



CHAPTER 3

# The Ethical Life of Rural Health Care Professionals

Ruth B. Purtilo

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### **Handbook for Rural Health Care Ethics: A Practical Guide for Professionals**

Dartmouth College Press  
Published by University Press of New England  
One Court Street, Suite 250, Lebanon NH 03766  
[www.upne.com](http://www.upne.com)

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Edited by William A. Nelson  
Cover and text design by Three Monkeys Design Works

Supported by NIH National Library of Medicine Grant # 5G13LM009017-02

# The Ethical Life of Rural Health Care Professionals

Ruth B. Purtilo

## ABSTRACT

The study of ethics helps professionals to recognize ethics situations, to reason about them, and to seek resolution of challenging situations. Each function can be put to use within one's professional life. This chapter introduces rural health care professionals to the difference between, and the significance of, morality and ethics in the rural professional's life. Each professional confronts three realms of morality: personal, professional and societal. Ethics tools can ease the navigation through each of these realms by ensuring integrity. In addition to defining ethical mechanisms, this chapter presents the relationship between ethics issues and ethics problems. Three basic types of ethics problems help the clinician recognize which components of morality are embedded in a situation: ethical distress, ethics conflicts, and appropriate locus of moral authority. Health care ethicists and others have concluded that ethics problems arise when moral values and goals compete. Ethical principles can act as intermediaries between general moral considerations and the specific situation, lending an enhanced opportunity to reason through the situation. Common principles include autonomy, beneficence, nonmaleficence, fidelity, veracity, and justice. Ethics theories centered on duty-based (deontological) reasoning tend to treat the principles as explanations of duties, while those based on utilitarian reasoning tend to consider the overall usefulness or "utility" of conduct governed by one principle in contrast to another. In addition to principles, character traits and attitudes of professionals must be taken into account. This chapter concludes with practical suggestions for sustaining ethical practice by fostering self-care and the use of available resources.

## INTRODUCTION

Like many of my colleagues in health care ethics, my familiarity with the rural environment is spotty. Mine is also largely second-hand, though my “roots are rural. My father grew up in rural Minnesota, the only son among six children, and became the breadwinner at an early age when my grandfather succumbed to a stroke. At 30, he left the small farm, with his mother now in the care of an unmarried sister, and went to the city. There he found a wife who had been “born and bred” in an urban environment. I anticipated my rural experiences with great enthusiasm as a child when, four or five times a year, we visited my father’s sisters—all of whom had stayed on or near their rural birthplace. To me these times represented sunshine and fresh air, the smell of the barn, running free in the fields and woods with cousins, amazing encounters with nature, and sumptuous amounts of food, all served against a backdrop of women’s chatter. I also recall them as the times when my father laughed more openly during the visit, and grew more silent on the trip home. Now I understand that one great gift he gave to his children was his attempt to share that country life and what it meant to him, as a rural man to the core.

Many years later, when I became the director of a health care ethics center in a largely rural state, I received a grant to travel across that state and the neighboring states, visiting with rural practitioners, health care administrators, and patients. I wanted to get my bearings about the environment from which most of my students had come and to which they might return after completing school. I wanted to understand the special needs and strengths that rural patients and their families brought to the university hospital, as well as to better understand the small towns and clinics to which they would return. These travels taught me that rural life had many blessings, but such life was not just sunshine and fresh air.<sup>1,2</sup> Today when I visit the remaining aunts and cousins, or read the newspapers and other literature on rural life, I see rural communities being as diverse as the unique neighborhoods in the city in which I live.

Living and working with health care professionals in both rural and urban settings, I have come to conclude that all professionals struggle with ethics issues in their practices. I have also learned that geographic context,

such as a small rural setting, can significantly impact the ethics issues we all face as tenants-in-common sharing the larger landscape of the human condition. Some of the questions that a professional will encounter on the journey of a rural health care provider are found in Box 3.1.

### **BOX 3.1**

#### **QUESTIONS ENCOUNTERED BY THE RURAL PROVIDER**

- What is the significance of morality and ethics to the rural professional?
- How can ethics be useful to rural professionals?
- How can one balance competing values?

