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Editor's Forum

Michael van Manen, MD, FRCPC, PhD
Endowed Chair in Health Ethics and Director, John Dossetor Health Ethics Centre;
Associate Professor, Neonatal-Perinatal Medicine, Department of Paediatrics, University of Alberta, Edmonton, Alberta

How do we understand the meaning of ethics in rural and remote healthcare contexts? To what extent have traditional health ethics discourses passed over the nuances of practicing in these settings? What can urban-centric healthcare providers learn from those who practice in such communities? How do we build on the strengths inherent in rural and remote contexts, particularly as we face crises in human and material resources in our healthcare system?

These questions are addressed in this issue of *Health Ethics Today*, which is composed of two contributions from the John Dossetor Health Ethics Centre Symposium "Rural and Remote Healthcare Ethics: Considering Issues for the Past, Present, and Future", a virtual event held on November 28, 2023. The first article is co-authored by Fiona McDonald, an Associate Professor in the Australian Centre for Health Law Research at Queensland University of Technology, Australia and Adjunct Associate Professor in the Department of Bioethics at Dalhousie University, Canada; and, Christy Simpson, an Associate Professor in the Department of Bioethics at Dalhousie University and Adjunct Professor in the Australian Centre for Health Law Research at Queensland University of Technology, Australia. Both have worked to advance health ethics discourse regarding rural settings, and are co-authors of the book *Rethinking Rural Health Ethics* (2017). The second contribution is from Jill Konkin, a Professor of Family Medicine in the Faculty of Medicine and Dentistry at the University of Alberta, Canada. For over 20 years, Jill Konkin has worked as a rural generalist family physician. Throughout her career, she has advocated

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for rural medicine and rural medical education as an international leader in this area.

I believe both contributions will challenge the reader who practices in urban settings. It is ever so easy to form assumptions and/or biases about rural contexts, particularly as I suspect most urban healthcare providers have an incomplete picture of life in rural and remote communities, despite many of their patients residing there. For many, training as healthcare providers has been largely urban-based. As presented in both contributions, there may be a tendency to think of rural as deficient, lacking, or otherwise wanting relative to the resourced practices of tertiary academic urban institutions. More so, it is all too easy to develop generalizations that fail to account for the richness and diversity of varied rural contexts (see Simpson & McDonald, 2017).

What I hope the reader appreciates is that there are ethically relevant differences to rural healthcare practice that emerge as a consequence of relationships, place, and other contextual aspects. On the one hand, this leads to ethical challenges such as those related to navigating personal and professional life boundaries, relationships with patients, privacy and anonymity, and scope of practice (Menezes & Eggleton, 2023). Yet, on the other hand, this also creates opportunities for a practice that forefronts the patient as situated in their community. This follows with a need for thinking and reflecting on the ethics of rural and remote healthcare contexts that takes a different starting place than one of the traditional bioethical discourse that forefronts respect for autonomy, beneficence, nonmaleficence, and so forth. Instead, rural and remote healthcare ethics engage the need for ethics that forefront relationships, narratives, and other aspects (Simpson & McDonald, 2017; Szumer & Arnold, 2023). Such work benefits from understanding not only the experiences of patients residing in rural and remote healthcare contexts, but also those of healthcare providers, and considerations regarding how we mentor, prepare, or otherwise train them (Konkin, et al., 2020; Nichols, et al., 2023).

I hope our readers enjoy this issue of *Health Ethics Today* as a source for reflection on this topic. I also encourage our readers to seek out further readings cited by the authors, recognizing there is a need for research and other forms of scholarship to address rural and remote healthcare practice (Nelson, et al., 2006).

