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The Ethics of Place: Differences in Ethical Perspectives Among Urban, Suburban, and Rural Physicians in Georgia

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Background

Many doctors agree that the practice of rural medicine varies radically from practice in an urban or suburban area. These perceived differences include the types of ethical issues faced by practitioners (Cook, Hoas, & Guttmanova, 2002; Nelson, 2009; Nelson, Pomerantz, & Howard, 2007; Klugman & Dalinis, 2008). Some authors suggest that rural ethical issues may be grounded in "disparities" (Nelson, 2009, p. 4) created by inequitable allocation of health care resources and the challenges created by poverty, education, and culture. Based on their research, Cook and Hoas (2006) report that "when rural healthcare providers describe their dilemmas, they reference not major bioethics theories, but the social, political, and economic contexts in which these issues unfold" (p. 51). Geographic isolation, enhanced familiarity due to close-knit relationships common in small communities, lack of resources and funding, stress from excessive demand, and cultural mores can raise ethical dilemmas unfamiliar to the urban or suburban practitioner.

Accumulated experience over years of practice and the interweaving of social and professional relationships in the rural community may increase the number of ethical dilemmas for physicians. Bolin, Mechler, Holcomb, & Williams (2008) explain the dynamics:

> While most of us would like ethical decision-making to be orderly, tidy, imminently fair, and transparent, nevertheless, in the real world of rural healthcare, ethical decisions are more complex, difficult, and uncertain because the mere fact of living in a smaller area makes it more likely that the 'accused,' 'accuser' and 'judge' will know each other (p. 63).

These dilemmas do not necessarily disappear with time or training. They can be ongoing challenges to rural practice, which may exacerbate hesitation to practice long-term in a rural community, further limiting access to care for residents in low-population areas already faced with physician shortages (Miller, 2014).

Some bioethicists ask whether there are place-based differences in ethics (Hardwig, 2006; Morley & Beatty, 2008). John Hardwig (2006) poses important questions for consideration as scholars attempt to differentiate between rural and urban ethics. He asks: "Do we even *believe in* rural health care?" (p. 54) and whether "the provision of most forms of health care in a rural setting is itself unjust because it will never be as good as urban care" (p. 54). Hardwig (2006) suggests that ethical differences might derive from the urban-based anonymous delivery of high-quality "subspecialty medicine" versus rural services delivered within a "healing relationship" (p. 54). Morley and Beatty (2008) describe the rural ethics issue as "ethical lethargy" (p. 59) and contend that the "fundamental problem of unequal distribution of healthcare workforce is the true illness producing these symptoms" (p. 60).

There are, of course, variables other than the place of practice that could affect the perceptions of physicians about ethical issues. Type of practice, socioeconomic status of the community, years of experience, and institutional relationships may affect the physician's perspectives. The primary purpose of this research, however, is to investigate whether differences in ethical dilemmas in eight specific domains exist in the minds of practitioners themselves, the analysis based solely on their location of practice: urban, suburban, or rural. A brief discussion of each domain follows.

Payment and Conflict of Interest Issues

"A conflict of interest is a set of circumstances that creates a risk that professional judgment or actions regarding a primary interest will be unduly influenced by a secondary interest" (Institute of Medicine, 2009, p. 46). Most familiar to doctors are allegations of conflicts of interest in relationships with drug companies and other vendors. "While free pens and vacations have gone by the wayside, the financial ties between drug companies and doctors are stronger than ever with consulting fees and contract research," writes Lois Shepherd (2013, p. 514). She contends that the myth that physicians are more altruistic than other professionals is harmful and "can blind professionals to the very real enticements of gifts, money, prestige, and acclaim" (2013, p. 513) that are often part of the practice of medicine. Conflicts of interest may also arise when a physician makes referrals or recommendations based on relationships, financial or social, rather than on quality of care.

A new variation on the conflict of interest issue is the result of the changing system of payment for care, in which neither the patient nor the physician is the ultimate decision maker. Referrals to in-network physicians or to the lowest cost provider may be required, limiting the physician's authority to recommend the best provider and which, in turn, may limit patient choice. Romain, Dorff, Rajbhandary, & Panush (2013) point out that, regardless of location, many of the ethical challenges in medical practice derive from:

> the interposition of other agents between the clinician and the patient. A bureaucracy now restricts our choices; there are persistent inequities in health care, obligations to proliferating corporate employers, and still other factors that further confound the simple model of doctor and patient. These diminish our ability to remain a largely independent self-regulating profession. Rather, society, with whom we contract, increasingly imposes controls on our activities. A colleague summarized much of this feeling of loss in suggesting that 'there isn't any ethics anymore; they just tell us what to do' (p. 2534).

