to discharge governmental obligations. (Allhoff & Golemon, 2019)

This highlights the dual nature of issues facing many rural communities— physical problems such as environment and infrastructure often go hand in hand with political will to resolve them. In the case of Alaska, many of the isolated communities are minority Alaskan natives who do not have the political clout needed to secure significant change in their treatment on their own. Furthermore, they lack the economic strength to secure adequate health care for their local communities. Many Alaskan communities are built around “hub communities”, that is a small population center and smaller settlements radiating out from these hubs. These areas are where most institutions are concentrated, efforts have been made to attempt to staff these areas with

medical professionals, with limited successes. However, further efforts to address local problems run afoul difficult politics, including conflicts with the national issues. Allhoff & Golemon cite the story of King Cove in the Aleutian islands. A road in King Cove would have had to run through a federal wildlife preserve, and so efforts to build a 25-30 mile road as an alternative to indirect flights to Anchorage “triggers broader issues in federalism: many Alaskans are certainly not so happy about a federal government thousands of miles away blocking their ability to build a road that underwrites the medical needs of its communities” (Alhoof & Goleman). This battle pitted national interests against local interests, underlining how rural minorities can run victim not just to local majorities but also to the needs of a distant majority. It also highlights the interconnectivity of the issues at hand, in this case the construction of infrastructure is blocked by political wills and needs.

Another look at mechanics at play in rural communities comes from far across the nation. Writing about a very different type of rural community, Dr Helen Ouyang wrote a piece for Harper’s Magazine titled *Where Health Care Won’t Go: A Tuberculosis Crisis in the Black Belt*⁵. Set in the warm-weathered state of Alabama, thousands of miles away from the Alaskan cold, this report focused heavily on the challenges with rural minorities in attaining adequate health care. The article starts with a jarring anecdote from state health care officers attempting to fight tuberculosis via a public screening:

[health care providers] convened at the basketball court and began setting up tables and supplies. But shortly after they got started, a group of young men appeared and threw beer bottles at them, which whipped past their heads and crashed near their feet. The health workers ducked for cover. The men shouted expletives, then ran off. Barrett called the police. Soon, two sheriffs stationed their car conspicuously out front. Eventually the testing began, and the health workers kept on until the afternoon. But turnout was low, and no active cases of TB were found. (Ouyang, 2017)

⁵ The Black Belt is a region in the American South, so called because of its high density of African American populations. It is known to have generally poorer quality of care and greater health incidences.

In this case, the Alabama's health care workers have good intentions, a far cry from the malice shown decades prior in Tuskegee. However, visible social strain and a breakdown of trust have already taken their toll, impeding progress in combating a deadly and infectious disease in rural, isolated communities. In retrospect, a member of the team screening for TB noted that "the health department ran into trouble...by popping in as outsiders," failing to build sufficient bridges with the local community. What's more, "they targeted African-American people...referred to them as 'the people on the Hill,' ... It was stereotyping" that destroyed the health initiative and actually forced the government to offer monetary bribes to convince people to get screened. Unlike the Alaska context, where physical and economic problems are at the forefront and political and social problems are merely the root cause, Ouyang's paper puts socio-political factors directly in the spotlight. A recurring motif throughout the article is mistrust, the inability for most health care providers to gain access to crucial personal information due to racial and political strains. Indeed, one of the local-raised physicians interviewed noted that "the uniform testimony from rural Alabama is: 'We're tired of missionaries and mercenaries. We need our kids in medical school'", indicating that a significant factor involved in the crisis is the perception that callous outsiders - motivated by greater income or a sense of patronizing generosity rather than genuine concern - are simply unable to make headway into cautious, insular rural communities.

That is not to say however that there are not economic factors at play, or infrastructure ones - indeed the communities Ouyang visited were often quite poor and struggled to maintain sufficient hospitals. However, what is more pressing to those interviewed and to health care providers attempting to aid residents becomes a matter of the frayed relations between patients

and providers. Political issues then trump the physical ones in this case, especially since the infrastructure involved cannot be built without a social settlement between suspicious sides.

Section III: Possible Solutions

If a political resolution could be found, there is no shortage of proposed ideas to combat rural health care problems. The writers of the Alaska Context and Where Health Care Won't Go both take time to point out solutions to mitigate the crisis.

