

Frontier Ethics: Mental Health Care Needs and Ethical Dilemmas in Rural Communities

Laura Weiss Roberts, M.D.

John Battaglia, M.D.

Richard S. Epstein, M.D.

Roughly 15 million of the 62 million rural U.S. residents struggle with mental illness and substance abuse. These rural dwellers have significant health care needs but commonly experience obstacles to obtaining adequate psychiatric services. Important but little-recognized ethical dilemmas also affect rural mental health care delivery. Six attributes of isolated settings with limited resources appear to intensify these ethical dilemmas: overlapping relationships, conflicting roles, and altered therapeutic boundaries between caregivers, patients, and families; challenges in preserving patient confidentiality; heightened cultural dimensions of mental health care; "generalist" care and multidisciplinary team issues; limited resources for consultation about clinical ethics; and greater stresses experienced by rural caregivers. The authors describe these features of rural mental health care and provide vignettes illustrating dilemmas encountered in the predominantly rural and frontier states of Alaska and New Mexico. They also outline constructive approaches to rural ethical dilemmas in mental health care. (*Psychiatric Services* 50:497-503, 1999)

Mentally ill individuals who live in rural communities have significant health care needs but may experience many obstacles to obtaining adequate health care services (1-6). Especially in the more remote "frontier" areas, existing in 25 states and representing approximately 45 percent of the land mass of the United States, barriers to care include insufficient access to multidisciplinary clinicians, crisis services, mental health and general medical clinics, hospitals, and innovative med-

icines and other therapies (2-5). More basic community services, such as transportation, electricity, water, and communication systems, that are important to the provision of optimal medical care also may not be available in many isolated rural areas (2,5). These obstacles to rural health care are increasingly acknowledged (1-3).

However, important and little-recognized ethical problems arise in health care in small rural communities, and these dilemmas may greatly influence how mental health services

are delivered by caregivers and experienced by patients (6-10). These issues merit greater attention to enhance our understanding and implementation of psychiatric care services for the 62 million rural U.S. residents.

This paper draws on early empirical literature in this field and our experience in two largely rural and frontier states—Alaska and New Mexico. A rural area is defined as one with less than 2,500 people per town boundary, and a frontier area as one with less than 6.6 people per square mile. This paper describes the significant need for mental health care services in rural areas. Case examples are used to illustrate several distinct ethical features of mental health care in small, isolated, and otherwise "closed" communities with limited resources. Key strategies to help address dilemmas in rural mental health care are also outlined.

Mental health needs in rural communities

In the United States at least 15 million rural residents struggle with significant substance dependence, mental illnesses, and medical-psychiatric comorbid conditions (1,3). For example, misuse of alcohol among rural adults and adolescents is widespread and well documented (1,3). Approximately 56 percent of adult nonmetropolitan dwellers have been identified as current drinkers, with more than 6 percent manifesting three or more signs of physiologic alcohol dependence, and more than 14 percent experiencing two or more social conse-

Dr. Roberts is assistant professor and director of the psychiatric empirical ethics group in the department of psychiatry at the University of New Mexico School of Medicine, 2400 Tucker, N.E., Albuquerque, New Mexico 87131 (e-mail, lroberts@salud.unm.edu). *Dr. Battaglia* is consultant psychiatrist in the community mental health center program of the Alaska Division of Health and Social Services in Anchorage. *Dr. Epstein* is clinical professor in the department of psychiatry of the Uniformed Services University of the Health Sciences in Bethesda, Maryland.

quences of heavy drinking (3). A 52 percent rate of alcohol use in the past 30 days has been found among rural 12th graders (3).

Compared with metropolitan areas, rural areas have a large proportion of alcohol-related motor vehicle accidents and resultant injuries and fatalities (3,11). Among certain subpopulations, such as rural women and rural Native Americans, problems related to alcohol use are particularly acute, as reflected in high levels of spousal violence, deaths due to medical complications of alcoholism, and fetal alcohol syndrome (1,3,12). In addition, although abuse of illicit substances such as marijuana, stimulants, cocaine, PCP, and heroin among rural residents is lower than among metropolitan residents, urban and rural trends are converging, and residents of remote rural areas are increasingly implicated in the trafficking and production of these drugs (1,3).