Employer policies, managed care limitations and formularies, network rules and limits, and insurance requirements not only take time away from the patient, but they also limit physician and patient choice. Pay for performance rules may tempt physicians to discharge noncompliant patients, even though continued care would be in the patients' best interest. Epstein and Delgado (2010) suggest that repeated instances of inability to deliver the most appropriate care may create "moral distress," brought on by an inability to perform what the physician believes is the proper action. The following hypothesis relates to conflict of interest and payment issues regarding physicians as differentiated by practice location: H_1: There will be no significant differences based on location of practice concerning ethical concerns about payment issues, conflicts of interest, and managed care.

Access to Care

Access to care raises issues of justice. Primary care providers may experience ethical concerns when they are unable to get a specialist appointment for a patient. Physicians with long-term patient relationships may face dilemmas about discharging those who lose insurance or change provider networks. Low reimbursement may cause doctors to limit or refuse patients covered by Medicare or Medicaid. High deductibles and payments through the Patient Protection and Affordable Care Act may be too costly for some patients and put a financial strain on physicians who cannot collect deductibles and co-payments for services. In resource-poor

rural areas, figuring out how to get patients the supplies and services they need to maximize effective care may raise the specter of upcoding. In some rural areas, physicians may be pressed to handle care or conduct procedures outside their normal scope of care or competence, because there is no one else to provide the service. The following hypothesis relates to access issues: H_2: Physicians in rural areas will report more experience with ethical dilemmas related to patient access to care than physicians in suburban and urban areas.

Boundary and Dual Role Issues

Townsend (2009) believes that "[t]he intimacy of rural life is a key factor to many aspects of rural health care ethics discussion" (p. 129). The close-knit nature of rural communities often means that the doctor not only knows local residents as patients, but also as friends, neighbors, or co-workers. This proximity creates what Crowden (2010) defines as dual relationships: "any situation where multiple roles exist between a professional and a recipient of care" (p. 68). Dual relationships are not necessarily negative, but they can create conflict and may affect the physician's judgment. Violation of boundaries, in contrast to dual relationships, implies prohibitions that cross the line on what is moral or legal. Crowden (2010) sees urban physicians as somewhat "shielded" (p. 70) from dual relationship questions that often are a source of moral distress for doctors in small communities, requiring an "ethical sensitivity to the nature of the rural practice itself" (p. 72). The following hypothesis relates to boundary and dual role issues: H_3: A greater proportion of physicians in rural areas will report experience with boundary and dual role issues than suburban or urban physicians.

Patient Autonomy Issues

Patient autonomy is clearly an ethical mandate, but familiarity can erode or enhance patient autonomy when the physician sees the patient within the context of other relationships or in a positional role in the community. The following hypothesis relates to patient autonomy issues: H_4: A higher proportion of physicians in rural areas will report experience with ethical dilemmas related to patient autonomy than physicians in urban and suburban areas.

Sociological and Cultural Differences

Cook, Hoas, and Guttmanova (2002) write that rural physicians are "more likely to encounter problems such as patients who fail to understand diagnosis and treatment, and patients who lack the financial resources to obtain needed treatment" (p. 222). Although there are exceptions, Georgia's rural populations are older, less educated, and have a higher percentage of residents in poverty than the state's urban and suburban areas (Wickersham, 2014), creating extra burdens for the rural physician. Since the 1980s, (Cossman, Cosby, & Cossman, 2010, p. 1418), rural populations have been more likely to have worse outcomes than their urban and suburban counterparts (Ingram & Franco, 2014; Singh & Siahpush, 2013; Zeng, You, Mills, Alwang, Royster, Studer, & Dwamena, 2012; Cossman, Cosby, & Cossman, 2010; Eberhardt & Pamuk, 2004), creating additional challenges for rural physicians. The stigma of mental illness can have greater impact in rural areas and can limit patients' willingness to seek care or have prescriptions filled for mental health diagnoses (Smalley, Yancey, Warren, Naufel, Ryan, & Pugh, 2010; Rost & Smith, 2008). The following hypothesis relates to ethical issues that are based on sociological and cultural differences: H_5: A greater proportion of physicians in rural areas will experience issues with ethical challenges related to sociological and cultural differences with patients than those in suburban and urban areas.

