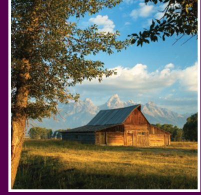

CHAPTER 6

Ethics Conflicts in Rural Communities: Overlapping Roles

Andrew Pomerantz

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Handbook for Rural Health Care Ethics:
A Practical Guide for Professionals

Dartmouth College Press
Published by University Press of New England
One Court Street, Suite 250, Lebanon NH 03766
www.upne.com

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Edited by William A. Nelson
Cover and text design by Three Monkeys Design Works

Supported by NIH National Library of Medicine Grant # 5G13LM009017-02

CHAPTER 6

Ethics Conflicts in Rural Communities: Overlapping Roles

Andrew Pomerantz

ABSTRACT

Health professionals who live and work within rural communities are more likely to interact with patients in multiple settings than are their urban peers. Outside the office or hospital, health care professionals may be their patients' friends, customers, parishioners, employees, or employers. The boundary that exists between patient and provider can become unclear in these contexts, potentially leading to ethics conflicts that are both personal and professional in nature. Knowledge obtained in the clinical arena may have significant relevance for the clinician in his or her community role(s). This chapter presents three situations that illustrate some of the ethics conflicts that can develop in rural contexts, when personal and professional responsibilities are challenged by blurred boundaries. These cases demonstrate professional responsibility conflicts that can develop for health care providers regarding the traditional patient-clinician relationship. In an urban area, lack of incidental patient contact outside the professional realm makes cases like these quite rare, whereas in rural settings they are the norm. The key to prevention and resolution of ethics conflicts is for the health care professional to prepare and anticipate such conflicts, and to develop appropriate management strategies.

CASE STUDIES

CASE 6.1 | A physician's family gaining an unfair advantage

Dr. Dallace, a family practitioner, attends a local farm auction with his wife. The young auctioneer, a grateful patient whom Dr. Dallace is treating for narcotic dependence, observes the doctor's wife examining and admiring a chair. When the bidding opens, the auctioneer makes reference to the chair needing a great deal of repair. Though she knows it needs no work, Mrs. Dallace offers a low bid that is accepted, thus allowing her to purchase the chair at a remarkably reduced cost.

CASE 6.2 | Choosing between loyalty to the hospital and loyalty to the patient

Dr. Boardman is a surgeon at a small rural hospital. The hospital is struggling to stay afloat in the face of competition from larger hospitals. All physicians at the hospital are being pressured to keep the beds full. While in the emergency room, Dr. Boardman is faced with a complicated case that he has not seen since he was in training years ago. He realizes that the patient may receive better care at one of the larger tertiary hospitals, but that would mean lost revenue as well as the lost opportunity to care for an interesting, complicated case. Faced with the choice, he elects to keep the patient in his hospital. Following admission, the patient asks her nurse, Linda Robinson, who is also a friend, if she ought to ask to be transferred to the large tertiary care center a hundred miles away because she is aware that they have more specialists. Ms. Robinson is aware of what Dr. Boardman said; she is uncertain how to respond.

CASE 6.3 | Breaching patient confidentiality to prevent possible harm

Andy Cox is a nurse in a physician's office some 30 miles from his hometown. He is also a member of his town's school board. One day Mr. Richards, a teacher from the school, visits the physician for

a check-up. Mr. Cox thinks it odd that Mr. Richards has traveled so far to see the doctor, since most people in his hometown see a family physician in the town. Andy Cox says hello, but has little contact with the patient. A few days later, Nurse Cox is retrieving lab information and learns that the teacher has tested positive for several drugs, suggesting substance abuse. The nurse wonders if he could or should warn school administrators or fellow school board members about the teacher's drug use.

OVERVIEW OF ETHICS ISSUES

Working in rural health care sets the stage for many overlapping relationships and responsibilities, since health care workers are also parents, siblings, friends and community members. In densely populated areas with multiple, separate neighborhoods and suburbs, these many responsibilities are less apparent to the provider's patients because their lives are less likely to intersect outside the office. Rural residents frequently live within the same community as their provider and, unless the provider avoids all community contacts, interactions with patients outside of the professional relationship are likely to occur on a regular basis. In many communities, physicians, nurses and other medical professionals enjoy a special status among the community's population, further enhancing the likelihood that they will be in public positions and thus interact with patients in multiple settings outside of the clinic or hospital. Rural clinicians are frequently challenged to keep their personal responsibilities from coloring their interactions with patients within the clinical arena.