Besides substance use disorders, rural residents are at risk for significant mental illness (1-3,11-16). Symptoms related to mood and anxiety disorders, trauma, and cognitive, developmental, and psychotic disorders appear to be at least as common among rural residents as metropolitan dwellers (1,2). Moreover, rural residents may experience more or more severe symptoms during certain seasons of the year, as at harvest time, or if they live in areas affected by natural disasters or severe economic conditions, such as during the farm crisis and the destabilization of rural communities over the past decades (1,3,13).

Rural suicide rates have surpassed urban suicide rates over the past 20 years (1). For example, there are 1.5 million rural elderly residents in the U.S., and in some regions, suicide rates in this group are three times the national average for adults and higher than the rate for elderly metropolitan residents (3). Rural residents who are women, who are poor, elderly, or who have heightened psychosocial problems such as unemployment are especially likely to manifest psychiatric symptoms (1-3,5,13-16).

Finally, rural residents have higher rates of chronic illness, life-threaten-

ing medical conditions, and limitations on physical activities, placing them at increased risk for medical-psychiatric comorbidities (16). Compared with metropolitan residents, rural dwellers experience greater environmental hazards, have increased overall age-adjusted mortality, and are more likely to subjectively assess their health status as fair or poor (16). For these reasons, mental health issues in the areas of substance dependence and psychiatric disorders, psychosocial stresses, and personal well-being are among the most prominent health concerns faced in rural regions (1-3,11-16).



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Two states, Alaska and New Mexico, illustrate a number of difficulties in mental health care needs and access experienced in rural and frontier communities. Alaska is the largest state (656,424 square miles) and the second least populous state in the United States, with 1.1 person per square mile. However, it has the third highest suicide rate in the nation, with 20 suicides per 100,000 residents. Similarly, New Mexico, which is the fifth largest state (121,598 square miles) and has a population of 1.7 million, with 13.6 people per square mile, is ranked sixth in the nation with respect to suicide, with a rate of 18 per 100,000 (17).

Both Alaska and New Mexico have

high rates of alcoholism and of deaths associated with medical complications of alcohol misuse, homicide, firearm-related fatalities, fetal alcohol syndrome, accidental injuries, and motor vehicle accidents (17-20). Mental health needs are very acute among Alaska Natives and American Indians, one-third of whom are believed to need mental health services for primary psychiatric disorders (3,21). American Indian and Alaska Native adolescent boys and young men commit suicide at a rate two to three times the national average for the general population, and the death rate due to alcohol abuse among American Indian and Alaska Native women is ten times greater than that of Anglo women in the U.S. (11,19,22).

Despite the great need for mental health care, Alaska and New Mexico have significantly limited services. Obstacles to rural mental health services include shortages of qualified mental health professionals; severely limited access to inpatient care and to emergency services for psychiatric and substance abuse problems; insufficient case management and community-based supports for special populations with mental disorders such as elderly persons, children, and chronically and severely ill persons; and inadequately integrated and poorly funded systems of general and mental health care (1-3). Specifically, 12 percent of Alaska residents and 18 percent of New Mexicans lack access to primary care, placing these states 33rd and 45th, respectively, among the 50 states in providing access to general health care (17).

In 1995 Alaska was ranked 50th and New Mexico 47th with respect to community hospitals, which are key institutions in providing mental health care. In Alaska the rate is .03 hospitals per 1,000 square miles and in New Mexico the rate is .30 (17). The national rate is 1.40 per 1,000 square miles (17). Only two psychiatric hospitals exist in Alaska, and only 12 serve the state of New Mexico. Hence, the majority of counties in these states have no psychiatric or alcohol treatment beds (18).

In terms of clinicians, both states have far fewer physicians per resident than the national average—1.4 physi-

cians per 1,000 Alaska residents, and 1.9 physicians per 1,000 New Mexico residents (17). Alaska has relatively few practicing psychiatrists (17), and less than 10 percent of New Mexico's counties have sufficient numbers of psychiatrists (18,19). Alaska and New Mexico thus resemble other less populous states with tremendous mental health care needs, limited access and resources, and significant vulnerable populations.