In this chapter I examine these questions, and make a few practical suggestions for nurturing the deep values that guide each provider's professional life.

### **WHAT IS THE SIGNIFICANCE OF MORALITY AND ETHICS TO THE RURAL PROFESSIONAL?**

Fortunately, health professionals in any environment can usually rely on common sense, counsel with professional colleagues, and lessons from past experience to provide sufficient moral traction for the clinician to address the day's many decisions with confidence. When decisions serve the patient's best interests, and are consistent with personal values and society's moral guidelines, a clinician usually can conclude that the attitude or conduct was morally correct. Even so, under scrutiny, this may not always be the case. Thoroughly taking stock throughout the day requires the clinician to use ethics as a tool. Occasionally, providers become aware that the gears of personal or professional values and goals are beginning to grind, and something is wrong. Any time the feeling that "something is wrong" threatens to mire your confidence in doubt, ethics is an essential tool.

You've heard it said, "This is the moral and ethical thing to do." Sometimes moral and ethical are used interchangeably. They are deeply related but not synonymous. A distinction between morality and ethics is useful for understanding why both are necessary. *Morality* is the sum

of attitudes, conduct and character traits that describe how humans in a particular setting have agreed to live so that everyone can exist in harmony.<sup>3</sup> Morality helps to delineate basic shared values and goals. Beauchamp and Walters describe morality as “certain things [that] ought or ought not to be done because of their deep social importance in the ways they affect the interests of other people.”<sup>4</sup> An individual’s morality becomes integrated into his or her identity as the individual grows, absorbing the influence of parents, mentors, the media, social norms, and other diverse sources.

*Ethics* is a systematic study of and reflection on morality. It is systematic because it is a discipline that uses special methods and approaches to examine moral situations; it is also reflection because it consciously calls into question assumptions about existing components of our morality.<sup>5</sup>

But no person lives in a social vacuum, least of all the professional. Health professionals know that they are expected to conform to certain moral expectations of themselves, their patients, and society. Whether or not a clinician agrees with everything society expects of him or her, at least he or she acknowledges the need to reconcile personal morality with societal morality. Doctors learn that professions themselves have a morality, one expression of which is in the public “professing” that is offered to society in code or shorthand form, each profession’s code of ethics. So even as one hits the road as a health professional, one deals with at least three realms of morality: personal, professional, and societal. In fact, every time a doctor makes a patient-care decision in his or her professional role, he or she deals with all three realms.

Consider the following story, focusing on the personal, professional, and societal moralities that Dr. Siegel encounters within one relationship:

Dr. Kim Siegel is very excited about being invited into the rural group practice. During her hiring interview with the group, she finds that the team of physicians, nurses, technologists, therapists, and others are compatible with her own commitment to high-quality health care. She tells them that she has grown up in a small town in another state, and, although she enjoyed the opportunity to attend medical school

in a large metropolitan center, she realized as she neared the end of her residency that she wanted to return to a rural area. The group is impressed with her enthusiasm and with the several academic and humanitarian awards she has received during her training, and offers her the job, which she accepts.

After a short time on the job, Dr. Siegel accidentally misdiagnoses the asthma symptoms of one patient, Mr. Ortega, as a temporary allergic response attributable to a high pollen count. She remembers having been exhausted on the evening when Mr. Ortega came in, and then feeling relieved that he was just another person reacting to pollen. She had wanted to be available that evening to serve at a community church supper. When asked if he had ever had such a reaction before, Mr. Ortega had said no. But when Mr. Ortega returns two months later, again complaining of difficulty breathing, it dawns on Dr. Siegel that she should probe further. She is aware that the allergy medication she previously prescribed probably has not done Mr. Ortega any harm, but also knows that untreated asthma can have severe and sometimes fatal consequences. The doctor conducts additional tests that confirm Mr. Ortega's asthma. She finds herself uncertain about whether to tell him that she had misdiagnosed him two months earlier, because she knows from experience that acceptance of new young doctors in a rural community is slow and that word travels quickly. "Why am I hesitating?" she asks herself; "I am an honest person!" She concludes that part of her hesitance stems from not wanting to disturb the trust she feels she has been building with Mr. Ortega and his ethnic community, many of whom have been suspicious of the "white doctors" and therefore have failed to come for care. To further complicate things, Dr. Siegel feels an increasing need to hold on to patients who might otherwise go to a larger facility 30 miles away.