Overlapping relationships can create ethics challenges between clinician and patient, because they are inherently unequal parties, at least in the medical relationship; clinicians are typically in a position of power, and patients may feel vulnerable or dependant. Patients put their trust in their health care provider(s); they must trust enough to provide very personal and often embarrassing information that is necessary for accurate diagnosis and effective treatment. Thus, it is particularly important for rural health care providers to clearly define their professional responsibilities, including roles and boundaries within the patient-clinician relationship.

Traditional ethical standards for the patient-provider relationship are based on respect, honesty, trust, confidentiality, promotion of the patient's well-being, and avoidance of self-interest. This basic understanding is grounded in the principles of nonmaleficence, beneficence, respect for patient autonomy, professionalism, and justice, discussed in Chapter 3 of this *Handbook*.[1] Furthermore, Gert's *Common Morality* emphasizes the moral rule of "do your duty."[2] "Duty" in this case refers to the responsibilities established by one's profession. For medical providers, this means that the physician's, nurse's or other clinician's behavior and actions are to reflect the ethical standards of the patient-clinician relationship. These principles guide the care of individual patients the clinician's obligation to society.

The American College of Physicians' *Code of Medical Ethics* states that, "The relationship between patient and physician is based on trust, and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest and above obligations to other groups, and to advocate for their patients' welfare…"[3] The physician should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.[3] The appropriate patient-clinician relationship stems from adherence to ethically grounded professional responsibilities, which include informed consent, shared decision-making, respect for privacy and confidentiality. Providers are also responsible for doing what is best for the patient, avoiding exploitation and harm, as well as for treating and distributing care equitably, without bias.

An ethics conflict typically arises when the above responsibilities compete with others, or when they are being violated. For example, a conflict arises when a provider treats a competent patient who does not wish to pursue a treatment, even one that the provider knows will clearly be helpful. In that instance, the conflict lies between the provider's responsibility to respect patient autonomy and the provider's desire to encourage what is best for the patient's health.

Professional responsibility conflicts may also arise when information provided by patients has health care implications for the community or soci-

ety at large. The ethical clinician must balance the needs of an individual patient with the needs of the community, professional ethical standards, and his or her own personal values. In some instances, the balance of these various perspectives is incorporated into laws. For example, all states have mandatory reporting of certain diseases (e.g., HIV/AIDS) in order to assure that the community at large is protected. A similar standard exists when a psychologist is bound to report cases of child abuse or threats of violence to authorities. In such instances, confidentiality for the individual patient becomes secondary to the good of society. In other cases, providers are burdened when they have information that could protect the health of others, but cannot breach patient confidentiality, as in the case of a sexually transmitted infection, where the infected party is refusing to inform his or her partners. In both situations, commitment to one's professional responsibility is key to resolving ethics conflicts. However, in other situations, there may be a moral justification to breach the responsibility, as with legally required mandatory reporting.

The law generally reflects accepted ethical standards such as the criteria for informed consent. However, clinicians sometimes find themselves confronted with a very difficult choice between what the law requires and what is best for their individual patient. A common example is the temptation of a clinician, faced with a patient lacking adequate financial resources, to enter a false diagnosis code in order to ensure that the patient's insurance company pays the claim. Regardless of the potential ethical justification for such an action, physicians and other providers still face the legal consequences and ethical repercussions of their actions, such as a formal ethics grievance brought to the attention of a medical society.[4] It is the clinician's professional responsibility to do his or her best for the patient under the parameters of the law.

