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Ethical Disparities:

Challenges Encountered by Multidisciplinary Providers in Fulfilling Ethical Standards in the Care of Rural and Minority People

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Abstract

Context—Health care disparities and well documented for people living in rural areas and for people who are members of ethnic minorities.

Purpose—Our goal was to determine whether providers report greater difficulty in providing care for rural than urban residents and for ethnic minorities than patients/clients in general in 4 practice areas of ethical relevance attaining treatment adherence, assuring confidentiality, establishing therapeutic alliance, and engaging in informed consent processes.

Methods—We received survey responses from 1,558 multidisciplinary medical and behavioral providers across rural and non-rural areas of New Mexico and Alaska in 2004 to assess a wide range of issues in providing health care.

Findings—Providers reported some difficulties in fulfilling various ethical practices for all types of patients, but not more difficulty when caring for minority compared to nonminority patients/clients. However, they do report more frequent additional problems related to the practice issues of treatment adherence, therapeutic alliance, informed consent, and confidentiality with minority patients than others. Difficulties and more frequent additional problems are greater for providers in rural than in non-rural areas. Results generalize across both Alaska and New Mexico with few differences.

Conclusions—We obtained evidence for disparity in care for patients/clients who were minority group members, and clear evidence of disparity for people residing in rural compared to non-rural areas of 2 states with large rural areas.

Illness burden and health-related resources are unevenly distributed across the United States.^{1–3} A pattern of greater burden and lessened resources exists among certain populations, such as rural and frontier residents and ethnic minority people, creating significant inequities or disparities in health for these groups.^{4,5} Over time, with our country comprised of nearly 60 million rural persons⁶ and more than 50 million ethnic minority persons,⁶ health disparities among these populations have been recognized increasingly as serious concerns for our society.

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Conflict of Interest Statement:

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The emerging literature has documented disparities for rural people compared to those living in non-rural areas in disease burden and disability level⁷ as well as regarding access to health care resources. Rural residents have higher rates of chronic illness, life-threatening medical conditions, physical and self-care limitations associated with disability, motor vehicle accidents, and environmental hazards.⁸ Rural residents more often use alcohol routinely and experience more severe consequences of alcohol dependence (eg, cirrhosis, nutritional compromise, fetal alcohol syndrome), alongside more rapidly escalating rates of substance abuse and dependence with compared with suburban and urban populations.⁹ Elders, farmers, and Native American adolescent males who live in rural areas carry very high risk for certain mental health-related health issues (eg, depression, co-occurring health conditions) and exceptionally high rates of completed suicides.¹⁰ Although prevalence of HIV is relatively low in rural areas, the incidence rates for HIV are increasing more rapidly in rural areas, and certain infections (eg, hepatitis B, hepatitis C, Chlamydia, tuberculosis) exist at higher than national averages in many rural states.¹¹ Finally, fewer individuals who live outside of urban areas assess their personal health as “excellent” and greater proportions of rural residents reported their health as “fair or poor,” with the poorest rural residents being 4 times as likely to give this negative assessment.⁵

Similarly, among ethnic minority people significant disparities exist for illness burden.^{12,13} Various minority groups show notable disparities for infant mortality, total death rate, death rates by violent means, and death rates for most major diseases, such as cardiovascular disease, asthma, cancer, and diabetes.^{14,15} Disparities for various minority groups are also present for many stigmatizing illnesses such as sexually transmitted diseases (including HIV), drug abuse, and depression.¹⁵ Health status indicators developed as a part of *Healthy People 2000* showed improvements for most ethnic groups during the 1990s, but these improvements were matched by generally similar improvements for nonminority groups, leaving the disparities at similar levels as a decade before.¹⁴

Ethnic minority people overall have significantly lower overall access to appropriate health care resources, including less access to a regular primary care provider, less preventive care, and lower rates of health insurance.¹⁶ Some but not nearly all such disparities can be attributed to differences in economic resources between majority and minority groups in the United States. In addition, evidence indicates that ethnic minority people often receive lower quality interpersonal health care than white patients,¹⁶⁻¹⁹ partly due to low levels of cultural competence of providers and partly due to discrimination, stereotyping, and other unconscious cognitive processes among providers and other members of the health care system.^{16,20} The Institute of Medicine report *Unequal Treatment*¹⁶ provides a detailed examination of ethnic disparities in health care as well as recommendations about how to reduce them. This is also the topic of the highly controversial January 2004 *Changes to the National Healthcare Disparities Report* from the US House of Representatives Committee on Government Reform.²¹ In addition, various approaches have been recently discussed for reducing health care disparities.²²⁻²⁵