The Alaska Context discusses briefly the slow efforts to expand the powers of nonphysicians. While short, they write glowingly of efforts to increase provider autonomy:

This sort of program shows promise and should continue to be funded and expanded as new tools become available. Nurse practitioners are already allotted much more autonomy and power...[that] might be extended to physician's assistants. When the driving problem is access to healthcare, getting healthcare from some non-physician...is better than no healthcare at all (Allhoff & Goleman, 2019)

Indeed, access to health care can be a challenge. The other half of a previously cited NPR survey of individuals who reported being unable to receive health care had patients responding "Health care location was too far or difficult to get to" (23%), "Could not get an appointment during hours needed" (22%), "Could not find a doctor who would take your health insurance" (19%) (Siegler, 2019). So perhaps there is merit in expanding not just the number of physicians but also empowering and utilizing other medical professionals currently in the field. A related proposal is discussed in a 2017 by Maragret Greenwood-Ericksen, Renuka Tipirneni, and Mashid Abir called *An Emergency Medicine - Primary Care Partnership to Improve Rural Population: Expanding the Role of Emergency Medicine*. As the long title suggests, this paper advocates for further empowering Emergency Departments (EDs), noting that "although EDs, were designed to provide care for emergency conditions, they have always served as the safety

net for the uninsured and underinsured”, mirroring the populations deprived of care mentioned in the NPR survey. The paper suggests the future of rural health care is the integration of primary care and emergency departments, which often have overlapping responsibilities in rural regions, thereby reducing the number of staff needed and speeding up primary care followup (Greenwood-Ericksen et al, 2019). This sort of restructuring would thereby better use existing human resources to address the problem. But while (and perhaps because) both papers espouse economic incentives to carry out such reshuffling of division of labor, political efforts have to be made to make for meaningful changes to entrenched systems.

A heavily featured proposal in Dr. Ouyang’s article on the blackbelt is the idea of a physician pipeline from underserved communities to medical school. This is not a new idea, within the article one of Ouyang’s interviewees, Dr John Wheat, notes that he started such a pipeline over 25 years prior to the article’s publication. An associate, Dr Lee, is quoted as saying ““They think the cure-all is to open another hospital...That’s the worst thing you can do! You’ve got to get physicians first”” pointing instead to enduring problems in recruiting and retaining physicians for an extended duration of time. Monetary bribes and charity have not worked, as the “missionaries and mercenaries” end up leaving after the monetary requirements or moral satisfaction run out. By contrast

since the [pipeline] program began, about 120 pipeline students have graduated...more than half have gone on to work in rural areas, compared with only 7 percent of their classmates...the addition of a single primary care physician to a community causes the local economy to grow by at least a million dollars per year (Ouyang, 2017)

Dr. Wheat is not the only one to have sponsored a physician pipeline initiative in the last few decades. Schubert et al released a literature review research paper aptly titled *International Approaches to Rural Generalist Medicine: A Scoping Review*, to review existing research articles

from around the globe on rural generalist medicine. They found that there is a common shortage of rural general physicians. The recruitment and training of physicians for rural areas, including rural training pipelines, are being attempted both in undergraduate training and post-graduate training. But they note debate over the scope of practice, whether or not generalists should be expected to perform tasks traditionally assigned to specialists (Schubert et al, 2018), harkening back to Greenwood-Ericksen et al's proposal about entrusting more power to a more generalized integrated emergency-department and primary-care system. Proponents of this sort of policy program point out that the economic benefits of implementing this system creates more wealth than it costs in the long term. In fact, Allhoff and Goleman of the Alaska Context go so far as to say "this will be a fiscally responsible move since fixing the problems of health care shortages by recruiting one's own physicians will be much cheaper in the long run than having to hire physicians by paying them enough to offset outside physician's preference not to practice and live in Alaska" (Allhoff and Goleman, 2019). The merits of this assertion is up to debate, but again one can see that it is not solely economic shortcomings that hamper the solution but also political concerns involved with the justice of shifting monetary spending.

Many proposals discuss the emergence of a new technology - that of telehealth. The role of telehealth in rural medicine offers great possibility but it has its share of limitations, making it often cited but concrete proposals difficult. Greenwood-Ericsen et al treat it as sort of a footnote, suggesting briefly that it may be integrated into their proposed rural health care system. The Alaska context delves deeper into detail over its possible application in a rural health care setting, saying that although there is promise, there are many shortcomings that have yet to be overcome. They note that as early as 2001 New York physicians were able to conduct a surgery

on a patient thousands of miles away in France using an electronic camera and robotic tools. But aside from costs and maintenance, which are high, such a model still require on-site expertise, that is people to prepare the physical operating room. It would also require faster and more reliable telecommunication networks, an infrastructure issue prevalent in rural regions. The authors instead suggest a shift towards non-surgical applications of telehealth, as “face-to-face clinical sessions could take place over Skype - or some related platform...issue prescriptions...mental health counseling.” Another detailed application is described in Doorenbos et al’s *Enhancing Access to Cancer Education for Rural Healthcare Providers via Telehealth*. Seeking to help AI/AN⁶ people in Washington State and Alaska, health care providers created an education program on cancer, previously “almost unknown in AI/AN communities until recently” using videoconferencing. This proved greatly helpful for those whose barriers to health care information include “geographic isolation, lack of financial resources, and the cost of travel, time away from work, and coverage”, and the writers expressed hope for the potential of this system (Doorenbos et al, 2011). Again, we see a solution that while requiring an initial investment is likely to pay off in the long term financially. It also helps to mitigate other factors such as terrain and infrastructure that plague some rural communities. But the will just isn’t there, and implementation appears to be slow.

