



Lead Essay—Rural Bioethics

Danielle L. Couch · Christopher Mayes

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In his landmark essay, “Famine, Affluence and Morality” Peter Singer argued that distance is not morally relevant (Singer 1972). Whether a child is drowning in a pond in front of us, or starving to death in a distant land, if we have the capacity to intervene then we have a moral obligation to act. According to Singer, our proximity to the situation is not morally relevant. Yet distance does matter. Not in the sense that it absolves our obligations to act in Singer’s scenario, but it matters in that distance creates and exacerbates moral dilemmas. The COVID-19 pandemic and recent natural disasters, such as floods and fires, have reminded us that space and geography have very real moral, social, and political implications for health, well-being, and security.

In nearly all countries there is a divide between urban and rural health, with inequalities in coverage and access to healthcare (Scheil-Adlung 2015). While regional and rural communities are diverse and varied, many have common features including reduced health status, shared values and culture, limited

availability of and accessibility to healthcare workforce and services, overlapping professional–patient relationships, and limited economic resources. Widely held perceptions of urban versus rural places and their communities may also impact on opportunities, workforce, and health and well-being.

Within a rural context there are multiple issues and situations that can raise bioethical issues, such as confidentiality, multiple and inter-connecting relationships, scope of practice, boundary issues, professional–patient relationships, allocation of resources, and access issues. Additionally, “geographic narcissism,” which Malin Fors describes as the devaluation of rural knowledge and privileging or urbanity (Fors 2018), compounds power differentials and inequities through urban-centric policy, planning and resource allocations, and understandings of place.

Bioethics seeks to highlight and address inequalities and injustice in the clinical encounter as well as in the healthcare system as a whole. Yet to date, the bioethics literature on the inequalities associated with rural and regional health and the unique ethical issues that arise in these contexts has been limited (Cook and Hoas 2008; Kelly 2003; Simpson and McDonald 2017). To deepen our understanding of issues and place within rural contexts we need bioethical interrogation and reflection on rural issues, experiences, and practices which impact rural people and their health and well-being.

This symposium brings together health researchers and practitioners, sociologists, science and

D. L. Couch (✉)
Monash Rural Health, Monash University, PO Box 666,
Bendigo, VIC 3552, Australia
e-mail: danielle.couch@monash.edu

C. Mayes
Alfred Deakin Institute of Citizenship and Globalisation,
Deakin University, 75 Pigdons Rd, Waurin Ponds 3216,
Australia
e-mail: Christopher.mayes@deakin.edu.au

technology studies scholars, social workers, psychologists, rural health workforce experts, and bioethicists from Australia, Canada, China, Sweden, and the United States to consider how rurality and experiences of rural places impacts on health and health outcomes and the role of bioethics.

Overview of the Issue

The papers within this symposium raise contemporary issues for provocation and consideration by practitioners and researchers working in rural and regional healthcare settings.

Szumer and Arnold (2023) draw attention to the reality and inevitability of the overlapping relationships rural and remote healthcare practitioners experience with their patients. Contending that the urban-centric stance that a treating practitioner must only have a singular relationship with their patient is unrealistic in rural contexts, they undertake a narrative review to determine whether there is a distinct “rural ethics” for navigating professional boundaries and whether there are approaches that may assist practitioners to manage professional boundaries in rural and remote healthcare. From the findings of this review, they propose a schema to assist practitioners to navigate overlapping relationships and develop and maintain ethical and sustainable relationships in their rural practice.

In their paper, McDonald and Malatzky (2023) apply a feminist informed approach to rural health ethics, to examine a report from a New South Wales (NSW), Australia inquiry into health outcomes and access to hospital and health services in regional, rural, and remote areas. Their analysis identifies that metrocentric norms are built into governance structures and that this undermines the ability of people in rural places to inform how healthcare is provided in-place. McDonald and Malatzky argue that metro-normative values and assumptions underlying the governance practices for the delivery of health services to regional, remote, and rural NSW populations may constitute a form of structural violence.

The COVID-19 pandemic has exacerbated rural-urban health disparities across the globe. Zou and Nie (2023) examine the ethical and health effects of pandemic control measures used on rural Chinese migrants. Using the ethical discourse of vulnerability,

they draw attention to the rural-urban divide in China and how it has shaped the social structures and institutions, which heightens the vulnerability of rural migrants when complying with quarantine restrictions. Zou and Nie argue that giving greater bioethical consideration to the lived experiences of rural Chinese migrants has ethical and political implications for local and global responses to the COVID-19 pandemic.