Despite real and often greater health care needs, fewer resources exist for rural and ethnic minority people.^{5,26,27} Rural areas often do not have adequate or up-to-date health care facilities, nor can they sustain a continuum of necessary services for physical and mental health needs of their patients.²⁸ Rural areas have insufficient numbers of generalists, specialists, and subspecialists, and providers in these areas take on expanded responsibilities in clinical care.²⁹ Just as rural hospitals and health care facilities are often under threat of closure due to financial challenges, the sustainability of rural clinical practices presents many difficulties as providers are exhausted by the immense and diverse health needs in their communities.²⁸

The lack of necessary services for rural and ethnic minority people aligns with other considerations. For instance, over 14% of rural people and over 22% of black, Hispanic, and Native American people in the United States live in poverty.⁶ Ethnic minority people are more likely to be uninsured for health care (over 25% uninsured).⁶ Moreover, geography and climate are relevant considerations outside of metropolitan settings, as many remote areas of the United States have no road or transportation system and/or are not accessible except by plane in certain seasons.³⁰ In addition, the actual use of existing services by rural and ethnic minority people is shaped by attitudes toward illness (eg, stoicism, stigma) and by issues pertaining to cultural sensitivity and competence (eg, views of illness, trust in technology and/or allopathic care, availability of translators).³¹ Thus, urban health care paradigms have become increasingly characterized by specialists, high technology, individualism, better access and insurance coverage, and, ultimately, a higher standard of care, whereas rural health care models are characterized by generalists, paraprofessionals and self-help, low technology, extended families and communal systems, poor availability, inadequate insurance, and overall lower care standards.²⁸

Attention to health disparities in the US originates in a fundamental commitment to the ethical principles of *justice* and *respect for persons*. Taken together, these principles hold the profession of medicine and the institutions of our society to the ideal of fair and equitable distribution of resources and to the expectation of nondiscrimination. For this reason, the examination of the phenomenon of health disparities is an endeavor that has an inherent ethical basis. A compelling question that arises is whether ethically important aspects of health care may themselves be disparate across distinct populations. Do multidisciplinary providers encounter greater challenges in fulfilling accepted ethical standards in establishing a therapeutic alliance, obtaining informed consent, safeguarding confidentiality, and facilitating treatment adherence while caring for rural and minority people? In essence, are ethical disparities in health care more salient for rural and minority people than in the care of other patients/clients? Answering these questions is the aim of this study.

Method

Survey

After an extensive literature review and qualitative data gathering, a 21-page survey was developed and piloted for this National Institute on Drug Abuse-funded project. The survey included items that assessed ethical challenges, perceptions of stigma, training and resource needs, experiences in providing health care, barriers in providing care, and treatment issues related to providing care.

Dependent Measures

The current report analyzes responses to 2 sets of items related to ethnic/racial minority groups. Consistent with federal definitions, majority individuals were described as “individuals who are White, Anglo, or Caucasian but who are not Hispanic, Latino, or of Spanish origin.” Minority individuals were defined as “people who consider themselves to be Hispanic, Latino, or of Spanish origin; African American or Black; Asian or Pacific Islander; Alaska Native, Native American, or American Indian; or any other group not included in the majority group defined above.”³²

The survey asked participants to compare the level of difficulty they encountered when working with patients/clients *in general* and, in separate questions, with patients/clients who are from a *minority* ethnic/cultural background for 4 ethical practice issues, namely: (1) assuring confidentiality; (2) establishing therapeutic alliance; (3) engaging in informed consent processes; and (4) attaining treatment adherence. For example, the first item asked, “How

difficult has it been to assure the confidentiality of your patients/clients in general?” and the second item asked “How difficult has it been to assure the confidentiality of your patients/clients who come from a minority ethnic/cultural background?” Items were rated on an 11-point scale from *not at all* (0) to *very much* (10).