Truth-telling and Professionalism Issues

The relative anonymity of urban medical practice may make truth-telling and denial of patient demand easier than for the rural physician. Professionalism comes into play when doctors place blame on other doctors for patient problems in care. The close-knit relationships of medical professionals in small towns may also make doctors hesitant to report incompetence or substance abuse that could harm patients. Doctors may also hesitate to report in cases where colleagues figure that an inadequate doctor is better than no doctor or where an institution's financial health is dependent on revenues generated by physicians. The following hypothesis relates to ethical issues related to truth-telling and professionalism: H_6: A greater proportion of physicians in rural areas will report experience with ethical dilemmas related to truth-telling and professional conduct than those in urban and suburban areas.

Stress and Burnout

According to the 2015 Medscape Physician Lifestyle Report, 46 percent of physicians report they are experiencing burnout (Peckham, 2015). Third party administrators that intervene between the patient and doctor may add to frustration. Pressures of time affect collegiality, and lack of collegiality reduces the informal sharing of ideas and burdens. In rural areas, the absence of other doctors creates additional stress when there is no one to call and no colleague to ask for advice. Some rural physicians find themselves on call around the clock, or if not on call, living with community expectations that they are serving in their professional roles 24/7. Compounding these demands are the added burdens that technology creates. Problems with implementation of electronic health records also cause frustrations and may limit face-to-face time between doctor and patient (Congdon, 2015).

Amy Haddad (2002) describes burnout as a moral issue because of its effect on patients. She writes: "In addition to emotional, mental, and physical exhaustion, burnout causes a loss of concern about patients, cynicism, and negativism" and may result in treatment of patients in a "in a detached or derogatory way." Gabel (2011) notes that burnout occurs when physicians are overworked, exhausted, and when they "sense a lack of alignment between their own values and those they perceive to the values of various health care-related organizations or groups with which they are associated." This lack of alignment creates "stress of conscience," which can lead to "depersonalization" when treating patients, thereby creating the moral dilemma. The following hypothesis relates to ethical issues deriving from stress and burnout. H_7: A higher proportion of physicians in rural areas will report experience with ethical dilemmas related to stress and burnout than suburban and urban physicians.

Ethics Training/Leadership

Hardwig (2006) describes bioethics as "an urban phenomenon" (p. 53) with an urban audience. Bioethicists are more likely to live in urban areas, where they are associated with universities or hospitals (Nelson in Klugman and Dalinas, 2008, p. 45). Research conducted by Cook and Hoas determined that the majority of rural hospitals do not have ethics committees ((in Klugman and Dalinis, 2008, pp. 62-63). This does not imply, of course, that there are not ethical dilemmas in rural healthcare settings, but issues may not be defined as such. Problems like patient safety, patient autonomy, patient rights, quality of care, conflicts of interest, and nonmaleficence may be observed as ordinary day-to-day events and might not draw the attention these issues would attract in a setting where someone is assigned to identify ethical concerns or where quality and safety concerns and values conflicts would be referred to an ethics committee.

Some researchers contend that "there is a 'disconnect' between the ethical concerns that develop in rural practice and those typically addressed in medical school and residency training" (Cook, Hoas, & Guttmanova, 2002, p. 222). Although doctors come out of school and residency armed with some basic tools, there is less support in rural areas for or interest in ongoing ethics training or consultation (Cook and Hoas, 2008, p. 53). Based on these findings, the final hypothesis relates to ethics training and leadership. H_8: A smaller proportion of rural physicians will report the availability of ethics resources and training than physicians in suburban and urban areas.

Methods

Actively practicing Georgia physicians were invited to participate in a 42-question, voluntary and anonymous survey prepared by the authors. Questions included location of practice (urban, suburban, or rural) and size of the county of practice, as well as questions about respondents' personal experiences with ethical dilemmas. Although the exact number of active practitioners is not available, the Georgia Board for Physician Workforce in June 2015 estimated that there are currently approximately 17,000 active physicians practicing in Georgia.[1] Given an email error rate of 10 – 15% and with approximately 3200 responses per question, the response rate ranged from approximately 20% to 22%. The sample of respondents closely matches the relative proportions of specialists and core/primary providers and practice locations reported by the Georgia Board of Physician Workforce (2013): 56% specialists versus 58% of respondents; 42% core/primary providers versus 43% of respondents; 90% practicing in urban areas versus 87% of respondents in counties above 35,000.[2] Analysis of results excluded not sure/not applicable responses, since all questions were not relevant to all participants. Descriptive statistics are provided for all yes answers. Contingency tables were used to compare urban, suburban, and rural data, with Cramer's V used to measure strength of association for statistically significant findings.