Like Zou and Nie, Gillespie considers the lessons to be learnt from the responses to, and the impacts of, the COVID-19 pandemic. Aware of and resistant to the inherent urban-centrism in health and ethics, Gillespie (2023) offers a Canadian-focused critical commentary on place-based health disparities, taking account of the changing economic and demographic profiles of northern and remote localities in Canada. In particular Gillespie considers whether the increased access to and use of online medical and allied health programmes and increased use of telemedicine during the COVID-19 pandemic may offer more support and opportunity to people in northern and remote areas or whether these changes may also in some instances exacerbate health disparities.

In another paper from northern Canada, Leader, Bighead, Hunter, and Sanderson (2023) present findings from qualitative and exploratory fieldwork undertaken as part of a community-based research project conducted in partnership with four primarily Indigenous (First Nations and Métis) Northern Saskatchewan communities. Informed by critical science and technology studies, the authors consider how space and place are vital to ethical telehealth use. Their findings highlight the need for Indigenous voices and perspectives to be at the forefront of decisions around telehealth implementation and service delivery.

In a qualitative study exploring the experiences of people in regional Australia accessing assisted reproductive technology services, Sassano, Mayes, Kerridge, and Lipworth (2023), examine how regionality and location impact upon access and quality of care. They highlight how participants’ locations impacted the services available to them, the considerable time required for travel, and the reduced continuity of care. They draw on their findings to consider the ethical implications of uneven distribution of reproductive services in commercial healthcare settings which rely on market-based

mechanisms and highlight the need for further political economy of health explorations around the geographical issues of access, particularly in relation to access to services that are provided in private healthcare settings.

In analysing representations of rurality in Australian media, Malatzky and Couch draw attention to the importance of rural place stigma. They observe how the concept of stigma, including spatial stigma, has been studied in various contexts but has been largely overlooked in rural areas. This neglect is particularly relevant for public and rural health and the aim to address health inequalities. Malatzky and Couch (2023) argue that better understanding rural place stigma is crucial for addressing spatial injustice and health disparities affecting rural communities worldwide. They contend that greater attention to rural place stigma can improve rural and public health and draw attention to the conditions and positioning of the rural in the public and political spheres.

The high incidences of accidents and harms faced by agricultural workers is a persistent problem around the globe. Yet, it is difficult to develop effective interventions. Becot, Inwood, and Buchanan (2023), propose Photovoice as a potentially useful approach to highlight safety concerns faced by farm and agricultural workers, especially children. Photovoice is a participatory research method that seeks to empower marginalized individuals and communities through visual media. However, Becot, Inwood, and Buchanan, draw on their past research in rural United States to show that Photovoice is not easy to implement and that it can produce its own risks and ethical concerns. In this paper they reflect on the importance of collaborating with research ethic committees, the need to increase preparation to limit psychological risks to participants and researchers, and avenues to augment the emancipatory power of Photovoice in a virtual environment.

Playing with the Swedish culinary understanding of the potato as plain but versatile side dish, Malin Fors (2023), introduces the novel idea “potato ethics.” Potato ethics is the idea of making oneself useful, pragmatic, and willing to bend or break formal rules to prevent further disaster or harms to vulnerable patients. Fors draws on her experience as a clinical psychologist living and working in the world’s northernmost town, Hammerfest, Norway to show how a potato ethic is lived out and required for rural health

professionals ‘who often live under the ceaseless stress of anticipating disasters’ (Fors, 2023). According to Fors, the lived experiences of rural healthcare professionals working in remote areas with vulnerable communities and with inadequate resources or support place them “among the most experienced people at solving extraordinary problems that no textbook has ever covered” (Fors 2023).

We are proud of the contributions to this symposium for drawing attention to spatial stigma, asymmetries of knowledge, barriers to access, unique research ethics protocols, blurred boundaries, and different vulnerabilities, and so on, among rural communities. These contributions do not exhaust rural bioethics or the topics requiring further analysis. Importantly, histories of rural and regional communities are an important dimension that is only partially explored in this symposium. The conception of rurality in countries such as Australia, Canada, New Zealand, South Africa, and the United States directly (Smith 2004) intersect with the histories and politics of settler-colonialism, Indigenous health, and racialized health service provision (Dasgupta et al. 2020). Questions about how space and the sense of belonging to a place is racialized are highly relevant to rural bioethics and requires further research (Stead, Butler, and Mayes 2023). As the paper from Leader, Bighead, Hunter, and Sanderson (2023) argues, Indigenous voices and perspectives need to be at the centre of these conversations.

We hope that this symposium may provide some impetus to explore the possibilities for bioethics to address rural and regional communities and to be more aware of, and attentive to, the influence of spatiality and geography within bioethical thinking and research.

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