One can readily see some of the moral considerations that face Dr. Siegel. Her personal morality counsels her to do her duty well, honestly, and fairly. Her professional morality requires competent patient care as well as concern about how her disclosure of the mistake may affect this patient and others. And the morality of the community expects that access to high-quality care would be available for all groups of patients.

The function of ethics as a tool is also highlighted in this incident. Thus, when people say it was “the moral and ethical thing to do,” it means that the realms of morality are identified as well as reflected upon, using appropriate methods of ethics designed for that purpose.

As the reader moves through this chapter and others, it might be helpful to break the idea of “reflection” into three components, so that ethics becomes a tool for the health care provider. The three forms of ethics reflection are defined in Box 3.2.

### BOX 3.2

#### FORMS OF ETHICS REFLECTION

**Recognition:** Being aware of morality in its three realms within the context of everyday practice

**Reasoning:** Analyzing the conflicts that might move an ethical issue into the category of an ethical problem or conflict

**Resolution:** Seeking to evaluate and propose potential solutions

I find the forms of reflection so fundamental that I think of them as the three “Rs” of ethics deliberation—ultimately making ethics useful in practical situations. We turn now to some of those methods. In this chapter, the major focus is on the first two “Rs,” and in Chapter 4 they are further elaborated into a full deliberative process that helps move the rural health care professional towards the third R.

### HOW ETHICS CAN BE USEFUL TO RURAL PROFESSIONALS

In learning to recognize the moral dimensions of a situation, I have found it helpful to distinguish ethics issues from ethics problems:

#### Ethics Issues

Ethics issues are situations or themes that are embedded with questions of morality that deserve reflection so the decision-maker is assured of continuing on a path consistent with the correct moral direction or disposition. The process that Dr. Siegel engages in during her first



meeting with Mr. Ortega illustrates this. On the first encounter, she is a reflective practitioner, acting consistently with her personal morality; consciously aware that in spite of her fatigue, she has a professional moral duty to treat her patient competently and humanely. She is pleased to be able to keep her societal commitment at the church supper as well.

## Ethics Problems

Ethics problems are on the horizon when there is no way to act according to the three realms of morality in a situation without something of moral worth being compromised in one or more of the realms. There are three general types of ethics problems. They include:

- **Ethics Distress:** The health care provider recognizes what is right, but can't act on it
- **Ethics Conflicts:** More than one right or wrong option is presented to the professional, but to act on one will compromise the other
- **Locus of Authority:** The clinician must ascertain who has the ultimate moral authority in this situation

In Dr. Siegel's situation, her confidence is shaken when Mr. Ortega returns after two months and she realizes she has diagnosed his condition incorrectly. This moment also raises serious questions about the relative weight each of the three realms of morality should have on her at different times in her relationship with Mr. Ortega. In short, she is coming to grips with the fact that she has an ethical problem.

**Ethics Distress:** Ethics distress occurs when the decision-maker (usually a team) knows what should be done to uphold the professional's personal moral values, as well as to support the patient's and society's values and goals, but external constraints keep the right thing from being accomplished. The constraints may come from scarce resources, policies, laws, or other sources. Scarce health care resources (e.g., limited personnel, equipment, time, space, money) are common reasons for such distress in rural health care environments. Ethics distress may occur when the wishes of patients or their families stray from what the medical team considers sound clinical practice, or when the health care team doubts that the family is reflecting the patient's true wishes. In Dr. Siegel's case, we have no clear indication that she has this type of ethics problem.

One thing that does deserve mention here in regard to Dr. Siegel's situation is the term "ethics distress" itself or, as some term it, "moral distress." Since the health professional actually knows what to do, his or her experience of distress is a helpful feeling, as a marker that more attention is needed. In this respect, Dr. Siegel is tuning in emotionally to the fact there is a problem when Mr. Ortega returns after two months and it dawns on her that she has made a mistaken—and perhaps hasty—diagnosis.