Results

Table 1. Survey Results and Analysis

Question	Descriptive Data	Statistical Analysis
Domain: Payment and Conflict of Interest	Percentage Yes Responses – Not Sure/NA Omitted	
Do you believe that managed care creates ethical dilemmas related to your ability to recommend adequate treatment to your patients?	Urban – 73% Suburban – 77% Rural – 79%	N = 2542 X^2 = 6.39 P = .041 Cramer's V = .05 - Small
Have you ever discharged a patient due to non-compliance when poor outcomes would affect your payment?	Not applicable to most physicians	Lack of experience with pay for performance resulted in most physicians responding NA
Have you ever experienced moral conflict about denying care or discharging a patient who could not pay for your services?	Urban – 49% Suburban – 50% Rural - 49%	Not significant

[1] Many physicians are licensed in Georgia who practice in other states. In addition, the database includes retired physicians who maintain licensure and deceased physicians until the Board of Medicine is notified of death or the license is not renewed.

[2] In Georgia, core/primary physicians are those practicing primary care, internal medicine, obstetrics/gynecology, general surgery, and pediatrics. In Georgia law, counties under 35,000 are considered to be rural, although physicians were asked to self-select their primary location of practice: urban, suburban, rural.

Have you ever experienced moral conflict related to friends' or associates' expectations for referrals?	Urban – 25% Suburban – 29% Rural – 27%	Not significant
Have you ever felt that a financial relationship influenced your referral patterns, even when you knew that another provider/institution might provide a higher level of care and quality?	Urban – 16% Suburban – 16% Rural – 18%	Not significant
If you are associated with an institution as an employee or staff physician, have you ever faced pressure to perform additional tests that you might not ordinarily order?	Urban – 21% Suburban – 21% Rural – 23%	Not significant
Have you have been pressured by an institution to transfer, retain, or discharge a patient due to financial reasons?	Urban – 32% Suburban – 33% Rural – 36%	Not significant
Have you ever adopted or recommended a product due to gifts or gratuities (including consulting, travel, financial rewards, gift items, and research funding) from a vendor or company representative?	Urban – 2% Suburban – 2% Rural – 3%	Not significant
Have you experienced any moral distress related to the struggle between supporting the community you serve vs. better financial outcomes for the institutions with which you are associated?	Urban – 21% Suburban – 20% Rural – 25%	Not significant
Domain: Patient Access		
Have you faced the dilemma of being unable to get a specialist outside of your practice to see your patients?	Urban – 60% Suburban – 64% Rural – 78% (Counties Under 35,000 – 79%)	N = 2880 P = < .0001 X^2 = 51.12 Cramer's V = .13 - Small
Does lack of access to acute care for your patients create professional and ethical dilemmas for you?	Urban – 38% Suburban – 35% Rural – 45% (Counties Under 35,000 – 49%)	n = 2611 X^2 = 14.8 P = .0006 Cramer's V = .07 - Small
Have you ever experienced pressure to upcode or exaggerate a condition in order to get a patient the services/products he or she requires for optimal outcomes?	Urban – 30% Suburban – 34% Rural – 37%	n = 2906 X^2 = 9.78 P = .0075 Cramer's V = .06 - Small
Do you limit the number of or refuse to see patients with Medicare and Medicaid because of the reimbursement rates?	Urban – 23% Suburban – 35% Rural – 21% (Counties Under 35,000 – 20%)	n = 2798 X^2 = 51.12 P = < .0001 Cramer's V = .14 - Small
Have you ever found yourself in the position of being forced to handle a medical issue (consult, procedure, visit), which you believed was beyond your scope or ability because there was not another option for the patient?	Urban – 42% Suburban – 52% Rural – 64% (Counties Under 35,000 – 63%)	N = 2935 X^2 = 74.67 P = <.0001 Cramer's V = .16 – Small
Does the poor quality of care available to your patients ever create ethical dilemmas for you?	Urban – 54% Suburban – 48% Rural – 59% (Counties Under 35,000 – 59%)	n = 2510 X^2 = 15.91 P = .0004 Cramer's V = .08 - Small

