CHAPTER 5

Ethics Conflicts in Rural Communities: Patient-Provider Relationships

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ABSTRACT

The patient-provider relationship is privileged and complex. Those who practice in rural areas encounter additional layers of complexity due to the commonality of overlapping roles, increased patient and provider visibility, and limited sources of ethics support. The core ethical principles of beneficence, nonmaleficence, patient autonomy, and justice have unique considerations in rural areas, and are the foundation for the patient-provider relationship. Rural ethics conflicts commonly involve concerns such as privacy, confidentiality, trust, professional duties, and boundaries. These conflicts may differ in nature and frequency from those encountered in urban areas. At times, the nature of the rural patient-provider relationship may lead to more effective and rewarding interactions. At other times, the complex interpersonal dynamics may be stressful and difficult to tolerate. This chapter will explore potential ethics issues in the rural patient-provider relationship, as well as approaches and methods for resolving them. Two case studies will highlight some of the ethics conflicts and ways in which rural communities might respond. This chapter will also recommend steps that rural health care providers can take to anticipate and prepare for ethics conflicts.

CASE STUDIES

CASE 5.1 | Provider stress and burnout

Dr. Alan Morrison has been the only physician in a small community of 1,500 people for about 20 years, and is known as the "Town Doc." When he first came to town, he quickly became involved in the community. The longer he practiced, the more awkward his social life became. Dr. Morrison volunteered as the school baseball coach, but he also treated one of the boys on the baseball team for chlamydia. The boy stopped coming to practice. Dr. Morrison did not sign up to coach the following year. As more and more acquaintances have become his patients, he has begun to turn down social invitations. As the years have passed, he has felt increasingly burdened and overworked, but unable to decrease his workload. He has attended to numerous horrific farm accidents and motor vehicle crashes, often as the only provider for multiple patients. He feels indebted to the community, but is beginning to feel resentful. Where he once took pride in the fact that people looked to him for support, he now feels overwhelmed and useless. Dr. Morrison recognizes that he is depressed, but has no idea where to turn for help. His patients have begun to notice that he seems tired and irritable. At the critical access hospital where Dr. Morrison is on staff, colleagues and administrators are increasingly concerned about his ability to practice, and they fear that their colleague might resign.

CASE 5.2 | Confidentiality in the context of dual relationships

Joanne Baker, NP, prescribes clonidine and lorazepam for a young man, Brian Murphy, for treatment of prescription opiate withdrawal. The young Mr. Murphy is outgoing and talented, and he plays on the same soccer team as nurse Baker's son. Three weeks later, Mr. Murphy is found unresponsive and requires intubation and medical evacuation to a city three hours away. The young man recovers, but does not want others in the community to discover that he has attempted suicide. He begins to spread rumors that his nurse practitioner, Ms. Baker, is incompetent and has prescribed

medications that she does not know how to use. Another patient brings up these rumors during his own appointment with nurse practitioner Baker. She wishes she could set the record straight, and let people know that Mr. Murphy had obtained opiates from a provider in a neighboring town, and had taken these in large quantities in a suicide attempt. The nurse is unsure how to address the situation without breaching her patient's confidentially.

OVERVIEW OF ETHICS ISSUES

An ethical patient-provider relationship is based on trust, honesty, confidentiality, privacy, advocacy for patient interests, and the shared desire for quality care.[1, 2] The American College of Physicians Ethics Manual states that the physician must be professionally competent, act responsibly, and treat the patient with compassion and respect.[3] Loewy and Loewy noted that the patient-provider relationship has at least three roots which are defined in Box 5.1.[4]

BOX 5.1

ROOTS OF THE PATIENT-PROVIDER RELATIONSHIP

Social Contract:	relying upon a mutual perception of interpersonal obligations as well as upon profession
Historical Tradition:	of society and profession
Personal Root:	deriving strength from the unique relationship produced by an interaction of the various professionals, patients as well as the differing personalities of members of the health care team

The American Medical Association Code of Medical Ethics notes that physicians can strengthen the patient-provider relationship by advocating for their patients and protecting basic patient rights.[2] In this relationship, commitment to quality patient care is paramount. Patient rights are outlined in Box 5.2.

BOX 5.2

Patient Rights

- The right to accurate information
- The right to make decisions
- The right to "courtesy, respect, dignity, responsiveness, and timely attention to (the patient's) needs"
- The right to confidentiality
- The right to continuity of care
- The right to the availability of adequate health care

The foundation for a patient-provider relationship is also reflected in personal behaviors. A 2006 Mayo Clinic study identified seven "ideal physician behaviors" via patient interviews,[5] and it may be useful for providers to consider these ideals. Ideal physician behaviors are listed in Box 5.3.