The second set of items asked respondents to judge the frequency of *heightened* difficulties in the care of patients/clients from a minority ethnic/cultural background for the same 4 ethical practice issues. These items asked participants to respond to: “Compared to caring for members of the majority group, how often did caring for minority group members involve more problems related to (confidentiality, therapeutic alliance, informed consent, treatment adherence).” Items were rated on an 11-point scale from *never* (0) to *always* (10).

Procedures

Potential participants were identified from publicly available lists of licensed physicians, psychiatrists, physician assistants, nurse practitioners, registered nurses, psychologists, social workers, and mental health counselors in the 2 study states: Alaska and New Mexico. From each profession, 125 urban and 125 rural providers per state were randomly selected. For professions with fewer than 250 licensees, all were selected; for rural groups of licensees with fewer than 125, the complementary urban group was over-sampled to reach the desired goal of 250 providers per profession per state. Through this process, 3,695 licensees (1,722 in Alaska, 1,973 in New Mexico) were selected to receive surveys.

After the investigators received approval from the Institutional Review Boards at the University of Alaska Anchorage and the University of New Mexico Health Sciences Center, participants were contacted using survey procedures as outlined by Dillman.³³ Each participant received a letter notifying them of the forthcoming survey, 2 mailings of the survey, and 2 reminder letters. Participants were compensated \$50 for returning completed surveys.

Data Analyses

To increase statistical power and because we had no hypotheses related to specific provider types, the 8 provider groups were categorized as either physical health care providers (ie, physicians, physician assistants, licensed nurse practitioners, and registered nurses) or behavioral health care providers (ie, psychiatrists, psychologists, social workers, and mental health counselors).

Using the addresses provided in the licensee lists, initial categorization of potential participants into rural versus urban was based on federal definitions of metropolitan and micropolitan areas.³⁴ Although this approach gave us adequate information for initial sampling purposes, the literature regarding the definition of rurality indicates that such dichotomies are insufficiently complex and reliable to capture community size differences.³⁵⁻³⁷ Thus, to gain greater insight into possible community size differences, respondents were re-categorized based on the size of their actual practice community, using cluster analysis. This cluster analysis was based on population numbers of the practice community itself if it was geographically isolated from an MSA or based on the population numbers of the community and other contiguous communities if they bordered each other. The optimal clustering solution resulted in the development of 4 community size categories to be used to define rural versus urban areas. Specifically, communities with discrete or contiguous populations of 35,000 and over were defined as “urban”; communities with discrete or contiguous populations of 15,000 to 34,999 were defined as “small urban”; communities with discrete or contiguous populations of 3,500 to 14,999 were defined as “rural”; and communities with discrete or contiguous populations of fewer than 3,500 were defined as “small rural.”

For the 8 items assessing *difficulty* experienced with 4 ethical practice issues “in general” compared to “patients/clients from a minority/ethnic cultural background,” a 2 (Discipline: Physical vs Behavioral Healthcare Provider) $\times$ 2 (State: Alaska vs New Mexico) $\times$ 4 (Community Size: Urban vs Small Urban vs Rural vs Small Rural) $\times$ 2 (Patient/Client Group Type: General vs Minority) $\times$ 4 (Ethical Practice Issue: Confidentiality vs Therapeutic Alliance vs Informed Consent vs Treatment Adherence) mixed model ANOVA was calculated with Group and Ethical Practice Issue as repeated measures. For the second set of 4 items assessing greater *frequency* of difficulties with each of the 4 ethical practice issues, a 2 (Discipline) $\times$ 2 (State) $\times$ 4 (Community Size) $\times$ (Ethical Practice Issue) mixed model ANOVA was calculated with Ethical Practice Issue as a repeated measure.

Results

Of the 3,695 potential participants, 222 had undeliverable addresses and 488 were ineligible due to working less than half-time or having moved out of Alaska or New Mexico. Completed surveys were returned by 1,558 participants, yielding an overall response rate of 52.2% (50.6% in Alaska and 53.7% in New Mexico). Missing data led to the exclusion of 3 participants, leaving a final sample of 1,555. Table 1 describes participant characteristics.