Domain: Boundary and Dual Role Issues		
Have you ever experienced ethical concerns over boundary issues with friends, social acquaintances, or other professionals in the community?	Urban – 32% Suburban – 36% Rural – 37% (Counties Under 35,000 – 38%)	n = 2827 X^2 = 7.34 P = .025 Cramer's V = .05- Small
Have you ever experienced ethical concerns over boundary issues with employees or employers?	Urban – 29% Suburban – 31% Rural – 32%	Not significant
Have you ever had difficulty being truthful about end of life issues because of your relationship with the patient/family?	Urban – 5% Suburban – 5% Rural – 6%	Not significant
Have you ever been conflicted about reporting suspected child or adult abuse because of relationships with the persons involved?	Urban – 2% Suburban – 4% Rural – 5%	n = 2792 X^2 = 10.62 P = .0049 Cramer's V = .06 - Small
Have you ever been conflicted about reporting knowledge of substance abuse of a patient who has duties that might put others at risk?	Urban – 7% Suburban – 10% Rural – 11%	n = 2793 X^2 = 9.99 P = .0068 Cramer's V = .06 - Small
Have you ever felt that lack of anonymity in your community created ethical challenges for you?	Urban – 19% Suburban – 22% Rural – 36%	n = 2783 X^2 = 54.01 P = < .0001 Cramer's V = .14 - Small
Domain: Patient Autonomy		
Have you ever had an ethical dilemma regarding a patient's autonomy when you believed that autonomy put the patient at risk of harm?	Urban – 40% Suburban – 39% Rural – 42%	Not significant
Have you ever followed the wishes of family members rather than the wishes of the patient when the two were in conflict?	Urban – 20% Suburban – 21% Rural – 21%	Not significant
Domain: Sociological and Cultural Issues		
Have you ever struggled with cultural or religious differences with your patients that make you feel less effective or that make you less accepting of their problems?	Urban – 41% Suburban – 40% Rural – 32%	Not significant
Have you had difficulty in communicating effectively with your patients due to social, cultural, or educational issues?	Urban – 61% Suburban – 59% Rural – 54%	n = 2908 X^2 = 7.33 P = .03 Cramer's V = .05 - Small
Have you found that cultural attitudes toward mental health and mental illness affected your ability to provide quality care or make referrals for care?	Urban – 39% Suburban – 40% Rural 42%	Not significant
Truth Telling and Professional Conduct issues		
Have you ever failed to tell a patient that you have made a mistake in providing care?	Urban – 26% Suburban – 24% Rural – 27%	Not significant
Have you ever blamed another provider for a patient's negative outcomes?	Urban – 18% Suburban – 19% Rural – 17%	Not significant
Have you experienced moral conflict when responding to patient/family demands to extend care when you knew it was futile?	Urban – 61% Suburban – 60% Rural – 66%	Not significant