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Celebrating Rurality: Embracing Rural Health Ethics

Christy Simpson, PhD
Associate Professor, Department of Bioethics, Dalhousie University, Halifax, Canada;
Adjunct Associate Professor, Australian Centre for Health Law Research, Queensland University of Technology, Australia

Fiona McDonald, JSD
Associate Professor, Australian Centre for Health Law Research, Queensland University of Technology, Australia;
Adjunct Associate Professor, Department of Bioethics, Dalhousie University, Halifax, Canada;
Senior Research Fellow, New Zealand Centre for Public Law, Victoria University of Wellington, New Zealand

Introduction

As Salter and Norris (2015, p. 87) note:

> "the field [of bioethics] relied heavily (either consciously or subconsciously) on the particularities of [urban tertiary hospitals] for the creation of its most seminal concepts and practices, from informed consent to models of clinical ethics consultation."

This reliance can create tension when thinking about how to practice ethically in different healthcare settings. Context matters. It matters for care and treatment, and it matters for ethics. Rural is not, to quote Farmer (2012, n.p.) "…urban with trees and animals, and it is heterogeneous: there is no one rural." If approaches to bioethics are based primarily on the premise of providing care for strangers in tertiary hospitals, how do we negotiate the ethics of caring for neighbours in rural areas and community health centres? Do we apply the traditional version(s) of ethics, or do we need to think further about how to complement existing ethical norms with practice- or place-specific ethical considerations? What if the reliance on traditional approaches to ethics leaves rural health professionals (or for that matter health professionals in other practice contexts), feeling a dissociation between what they are taught and what their code of ethics says and the realities of their practice context? What if what is considered a 'good' health professional is based on norms that are, we argue, primarily determined in urban settings based on urban practices predominantly by urban practitioners? This, as we have noted in previous work (Simpson & McDonald, 2017), may result in rural health professionals feeling as though they have been set up to fail when they do not recognise themselves and their practice in those norms. Further, if, as we have also argued elsewhere (Simpson & McDonald), the ethical norms of health professions assume that everyone is caring for strangers, then the interconnectedness that characterises both rural practice and rural communities is problematized from the outset.

We approached our work on rural health ethics by drawing on feminist approaches to critically consider power relationships between rural and urban contexts and between and amongst neighbours and relationality. We also utilized insights from feminist epistemology – in particular, that our identity is a function or creation of our past experiences and where we came from. This includes how attachment to place and/or community can shape a person's sense of identity, as discussed below, (commonly expressed as "you can take the person out of the country, but you can't take the country out of the person").

Stereotyping

Considering the questions and concerns raised above, we need to reflect on how metro-normativity impacts our thinking about rural healthcare. There are two common framings for what it means to live rurally

and provide health care in rural settings. These are the deficit perspective of rurality and the rural idyll (Simpson & McDonald, 2017). It is important to pay attention to these stereotypes as they can influence and shape what seems ethically relevant, but also for how they may influence or shape care decisions and/or health policies.

The deficit perspective suggests that everything is less than or not as good in rural settings (Malatzky & Bourke, 2016; Simpson & McDonald, 2017). In health care, this perspective emphasizes the lack of resources, inability to access health care services, and poorer health outcomes to suggest that rural areas are where professionals who are "not good enough" for urban practice go (something which we obviously contest). The deficit perspective positions the urban as the ideal (where everything is better). While these 'deficits' can be leveraged by rural communities to demand more and better services, they can also influence those whose point of reference is metro-normative to view it as being inevitable that rural health services are and will always be problematic (McDonald & Malatzky, 2023). This perspective can also contribute to the stereotyping of rural residents as lesser than urban residents; e.g., that rural residents are less intelligent; less educated; red-neck and so on, with potential negative impacts on their treatment and care (Simpson & McDonald). Similarly, rural health practitioners can sometimes be treated as "lesser" by metro-based practitioners – a combination of residence in rural areas with the (mis)perception that rural practitioners are practising rurally because they were not skilled enough for urban practice (Simpson & McDonald).