Level of Difficulties With Ethical Practice Issues in Caring for Patients/Clients

Results (see Table 2) of a Discipline $\times$ Community Size $\times$ State $\times$ Patient/Client Group Type $\times$ Ethical Practice Issues mixed model ANOVA with Group and Issues as repeated measures revealed Group and Community Size main effects and Patient/Client Group Type $\times$ Ethical Practice Issues, Patient/Client Group Type $\times$ Community Size, and Patient/Client Group Type $\times$ State interactions.

A main effect for Patient/Client Group Type, $F(2, 1,472) = 1,710.77, P < .001$, indicates that providers overall reported greater difficulties with patients/clients *in general* ($M = 3.23, SD = 1.81$) than *minority* patients/clients ($M = 3.20, SD = 1.90$). However, the difference between the 2 types of patients yields only a very small effect size (Cohen's $d = .02$). The main effect for Patient/Client Group Type was qualified by a Patient/Client Group Type $\times$ Ethical Practice Issues interaction, $F(6, 1,468) = 119.09, P < .001$, which showed that greater difficulties were reported with informed consent with *minority* patients/clients ($M = 3.01, SD = 2.60$) than those *in general* ($M = 2.78, SD = 2.57; d = .09$) but that more difficulties with confidentiality were reported with patients/clients *in general* ($M = 2.91, SD = 2.70$) than *minority* patients/clients ($M = 2.46, SD = 2.58; d = .17$) with no reliable differences by Patient/Client Group Type for therapeutic alliance or treatment adherence.

The main effect for Community Size, $F(3, 1,473) = 6.59, P < .001$, revealed that providers in small rural ($M = 3.67, SD = 1.92$) and rural ($M = 3.44, SD = 1.64$) areas reported greater difficulties than those from urban ($M = 3.09, SD = 1.73$) and small urban ($M = 3.03, SD = 1.77$; maximum $d = .35$) areas across all ethical practice issues and types of patients. The main effect for Community Size is qualified by a Patient/Client Group Type $\times$ Community Size interaction, $F(6, 2,944) = 4.26, P < .001$. Averaged across all Ethical Practice Issues, ethical difficulties encountered with patients/clients *in general* in urban ($M = 3.09, SD = 1.78$) and small urban ($M = 3.03, SD = 1.80$) areas were similar to difficulties encountered with *minority* patients/clients in urban ($M = 3.09, SD = 1.87$) and small urban ($M = 3.03, SD = 1.97$) areas, but difficulties encountered with patients/clients *in general* in rural ($M = 3.49, SD = 1.71$) and small rural ($M = 3.72, SD = 1.98$) areas were significantly higher than difficulties encountered with *minority* patients/clients in rural ($M = 3.39, SD = 1.77$) and small rural areas ($M = 3.62, SD = 2.04$); however, this difference yielded only a very small effect size ($d = .05$). Further, as shown in Table 2, no significant differences on any of the individual Ethical Practice Issues were found.

The Patient/Client Group Type $\times$ State interaction, $F(2, 1,472) = 5.56, P < .005$, revealed that across all Ethical Practice Issues, providers in Alaska rated patients/clients *in general* ($M = 3.25, SD = 1.82$) and *minority* patients/clients ($M = 3.30, SD = 1.89$) equally, whereas in New Mexico providers reported more difficulties with patients/clients *in general* ($M = 3.21, SD = 1.80$) than *minority* patients/clients ($M = 3.11, SD = 1.10; P < .01$), a difference that yielded only a very small effect size (Cohen's $d = .05$).

Frequency of More Problems in Fulfilling Clinical Ethical Practice Standards for Minority Patients

Results (see Table 3) of a Discipline $\times$ Community Size $\times$ State $\times$ Ethical Practice Issues mixed model ANOVA with Ethical Practice Issues as a repeated measure revealed significant main effects for Ethical Practice Issues, Community Size, and Discipline, and interactions between Ethical Practice Issues and Community Size, State, and Discipline. For the main effect for Ethical Practice Issues, $F(3, 1,482) = 182.90, P < .001$, providers reported the most frequent *additional problems* when caring for minority patients/clients for treatment adherence ($M = 4.45$), followed by therapeutic alliance ($M = 3.87$), informed consent ($M = 3.18$), and confidentiality ($M = 2.77$, all $P < .001$, maximum $d = .65$).