Have you ever caved into pressure to order unnecessary medicines or diagnostics because your patient/family members demanded it?	Urban – 64% Suburban – 69% Rural – 71%	n = 2818 X^2 = 9.54 P = .0085 Cramer's V = .06 - Small
Have you ever practiced defensive medicine?	Urban – 85% Suburban – 89% Rural – 94%	n = 2805 X^2 = .28.74 P = < .0001 Cramer's V = .10 - Small
Have you ever had ethical concerns about reporting a friend or colleague who you believed was impaired, physically or emotionally?	Urban – 18% Suburban – 18% Rural – 24% (Counties Under 35,000 – 30%)	n = 2631 X^2 = 7.88 P = < .02 Cramer's V = .05 - Small
Domain: Stress and Burnout		
Have you ever found yourself in the position of putting your own health at risk or failing to meet family commitments due to meeting the needs/demands of your patients?	Urban – 75% Suburban – 74% Rural – 80%	n = 2897 X^2 = 7.16 P = .03 Cramer's V = .05 - Small
Have you ever felt "burned out" or emotionally exhausted by the demands of your patients?	Urban – 79% Suburban – 81% Rural – 85%	n = 2905 X^2 = 6.38 P = .04 Cramer's V = .05 - Small
Have you ever felt isolated professionally?	Urban – 43% Suburban – 48% Rural – 57% (Under 35,000 – 58%)	n = 2876 X^2 = 26.22 P = < .0001 Cramer's V = .10 - Small
Have you ever been in the position of needing advice from other physicians but felt that you had no one in which you could confide?	Urban – 29% Suburban – 31% Rural – 38%	n = 2867 X^2 = 14.65 P = .0007 Cramer's V = .07 - Small
Have you ever felt moral distress because your values as a practitioner are not the same of those of payers and the health care organizations with which you are associated?	Urban – 68% Suburban – 71% Rural – 79%	n = 2784 X^2 = 20.35 P = < .0001 Cramer's V = .09 - Small
Domain: Ethics Training/Leadership		
Have you ever had training that helped you in making a decision when faced with an ethical dilemma?	Urban – 68% Suburban – 63% Rural – 63%	n = 2843 X^2 = 7.62 P = .02 Cramer's V = .05 - Small
Have you served on an ethics committee in your current practice setting?	Urban – 18% Suburban – 21% Rural – 21%	Not significant
Have you ever participated in an ethics consult with an ethics professional?	Urban – 42% Suburban – 29% Rural – 29%	n = 2905 X^2 = 50.18 P = <.0001 Cramer's V = .13 - Small
Do you have ethics resources available to you in your current practice setting?	Urban – 75% Suburban – 61% Rural – 50%	n = 2438 X^2 = 96.83 P = <.0001 Cramer's V = .20 - Moderate

Findings

H_1 is substantiated. There is widespread agreement among physicians, indicated in yes/no questions, that "the business of medicine" interferes with their practices and "limits the ability to recommend adequate treatment to patients." The fact that more rural physicians than urban physicians experience ethical issues in managed care may reflect the lack of resources and options for patients in smaller communities where networks are often shallow and narrow. There were no significant differences in physician responses to questions concerning gratuities and gifts from vendors, conflicts of interest with institutions or referrals, or business-based decisions about discharging patients. This lack of significance points to almost universal standards among physicians and stringent regulatory policies in this domain.

Although concerns about access to care were spread across all locations, it is clear that rural areas have the greater burden in assisting patients with access to specialty care and acute care, thereby substantiating H_2. Of rural physicians, 78% find it difficult to arrange specialist appointments for their patients, compared to 60% of urban physicians. For physicians in counties under 35,000, 49% expressed concerns over lack of access to acute care, compared to 38% of urban physicians. This lack of access may be responsible for the fact that a higher proportion of rural physicians, 37% in rural versus 30% in urban areas, admit to "exaggerating a condition" to get patients the services/products they need for optimal outcomes. Rural and urban practitioners are less likely to refuse Medicare and Medicaid than suburban doctors. In the case of rural areas, most rural Georgia counties have relatively high proportions of Medicare and Medicaid recipients. Lack of access to specialists, either because they are not local or because they do not accept Medicare and Medicaid, may force rural providers to exceed their scope of care at a higher rate than suburban or urban providers (64% for rural versus 42% for urban). Quality of care was also of greatest concern to rural providers, followed by urban and suburban physicians, perhaps a further indication of lack of resources for patients.

Differences in responses on boundary and dual role issues by location of practice varied only marginally across the board, therefore, H_3 is not substantiated. Most significant in responses in this category was rural physicians' belief that lack of anonymity creates ethical problems. Of yes/no respondents, 36% of rural physicians, compared to 22% of suburban and 19% of urban, see lack of anonymity as an issue.

Patient autonomy is for physicians across all locations of nearly equal concern. H_4 hypothesis is not substantiated, providing support for those theorists who believe "ethics is ethics" regardless of place.

H_5 is not substantiated, the results virtually opposite of the prediction in the hypothesis. Urban and suburban physicians report that they have more issues with cultural or religious differences and more issues in communicating effectively with patients for optimal outcomes than rural physicians. These findings may reflect the higher proportion of primary care physicians in rural areas with an ongoing relationship that enhances communication contrasted with a higher proportion of specialists with short-term relationships with patients in more urban areas. There was no significant difference in attitudes toward mental health across locations.