Ethics and rural mental health care

Rural caregivers face serious clinical ethical dilemmas every day. Because of isolation and poor resources, rural clinicians commonly provide care without optimal supports, services, and safeguards for their patients (1,3,4,6,23-27). Rural clinicians find it necessary at times to ration care, to provide care outside of their usual areas of expertise and competence, to deal with patients' "noncompliance" related to access problems, to respond to complaints about colleagues' impairments, and to make complex clinical decisions about reproductive, end-of-life, and quality-of-life issues without the benefit of specialists (8-10).

Care for rural patients with mental illnesses poses further problems, such as addressing patients' potential for self-harm and violence, dealing with the heightened social stigma associated with mental disorders, protecting vulnerable patients from potential abuse or exploitation, and grappling with care planning for individuals with impaired decision-making capacity (1,3-6). These ethically rigorous issues are often more acute in rural or isolated health care settings primarily because usual practices to ensure ethical conduct are narrowed by the scarcity of health care resources (1-10,23-27).

In this paper, we describe and illustrate six ethically important attributes of isolated settings that intensify the dilemmas encountered in rural mental health care.

Relationship, role, and boundary problems

Vignette 1. A mental health clinician in a remote rural area in Alaska, accessible only by boat or plane, had to

buy her winter fuel supply from a man who was her psychotherapy patient. Typically, the winter fuel purchase in this community is a major negotiating event, and the final trade price is highly dependent on the nature of the relationship between the buyer and seller. For the clinician, no other options existed for buying winter fuel in this community. The clinician struggled with how to obtain a "fair market price" with her patient, in light of the dual nature of their relationship.

Vignette 2. New to a small town, a psychiatrist began dating a woman he met socially. Later, her sister was brought to the emergency room, intoxicated and disheveled, and disclosed that she had been raped. The community had no other psychiatrists, and the mental health nurse who worked with sexual assault victims was supervised by the new psychiatrist. The woman was hesitant to talk about her experience because she felt ashamed in front of her sister's "boyfriend."

As these vignettes illustrate, rural health providers routinely interact with patients in nonmedical or overlapping roles. A study of 510 clinicians in Kansas, for example, revealed that 46 percent of family physicians and general-practice physicians in towns of fewer than 5,000 inhabitants had a significant number of patients who were family members or friends either of the physician or of the physician's staff (7). The great majority of these small-town physicians had interacted in nonmedical roles with patients, compared with only 13 percent of physicians practicing in cities with populations over 20,000.

The smaller and more remote a community is, the more dependent each community member is on others to meet needs for food, water, shelter, health, education, and companionship (28). The likelihood of overlapping roles is greatest in isolated native villages where most of the inhabitants have some kin connection as well. In these naturally "enmeshed" communities, there are few options for relationships other than overlapping ones.

Overlapping relationships are ethically problematic and potentially ex-

ploitive of patients because of their impact on treatment boundaries. Treatment boundaries, especially important in the care of mental illness, define the professional relationship as fundamentally respectful and protective of the patient and as dedicated to the patient's well-being and best interests (29-36). However, overlapping relationships place clinicians at risk for ethical problems, as reflected in the observation that half of the ethics complaints reviewed by the American Psychiatric Association in 1996 related to harms perceived in association with overlapping relationships (28,29,31,33).

Rural clinicians routinely experience the ethical bind of caring for each individual patient while also balancing the competing needs of other patients and the community and keeping separate their personal motivations. Rural clinicians thus naturally function in a context of overlapping relationships, potentially conflicting roles, and altered therapeutic boundaries, which may be riddled with ethical problems (28).

Confidentiality

Vignette 3. A 35-year-old man drove 200 miles to an Albuquerque emergency room with a .22-caliber pistol in his hand because he felt suicidal. He stated that he had spent the night in a field near his home, repeatedly holding the gun to his head and then "losing nerve" and shooting into the sky.

The man said that two weeks earlier he himself had found a suicide victim, and since that time he could not rid himself of the idea of killing himself. He reported nightmares, intrusive thoughts, irritability, avoidance, and anxiety. He had not sought care because he didn't want to be identified going to the rural "mental clinic" and had little money to go elsewhere. "Everyone watches who goes in there," he said. "My mom works down the street. . . . If you go in, they think you are crazy. I didn't want them to know I was weak. I didn't want to lose my job. I didn't want the whole town to know I was nuts."