BOX 5.3

Ideal Physician Behaviors

- Confident
- Empathetic
- Humane
- Personal
- Forthright
- Respectful
- Thorough

The patient-provider relationship, by its very nature, engenders complexities that are often difficult to navigate. For example, the patient-provider relationship is characterized by an inherent power differential, and providers must be careful to maximize patient autonomy. Patients and providers may not share similar value systems, and may originate from very different cultures. So it is important that patients know that their values will be respected and considered, even when such values differ from those of their provider.[6] The degree of trust necessary for a successful patient-provider relationship exceeds the level of trust found in most other relationships, and these dynamics often occur in a context in which both participants know relatively little about each other. For these reasons, society requires a higher moral standard in the behavior and conduct of professionals.[7]

The patient-provider relationship has come under increased scrutiny in recent years, and determining what constitutes ethical patient-provider interactions has been complicated by evolving legal and ethical standards.[8] Those who practice in rural areas encounter additional layers of complexity, due to the commonality of dual roles. The local pastor is likely to be a patient of the rural provider, as are the town mechanic and postal carrier. These dual relationships can create awkward and ethically challenging situations.

Health care providers may find it useful to familiarize themselves with the four core ethical principles presented by Beauchamp and Childress: beneficence, nonmaleficence, respect for autonomy, and justice.[9] The principle of beneficence refers to the obligation to contribute to the well-being of others. The principle of nonmaleficence relates closely to the adage, *"Primum non nocere"* (First, do no harm).[9] The principle of respect for autonomy maintains that providers should strive to include individuals in health care decisions and involves the aspects of informed consent and refusal of treatment. The principle of justice refers to the attempt to delineate the fair allocation of health care resources. These and other related principles are described further in Chapter 3 of this *Handbook*.

Ethics conflicts occur as the result of competing ethical principles, or when a provider considers violating one of the principles; for example, when a provider ponders whether it is morally justifiable to breach confidentiality. Therefore, it is important for rural health care providers, when addressing conflict situations, to be aware not only of the basic principles, but also to understand how they may interact within a coherent system of ethics reasoning.

Beneficence and Nonmaleficence

Several factors unique to rural areas complicate the task of balancing the benefits and risks involved in medical treatment. In particular, the commonality of dual relationships contributes to this difficulty. Providers may feel compelled to practice outside their areas of expertise in order to provide necessary care to a patient who is an acquaintance or friend. A health care provider may be less impartial in balancing the presentation of benefits against risks regarding a recommended

treatment if the provider believes he or she knows the values and health goals because the patient is also a neighbor. These situations increase both the potential for benefit and the risk for harm.

Similarly, because patients may have a personal relationship with the provider, it is possible that patients will not view the patient-clinician relationship as private and confidential. They may fear sharing potentially embarrassing information. Despite the obligation that patients have to be honest and open about health-related issues and behaviors, patients may withhold information on problems such as substance abuse, psychiatric illnesses, sexually transmitted diseases or other stigmatized illnesses; thereby limiting the provider's ability to give necessary assessment and treatment. As a result, patients may be at increased risk for harm. For example, a patient with secondary syphilis who presents with fatigue, fevers, and malaise, but fails to disclose that he has had sexual intercourse with prostitutes, and had some genital lesions a few months ago, risks unnecessary medical testing and further progression of his illness.

Yet another area of concern is the risk that a rural community may tolerate substandard care or unethical behavior for fear of losing their health care provider. The belief that "some care is better than no care" may lead clinic administrators and other rural community members to avoid addressing issues like provider substance abuse, burnout, or illness. Health care providers with an understanding of the principles of beneficence and nonmaleficence will be better equipped to recognize and address conflicts among professional duty, trust, and confidentiality.

Respect for Patient Autonomy

Unlike the typical urban patient-provider relationship, it is common for rural providers to have "everyday" casual community contact or relationships with the same individuals they see in the privileged, professional patient-provider relationship. Health care providers may have children in the same class as their patients, or the local grocer or pharmacist may be their patient. They may even end up caring for their own family members. As a result, providers have increased knowledge of their patients' lives, behavior, and activities that may potentially influence their perception of those patients. For example, a provider has

only to drive by the local bar to recognize the car of a patient who had adamantly stated that he or she no longer drinks. When providers know their patients[6, 10] outside of the clinical setting, they may be tempted to make assumptions about a patient's preferred treatment or be more apt to cave to a patient's request to, "just do what you think is best, 'doc'." Knowing patients in non-professional settings can also lead health care providers to be less thorough with history-taking, because they assume they know the whole story. Health care providers must take care to maximize patient autonomy and to treat all patients with respect and dignity, while carefully considering how their own assumptions might influence the situation.