The Ethical Practice Issues $\times$ Community Size interaction, $F(9, 3,607) = 5.47, P < .001$, revealed that providers in small rural and rural areas reported more frequent problems in caring for minority patients/clients than providers in small urban and urban areas for 3 of the Ethical Practice Issues. Specifically, in working with minority patients/clients, providers in rural and small rural areas reported more additional problems with confidentiality (maximum Cohen's $d = .36$), informed consent (maximum Cohen's $d = .19$) and treatment adherence (maximum Cohen's $d = .21$) than reported by providers in urban and small urban areas. Providers in all areas did not differ significantly on additional problems associated with treatment adherence; however, as with the other 3 issues, the trend for treatment adherence was in the direction of rural and small rural providers reporting more frequent problems than urban and small urban providers. Additionally, in all areas except small rural areas, the ranking in terms of most to least frequently reported difficulties in the care of minority patients/clients was treatment adherence, followed by therapeutic alliance, informed consent, and confidentiality. In small rural communities, however, confidentiality evoked greater reports of frequent difficulties than informed consent.

The Ethical Practice Issues $\times$ State interaction, $F(3, 1,482) = 7.27, P < .001$, revealed that providers in Alaska reported more frequent problems with confidentiality ($d = .14$), therapeutic alliance ($d = .20$) and treatment adherence ($d = .11$) than providers in New Mexico. Providers in the 2 states were similar on frequency of more problems in caring for minority patients for informed consent ($d = .06$). A main effect for Discipline showed that behavioral health care providers reported more frequent problems with minority patients/clients on all Ethical Practice Issues combined than did physical health care providers, $F(1, 1,484) = 6.76, P < .01, d = .16$. The Ethical Practice Issues $\times$ Discipline interaction, $F(3, 1,482) = 17.92, P < .001$, revealed that behavioral providers reported more frequent additional problems with confidentiality ($d = .24$) and therapeutic alliance ($d = .27$) than did physical health care providers; however, the 2 provider groups were similar on treatment adherence ($d = .02$) and informed consent ($d = .00$).

Discussion

In this novel study across rural and urban communities of Alaska and New Mexico, we found that multidisciplinary health care providers report some difficulties in fulfilling ethical practices in their care of patients/clients. The *difficulties* for patients/clients in general are greatest in attaining treatment adherence, followed by assuring confidentiality, establishing a

therapeutic alliance, and engaging in informed consent processes, with little difference among the last 3 issues. Similar levels of difficulties are seen by providers for their patients/clients who are *members of minority groups compared to patients in general*, except that assuring confidentiality was seen as less difficult for minority patients than *patients in general* and engaging in informed consent processes was seen as more difficult with minority patients than *patients in general*. Further, overall, the multidisciplinary providers reported *more additional problems* in fulfilling practice standards for minority compared to nonminority patients, particularly with regards to attaining treatment adherence and establishing a therapeutic alliance.

For all ethical practice issues, providers from rural communities encounter more *difficulty* than those reported in urban communities. Small rural and rural clinicians also indicate that *additional problems* are more frequently encountered in caring for minority patients/clients than others with the ethical practice issues of treatment adherence, informed consent, and confidentiality, but not with therapeutic alliance. Taken together, these data provide support for the primary and corollary hypotheses of the study, which predicted heightened challenges in fulfilling ethical practices in the care of rural and ethnic minority people.

Some unanticipated state differences were identified in this study. Multidisciplinary providers in New Mexico more strongly endorsed difficulties in caring for patients/clients in general than with minority patients/clients, a difference not found in Alaska. Alaska providers, on the other hand, reported relatively more problems with fulfilling confidentiality safeguards and attaining treatment adherence than did respondents in New Mexico. Finally, behavioral health clinicians more often encountered additional problems with confidentiality and therapeutic alliance ethical practice issues than did physical health care providers in the care of ethnic minority patients/clients.

The strengths of this survey study are its multidisciplinary perspective and its focus on ethical considerations in the care of patients/clients in general and on ethnic minority patients/clients who reside in communities of varying size across Alaska and New Mexico, 2 predominantly rural states. Just under half of the clinicians we invited into the study chose not to participate; thus the generalizability of our findings remains to be tested by future research. Finally, ours was a sample targeting 2 states with the highest proportion of rural minority counties, and we do not know how our results would compare to those derived from a national sample of multidisciplinary clinicians.