The rural idyll on the other hand suggests rural life is pastoral, calm, quiet, simple, and neighbourly and rural residents are stoic and resilient (Malatzky & Bourke, 2016; Simpson & McDonald, 2017). This perspective obviously glosses over the complexity of what it means to live rurally. Arising from this may be the stereotype that rural communities (and especially rural women (Simpson & McDonald, 2019)) always can and do care for their members. This can then contribute to an assumption that support will be provided by and within each rural community and, therefore, does not need to be provided (or supplemented) by the health system or other government agencies (Simpson & McDonald, 2017; McDonald & Malatzky, 2023). These stereotypes raise ethical issues that impact the delivery of health services.

Ethics

Taking the above into account, we can begin to see the deeper complexity and critique that is required of traditional ethical approaches, including, for example, principlism (particularly as it is one of the predominant ethical approaches in use in Western health care). Principlism, in our view, does not fully address nor adequately capture the complexities of rural health practice and the provision of health care in rural settings. There are several explanations for this, including the differences between the care of strangers and the care of neighbours, individualistic versus communitarian perspectives, and the relatively narrow expression of beneficence and non-maleficence in principlism that does not encompass a broad understanding of relationality (for further discussion, see Simpson & McDonald, 2017). The implications of this are twofold:

1. principlism is, in and of itself, insufficient to support analysis of everyday ethical issues faced in different practice contexts (recognizing that some argue that principlism needs to be supplemented within tertiary care settings, where it was developed, as well); and

2. additional values that may better reflect key aspects of a specific practice context, and critical reflection on how these values are utilized as part of making decisions about health care, may be necessary to employ to further support and enable meaningful ethical analysis and reflection.

What might these values be? We contend that, at a minimum, we ought to include the values of community and place as well as as a need to the role and value of relationships (Simpson & McDonald, 2017). While these values may arise in a variety of

settings, including urban, it is in starting from a rural health perspective that these values are more easily identified.

Relationships

Metro-normative formulations of ethics based on the assumption of care of strangers position dual relationships as problematic. Rural health professionals often find themselves navigating overlapping or dual relationships (personal, professional). These relationships may be, perhaps often are, framed in professional ethics as creating problems, causing conflicts of interest, and negatively affecting the therapeutic relationship. The setting of no overlapping relationships as the "norm" is frequently (if not always) positioned as ethically best. However, the occurrence of dual relationships is a mostly unavoidable part of rural health practice, something that can be anticipated and, as such, should be acknowledged, discussed, and we contend, valued (Simpson & McDonald, 2017).

If ethics positions such inevitabilities as unethical, we are from the outset setting up health professionals who work in rural (or other small) settings in a difficult and conflicted position – from the outset their day-to-day practice is categorized as being ethically wrong or at the very least problematic (Simpson & McDonald, 2017). While some dual relationships, such as sexual relationships between a patient and a health professional, are almost certainly unethical, due to the exploitation of the professional role, others are not. Indeed, dual relationships may actually enhance professional practice and care in some circumstances. While (health-related) informational asymmetry remains, in rural settings, where patients and providers are in dual relationships, there may be occasions when the power within the relationship is renegotiated due to the fact that the patient may also be the banker, teacher of the health professional's child, or the major local landowner (i.e., there are then overlaps between the health and other contexts in which power operates) (Simpson & McDonald). This requires a sophisticated approach to the navigation of complex contingent relationships (see, e.g., Gingerich, Van Volkenburg, et al., 2021; Gingerich, Simpson, et al., 2023; Simpson & McDonald) – a skill set that is undervalued when the expectation is that dual relationships are ethically problematic and should be avoided.