Justice

Rural health care providers are often acutely aware of the competition between justice and beneficence. What is in the best interest of an individual patient may be detrimental to the community in general. For example, a provider may feel that it is in a patient's best interest to have a procedure in a nearby city rather than at the local surgery center. However, this would deprive the community's health care system of income that helps sustain the local health facilities. Only 8% of physicians practice in rural areas, while 20% of the population resides there.[11] Due to the high levels of uninsured patients in rural areas, providers or health care organizations may provide a large amount of uncompensated health care. This may occur to the extent of endangering the ability of such institutions to continue to provide care.[12, 13] Providers (who often do not have backup or "on call" coverage as they might in a larger hospital or private practice with more partners) may feel obligated to provide necessary treatment to patients at all hours of the day, therefore risking exhaustion and burnout. Because a rural community may only be able to support one health care provider, getting coverage for the provider to have time off can be a challenge. J.C. Hadley, a rural physician, noted in conversation that there were times when he had to leave town during which no medical coverage was available (Personal communication, Hadley JC, September 2007). While this situation would certainly be unethical in an urban area, it is less clear in rural areas.

All of these issues complicate and challenge the traditional, ethically grounded patient-provider relationship. Therefore, patient-provider ethics

issues must be understood within the broader context of the community in which the provider and the patient reside.[6, 10]

CASE DISCUSSION

The following case discussions are based on the analysis method discussed in Chapter 4.

CASE 5.1 | Provider stress and burnout

This case highlights the ethical principles of beneficence, justice, and nonmaleficence, particularly in the areas related to self-care, as well as the community's tolerance of deviant behavior or substandard care by providers. This case also examines the issues of confidentiality and privacy.

Dr. Morrison was initially eager and involved in the community. As he has begun to encounter the numerous layers of complexity in patient relationships, he has come to feel isolated. The concerns of confidentiality and privacy are particularly awkward, such as the sexually transmitted disease situation mentioned. Dr. Morrison deals with these situations by pulling away from the community.

J.C. Hadley described his own personal experience as a country doctor as one of avoidance. "Only go to the post office after hours, when nobody else is there. Be wary of going into businesses where there is only one entrance and exit… no good escape route… easy to get cornered. Check out who might be in the place before you enter" (Personal Communication, Hadley JC, September 2007). It is important that providers consider alternate means of interaction, so that they do not find themselves isolated from their communities.

Dr. Morrison has become exhausted, resentful, and impolite. The community fears losing him, so they tolerate his behavior. This creates a perilous situation. The community will suffer if they lose their physician. If Dr. Morrison stays, he will likely continue to decompensate until change is forced, be it by a serious medical mistake, substance dependence, suicide, or any other number of possible negative outcomes.[14-16]

Some of these difficulties stem from the tendency of society to hold health care providers to a higher standard than those in most other professions.[8] A rural provider may not be able to go home at night, even if exhausted, because there is no one else to provide needed care for the victims of a motor-vehicle accident. A provider may try to uphold the most rigorous set of professional responsibilities and values, and yet be regularly challenged to fulfill either his or her own expectations and/or those of the community.

There is often some inherent conflict in ranking the needs of a provider and the needs of a community. There may also be conflict between beneficence that a provider directs toward the entire community (via the community having a healthy physician to care for its members) and the beneficence she directs toward an individual patient (for example, if the provider sees patients every weekend because no one else is available). Rural health care providers face unique challenges as they seek to balance their personal values with the community's needs, while maintaining professionalism within each patient-provider relationship.

Another aspect highlighted by the case above is the degree of trauma encountered in rural areas—a reality that intensifies the stress faced by Dr. Morrison. This can have a strong impact on rural health care providers, more so than in urban areas, for several reasons which are outlined in Box 5.4.