Although strength of associations were small, rural physicians are slightly more likely to "cave into pressure to order unnecessary medicines or diagnostics because patients/family members demand it." Defensive medicine is almost universal, according to survey results, but 94% of rural physicians admit to practicing defensive medicine, compared to 85% of urban practitioners. Rural doctors also had greater concerns about reporting impaired colleagues than suburban or urban doctors. This result may be due to the close-knit relationships in smaller

communities or the fear or losing an essential provider, thereby increasing one's own burden of care in the community. Questions about futile end of life care and telling patients about mistakes showed no significant differences across locations. H_6 is, therefore, only partially substantiated.

H_7 is substantiated, though differences across locations were relatively small. Rural physicians were more likely than their more urban counterparts to say that they "have put their own health at risk due to meeting the demands of patients" and that they have experienced more emotional exhaustion and burnout due to patient demands. The nature of rural practice means fewer providers, and this is reflected in higher response rates from rural physicians that they "feel isolated professionally" and, when "needing advice from other physicians," that they have no one in whom they can confide. The unstable nature of many rural health systems, a flurry of mergers and acquisitions, and pressures to produce, order, admit, discharge, or transfer may also relate to the higher proportion of rural physicians who say that their values as practitioners "are not the same of those of payers and health care organizations with which they are associated."

H_8 is substantiated. Only half of physicians in rural areas say that they have access to ethics resources, compared to 75% in urban areas. While 42% of urban physicians have participated in an ethics consult with an ethics professional, only 29% of suburban and rural doctors have had this experience.

Discussion

Data from this survey of Georgia physicians lends much support to the ideas that "ethics is ethics" no matter the location. While some doctors admit concerns in all traditional areas of ethics, there is broad agreement in responses among urban, suburban, and rural practice locations in the following areas: conflicts of interest concerning payments, referrals, and gratuities; patient autonomy; truth-telling regarding end of life care and admitting mistakes; and boundary and dual role issues. These are focus areas in the ethics curriculum and are the subject of laws and regulations about which most doctors are well-versed.

There is also broad agreement among Georgia doctors across all practice locations about the following: the interposition of third party decision-makers between the physician and the patient; treatment decisions made by insurers and institutions based on the bottom line; the need to practice "defensive medicine" due to the threat of lawsuits; the propensity to "cave-in" to patient demands due in part to institutional requirements for patient satisfaction and in consideration of potential revenue; and the inability of the doctor to prevent futile care. Most Georgia doctors responding to the survey admit to feeling moral distress because their values are not the same as those of payers and the health care organizations with which they are associated. The great majority of doctors admit to "putting their own health at risk" and to feeling "burned out" or "emotionally exhausted" with the demand of the practice, thought these concerns are slightly higher in rural areas and may help explain workforce shortages.

It is clear from survey results, however, that the primary differences between ethical perspectives between rural physicians and their more urban counterparts relate to the maldistribution of resources. Issues of access to acute care, specialty care, and quality care are of greater concern to rural doctors than to other respondents. Rural physicians are more likely to find themselves in the position of being forced to handle a medical issue outside of their scope of care due to lack of alternative resources. Rural physicians are also more likely to exaggerate a condition than other physicians, likely because of scarce resources and a higher level of poverty that reduces access to specialty care.

The more intimate nature of small communities may also be the reason that rural physicians are less likely to report doctors with problems or substance abuse. Rural doctors are considerably more likely to find lack of anonymity creates problems than doctors in more urban areas. Professional ethics may indeed, as Hardwig (2006) puts it, be "an urban phenomenon" (p. 53).

An open-ended question provided insights into ethical issues not discussed in this survey: electronic health records, patient refusal of care, performance measures, unrealistic expectations of patients and families, lack of follow-up for emergency room patients, mergers, the shifting dynamics of institutions and institutional employees, patient fraud and abuse, reliance for education on pharmaceutical companies, physician-assisted suicide, board requirements for reporting health issues, risks versus benefits of expensive treatments, password sharing, confidentiality, pharmacy benefits managers, overregulation, state and federal laws, failure of the State of Georgia to expand Medicaid, inappropriate referrals, and substandard care. These are vital issues that should also be explored.

The results of this survey suggest the reasons why physicians are not choosing to practice – or at least to remain after some initial period – in rural areas. Lack of resources, high demands, lower reimbursements from the higher proportion of government payers in rural areas, and an unstable institutional environment may help explain why only a small fraction of graduates from Georgia's medical schools are choosing to practice in rural communities. Recognition of the need to support ethical decision-making for rural doctors could increase their willingness to serve high-needs rural communities and ease the burdens inherent in rural medical practice.

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