***Ethics Conflicts:*** In ethics conflicts, the decision-maker is confronted with more than one right (or wrong) course of action that honors personal, professional, and societal morality, but acting in accordance with one will compromise the other. For example, rural practitioners often face confidentiality conflicts. They must adhere to a professional moral dictum to honor confidential patient information. At the same time, the close web of families, neighbors, and the community as a whole may make sensitive information recorded on a patient's medical record public knowledge. But not to document such information may compromise the patient's best interests if he or she requires care outside of the immediate environment.

Another type of ethics conflict involves implementing life-sustaining technologies that would require a patient to be moved from the local community to a distant site. This can compromise local support systems, often adding burdensome expense to the family and generally disrupting the lives of patients and their families. Similarly, limited resources create ethics conflicts, because energy and financial resources can be spent only once, even though an equally compelling need exists.

Dr. Siegel has identified an ethical conflict during her deliberation following the return of Mr. Ortega. Both her personal and professional moral compasses direct her to be honest about her mistake. Still, she fears that this disclosure may have a negative effect on the complex relationships that she and the group's facility have with Mr. Ortega and his community of patients. She also knows that if enough patients were siphoned off to the competing facility down the road, her office might be forced to close, leaving many of the already underserved patients without health care access.

**Locus-of-Authority Conflicts:** Locus-of-authority conflicts, like those experienced by Dr. Siegel, are not unique to the rural situation, although when they arise, the long-standing practices of the rural community are likely to prevail over hard-and-fast policies. This type of problem shifts attention from quandaries regarding what should be done, to a consideration of who has the morally authoritative voice. For example, in situations where it is uncertain how to proceed with treatment, the opinion of a therapist who has served the area for years likely will trump the judgment of a new clinician. This might occur even though the health care team and/or an objective outside reviewer may believe the new clinician is more equipped to make the call. Customary and long-standing practices also spill over into the relationship within families. If a professional were to encourage the wife of an incapacitated man to speak on her husband's behalf, she might balk if she feared that the whole community would judge her negatively if she attempted to express her own preferences. Or a local religious leader might hold almost complete sway over reproductive care, end-of-life care, or other types of health care decisions, and it might be futile for a clinician to present alternatives to a patient or family without the leader's input.<sup>6</sup>

Locus-of-authority questions also take another turn. With the increasing ethnic and religious diversity in many rural communities, the professional health care provider may be confronted with customs that seem foreign, and contrary to the customary rural practices. Dr. Siegel's story does not suggest whether she has considered consulting anyone for insight regarding her concern about disclosure on the basis of Mr. Ortega's ethnic community. She has assumed that it is up to her to decide whether and how much to say. In this case she has seen herself as the sole team member involved in this situation. She has not lost moral direction, but may be cheating herself of valuable ethnically knowledgeable professional resources who might advise her after learning the news that a mistake has been made.

Not all challenges involving the recognition of ethics issues and ethics problems are embedded with one of the three types of problems outlined above (ethics distress, ethics conflicts or locus-of-authority problems). For instance, a dilemma about the withdrawal of a life-sustaining technology, such as a feeding tube, may be resolved by

including active debate about who holds the appropriate moral and legal authority to have the final say.

In summary, learning to recognize these three major types of ethics problems provides one ethics tool that a clinician can utilize when reflecting upon the morality of his or her professional role, the need to integrate it into personal morality, and the expectations of society. Moreover, this tool will begin to allow the rural professional to steer through the first “R,” recognition, towards reasoning. To complement ethics work, the next section outlines another type of ethics tool by describing some basic ethical principles.

### **HOW PROFESSIONALS BALANCE COMPETING MORAL VALUES AND GOALS**

Several ethical principles are used widely in medical and professional ethics circles to help professionals reason about the moral components present in a given situation. These principles are often viewed as conceptual tools, which are helpful for reasoning among the duties, rights, character traits, and other components of morality and the particularities of a specific situation. A short definition of each ethical principle is found in Box 3.3.