Community

Community is often utilised as a concept more instrumentally in traditional ethical approaches as a means to an end i.e., a way to achieve health-related goals, rather than being a value in and of itself (Simpson & McDonald, 2017). While we do not want to idealise the concept of community, we do want to acknowledge that for some people the concept of community has intrinsic value and is, in part, constitutive of their identity. It is our position that, for some people, membership in a community positively shapes that person's ideas of who they are, what they "know", and how they understand their obligations to others. Others may feel excluded from the community around them. For those for whom community is part of their identity, they may take the further step of having community as a moral value, even if they do not explicitly name it as such (Simpson & McDonald). This value may manifest in what might loosely be termed the 'obligations' they feel towards others in their community and could be grounded in a sense of solidarity or reciprocity or it may draw from both (Simpson & McDonald). When thinking about this value, what does it mean and how might it influence or shape health care decisions? What are the ethical and practical implications, for example, of:

- not wanting to be a burden on one's community (which is broader than the more typical discussion about not being a burden on one's family);
- to feel that one "owes" others some form of caregiving;

• to lose connections to one's community if that person must leave to access health services whether that is in the short, medium, or long-term?

Place

The importance and spiritual connection to place in the lives and decisions of Indigenous communities around the world is well recognised and its impact on decision-making about health services is acknowledged. But some non-indigenous persons may also feel a connection to place and this may be an important element of understanding their decision-making processes and their needs as a patient (Simpson & McDonald, 2017).

There is some literature on place and health care. But as Thien and Hanlon (2009, p. 156) suggest, "[m]uch of this literature … treats place as a mere backdrop or container of social activity; that is, meaningful differences in health are acknowledged to exist between places, but these are regarded primarily as a by-product of other processes known to influence health ." However, there is research that indicates that place is a more meaningful concept for some, finding that those who live in rural areas have a stronger attachment to place and rural residents may "imbue rural places with health enhancing properties" (cited in Simpson & McDonald, 2017, p. 63). Other research indicates that rural residents may feel more connected to the land and may be reluctant to leave it, even if experiencing health problems (cited in Simpson & McDonald). For some rural residents, then, place and their connection to "this place" plays a potential role in decision-making – and may thereby become a value that they hold.

In other words, drawing again on feminist epistemology, we agree with Preston (2009, p. 176) that "the ways our beliefs, thoughts and values are shaped by the places that we love and live in is not just a biographical question but also an epistemological question". Preston goes on "in some fundamental but elusive way, places help make us into the people we are …" (p. 175-176). Thus, for some people place is constitutive of their identity and becomes morally relevant. If we don't consider an aspect of a patient's being, then the risk is that we may not see the whole person and what matters to them. Recent work in health ethics (e.g., relational autonomy) has emphasised the importance of thinking about the patient's relationships, their social, economic, and cultural networks and how these may support and detract from their ability to make informed choices about health care.

Final thoughts

So how do these reflections from a rural health ethics perspective (begin to) fit together? As one example, there is some evidence that for some rural residents, their decisions about where to have surgery or what surgery to have or to have surgery at all are affected by their connections: connections to family, to community and to place (cited in Simpson & McDonald, 2017). But connection to place, and of course relationships with one's family and friends and one's community, can also make transfers to receive care in other places potentially dislocating and disorientating, particularly if the deficit/idyll stereotyping imbues how rural patients transferred to urban areas are treated (Simpson & McDonald). How might these insights influence discussions about transfers of care and/or policies about whether and when care partners can travel with (or follow) a patient who is transferred away from their home community and place?

Further, at a policy level, is it a working premise that the informal networks in "all" rural communities will take care of someone who needs additional

support to be at home? Does this type of assumption – particularly if unquestioned – mean that fewer resources and time will be given to building community resources in rural communities (expecting that rural residents will 'always' fill in the gaps)? We know that rural communities on aggregate are aging and that many communities are struggling, if not dying, and may not have capacity. There are also power relationships within communities that may lead to some being included and some excluded. If commitment to community is based on reciprocity and a person is not exchanging "credit in the system" what happens to them (Pesut, Bottorhoff, & Robinson, 2011; Simpson & McDonald, 2017)?