Many patient-provider role and boundary ethics conflicts arise in rural settings when there are personal and professional relationships with patients. Conflicts also can arise between the provider's obligations to individual patients and to the broader community, as is the case where the nurse worries about the impact of the teacher's potential drug abuse on his students. Providers struggle to balance or rank their obligations to both individual patients and society as a whole. Overall, the provider's obligation is first to the patient. The provider must offer respect, must

avoid deception and disclosure of pertinent information, must maintain confidentiality, must keep promises, must act in the best interest of the patient, and must allocate resources justly. Providers should review exceptions to these duties and/or consult a third party ethics resource, as needed, to help assess any ethics conflicts.[5, 6]

CASE DISCUSSIONS

The discussion of the following cases is based on the analysis method presented in Chapter 4.

CASE 6.1 | A physician's family gaining an unfair advantage

Dr. Dallace's dilemma merits careful reflection, including an understanding of the values of the various stakeholders. He, his patient, his wife, and the person harmed by his wife's purchase of a chair at reduced cost all have important roles. It appears that Dr. Dallace's wife has gotten the chair only by virtue of her husband's professional relationship with the auctioneer. Does her acceptance of the falsely low purchase price constitute patient exploitation by her husband, the doctor? Perhaps the auctioneer may now want more favorable attention and treatment. Will Dr. Dallace be likely to give him "favored" status at the expense of other patients?

There are also ethics questions regarding the relationship between Dr. Dallace and the chair's original owner, other patients, and other health care providers in the community. If Dr. Dallace's wife buys the chair at the reduced cost, the original owner of the chair will receive less reimbursement. The auctioneer's lying about the chair has also misled other potential buyers. If other patients or health care providers find out about this special behavior, how will they be impacted or influenced?

Dr. Dallace feels that the chair "deal" is wrong, but is unsure about how to proceed. He fears exploiting the patient, but doesn't want to hurt his feelings by refusing the "gift." Dr. Dallace also is concerned about the chair's original owner receiving reduced reimbursement. Finally, Dr. Dallace does not want other patients to think that they will receive favored care if they give him gifts, and does not want his medical colleagues to think he favors or exploits patients. Though the offer for

the chair is thoughtful, Dr. Dallace knows he and his wife should not accept it in its current form, if at all.

In large health care facilities there are often formal policies about accepting gifts. However, in clinics and small rural hospitals, such policies are rare, and are even more so in rural clinics.

CASE 6.2 | Choosing between loyalty to the hospital or to the patient

With their extensive medical knowledge, nurses in rural settings are often important community resources. This is particularly true when community members are looking for a second opinion. Such is the case for nurse Linda Robinson, who believes that Dr. Boardman has chosen a course of care that may be good for the hospital's bottom line, but may be potentially risky for his patient. Nurse Robinson believes that Dr. Boardman should instead foster the patient's autonomy, and support it through full disclosure and informed consent regarding the treatment options.

Dr. Boardman, like many providers in both rural and urban settings, feels a strong responsibility to his hospital. He believes that there may be a greater good to the community in preserving the hospital rather than providing the best care for one individual patient. This thinking is based on a utilitarian perspective, i.e., to do the greatest good for the greatest number of people.

Nurse Robinson has both a commitment to quality care and a strong allegiance to the hospital that provides her employment. If the hospital were to fail, she might not have a job, and the community would lose both an important source of health care, and a socioeconomic asset —the hospital being the major local employer. However, if the procedure were done at the hospital and a bad outcome resulted, negative word-of-mouth publicity might steer other patients away, and further threaten the hospital's viability. In this case, the patient is seeking Ms. Robinson's opinion as both a professional and a friend.

Nurse Robinson thinks the patient should be fully informed about the procedure, and worries that Dr. Boardman is inadvertently exploiting the

patient for the hospital's gain. She feels that the patient should be given full disclosure and understanding of the treatment options—including the choice to stay or to go to the larger tertiary hospital, and the benefits and drawbacks of either choice. Ms. Robinson wants to inform the patient of her honest opinion, but is unsure how to do so without undermining the credibility of either the local hospital or Dr. Boardman himself.