BOX 5.4

Reasons for Intensified Trauma Impact on Rural Providers[15-17]

- Lack of colleague support
- Lack of resources
- Technological limitations
- Delays in advanced treatment
- Need for medical care beyond one's own expertise
- Greater sense of responsibility and duty
- Increased frequency of death related to severe trauma
- More familiarity with the victims of these tragedies and traumas

CASE 5.2 | Confidentiality in the context of dual relationships

The case of nurse practitioner Joanne Baker focuses on the ethical issues of trust and confidentiality within dual relationships. Dual relationships may be difficult, if not impossible to avoid in rural areas.[6, 10] Dual relationships may have many benefits, including allowing the provider a greater awareness of a patient's entire life, fostering a deeper sense of trust, or encouraging a stronger sense of duty. However, dual relationships, as illustrated in this case, also complicate the patient-provider interaction. Ms. Baker knows Brian Murphy as a member of her son's soccer team. Her knowledge of him may have prevented her from asking important questions about his mental health. Likewise, Brian Murphy may have been hesitant to disclose the extent of his problems due to his knowledge of Joanne Baker not only as his provider, but also mainly as "Jason's mom."

Many patients will talk, gossip, and spread rumors while providers are professionally and ethically bound to maintain confidence.[18, 19] When the second young man comes in and confronts her with the rumors spread by Mr. Murphy, Ms. Baker is caught between reassuring her new patient of her knowledge and expertise, and violating the first young man's patient confidentiality. Not only is her reputation perhaps marred by Brian Murphy's rumors, but other patients are beginning to have more difficulty trusting her. Trust is an essential component of the patient-provider relationship. Whereas patients in urban areas must base their trust in physicians on experience related to their medical care and treatment interaction alone, those in rural areas may base their trust on their broader understanding of the provider as a member of the community and as a human being. At times, this may be beneficial and serve to foster trust. At other times, as in the case with Brian Murphy, patients may be more wary and distrustful.

Ms. Baker would be breaching confidentiality and privacy requirements if she were to disclose to other patients the factual circumstances. She would be violating Mr. Murphy's confidentiality, which would likely harm him. The principle of justice competes with the principle of nonmaleficence in this scenario. One would hope community members would judge Ms. Baker based on the sum of her care, not just one patient's rumors. But that is not always the situation. Despite being

unfair, members of the community can hold to the false belief that their health care provider is incompetent. They may wait longer before seeking necessary treatment, or they may disregard important treatment options. Does she uphold the principle of nonmaleficence, by not violating Brian Murphy's confidentiality, despite the reality that, as a result of his gossip, some patients may hold false beliefs regarding their safety and the medical care they receive from her? Would it be morally justifiable for her to simply mention to her patients that they had been misinformed about the circumstances surrounding her patient Mr. Murphy?

RESPONDING TO PATIENT-PROVIDER ETHICS CONFLICTS

CASE 5.1 | Provider stress and burnout

Dr. Morrison faces a problem that is common to health care professionals in small, rural towns. In cases of provider stress or burnout, both the provider and the clinic administration have ethical obligations. The provider, once he recognizes that stress is interfering with his ability to provide care, must address his limitations and seek help.[20] Most states have confidential resources for health care providers. For example, the Colorado Physicians' Health Program offers confidential evaluation and referral for medical, mental health, and substance use disorders.[21] If the physician in this case fails to acknowledge the situation, then his professional colleagues and/or hospital administration should respectfully confront him and assist him in problem-solving. It will not benefit the physician, his individual patients, or the community in general to ignore the signs of burnout. Likewise, it is of no benefit to address the situation in a punitive, disrespectful manner.

In circumstances in which patients have actually been harmed, the provider is obligated to report himself to his professional organization to obtain the necessary help. Those aware of this provider's difficulties have an ethical obligation to address his performance, rather than ignore it because they fear losing the physician.[21] Administrators can often provide help and support to providers, without needing to alienate them, or terminate them in the more extreme case. Management may provide medical leave, suggest treatment resources, limit the provider's hours, or allow time for continuing medical education.

In the case of Dr. Morrison, following a careful review of the situation with clinicians and administrators from the nearby critical access hospital, local administrators decided to discuss Dr. Morrison's behavior with him. The clinicians and management decided that two colleagues with whom Dr. Morrison had good relationships, a fellow physician and a nurse, would privately approach him to discuss changes in his behavior and attitude. Initially, he was angry, and gave his resignation to the hospital. The hospital administrator worked with Dr. Morrison and other clinicians to negotiate a lighter schedule and provide coverage through a *locum tenens* agency. In addition, the administrator referred Dr. Morrison to the local physician's health program. Dr. Morrison began seeing a therapist in a city two hours away, and took some vacation time. He also obtained a mentor through the physician's health program, and continued to work a lighter schedule. The hospital had to rely on *locum tenens* coverage for almost a year until they were able to recruit another physician to help fill the schedule.