We acknowledge that the hitherto dominant approach to health ethics, with its roots in the enlightenment, also perpetuates the norms of colonization (Pieper, McDonald, & Tomossy, 2023). The rethinking we propose here does not attempt to create an ethics to govern Indigenous values around health and health care – that is for the self-determination of Indigenous peoples to shape. But equally, we acknowledge bioethics needs decolonising. All journeys need first steps and in questioning metro-normative assumptions and assumptions about rurality we hope that this work on rural health ethics contributes to the broader conversation challenging normative assumptions, especially place-based assumptions. There is value in naming, discussing, and addressing ethics issues in context, especially in rural settings. Such discussions can help reshape and inform traditional approaches to ethics, generally and in practice. It can expand the range of what is considered and utilized, as well as taught. Rural health professionals and rural residents (patients) have much to teach the field of ethics about managing complex interconnected relationships between people, with communities and with place, and about how and on what basis decisions about health care are made.

Acknowledgement

This is a summary of a broader argument about rural health ethics presented at the *John Dossetor Health Ethics Centre's Health Ethics Symposium 2023* and published in Christy Simpson and Fiona McDonald, 2017. *Rethinking Rural Health Ethics*. International Library of Ethics, Law, and the New Medicine. Springer.

We acknowledge the traditional custodians of the lands on which we work, walk, and live.

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Rural, Northern and Remote Health Professionals and Rural Health Ethics

Jill Konkin, BA(Hons), MD, MClSc, CCFP, FCFP, FRRMS
Professor, Department of Family Medicine, Faculty of Medicine and Dentistry, University of Alberta, Edmonton, Alberta

In their book, *Rethinking Rural Health Ethics*, Simpson and McDonald (2017) argue that "traditional, mainstream approaches to health ethics are often urban-centric, making implicit assumptions that urban-focused values and norms apply in all contexts of health care practice." (p. 6) The authors base their work on a feminist ethics perspective where relationships and context are foundational. In other words, ethics is based in community and connection rather than on rules and regulations that are universal. They question whether values are missing from urban-centric ethics or as they referred to in a recent presentation, metro-normative ethics. Simpson and McDonald identify two additional values that inform rural ethics – place and community. They go on to assert that "the different quality of the relationships between many rural residents and health providers are, in part, grounded in the values of place…and community…" (p. 98).

On the topic of metro-normativity, there is an article by Malin Fors (2018) on geographical narcissism that helpfully describes this urban centricity in all things and the consequences for rural, northern and remote (RNR) populations. The argument is that power and privilege reside in urban centres. Rural, northern and remote resources are exploited such that not as much value is returned to RNR communities relative to what is taken away. More so, RNR as a whole is depicted as deficient. There is an implicit urban moral superiority that leads many to assume that urban services and specialists are better than those health professionals who work in RNR communities. Geographical narcissism is an important concept to understand for many of the issues between urban and RNR, including health ethics.

In comparison, in a recent article on rural ethics, Fors (2023) adds a social justice perspective to the two major influences on medical ethics "philosophical theorizing and clinical problem-solving" (p. 266). She describes rural health ethics as "potato ethics" based on the Swedish view of the potato as a "humble side dish – plain, useful, versatile, and compatible with any main course" (p. 265). For her, potato ethics involves: 1) making oneself useful, 2) being an accountable participant in the community, 3) being pragmatic, and 4) working to prevent discontinuity. Discontinuities in this context include issues such as lack of staff, practical circumstances like distance and weather and working at the edge of one's scope of practice (clinical courage). Rural, northern and remote health professionals are portrayed as fully connecting to the context – of their work and of their community.

When considering rural health ethics, the authors cited above, and others not mentioned, identify key considerations, both for and utilized by RNR health professionals (Fors, 2023; Gingerich, et al., 2021;

Gingerich, et al., 2023; Simpson & McDonald, 2017; Szumar & Arnold, 2023). These include relationships, community, place, confidentiality, and boundaries among others. One needs to take a critical perspective to the colloquial expression "if you see one rural community, you've only seen one rural community." All rural communities are different which highlights why context is such an important consideration and why universal rules and regulations can be unhelpful with few exceptions.