At the end of the day, the same forces that underlie the woe and difficulties in rural communities also undermine these efforts at change. Many shortcomings in these efforts are from natural causes that cannot be avoided. But as one can see, finding funding to combat health

⁶ American Indian/Alaskan Native

care conditions, whether it be a medical school pipeline, developing new technologies, or empowering nonphysicians, though it has been trickling in, is also difficult.

Section IV: Looking Back to See Forward

Is there a light at the end of the tunnel? The optimist in many would like to say yes, that all is needed is a spirited, multifaceted response. And if one draws the conclusion that political factors are the more critical ones to be addressed, then it would make sense that an organized and energetic response by the US political establishment is in order. Unfortunately, this paper is not the first to draw this conclusion - people have come to this conclusion decades ago. For the sake of brevity, this paper will use Charles W. Fluharty's *Refrain or Reality: A United States Rural Policy?* to examine pressing rural health care problems from 2002. It demonstrates the sobering reality that not much has changed, and is unlikely to change.

Fluharty's paper attempted to answer the questions of whether or not the US had a comprehensive plan to address rural issues and whether or not one was possible. The sections about rural economies actually take time to attempt to deconstruct popular misconceptions about rural regions, some of which may continue today—namely that they are universally poor and agricultural. In fact, Fluharty argues that at the turn of the milenia agricultural regions were generally improving, despite “persistent pockets of intractable rural poverty”, and cited statistics showing that only 6.3% of rural Americans live on farms and only 7.5% rural Americans worked in farming (Fluharty, 2002). But this sort of uneven development, with communities being left behind even as the economy grows, rings true today. The existence of the blackbelt in Ouyang's article, and poverty associated with it, highlights the idea that many issues have remained stagnant since 2002 for poor regions in America.

What's more, Fluharty cites the nation's federal structure as a coming challenge to rural areas, mirroring concerns presented in *the Alaska Context*. He notes that despite the fact that "2305 of our nation's 3043 counties are rural...and between 20 and 25% of our nation's population," the emerging dominance of the suburban class and the "one person, one vote" Supreme Court decisions of the 1960s left only 13 states with a rural majority and 59 electoral votes - less than California. In addition, he cites statistics indicating that from 1966 to 1996 the number of house districts with a rural majority has fallen from 42% to 15%. And this is without factoring in disparities in district wealth and indirect influence. A look at the 2010 census report number CPH-2 (regrettably, the timing of this paper means the 2020 census is not yet available) suggests that the problem of representation has only worsened; rural populations have fallen to 19.3% of the total population. This does not reflect a decline in rural population, which would suggest the problem would eventually disappear when rural areas do, but instead there was faster growth in urbanized areas (US Census Bureau, 2012). A swing in political representation to secure greater concern for rural populations was unlikely then, and unlikely now.

In fairness however, Fluharty does end his paper on a positive note. He cites the fact that various groups have formed to combat the problems in rural health care, from the Congressional Rural Caucus (CRC) and the National Rural Network (an assembly of over 80 nongovernmental organizations). He also notes that states and the federal government have established dedicated offices to attempt to combat the crisis. But these efforts, as the previous sections have shown, have not been able to eradicate the problem and many of the basal factors outlined in Section I of this essay that could be changed (economic, infrastructural, political) are the same ones Fluharty discusses years ago. So for all the tentative hope and optimism, the united and integrated front

Fluharty proposes does not appear to have materialized. Or at least change has not been as rapid as he'd like. Perhaps their efforts lacked coordination or perhaps they lacked the public will, but regardless a look back does not bode well for the future.

Conclusion:

This essay sought to examine to what extent did political neglect cause the current crisis of rural health care. It was hypothesized that political neglect is the primary cause, and further suggested that change is not likely in the future. Rural health care in the United States is generally agreed to be worse than that of urban regions and factors involved include terrain, infrastructure, economic shortfalls, short staffing, social tensions, and lack of political will to do anything about it. As case studies have indicated, while the factors at play are not easily isolated and often have complicated interactions, positive change is still possible in many cases. Rural communities aren't doomed to poor health care just because they are rural - solutions have been presented to combat the difficulties these communities face. The solutions also have to confront these challenging factors, but many present long-term fixes not only to rural health care shortages and unavailability but also to the underlying problems such as economic solvency, short staffing, and social divides. But change requires a push to do so, and that does not appear to have materialized. A brief look at the past shows that despite efforts to organize a national rural policy, many of the factors that caused the rural health care crisis in the past have not been resolved today. There certainly has been an effort, but the will behind it seems transient. At the end of the day it is the lack of political determination, a national and enduring desire, to bring the health care systems of rural America forward. This sort of political neglect therefore is the primary cause behind the crisis, and until that neglect is overcome, significant change is unlikely.

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