These unique data indicate that context may be a significant influence upon ethically salient components of care for minority patients/clients as well as patients/clients in general. Stated differently, individuals who reside in rural settings or who derive from ethnic minority backgrounds may be more likely to receive care that does not fulfill or has greater intrinsic barriers to fulfilling accepted ethical practice standards. This pattern suggests the possibility of ethical disparities as a new concern in the national discussion of health disparities for rural and ethnic minority individuals. Further, although expectations pertaining to the 4 ethical practice issues examined in this study are anchored in professional codes of conduct and in clinical practice standards, confidentiality and informed consent are also more formally governed through both regulations and laws. Deviation from established practices may lead not only to negative professional and clinical consequences but also to greater legal vulnerability for providers who work in certain contexts or with certain populations. These findings are preliminary and fall into an area that has received little attention in the past. For these reasons, we hope that this initial work will serve as a stimulus for further inquiry.

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Table 1

Participant Characteristics

Variable	Alaska		New Mexico		Total	
	Number	Percent	Number	Percent	Number	Percent
Total of respondents	730	46.9%	825	52.6%	1,555	100%
Gender						
Men	229	31.4%	278	33.4%	507	32.6%
Women	501	68.6%	547	66.6%	1,048	67.4%
Cultural heritage						
Hispanic	17	2.3%	129	15.3%	146	9.4%
Asian or Pacific Islander	6	0.8%	13	1.6%	19	1.2%
AK Native/Native American	43	5.9%	33	4.1%	76	4.9%
Black or African American	12	1.6%	7	0.8%	19	1.2%
White	625	85.6%	624	76.0%	1,249	80.3%
Other or refused	27	3.7%	19	2.2%	46	3.0%
Practice community						
Small Rural	95	13.0%	55	6.6%	150	9.6%
Rural	208	28.5%	160	19.4%	368	23.7%
Small Urban	148	20.3%	244	29.6%	392	25.2%
Urban	278	38.2%	367	44.5%	645	41.5%
Type of care provider						
Physical health care						
Physician (nonpsychiatry)	78	10.7%	74	8.8%	152	9.8%
Registered nurse	113	15.5%	108	12.9%	221	14.2%
Nurse practitioner	120	16.4%	131	15.9%	251	16.1%
Physician assistant	108	14.8%	124	15.0%	232	14.9%
Behavioral health care						
Psychiatrist	29	4.0%	71	8.0%	100	6.4%
Psychologist	63	8.6%	100	12.3%	163	10.5%
Counselor	115	15.8%	111	14.0%	226	14.5%
Social worker	104	14.2%	106	13.3%	210	13.5%
	Mean	SD	Mean	SD	Mean	SD
Years of age	48.8	9.2	49.0	9.8	48.9	9.5
Years of experience	12.4	9.3	12.5	9.6	12.5	9.4

Table 2
Level of Difficulty in Fulfilling Clinical Ethical Practices in Caring for Minority Patients/Clients