CASE 6.3 | Breaching patient confidentiality to prevent possible harm

Nurse Andy Cox's situation—personal knowledge of another individual's life—can be the norm in any health care environment, but is particularly problematic in rural areas.[7] Mr. Cox has two different professional roles that are intersecting: licensed medical nurse, and community leader. As a school board member, Mr. Cox is Mr. Richards' employer; the teacher's drug screen implies that he engages in illegal behavior that is prohibited by the school. Mr. Cox, as school board member, worries that the children in the school may be at risk, and wonders about the outside possibility Mr. Richards is selling drugs to students. Mr. Cox, as nurse, is aware that he has confidential information that could jeopardize Mr. Richards' employment in the school. Releasing the health care information would be a clear violation of both ethical and legal standards, regardless of how ethical Nurse Cox might believe the action to be. Does Mr. Cox have ethical justification to violate his professional responsibility of not breaching patient confidentiality?

Mr. Cox wants to prevent harm to the students, but is unsure about how to proceed without violating Mr. Richards' right to confidentiality. The nurse also would like to prevent harm to Mr. Richards by encouraging him to seek drug treatment. He wonders how he can balance his professional responsibility as a health care provider and as a community and school board member.

RESPONDING TO PROFESSIONAL RESPONSIBILITY ETHICS CONFLICTS

Adhering to appropriate professional boundaries is a critical part of maintaining professional responsibility in patient-clinician relationships. The physician, nurse, or other provider must identify and maintain his

or her professional and personal roles in relation to those of the patient. When patients and providers have overlapping relationships, the resulting boundary conflicts can cause confusion and concern. Therefore, it is imperative for health care providers to clearly communicate to patients their professional responsibilities and limits, as well as their concerns about inevitable ethics conflicts caused by overlapping relationships.

In the past, boundary crossings have been viewed as the first step on a "slippery slope" that leads to increasing frequency and magnitude of such boundary conflicts. More recently, authors have argued that this is not inevitable, and that conflicts should be more closely examined for their merits and not universally categorized as "wrong."[6] What is applicable in one specialty may be contraindicated in another. For instance, the office setting is often where general physicians first meet people who eventually become friends or even romantic partners. For psychiatrists or psychologists, this is unacceptable; an ethically grounded therapeutic relationship forecloses such possibilities.

CASE 6.1 | A physician's family gaining an unfair advantage

After weighing several options, including returning the chair, Dr. Dallace decides to voluntarily pay a fair price for the chair. In doing so, he can clarify his reasoning. Though he feels better after making this decision, he then ponders how best to explain the decision his wife. If he tells her directly why he is paying more for the chair, he might be violating patient confidentiality. In his mind, the fact that he is treating the auctioneer for a narcotic dependence makes his role similar to that of a psychiatrist. He therefore believes that he should maintain a strict standard of confidentiality that applies to that specialty. If he fabricates a story to tell his wife, he will further escalate the situation by deceiving her. In the end, Dr. Dallace thanks the patient for his kind gesture, and communicates his concerns regarding the potential for conflict of interest and his commitment to professional ethics. Dr. Dallace determines the chair's fair value, contributes the money to the auction proceeds, and keeps the chair.

The ethical guidelines and practice standards of medical specialties preclude using patients to meet the personal needs of the physician.[3]

However, in many instances, accepting a small gift from patients is an acceptable community expectation. As the clinician, ethicist Dr. Lo argues, “Indeed, patients would rightly feel insulted if physicians did not accept home-made cookies, toys at Christmas, or clothes for a new baby. Similarly, it would be unfeeling not to accept a small gift after the physician has devoted a great deal of effort in helping a patient recover from a difficult illness.”[5] Providers must be aware, though, that some gifts are problematical, often because of monetary value. These gifts should not be accepted if doing so causes conflict with other health care providers or patients. In this case, Dr. Dallace is right to dispute the chair’s value, because to accept it at the reduced cost would be detrimental to the chair’s original owner and might also trouble Dr. Dallace’s co-workers and community if they became aware of the situation. Likewise, Dr. Dallace gives proper thought to the role played by his own family when he considers how his actions might affect his spouse. In rural areas, family members are often very much a part of the professional’s role conflicts, particularly regarding confidentiality.[8]

CASE 6.2 | Choosing between loyalty to the hospital or to the patient

Nurse Linda Robinson believes that an individual patient’s quality of care should not be compromised to enhance her hospital’s economic situation. She is concerned about the hospital’s precarious economic situation and recognizes the important role that the hospital plays in the community. However, Ms. Robinson also feels that any patient should be aware of her health care options, including potential differences in the quality of care from one facility to another, because of the risk-benefit and volume-based sensitivity of many treatment procedures.

