Rural Health Care Ethics: What Assumptions and Attitudes Should Drive the Research?

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Nelson, Lushkov, Pomerantz, and Weeks (Nelson et al. 2006) have provided a valuable service in checking and documenting the widespread suspicion that there’s just not much out there on rural health care ethics. The authors call for more research, particularly “scientific research . . . empirical studies comparing rural and non-rural ethics issues” (44). Since most of the existing literature focuses on clinical ethics, there is also “the need to expand the focus of rural health care ethics to include areas of organizational and national policy, in particular issues addressing access and allocation of resources.” I have no disagreement with any of this.

But it may be worthwhile to pause and ask why there is so little literature on rural health care ethics. Part of the answer, surely, is that bioethics is an urban phenomenon. Most bioethicists work in universities and large, tertiary care hospitals. Our intended audience—other bioethicists, health planners and health professionals working in these centers—is similarly urban. This is true even for bioethicists located in states with large rural populations. (A research university is part of the urban culture.) Accordingly, the authors supplemented this list with 2) “the author’s knowledge and experience of common rural ethics concerns” (44). These two lists were 3) “confirmed by focus group discussions with rural health care professionals” (44).

The last of these presupposes that the rural health care professionals have found their ethical voices. They can already (despite lack of support and training from us) identify which of their concerns are ethical and express them without feeling intimidated or abashed in the presence of urban bioethicists who come armed with a list of ethical categories derived from the best textbooks in bioethics. It also presupposes that these rural health care practitioners have overcome the socialization into an urban bioethics they received at the university and from the literature they have since encountered.

This three-part approach is probably the best methodology available to the authors. But it is not so easy to spell out previously undiscovered ethical issues and to argue that they are indeed ethical despite their exclusion from the literature. (Feminist philosophers, ethicists and bioethicists would attest to that!) So, it would be interesting to know which of the search terms the authors found in bioethics textbooks and which were not there but were derived, instead, from...
“the author’s knowledge and experience” or, indeed, from “the focus groups of rural health care practitioners.”

These reflections lead to the question of what kind of research we intend to do. Do we have enough confidence that our urban bioethics applies to rural settings; that it just needs to be tweaked a little to take into consideration the rurality of the context? Have we already identified the relevant ethical issues and developed the tools needed for dealing with them? Can we be confident of this despite our previous lack of interest and experience in rural health care, and our training in urban bioethics? If so, we can go into rural settings as missionaries, intent upon helping the natives see the light. That presupposition would drive one kind of rural ethics research.

Quite a different research program would emerge from the assumption that we bioethicists do not know what the ethical issues in rural areas are or what categories and tools we will need in order to deal with them. On this view, we would go into rural areas as into a foreign land. We would approach rural health care practitioners with all the sensitivity to our urban cultural biases and blinders that cultural anthropologists have developed over the past century. We would utilize techniques developed by these anthropologists to learn to hear what these rural practitioners are saying without forcing it into our familiar language. Perhaps, like anthropologists, we would need to live among rural peoples and their caregivers for several years before we could hear and understand what they are saying.

One of the agendas that seems to motivate Nelson et al. is the desire to demonstrate the inequitable allocation of health care resources and the injustice of this distribution. This is a laudable motive. The problem of access raises important ethical questions of justice and resource allocation. It also highlights the difficulties of getting any political and economic purchase on them. By definition, rural communities contain few votes and little economic clout, and thus are inviting political targets for cost-containment measures.

Finally and perhaps most basically, in formulating research agendas, we bioethicists will need to ask: Do we even believe in rural health care? There are two, related issues nested within this question. 1) Do we believe that there will continue to be rural health care? 2) If so, is this a good or a bad thing?

Someone has said of Aristotle that he provided the definitive rationale for the city-state just when that political institution was disappearing forever from the pages of history. Similarly, we bioethicists might work to define a rural health care ethics just at the moment when rural health care disappeared, at least in the U.S. Surely, not all rural health care will cease to exist. Walk-in clinics and small, office practices will survive in rural areas, their survival assured by sheer distance from the metropolis. Yet, rural hospitals are closing or imperiled. Those that manage to survive may be increasingly reduced to emergency centers serving primarily to stabilize trauma patients for transfer to urban medical centers. But primary care office practice aside, rural health care may be largely a thing of the past.

Isn’t that all to the good? “Rural” means primitive, outdated, and crude in medicine, as elsewhere. Surely, high-tech, up-to-the-minute, subspecialty medicine is better. Surely, modern, urban medical centers deliver “better care” than a rural hospital ever could. Confidence in medical technology is so strong that a new technology is often widely adopted long before it is proven to be efficacious. There is also absolutely no prospect that we will build subspecialty medical centers for our rural areas, regardless of what a rural health care ethics research program might uncover. So, on this line of thought, what rural areas need is helicopters to whisk sick people off to urban medical centers where they will get better care in that high-tech, anonymous setting. This attitude could also drive a research program in rural health care ethics—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.

Is anonymous, subspecialty care better? Obviously, there are exotic diseases and acute episodes for which rural patients are already routinely transferred to large, urban medical centers. But is that kind of health care better across the board? Is it better for the extended care of chronic illnesses that are becoming the predominant maladies? Is it better when successful treatment requires the active participation of the patient? These questions go to the heart of what medicine is. Anonymity raises questions about what it is in the medical relationship that does the healing. Is healing simply the result of knowledge and the technology? If so, a computer program might do as well or better than a physician, urban or rural. Or can there be a healing relationship?

In any case, if there really is a different kind of medicine and a different health care ethics in rural areas, we need to think carefully. If we substitute urban for rural care, we choose one kind of medicine and one kind of ethics over another. We would be well advised not to do so unthinkingly. Multiple research programs like those advocated by Nelson et al. might help us make this decision on a more rational and more thoughtful basis.

REFERENCES

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