These principles are especially useful when a physician recognizes a potential ethics problem and needs some conceptual tools to help sort out what’s going on. For example, when the principle of justice cannot be accomplished because of policy constraints, a clinician has a situation of ethics distress. An ethics conflict exists when patient autonomy conflicts with a physician’s best judgment about what will prevent harm. Thus, conduct according to one would preclude also honoring the other. Taken alone, each principle is worth honoring, but the particular situation puts a professional between a rock and a hard place.

A detailed deliberative process is required to move from reasoning at this level to possible resolution of an ethics problem. Such a complete process is presented in Chapter 4 of this *Handbook*. However, this chapter gives professionals an opportunity to familiarize themselves with the most frequently used ethical principles in health care ethics.

**BOX 3.3****BASIC ETHICS PRINCIPLES****Autonomy**

Autonomy is when an individual has the final say in decisions affecting his or her well-being, even at times of life-and-death decisions

**Beneficence**

Beneficence, meaning “bene” or “good,” implies that health professionals must act with the patient’s interests as the top priority

**Nonmaleficence**

Nonmaleficence is the stringent moral claim on health professionals not to put a patient in harm’s way

**Fidelity and Veracity**

Fidelity is from the root *fides*, faithfulness. Veracity is the devotion to truth. In the patient-clinician relationship, faith and truth combine in the form of trust

**Justice**

Justice helps clinicians make moral choices when one claim for resources trumps others, using criteria including relative degrees of merit, contribution, or need among people or groups

**Autonomy**

*Autonomy* is when an individual has the final say in decisions affecting his or her well-being, even at times of life-and-death decisions. In western societies, where independence of thought and action is considered the norm, the term “self-determination” is commonly used. Professional autonomy, as a guide for health professionals, is necessary in order for a clinician to make informed and accountable decisions. A patient’s autonomy may be expressed through his or her own words, or through surrogates, in instances when the patient can’t personally express his or her informed preferences. No one would argue with trying to determine the patient’s informed preferences as a tool for directing the health professional’s decision-making. One caveat

regarding traditional interpretations of patient autonomy as a reliable ethical principle is the emergence of groups whose understanding of their individual well-being are not viewed as dependent on individual preferences. This is particularly important in rural communities where new ethnic and religious groups are becoming more prevalent against the backdrop of individualism.

### **Beneficence**

*Beneficence* is from the Latin root “bene” or “good.” In common health care ethics and health care usage, this term implies that action by health professionals and others must be conducted with the patient’s interests as the top priority. Some writers break beneficence down into at least three components: doing good, preventing harm, and removing harm.<sup>7</sup> Health care teams today are faced with a lot of ethical distress, due to limited resources and other constraints on what they believe would support care consistent with the patient’s best interests. Also, a patient’s informed preferences may sometimes depart from the ideas of health professionals or ethics committees about how to best help patients and prevent or remove harm. When Dr. Siegel weighs the benefits of disclosing her mistake against the benefits of withholding it, she is making beneficence-based deliberations.

### **Nonmaleficence**

*Nonmaleficence* is the stringent moral claim on health professionals not to put a patient in harm’s way. This, too, can bump into other principles. Take the simple example, not uncommon in rural settings, where good clinical judgment suggests moving a patient to a distant tertiary-care facility for life-saving interventions that are not available locally. Not to do so, the professional argues, makes him or her agent of potential harm to the patient. However, viewed from the larger social fabric of the patient’s life in this dire circumstance, to remove the patient from his or her local support network also may cause harm. Though Dr. Siegel does not face this situation, it is so prevalent in the rural setting that it is likely a part of her everyday reflection on her moral life as a health professional.

### **Fidelity and Veracity**

*Fidelity* is from the same Latin root, *fides*, as faithfulness. *Veracity* is the devotion to truth. On the journey of the patient-clinician relationship,

faith and truth combine to form a main road marker in the form of trust. Both terms reflect the insight that honoring reasonable expectations of a relationship is a good thing. Understandably, Dr. Siegel is concerned about any course of action that may involve withholding the truth about her mistake from Mr. Ortega. Our moral intuition and historical reflection support the idea that faith and truth support human life. Still, every reader is familiar with the ethics conflict that arises when conveying the truth also carries the possibility of harm, and Dr. Siegel is face-to-face with that concern.