Vignette 4. A therapist in a remote town conducted psychotherapy with a man who took great caution to keep

his visits confidential. Therapy sessions involved many discussions about problems in his marriage and his desire to become a better husband. Unbeknownst to the man, his wife entered counseling under an assumed name with the same therapist. She was seeking ways to improve her independence and leave her husband. Once the therapist realized who she was, he struggled to maintain an impartial, balanced stance in his work with each. No other counselors were available in the region.

Rural communities have been likened to "fishbowls." Comings and goings at the mental health clinic are observed, and people listen carefully to comments of clinic staff members. Thus the chances of confidentiality breaches with significant consequences for personal, family, and professional relationships are intensified, as illustrated in vignettes 3 and 4. Protection of the rural patient's privacy is quite difficult, despite its importance to sound clinical care practices (28, 31,33-35).

This situation has several ramifications. First, fear of confidentiality breaches may prevent patients from seeking or complying with necessary mental health care due to the consequences of stigma and social ostracism (1,3,6,8,33,37). Second, decisions to disclose confidential patient information, as required by law, for instance, are especially worrisome when the practitioner can directly see how damaging it may be to an individual to reveal the information. In such cases, the duty to act beneficently and nonmaleficently (30) stands in disquieting contrast with the need to be law abiding and the desire to fulfill one's perceived obligations to the community—for example, to protect area residents from potential harm, violence, sexually transmitted infections, or sexual or domestic abuse (6-9).

A third ramification of confidentiality dilemmas is evident when rural mental health clinicians perform maneuvers to protect patients' privacy that interfere with optimal documentation and health care (6-9). Unethical confidentiality "techniques" have been reported in a survey of 510 physicians (7). They included omit-

ting certain details from insurance forms (37 percent), failing to report illness to local public health officials (21 percent), and purposefully misrepresenting details in the medical record (6 percent) or insurance forms (5 percent). For these reasons, confidentiality dilemmas appear to be important factors influencing rural health care practices as well as care-seeking behaviors.

Cultural issues

Vignette 5. During a recent conference, a frontier psychiatrist described the importance of respecting the customs of Alaskan Natives in providing



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mental health care. He stated that, although it is perceived to be "against the ethics principles of the American Psychiatric Association," to enter a home of an Alaskan Native and not accept a gift "would amount to complete effrontery." The psychiatrist felt that this behavior would preclude a therapeutic relationship from developing, and yet it would be seen as exploitive by "urban" ethics standards.

Vignette 6. "Where I live and practice," a psychiatrist commented, "bartering and 'extended credit' are a way of life. There is no money there. . . . You cannot avoid participating in

the ways of the community if you are to survive and if you are to be accepted. In most cases, it is also more therapeutic to make arrangements that your patients can fulfill."

Experiences of suffering, definitions of illness, and care-seeking behaviors are influenced by cultural values and beliefs (1,3,5,6,12-16,22, 37,38). Particularly among mental health practitioners who are new to rural areas, cultural ethical "errors" may occur through underinterpretation or overinterpretation of the cultural meanings of certain symptoms, signs, complaints, or behaviors (6,37, 39-41). Such errors may greatly interfere with mental health care of patients and their families and members of their small community in the future.

Sensitivity and acumen about the cultural dimensions of mental health care are critical so that patients' concerns are accurately identified and treatment planning is attuned to patients' concerns and circumstances. This type of sensitivity may be especially necessary in issues related to mental health. However, professional ethics guidelines in medicine and psychiatry seldom shed adequate light on the role of cultural beliefs and practices in sound clinical ethical decision making in rural or other resource-poor settings (1,3,5,6,12-16, 22,37,38).

"Generalist" care and multidisciplinary team issues

Vignette 7. In talking about his practice, a psychiatrist commented to colleagues, "I oversee 12 nurse practitioners and three nursing trainees in my area. I have to trust their judgment, even though I'm sometimes worried about all of the prescriptions that are being written, prescriptions that I will ultimately be held responsible for, legally and in the eyes of the community leaders, if anything goes wrong. The nurses carry the burden of the direct care, sometimes with very, very sick patients. And they don't necessarily have mental health expertise. But I carry the burden of other things, too. We couldn't practice in Montana or New Mexico the way they do in, say, New York or Los Angeles."