Ms. Robinson decides to discuss the situation and the patient’s question with the director of nursing, who also chairs the newly formed ethics committee. They discuss the situation with Dr. Boardman. Dr. Boardman acknowledges that he wanted to give information selectively that would benefit the small hospital. The director clarifies that, while he and Ms. Robinson (like any employees, including even herself, the director) have a financial interest in the hospital’s success, their first obligation should always be to the patient. Dr. Boardman and Ms. Robinson realize that if

they did not fully inform the patient and the procedure were to result in a poor patient outcome, both Dr. Boardman and the hospital might suffer negative consequences, including poor public relations, and financial loss that might well include a lawsuit. Dr. Boardman admits that he would have shirked his professional responsibility and displayed a conflict of interest if he had put the hospital's success above the patient. Instead, he should communicate the strengths and weaknesses of both hospitals to the patient, and allow her to decide the most acceptable treatment site.

Following their meeting, Ms. Robinson and Dr. Boardman meet with the patient and review her treatment and facility options. The patient decides to be transferred to the large tertiary medical center. After the successful treatment, the patient returns to small rural facility for follow-up care. The case is later presented at a clinical staff meeting to discuss the scope of sharing decision-making and other ethics issues that were raised by the case.

CASE 6.3 | Breaching patient confidentiality to prevent possible harm

Since he has always been careful to draw a clear line between his professional and personal lives, Andy Cox first wonders if he can simply ignore the laboratory results. This option leaves him feeling uncomfortable, because he doesn't know how the drug use might be affecting Mr. Richards' work or the teacher's interactions with students. Nurse Cox worries that Mr. Richards' drug use, even if not directly affecting his work, might impact his ability to participate in the required drug education by all teachers. As a school board member, Mr. Cox knows that drug use excludes individuals from teaching, and thinks he might be justified in divulging the privileged information.

Mr. Cox considers bringing the matter directly to his fellow school board members, but he knows that to do so would betray his professional relationship and responsibilities. Still, he believes that a potentially unsafe situation exists in the school and that he is obligated to do something. Mr. Cox wonders if the potential harms are great enough to justify disclosing the confidential information to others as part of the "duty to warn and protect." Alternatively, he considers confronting Mr. Richards directly with

the information, exploring the situation and, if necessary, having Mr. Richards come forward to the school authorities regarding his drug problem.

Mr. Cox knows that he cannot safely breach patient confidentiality with a third party, without more information, so he begins by exploring ethical guideline literature on the Internet. He realizes that confidentiality is key to successful patient-clinician relationships because it helps to establish trust and protects patients from the stigmatization and discrimination that might be associated with their illness.[5] There are several generally accepted exceptions to confidentiality that require health care professionals to report certain behaviors, potential behaviors, and illnesses to various public officials as noted below.

However, rural caregivers and administrators should be aware of their state-specific reporting requirements. Despite the ethical obligation to respect patient confidentiality, as noted in Chapter 7, there are several morally justified exceptions to preserving confidentiality that may be permitted by law, depending on the particular jurisdiction.

In this situation, Mr. Cox believes that the risk to third parties (such as students) does not allow him to breach the patient's confidentiality, but he is still uncertain as to how to proceed.

Unable to confidently choose among his options, Nurse Cox contacts a nurse friend with whom he has gone to school. This nurse lives in another state and doesn't know any details of the situation or the person involved. Mr. Cox's friend suggests talking to the physician who has ordered the blood test. She also suggests contacting the local nursing board ethics representative for advice.

Nurse Cox takes the advice and talks with the physician, who confirms that the testing has been done as part of a routine insurance exam, and the patient has not yet been told of the results. After more discussion, the physician and Andy agree that the two of them should meet with Mr. Richards and review both the testing and Mr. Cox's difficult predicament. The teacher acknowledges that he has a drug problem, but denies that it is affecting his teaching. After talking with his physician, and having several sessions with a drug counselor through a telehealth network,

the teacher speaks with school officials about his problem and takes a voluntary leave of absence to enter drug treatment, with the goal of being totally clean before returning to teaching.