Ethical Practice Issue:	Patients/Clients:	All Providers Mean (SD) (n = 1,555)	Community Size			Discipline		State		
			Urban Mean (SD) (n = 645)	Small Urban Mean (SD) (n = 392)	Rural Mean (n = 368)	Small Rural Mean (SD) (n = 150)	Physical Mean (SD) (n = 856)	Behavioral Mean (SD) (n = 699)	Alaska Mean (SD) (n = 729)	New Mexico Mean (SD) (n = 826)
Difficulty in attaining treatment adherence	In general Minority	4.32 (2.21)	4.18 (2.22)	4.18 (2.18)	4.54 (2.10)	4.71 (2.39)	4.17 (2.24)	4.50 (2.16)	4.30 (2.16)	4.33 (2.24)
		4.34 (2.36)	4.20 (2.32)	4.26 (2.42)	4.58 (2.27)	4.61 (2.49)	4.25 (2.40)	4.46 (2.30)	4.41 (2.33)	4.28 (2.38)
		No significant difference	Main effect (P < .005): Rural, Small Rural > Urban, Small Urban			No significant differences		No significant differences		
Difficulty in establishing a therapeutic alliance	In general Minority	2.89 (2.33)	2.75 (2.28)	2.73 (2.34)	3.16 (2.36)	3.22 (2.42)	3.05 (2.39)	2.69 (2.24)	2.98 (2.33)	2.81 (2.34)
		2.98 (2.31)	2.92 (2.26)	2.85 (2.39)	3.14 (2.26)	3.22 (2.39)	2.96 (2.38)	3.01 (2.23)	3.18 (2.34)	2.81 (2.28)
		No significant difference	Main effect (P < .05): Rural, Small Rural > Urban, Small Urban			No significant differences		Main effect (P < .01): Alaska > New Mexico		
Difficulty in engaging in informed consent processes	In general Minority	2.78 (2.57)	2.71 (2.58)	2.50 (2.54)	3.06 (2.50)	3.10 (2.65)	2.79 (2.6)	2.77 (2.52)	2.72 (2.53)	2.83 (2.60)
		3.01 (2.60)	2.99 (2.58)	2.73 (2.63)	3.23 (2.57)	3.28 (2.67)	2.99 (2.64)	3.02 (2.56)	3.01 (2.57)	3.00 (2.64)
		Main effect (P < .001): Min > In gen	Main effect (P < .001): Rural, Small Rural > Urban, Small Urban			No significant differences		No significant differences		
Difficulty in assuring confidentiality	In general Minority	2.91 (2.70)	2.70 (2.64)	2.66 (2.66)	3.19 (2.62)	3.83 (2.97)	3.01 (2.81)	2.80 (2.54)	2.96 (2.74)	2.87 (2.66)
		2.46 (2.58)	2.31 (2.51)	2.23 (2.51)	2.60 (2.51)	3.33 (3.02)	2.44 (2.65)	2.48 (2.49)	2.58 (2.68)	2.35 (2.49)
		Main effect (P < .001): In gen > Min	Main effect (P < .001): Small Rural > Rural, > Urban, Small Urban			No significant differences		No significant differences		

* Means and standard deviations are based on an 11-point scale from *not at all* (0) to *very much* (10).

Table 3
Frequency of *More* Problems in Fulfilling Clinical Ethical Practices in Caring for Minority Patients/Clients

Ethical Practice Issue	All Providers Mean (SD) (n = 1,543)	Community Size				Discipline		State	
		Urban Mean (SD) (n = 644)	Small Urban Mean (SD) (n = 388)	Rural Mean (SD) (n = 368)	Small Rural Mean (SD) (n = 145)	Physical Mean (SD) (n = 849)	Behavioral Mean (SD) (n = 694)	Alaska Mean (SD) (n = 724)	New Mexico Mean (SD) (n = 819)
More problems in attaining treatment adherence	4.45 (2.71)	4.23 (2.68) Main effect (P < .001): Rural, Small Rural > Urban, Small Urban	4.44 (2.70)	4.78 (2.64)	4.68 (2.98)	4.43 (2.74) No significant difference	4.49 (2.68)	4.62 (2.71) Main effect (P < .05): AK > NM	4.31 (2.70)
More problems in establishing a therapeutic alliance	3.87 (2.60)	3.82 (2.59)	3.75 (2.59) Main effect: No significant differences	4.00 (2.60)	4.10 (2.67)	3.56 (2.59) Main effect (P < .001): Behavioral > Physical	4.26 (2.56)	4.16 (2.63) Main effect (P < .001): AK > NM	3.63 (2.55)
More problems in engaging in informed consent process	3.18 (2.48)	3.10 (2.43) Main effect (P < .05): Rural, small rural > Urban, Small Urban	2.99 (2.49)	3.47 (2.55)	3.28 (2.44)	3.17 (2.55) No significant difference	3.18 (2.39)	3.26 (2.49) No significant difference	3.10 (2.47)
More problems in assuring confidentiality	2.77 (2.51)	2.49 (2.35) Main effect (P < .01): Rural, Small Rural > Urban, Small Urban	2.57 (2.34)	3.19 (2.73)	3.51 (2.76)	2.51 (2.44) Main effect (P < .001): Behavioral > Physical	3.10 (2.55)	2.96 (2.61) Main effect (P < .05): AK > NM	2.62 (2.41)

* Means and standard deviations are based on an 11-point scale from never (0) to *always* (10).