Vignette 8. A bachelor's-level counselor for the Indian Health Service described his caseload and supervision in this way. "I am responsible for everyone's mental health in my tribe. . . . I cover hundreds of people, really, and I don't know how many hundreds of miles. I have a nurse I can call and I have a family doctor I can call when there are big psychiatric problems, but they are busy, and they sometimes don't know about new medicines, especially for my patients with schizophrenia or mental retardation and seizures. So the patients and families do what they can. They do without care and medicines a lot of the time unless we drive more than 200 miles to the university or the VA."

Vignette 9. A rural nurse in New Mexico observed, "I had a tough case the other day. I have tough cases every day, in fact. I could discuss them with the 'circuit-riding' psychiatrist in six weeks—and I do. But I usually have to make a decision on the spot."

Multidisciplinary approaches to mental health care are recognized as beneficial and practical because strengths from various professional specialty fields may be combined to implement more robust, comprehensive care (42). However, in rural settings, "generalist" care is the rule (1,3, 23,24,43,44–46). Generalist care is characterized by individuals without specialty training who function in expanded roles to care for complex, multiproblem patients, as illustrated in vignettes 7, 8, and 9. Primary care professionals, nurse practitioners, physician assistants, paraprofessionals—for example, Indian Health Service community health practitioners—and nonprofessionals provide treatment in rural areas but often without the support or backup of specialists' expertise in mental health (4,6,23,24,28). In remote villages, families and "deputized" community members without support or training may bear the full burden of caring for very sick, sometimes very dangerous patients.

Rural clinicians thus commonly perform their professional work with broadened responsibilities, with more independence, and with a heightened

need for specialist support, but with less training and supervision and fewer resources than their urban counterparts (24,44). These generalist issues have critical ethical ramifications because working outside of one's sphere of competence in mental health care, except in emergencies, essentially violates ethical norms for the profession of medicine and related fields (28,34,35,47). Moreover, it has been shown that caregivers from different disciplines see and resolve ethical issues differently and, at times, incompatibly (9).

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In sum, substantial responsibilities are placed on generalist providers at all levels of rural mental health care. Inconsistencies in responding to ethical problems by caregivers from different disciplines may trigger new dilemmas that are themselves not easily resolved.

*Limited consultation
for ethics issues*

Vignette 10. "I was in over my head. I could tell. The situation was intense. One of the family members was sexually abusing my patient. I later

learned that he was abusing other children too. But the family was the most powerful in the community, and it was 'professional suicide' to notify the authorities of the abuse. I agonized over the decision, alone. There was no one I felt I could call. Ultimately, I reported him. I lost my job, and we eventually had to leave the area. It was the right decision, but I had no support."

Sound ethical care in complex cases at times requires a consultative process, with a bioethics committee, an ethics or legal expert, or a knowledgeable colleague (6,36,47). Indeed, a crucial skill employed by clinicians to prevent ethical mistakes is the use of collaboration, consultation, and referral. However, ethics review processes, both formal and informal, are not available in many rural situations (10,23–26,28) as illustrated in vignette 10. Ethics committees do not exist in most small-town hospitals and clinics, and when they do, they struggle with the same overlapping role and role conflict issues, confidentiality problems, and other dilemmas of rural providers (6,23,25,26). Furthermore, ethics experts and specialist colleagues, peers, and supervisors may not always be available in isolated areas, and outside consultants may not appreciate the subtleties of the small community's culture and expectations (6,25,27,48).

Rural providers often feel that sources of information about clinical ethical dilemmas, such as bioethics literature, forensic textbooks, and professional ethics codes, are so urban biased or culturally incongruent that they are unhelpful in remote communities (28). Because of these problems, rural providers sometimes adopt their own set of rules in resolving ethical problems. Because the "solutions" may deviate from national standards, these factors place the rural practitioner at risk for true ethical misjudgments as well as complaints of perceived misconduct (28).

Heightened stresses on caregivers

Vignette 11. At a recent conference, a psychiatrist in Alaska described how loneliness and isolation are everyday experiences for him and his mental

health colleagues. "You can't say what you know to anyone. At first you are a stranger to them, you can't share how you feel, and you can't become personally intimate with the people you meet because they need you too much. The married physicians do much better with the burn-out. Alcohol becomes a problem for some physicians after a while. How can you help the mental health problems of patients when you are in a bad way yourself?"