CASE 5.2 | Confidentiality in the context of dual relationships

The case of Joanne Baker, the nurse practitioner, highlights the difficulties that are common in dual relationships. Providers must be especially careful not to overlook important aspects of a patient's history due to assumed familiarity. For example, Ms. Baker had known Brian Murphy as an outgoing and talented young man, not one who was, to her knowledge, suicidal and drug-addicted. She should openly discuss with Mr. Murphy the difficulties that their dual relationship poses, and offer a referral to another provider if this patient does not feel comfortable working with her. Patients who have believed Brian Murphy's slandering comments about this nurse may have to weigh the difficulties and benefits of continuing to work with Ms. Baker, compared to the inconvenience of traveling.

Another unfortunate, yet common, problem is that people often gossip in rural areas because of the close-knit living environment, and the fact that residents tend to be so familiar with their neighbors' and friends' activities. In many rural areas, a large fraction of the inhabitants are related to each other, after decades or centuries of their extended families living in the area with the core families intermarrying.

Despite the negative impact on Ms. Baker's professional image, she must maintain Brian Murphy's confidentiality. There may be some people left with inaccurate perceptions of her abilities, but Ms. Baker cannot comment to one patient about another patient. It is not possible to control what people choose to say or believe. This is the responsibility of each individual, not the provider. J.C. Hadley noted, "Gossip will always occur, and it will always be hurtful and potentially damaging to you professionally . . . Unfortunately I have no defense against those patients who . . . tell any story that might be far from truthful… you just have to continue to prove yourself to others through good health care" (personal communication, Hadley JC, September 2007).

ANTICIPATING PATIENT-PROVIDER ETHICS CONFLICTS

Health care providers can anticipate potential patient-provider ethics conflicts in order to prevent or minimize them, as opposed to only addressing conflicts as they arise. Both individual health care providers and administrators can play a role in anticipating potential ethical conflicts as noted in Box 5.5.

BOX 5.5

Anticipating Patient-Provider Ethics Conflicts

- Be aware of local culture, customs, and resources
- Identify a professional mentor
- Develop a support network
- Set and communicate professional boundaries and limits
- Develop skills in analyzing boundary crossings
- Actively address potential conflicts in dual relationships
- Emphasize confidentiality to patients and colleagues
- Be proactive about self-care

Enhance Understanding of Local Culture, Customs, and Resources

Lisa Cooper-Patrick, *et al.* note that improved cross-cultural communication results in improved patient care, satisfaction, and outcomes.[22] When taking a new position in a rural setting, providers should seek venues to understand the local culture. For example, if the situation allows, health care providers may consider moving to the

area in which they will be practicing prior to actually beginning work. This allows them the time to become familiar with the local culture and customs.[23] Providers can begin this process by reviewing the cultural diversity literature and other resources. Administrators of rural facilities should consider providing both time and financial support so that new health care providers can familiarize themselves with the local culture and customs. To maximize new providers' efficiency and to ease their orientation, administrators of small rural hospitals should also supply a directory of local resources and referral sources. Providers may find it useful to meet with community leaders, such as clergy or law enforcement officers, to discuss the community's culture and explore how such community leaders handle issues like confidentiality and dual relationships. It is equally important that providers be aware of the mechanism for obtaining medical or mental health help for themselves, which could also be introduced by administrators at orientation time.

Identify a Professional Mentor

Providers should identify professional mentors throughout their careers. Since rural providers often reside in remote areas, a mentor may be someone who lives at a distance, but is available via phone or e-mail when doubts or conflicts arise. For example, a mentor may be a professional who has previously practiced in the community, or the mentor might be a provider in another rural community. It would have potentially been very helpful for both Dr. Morrison and Ms. Baker to have had a relationship with a trusted, supportive, rural provider, with whom to discuss problems.

Develop a Support Network

Health care providers should also develop relationships with members of the local health care community, including a mix of mental health professionals, doctors and nursing staff, hospital technologists, and alternative providers, as well as health professionals in neighboring communities. It is also important to develop local ethics resources and mechanisms for addressing ethics conflicts, as discussed in Section III of this *Handbook*. These mechanisms provide confidential resources for providers to consult when conflicts arise. In the first case presented, Dr. Morrison would have benefited from having a support network to help him deal with difficult patient interactions, to prevent him from

becoming overwhelmed, and to support him when he began feeling depressed. Such a support network might also, in general, develop coverage arrangements, so that each provider might have time off when necessary, and could have backup medical and technical support when traumatic events require additional help.