Dual or overlapping relationships are the norm for rural health professionals. Many live in a community that can be likened to a fishbowl. Everyone knows where they live, who their families are, where they usually are on Wednesday nights, run into them in the grocery store, and many other things that are rare for patients in urban centres. In contrast, dominant codes of ethics are based on professionals working in metropolitan hospitals where most, if not all, of their patients are strangers (Simpson & McDonald, 2017). This is also not the case in RNR communities.

Living in a fish bowl and the understanding that "even the doctor needs friends" need to be considered in all discussions about relationships and, in particular, boundaries. Overlapping relationships add nuance when discussing boundaries. Working in a structurally urbanist system results in unnecessary resource constraints (Probst, et al., 2019) which then impacts the services that can be provided by RNR health professionals which leads to other ethical issues. Support for RNR physicians with patients needing care beyond their scope of practice or for whom local resources are insufficient is not always forthcoming from urban colleagues. These and other RNR realities speak to the necessity of a robust rural health ethics framework and ongoing dialogue.

Rural health professionals are part of the community. They sit on community boards and participate in sports. They are involved in their children's schools. They are out and about in the community, shopping for groceries, meeting friends at a local coffee shop or eating out at a local restaurant. Through participation in the community, health professionals develop friendships and non-therapeutic relationships with many people over time. They will also be recognized wherever they go. Many of these people will be or will become patients. They are hardly strangers.

Returning to the notion of potato ethics, Fors' (2023) concept of being useful includes the expectation that RNR health professionals will be part of the community. It is also an important aspect of a professional's sense of belonging (Mandal & Phillips, 2022) which is necessary for long-term commitment to working in a rural or remote community. For many reasons, overlapping relationships are inevitable. Unfortunately, they are seen as problematic by metro-normative ethicists and professional bodies.

Further to the discussion of relationships is the concept that "Even doctors need friends." This comes from a conversation an urban emergency physician had with the daughter of a patient that he was caring for. The daughter came from the same rural community that a colleague of his had worked in for years. When the emergency doctor asked if the daughter knew Dr. "X", she replied that they had been friends. When the urban doctor expressed his surprise, her response was "Even doctors need friends." Sometimes friends are patients too. This situation shows complex issues that RNR health professionals learn to manage ethically. Studies like those of Szumer and Arnold (2023) and Gingerich, et al. (2021) detail the sophisticated way that RNR health professionals navigate these overlapping relationships.

A rural health professional must honour the trust and connection developed with patients. A key element of honouring that trust is confidentiality. Patients need to know that a health professional that they have

seen will not say a word to anyone unless they ask for or permit it. Health professionals need to critically reflect on circumstances that may seem benign but could raise questions about what a professional will or will not say outside of a clinical encounter. In the same way that RNR community members know a lot about their health professionals, they also know a lot about each other which makes anonymity difficult for everyone.

For example, after a night attending a woman in labour, a physician decides to drop by the local deli on the way home. The deli owner, a husband of a nurse at the hospital and the physician's friend, had seen the family's car and the doctor's bike at the hospital on his way to work that morning. He became upset when the physician would not confirm that a baby had been born let alone what the sex of the baby was. The doctor's thinking was that this was something for the happy parents to tell family, friends, and neighbours. In other words, this was not the doctor's news to share. Also, would people wonder where her limits were if she divulged this information; what else she might disclose if she was willing to say this in public? She recognized that the slippery slope would be to say anything.