## **Justice**

*Justice* is a reminder to take into account the fact that moral claims for resources may not be equal in moral weight. The concept of justice provides criteria regarding how to make moral choices when one claim for resources trumps others. Some common criteria include relative degrees of merit, contribution, or need among people or groups. Justice is different from the other principles insofar as the unit of consideration is a group or population with similar characteristics. However, the clinical decision-maker experiences justice in a manner similar to how he or she experiences other ethics problems. For instance, ethics distress would result if a doctor were unable to offer effective treatment to a child with a rare metabolic disorder, because policies did not support the cost of treatment. The same clinician or ethics committee might face an ethics conflict when considering whether to support expensive life-saving treatment, knowing that the drain on a limited pool of financial resources would harm future patients.

These basic ethics principles are included in the classic ethics theories and are imbedded in health professionals' codes of ethics. For a fuller discussion of these ethical principles see Beauchamp and Childress' book *Principles of Biomedical Ethics*.<sup>8</sup> This list is by no means exhaustive. For example, the moral concept, "do your duty," as noted by Bernard Gert in his book *Common Morality*, relates to one's duty as a member of a particular profession.<sup>3</sup> This has also been referred to as professional ethics or group-specific ethics. If one elects to be a member of a particular health profession, such as nursing, occupational therapy or health care administration, the person should accept the ethical standards and guidelines that reflect the expectations of the

profession. Applying these various ethics principles to one's work can help to highlight the basic ideas about harm and good, right and wrong.

### **Weighing Ethics Principles**

There are two common, conduct-oriented ethics theories that propose how to weigh the aforementioned principles against each other when ethics questions arise. They are the deontological and utilitarian approaches.

*Deontology*, from the Latin root “deonto” or duty, focuses on principles as a means of delineating duties. This approach does not provide hard-and-fast rules about which duty is the most binding, though the history of medical ethics places a high priority on nonmaleficence.<sup>6</sup>

The *utilitarian* approach, is from the Latin root meaning “utility” or “usefulness,” considers options by which a course of action will bring about the best overall consequence. This good is not just moral, but positive, in terms of its widely considered consequences.

While this is a great oversimplification of these two rich theories, my intent is simply to give professionals a basic idea of where they may see the principles popping up in writing in the fields of health care ethics, professional ethics, and other health care publications and policies.

The essential idea in ethics is that the moral character of any decision-maker has relevance along with the course of action that he or she chooses (or that a group of decision-makers jointly choose). In addition to ethics principles and theories, it is important to consider the character traits of clinicians, administrators, and others who are involved in reflection and decision-making. The list of potential character traits is long, and traits that are often named as particularly relevant include respect for human life, commitment to competence, compassionate disposition, patience, sympathy, honesty, trustworthiness, kindness, humility, and fairness. A professional may make his or her own appraisal of which character traits Dr. Siegel seems to exhibit as she moves through the visits with Mr. Ortega. Are there other traits that might be helpful? Are there other traits that she may have to work to cultivate for future situations of this type? These types of questions are useful in the process of ethics reasoning. Ethics tools for reasoning are described in Box 3.4.



**BOX 3.4****ETHICS TOOLS FOR REASONING**

- Ethics principles help make a link between personal moralities or values and specific situations
- Ethics principles can enhance reasoning about ethics issues/problems
- Conduct-oriented ethics theories, such as deontology and utilitarian theories, highlight the importance of duty and the outcomes of one's acts
- Character traits of decision-makers help position them for morally right action

Using these tools, rural health care professionals can better navigate ethics situations and reflect on their own ability to provide ethically grounded care.