ANTICIPATING PROFESSIONAL RELATIONSHIPS ETHICS CONFLICTS

In each of the cases, it was very important that the clinicians step back to reflect on their overlapping professional and personal responsibility conflicts. Rarely is there only one reasonable action and some clinicians might have chosen courses different than those presented here. For example, even after considering his options, Mr. Cox still had no clear solution, so he sought counsel from other trusted sources. Ultimately, his solution came when he clarified his roles—with himself and with the patient in question.

The best approach to preventing ethics conflicts related to professional responsibility is through communication and planning. Rural providers who maintain clarity regarding their responsibilities in the lives of patients will help prevent ethics conflicts and the problems that arise from them. Preventing ethics conflicts can be aided by keys listed in Box 6.1.

BOX 6.1

Keys to Anticipating and Preventing Ethics Conflicts

- Be aware of the ethical standards guiding the patient-clinician relationship
- Communicate with patients about professional responsibilities
- Expect ethics conflicts due to multiple roles
- Be able to recognize when boundaries are being crossed
- Recognize potential fallout from the professional realm to the interpersonal one
- Analyze ethics conflicts, and generate multiple potential responses—there is rarely only one solution
- Identify and use colleagues to discuss patient-clinician conflicts
- Identify and seek support from ethics resources regarding patient-clinician conflicts

Awareness of Ethical Standards

Maintaining awareness of the ethical aspects of professional responsibility is an important tool for the medical provider to use to successfully navigate the ethics challenges to patient-provider relationships in a rural community. Clinicians cannot assume that patients will fully understand all aspects of the ethical standards that guide the patient-provider relationship. Health care providers should be aware of those standards as part of their professional responsibilities, and communicate such standards to patients.

Communication with Patients

Although a clinician may be well aware of the difficulties caused by overlapping roles, such issues are generally unappreciated by patients unless made explicit. Patients may even see any personal relationship they have with the provider, outside of the clinic, as a positive influence on care and may thus emphasize it. It may sometimes be the case that an outside relationship would enhance care; however, any future conflicts may be prevented if the provider thoughtfully explains and discusses with patients how overlapping relationships might create problems.

Expect Ethics Conflicts

Role conflicts are the norm in rural health care. By expecting conflicts, providers are less likely to miss them or be surprised by their occurrence. The failure to recognize such conflicts will diminish the probability of successfully managing them.

Recognizing Boundary Crossings

At times, a provider may allow boundary crossings that do not harm patients, as when the provider accepts a friendly, small gift. At other times, such as when Dr. Dallace was offered the larger gift, boundary crossings could lead to harm, including patient exploitation. If boundary crossings are not recognized, proper analysis cannot occur. Patient-provider relationships and boundary crossings are discussed further in Chapter 5.

Fallout from Professional and Personal Overlapping Roles

Health care providers need to be aware that they may be susceptible to the influences of friendship on the professional relationship. A provider might, for example, fail to ask a friend (who is also a patient)

an embarrassing personal question during an office visit. This omission could preclude the collection of medical data that might be vitally important to diagnosis and treatment.

Seeking Consultation

It can be difficult for the clinician to fully maintain objectivity if he or she has multiple relationships with a patient. If conflicts arise, such as the one Mr. Cox encountered, finding an uninvolved colleague for advice can be invaluable. Though often geographically and socially isolated from colleagues, the rural provider still has resources that include regional ethics networks, hospital ethics committees, and a growing number of Internet resources.

CONCLUSION

Providing health care in the rural setting poses many challenges for professionals that differentiate rural health care from medical practice in urban areas. The closeness of the rural setting makes it more likely that clinicians will interact with their patients in many situations outside of the professional office. In those situations, the professional will be in a very different role, perhaps friend, customer, or even employer. The three examples given illustrate some of the ethics conflicts related to professional responsibility that can develop in such contexts. Oftentimes, conflicts that arise have many potential solutions. Successful resolution requires that the provider undertake a great deal of thought and analysis, using ethical principles and resources, such as ethics committees and consultants. Methods of conflict anticipation and prevention, including open communication with patients, are essential steps that the provider can take toward minimizing and/or solving such conflicts.

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