Vignette 12. A rural physician reported, "I had an old patient. I knew him my whole life because his land neighbored ours. He had been a friend of my parents and grandparents. He had dementia, the kids had moved from the reservation, and his wife was barely managing. When he got worse, I had to make the decision to send him to the city for an inpatient evaluation. There was no other choice. They then sent him to a nursing home. He died just a few weeks later from pneumonia. I wonder sometimes whether I was indirectly responsible for him dying."

Taken together, professional isolation, overlapping relationships with community members, immense clinical responsibilities, and emotional and physical exhaustion are a tried-and-true recipe for stress among rural providers (5,6,23), as can be seen in vignette 11. Every traumatic event in a rural community will be personally experienced by the local care providers, and they will inevitably have to deal with it professionally as well, as did the physician in vignette 12. Rural mental health practitioners who care for suicidal or violent patients carry particularly heavy burdens, and may commonly feel that they have no respite (28). Outlets and supports for combating such intense stress may be restricted, and this situation appears to contribute to the poor retention of clinicians in very underserved, remote areas (1,3-6, 23,24).

Providers' stress and impairment are thus ethically important not only because of their obvious potential negative effects on clinical judgment but also because of the inequity and injustice arising in the provision of adequate, stable mental health ser-

vices across the country and because of the profession's moral duty to care for and watch over itself (1,3-6,23, 35,47,49,50).

Constructive approaches to dilemmas

Rural mental health clinicians must respond with sensitivity and skill to significant ethical binds in their everyday work. Constructive, sound approaches to these dilemmas are predicated on clinicians' abilities to work with patients, gather expertise, structure clinic practices in an informed manner, mobilize scarce resources, and build collegial and personal support (5-10,23-27,39,41,43-47,51).

Concretely, learning more about bioethics and about clinical ethics decision making may be helpful in resolving specific dilemmas arising in rural mental health care (30,36). The problems associated with altered therapeutic boundaries in isolated settings, for example, include educating patients about standards of care and working together to identify potential problems that may arise with extratherapeutic or overlapping interactions. Enlisting patients' own intelligence and creativity in the search for solutions is invaluable (28). Protecting patients' privacy may be enhanced through methods such as maintaining separate charts for sensitive patient information and discussing the importance of confidentiality principles and procedures with all clinic staff who have any access to patient materials (7,9,28). Seeking supervision and expertise from colleagues outside the immediate clinical situation may offer clarity and objectivity while also preserving patient confidentiality (26,28,35,44,47).

Developing networks of clinical support and consultation is indeed a critical strategy for dealing with the dilemmas encountered by overburdened generalist providers. With the emergence of electronic communication and telemedicine and with greater organization of information and care through federal, state, and private systems, the opportunities for specialist consultation may greatly improve for rural clinicians. Maintaining connections with colleagues in

the area and throughout the country via meetings and electronic communication is worthwhile in staving off professional isolation and preventing significant departures from national standards of care.

Rural clinicians may find it helpful to become knowledgeable about the rationale behind ethics standards developed for the mental health professions, although they may be more attuned to the urban situation. Engaging in active and explicit problem solving with colleagues to translate ethics principles to the specific rural setting is often necessary. Professional organizations such as the American Psychiatric Association have established state and national ethics committees that provide consultations for clinicians seeking advice about ethical predicaments. Such organizations can also support these translation efforts by formally recognizing, through publications, conferences, and guidelines, the distinct nature of rural ethical dilemmas and encouraging research.

Finally, learning to pace one's professional life and striving to find a balance with an enriched personal and family life are key issues for any health professional, but are critically important for the rural clinician. Recognizing and managing stress as it occurs and recognizing unrealistic professional and personal expectations—"know all, love all, heal all"—are fundamental ethics "skills" for rural mental health practice.

Conclusions

The mental health needs of rural America are immense, and it is increasingly recognized that implementation of adequate psychiatric services in nonmetropolitan areas is a critical national health imperative. Ethical dilemmas in rural mental health care may be recognized in connection with overlapping relationships and altered therapeutic boundaries, patient confidentiality, cultural aspects of health care, generalist care and multidisciplinary team functioning, limited resources for consultation about clinical ethics, and heightened stresses on caregivers. These issues in rural mental health ethics have yet to receive systematic study. Nevertheless, they

are prominent considerations for rural clinicians, and they may greatly influence rural mental health practices and services now and in the future. ♦

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