Set Boundaries and Limits

Rural providers may frequently be afraid to set limits on their work time or skill set for fear of alienating members of the community. Some find it useful to be direct, clear, and concise with patients about their professional-personal limits. It is a challenging balance to completely separate professional responsibilities from a personal life, and may result in awkwardness and resentment for both the provider and the patient. Proactive, open communication is essential to clarifying an understanding between the provider and the community. Once the understanding is communicated, providers should adhere to the boundaries based on their own needs, values, and personalities.

Providers should also be prepared for queries about their personal lives. Different individuals will have different comfort levels. Some may find it most useful to be direct and concise when asked about a personal experience while others may find it more comfortable to provide some level of detail. Providers should not be surprised by these inquiries (often they are made out of sincere, friendly interest or even small talk on the part of a patient—especially during an encounter that could occur outside of the clinic—say, at the grocery store or golf course) and should think about how much they want to share prior to such inquiries.

Develop Skills in Analyzing Boundary Crossings

It is important to be aware of potential conflicts in dual relationships. Dr. Martinez refers to a graded-risk model for boundary crossings and speaks of four types of boundary crossings as listed in Box 5.6.[24]

BOX 5.6

Types of Boundary Crossings

Type I

Type I boundary crossings are discouraged and/or prohibited. They include behaviors that are liable to criminal and civil litigation. Examples include physically abusing a patient or conspiring to commit a crime with a patient.

Type II

Type II boundary crossings involve a high risk of harm and low risk of benefit to the patient or the patient-provider relationship. Examples include a provider falsifying an insurance form for a patient, or trading psychotherapy for housecleaning services.

Type III

Type III boundary crossings involve a low-to-medium risk of harm and a medium-to-high opportunity for benefit. Examples include attending a patient's wedding or disclosing significant personal information. Use of professional judgment and consideration of cultural context are very important in Type III.

Type IV

Type IV boundary crossings involve either a low risk of harm or no risk of harm, and a medium-to-high opportunity for patient benefit. These boundary crossings will often have a positive effect on the provider-patient relationship. Examples include using sliding-scale fees, making a home visit to a terminally ill patient, or making a cup of tea for a patient.

Dr. Martinez further writes that six ethical guidelines should be considered when analyzing potential boundary crossings.[24] These guidelines are found in Box 5.7.

BOX 5.7

Potential Boundary Crossings

- Actions under consideration should involve a low-to-medium risk of harm to the patient and to the patient-provider relationship
- Coercive and exploitative elements should be absent on both sides
- There should be some potential benefit to the patient or to the patient-provider relationship
- Patient interests should be greater than professional self-interests
- The provider should aspire to maintain professional ideals
- The context of potential boundary crossings should always be considered

Actively Address Potential Conflicts in Dual Relationships

Health care providers should be careful not to make assumptions, even though they may be aware of patients' lives outside the treatment setting. Providers and patients should explore health care options and treatment possibilities, even when value-based differences may exist. If a patient is aware that her provider's value system is different from her own, and could influence the treatment, both the provider and patient should openly discuss any potential conflict. For example, if a patient is interested in discussing birth-control options, but knows that her provider attends a conservative Catholic church, the patient should still be able to openly discuss the various medical options. When a provider feels that her personal values may impede her ability to support patient autonomy—for example, if a patient requests the morning-after pill and the provider is uncomfortable giving it—the professional should offer appropriate referrals to address the patient's need.

In rural communities, it's not always possible for providers' friends to see different providers. When patients are also friends, providers should talk openly about the difficulties in a dual relationship. There may be situations in which the patient needs to be referred to a different provider, even if it creates hardships such as driving a certain distance

away. During patient-provider interactions, providers should initiate conversations about stigmatized issues such as sexual health, mental health, substance dependence, and domestic violence, so friends are aware that they can ask for referrals if needed.[25] As in the second case, Ms. Baker should have discussed with Mr. Murphy their relationship outside the clinic and made sure he was comfortable discussing sensitive issues with her before proceeding with treatment.

J.C. Hadley commented on the difficulties with friendships in rural areas, stating that, "Anybody can get upset with the health care provider for any number of reasons, such as access, cost, and unsatisfying outcomes, which can affect a relationship of any type. Realizing this reality helps you to prepare. I deal with this by being true to my professional ethical standards first, (and) doing what is best for them as a patient; true friendship will survive professional glitches" (Personal Communication, J. C. Hadley M.D., September 2007).

Emphasize Confidentiality

Health care providers need to reassure patients of the importance of confidentiality. Medical professionals are repeatedly reminded of its significance, but patients may not be aware of its value or the role it plays in the patient-provider relationship. Remind office staff of the importance of confidentiality, and develop strategies for assuring it is maintained. Clinicians and administrators need to collaborate to enforce consequences when confidentiality is breached. When other patients confronted Ms. Baker with questions about Brian Murphy, she could have used the opportunity to explain the patient confidentiality rules and the value of privacy, rather than being tempted to defend herself or her actions as a clinician.