Boundaries for RNR health professionals are more nuanced and take significant skill and reflection to negotiate. They are not as black and white as urban ethics demand except that there must not be sexual relationships with patients. Those boundaries must not be crossed, a rule that all health professionals must abide by no matter whether urban or rural. There is a growing literature about RNR health professionals and their negotiation of overlapping relationships. In their recent narrative review, Szumer and Arnold (2023) explored the literature focusing on dual relationships for health professionals working in rural and remote communities. They concluded "that the existence and navigation of dual relationships is already part and parcel of sound ethical practice in 'the bush,' and an everyday aspect of clinicians' lives" (p. 187). In comparison, in a study of physiotherapists working in Northern British Columbia, Gingerich, et al. (2021) concluded that "overlapping relationships are a rural norm" (p. 1183) and used the lens of paradox theory to show that these health professionals used "sophisticated cognitive framing of the conflicting and interrelated aims inherent to living and practicing in RNR communities" (p. 1183). Gingerich, et al. (2023) have also studied rural physicians and identified four strategies employed by them to manage overlapping relationships. They go on to suggest that curricula on boundaries for medical learners need to include teaching around managing "multiple professional and social roles" (p. 13).

Resource constraints are prevalent in rural communities. While it details the issues in the United States of America, Probst, et al. (2019) discuss how structural urbanism underpins the underfunding of rural health services. This has direct consequences for RNR health professionals in the context of inadequate staffing, lack of equipment and testing capabilities, and closure of previously available services among other issues. Rural, northern and remote clinicians are innovative and creative with the resources that they have in providing as broad a service to their RNR communities as is possible and safe. Rural, northern and remote health professionals often need to work at the edge of their scope of practice in service of their patients. Relationships, both with patients and the community, are key to physicians' clinical courage (Walters, et al., 2021). [note: This probably relates to other RNR health professionals but, to date, research has only been conducted with rural physicians.]

Finally, working in a system that is not a system presents many ethical situations for rural clinicians, especially physicians. What does a rural doctor do when a critically ill patient who needs a level of care

unavailable in their community is not accepted in the tertiary care hospital or where acceptance or transport is significantly delayed? The current health services delivery system's situation in Alberta is in distress everywhere, urban and rural, but in resource-limited RNR situations what is to be done when the needs of the patient exceed the resources and/or skills available locally? Why is it that other physicians are in a position to say "no" to an RNR physician asking for assistance for their critically ill patient? Is this not an ethical issue? Australia is a leader in this area. They passed a law a few years ago that regional and metropolitan hospitals cannot decline the transfer of an RNR patient when the RNR physician indicates that the patient's condition can no longer be managed in the local community. Even when a patient is accepted for transfer or, more appropriately, named by Simpson and McDonald (2017) as accepted for "dislocation", often complex conversations with patients and their families are necessary with regard to the severity of their illness, the possibility that they might die while being transported or while in the hospital in the city, advocating for a family member to accompany them, and many other issues that arise with a critically ill patient a long distance from the services they need at that time.

This is also where "place" is important to understand. For many RNR residents, their sense of self is grounded in place and contributes to their identity. What does it mean to them to be dislocated to a distant city? How will that impact their health and sense of well-being? Ethically, this is an important consideration for those accepting RNR patients into their care in the city.

"Rural is not simply urban with trees and animals" (Farmer, 2012). The field of rural health ethics has grown significantly in the last decade or more. Concepts of community, place and relationships are values in RNR ethics that need to inform a more nuanced approach in such areas as boundaries. It is time for health professional organizations to recognize this, let go of their metro-normative approach, and incorporate RNR ethical principles into their codes of ethics and other ethical guidance. Health professional educators need to incorporate rural health ethics into the curriculum for their learners at all levels.

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University of Alberta
John Dossetor Health Ethics Centre
5-16 University Terrace
EDMONTON, AB T6G 2T4
Email: dossetor.centre@ualberta.ca

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John Dossetor
Health Ethics
Centre

John Dossetor Health Ethics Centre
University of Alberta
5-00 University Terrace
Edmonton, Alberta, Canada T6G 2T4
Telephone: (780) 492-6676
Website: www.ualberta.ca/john-dossetor-health-ethics-centre/

Email: dossetor.centre@ualberta.ca

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