Be Proactive About Self-Care

It is critical that providers maintain their own health to maximize their ability to maintain an ethically grounded patient-provider relationship. Physicians who are experiencing burnout are more likely to provide sub-optimal care.[26, 27] A list of suggestions for rural providers is supplied in Box 5.8.

Rural providers may need to be creative to develop a support network; some examples might include obtaining a therapist in a different

BOX 5.8

Provider Self-Care

- Develop a support network
- Network with community officials and leaders
- Spend time alone (and with friends and family)
- Maintain physical and mental health care, including having one's own health care provider(s)
- Exercise, get regular sleep, and maintain healthy nutrition
- Set limits with staff to maintain professional boundaries
- Anticipate and allow for the grieving process that providers may experience following a patient's death, particularly if there had been a close friendship or relationship
- Expect criticism, learn to tolerate it, and be comfortable changing or not changing in response
- Take time off
- Work with colleagues or administration to address unreasonable or unmanageable workloads

community, or joining a hiking club in a nearby city. It may be especially useful for providers to maintain contact with other community officials or leaders to help decrease a sense of isolation. Health care providers with mutual patients may offer support to each other during difficult times. Health care professionals such as physicians, nurses, and administrators can offer support by attending funerals and contacting each other following difficult situations, such as patient deaths or particularly horrific accidents.

It is important to be in contact with people who can offer a realistic perspective, since providers are often idealized or criticized unrealistically. There are few places like small, rural towns where your faults are quite so obvious and open to public scrutiny. Likewise, there are few places where people may so readily construct "faults" in response to perceived injustice or differences in belief systems. When faced with negative perceptions, providers must be prepared to sort areas for improvement from those that they are not compelled to change.

Health care providers are trained to take care of others and often neglect self-care.[28] Despite time constraints or geographic barriers, rural health care providers should have their own medical and mental health providers available to address personal health issues. In general, people frequently need time to be alone[28] and providers may find that continuing or developing a hobby or exercise routine is relaxing and enjoyable. Time alone may also be an opportunity for meditation or prayer.

It may be difficult to set professional limits with staff when they are friends or acquaintances, but doing so is critical. One necessary limit is the amount of time providers are willing to work. Providers need to take time off, even if they are the only local health care provider, and they shouldn't take work along on vacation.[28] If the workload is unreasonable and unmanageable, this should be addressed by working with colleagues or clinic administration.[28] Hospital administrators will likely prefer having you work fewer hours, rather than having you resign in frustration and then having no health care provider at all. If the unreasonable workload is not addressed, providers might consider moving to an area with more support.

CONCLUSION

The unique nature of the rural patient-provider relationship presents both rewards and challenges. Rural health care providers and patients enjoy a broad understanding of each other, as members of a community and as human beings. This closeness often enriches relationships, fosters trust, and deepens understanding. It also presents many challenges and potential ethics conflicts. These conflicts can be overwhelming and frustrating to a provider, if they are addressed blindly and without support. However, providers who develop an understanding of the core ethical principles and how these principles interact in rural patient-provider relationships can be proactive about addressing these conflicts.

Health care providers are obligated to provide care that is beneficial to patients and to minimize interventions or actions that are likely to be harmful. They should seek to maximize patient autonomy, by regularly and non-selectively practicing thorough history-taking, and by including their patients in discussions and decisions about the risks and benefits of medical treatment. Because rural health care resources are often

scarce, rural providers must routinely consider the ethical principle of justice in their daily decisions. Most importantly, rural health care providers must insure that their own mental, emotional, and physical needs are met so that they are able to provide excellent, ethically grounded health care.

REFERENCES

1. Balint J, Shelton W. Regaining the initiative. Forging a new model of the patient-physician relationship. *JAMA.* Mar 20 1996;275(11):887-891.

2. American Medical Association, Council on Ethical and Judicial Affairs. *Opinions on the patient-physician relationship. Code of Medical Ethics.* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion1001.shtml. Accessed April 5, 2009.

3. Ethics manual. Fourth edition. American College of Physicians. *Ann Intern Med.* Apr 1 1998;128(7):576-594.

4. Loewy E, Loewy R. Patients, society and healthcare professionals. IN: *Textbook of Health care Ethics.* 2nd ed. Boston, MA: Kluwer Academic Publishers; 2004:97-140.

5. Bendapudi NM, Berry LL, Frey KA, Parish JT, Rayburn WL. Patients' perspectives on ideal physician behaviors. *Mayo Clin Proc.* Mar 2006;81(3):338-344.

6. Roberts LW, Battaglia J, Smithpeter M, Epstein RS. An office on Main Street. Health care dilemmas in small communities. *Hastings Cent Rep.* Jul-Aug 1999;29(4):28-37.

7. Martinez R. Professional role in health care institutions: towards an ethics of authenticity. In: Wear D, Bickel J, eds. *Educating for Professionalism: Creating a Culture of Humanism in Medical Education.* Iowa City, IA: University of Iowa Press; 2000:35-48.

8. Henry MS. Uncertainty, responsibility, and the evolution of the physician/patient relationship. *J Med Ethics.* Jun 2006;32(6):321-323.

9. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics.* 5th ed. New York, NY: Oxford University Press; 2001:57-282.

10. Nelson W. Addressing rural ethics issues. The characteristics of rural healthcare settings pose unique ethical challenges. *Healthc Exec.* Jul-Aug 2004;19(4):36-37.

11. Rural health fact sheet. Health Resources and Services Administration, US Dept of Health and Human Services. Available from: http://www.hrsa.gov/about/factsheets/orhp.htm. Accessed Jan. 19, 2009.

12. Rowley T. The rural uninsured: highlights from recent research. Office of Rural Health Policy, US Dept of Health and Human Services. http://ruralhealth.hrsa.gov/policy/UninsuredSummary.htm. Accessed Feb. 23, 2009.

13. Bailey J. Health care in rural America: a series of features from the Center for Rural Affairs Newsletter. Center for Rural Affairs; 2004. http://www.cfra.org/pdf/Health_Care_in_Rural_America.pdf. Accessed Feb. 23, 2009.

14. Warner TD, Monaghan-Geernaert P, Battaglia J, Brems C, Johnson ME, Roberts LW. Ethical considerations in rural health care: a pilot study of clinicians in Alaska and New Mexico. *Community Ment Health J.* 2005;41(1):21-33.

15. Moszczynski AB, Haney CJ. Stress and coping of Canadian rural nurses caring for trauma patients who are transferred out. *J Emerg Nurs.* Dec 2002;28(6):496-504.

16. Levin A. Stress of practicing in rural area takes toll on psychiatrist *Psychiatric News.* Dec. 13, 2008 2006;41(9):4.

17. Rogers FB, Shackford SR, Hoyt DB, et al. Trauma deaths in a mature urban vs rural trauma system. A comparison. *Arch Surg.* Apr 1997;132(4):376-381; discussion 381-372.

18. American Medical Association, Council on Ethical and Judicial Affairs. *Opinions on confidentiality, advertising, and communications media relations. Code of Medical Ethics.* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.shtml. Accessed April 5, 2009.

19. Confidentiality. Colorado Physician Health Program. http://cphp.org/confidentiality.html. Accessed Dec 5, 2008.

20. Schneck SA. "Doctoring" doctors and their families. *JAMA.* Dec 16 1998;280(23):2039-2042.

21. American Medical Association, Council on Ethical and Judicial Affairs. *Reporting impaired, incompetent, and unethical colleagues, Opinion 9.031. Code of Medical Ethics.* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion9031.shtml. Accessed April 5, 2009.

22. Cooper-Patrick L, Gallo JJ, Gonzales JJ, et al. Race, gender, and partnership in the patient-physician relationship. *JAMA.* Aug 11 1999;282(6):583-589.

23. Han GS, Humphreys JS. Overseas-trained doctors in Australia: community integration and their intention to stay in a rural community. *Aust J Rural Health.* Aug 2005;13(4):236-241.

24. Martinez R. A model for boundary dilemmas: ethical decision-making in the patient-professional relationship. *Ethical Hum Sci Serv.* Spring 2000;2(1):43-61.

25. Rourke LL, Rourke JT. Close friends as patients in rural practice. *Can Fam Physician.* Jun 1998;44:1208-1210, 1219-1222.

26. Maslach C, Jackson SE, Leiter MP. *Maslach Burnout Inventory Manual.* Palo Alto, CA: Consulting Psychologists Press; 1996.

27. Shanafelt TD, Bradley KA, Wipf JE, Back AL. Burnout and self-reported patient care in an internal medicine residency program. *Ann Intern Med.* 2002;136(5):358-367.

28. Gendel M. Physician work stress. Colorado Physician Health Program; 2007. http://cphp.org/list-of-informative-articles.html. Accessed Mar 4, 2009.