**CARING FOR YOURSELF AS A RURAL HEALTH PROFESSIONAL**

I have rarely met a health professional who puts self-care on even par with the demands of caring for others. This is not surprising, since health professions' codes are built on the idea of putting others first. Health professionals' education has been less than successful in preparing professionals for the relationship between self-care and the ability to care for others effectively. As a result, there is a deeply disturbing profile of the health professions as a career line, with a disproportionately high percent of burnout, stress-related illnesses, addictions, divorce, and even suicide. These are often the sad end-points that result from a health care professional overextending for others at the price of his or her own health over a period of months or years. Fortunately, some professional preparation programs are now recognizing the high human, social, and economic price that such a lifestyle exacts, and are placing more attention on helping future professionals create the time, space, and skills to engage in health-sustaining and stress-relieving activities.

Rural health care practice can be a special challenge, because the rural environment promises to provide some of the most healthy and

relaxing lifestyles on the planet. Examples include physical beauty, relatively clean air, and an abundance of nature. I have talked to many former students who would not trade those energizers for the “lights and excitement of the big city.” But against this stereotypical backdrop, the rural health professional is vulnerable to the pressures of close, overlapping relationships, concerns about unfinished tasks and unmet duties, and other vicissitudes of life. The rural health professional inevitably is in the eye of the storm whenever natural disasters, major accidents, or violence occur. When these events are compounded by clinician exhaustion or illness, it can be difficult for both the patient and for the clinician. And when the clinician needs self-care, it is often even more difficult to allow the roles to be reversed.

There is a story of the famous psychoanalyst Carl Jung, who refused to see a distraught client when she called to beg for an appointment the next day. He told her that he already had an important appointment that he did not want to change. And so her anger was fueled when the next day, she saw him sitting quietly beside a stream in the local park. She gathered up her courage and confronted him with his apparent disregard for her need. He turned to her quietly and said, “Today I had an important appointment with myself.” I would wager that this is one of the most difficult decisions any reflective professional makes, no matter how justified the need is for keeping an important appointment with oneself. It is impossible to fully assess from the story of Dr. Siegel whether or not she felt that her evening appointment at the local community supper was a way to help restore her flagging energies from the long days at the clinic, or if this, too, would be an energy drain, a commitment undertaken only because of her belief that she should be a good community participant. We do know that she acknowledged feeling exhausted when Mr. Ortega first came to the clinic, and remembered that fatigue when she reflected on her diagnosis.

Taking good care of one’s self is an intentional decision and discipline, more than the task of carrying out any prescribed activity. Depending on personal circumstances and personality, one professional may find a fast hike restorative, while someone else needs to “veg out” in front of the TV, enroll in a class to learn a new skill, or cook up a good meal. It is almost always a good idea to plan time out from the immediate physical

environment in which one works, especially in the fishbowl setting of most rural health care clinics.

I don't offer these suggestions because I believe that the rural health care professional's status in the community, or his or her work habits, make him or her deserve privileges not available to others. To the contrary, self-care is essential for all. Self-respect for one's true needs is manifested through simple acts of self-care, and from that strength, true respect and regard for others' needs are optimized.<sup>9</sup> In other words, self-care is essential to ethical practice.

### **Allowing Others to Care For You**

Using and celebrating the availability of support and counsel from various resources is another vital part of a sustainable ethical practice. Accepting care from others seems almost an impossible task for many professionals. Dr. Siegel is like many other health professionals when she goes through the decision process alone in determining the best course of action regarding disclosure of her mistake without seeking help. There is little mention of the nurses and others in the clinic who may have met several situations similar to hers, might be more familiar with the local ethnic community of which Mr. Ortega is a part, might know the foreman who brought him back to the clinic the second time, might be cognizant of the likely reactions, and who also might be able and willing to support her decision about how to proceed.

Not every clinic, particularly those in rural areas, may have an ethics consultant or ethics committee. However, advice and assistance with reasoning through thorny ethics problems are almost always available in the vicinity. Much more is said about these resources throughout this *Handbook*. It is enough of a reminder for the health care professional that allowing others to help is not negotiable, if one is to sustain an ethical professional life. It is essential.

### **CONCLUSION**

I occasionally travel to the rural northern Minnesota community where some of my relatives live. If you are from the Midwestern United States, you will know that I am heading "up north." But this "up north" rural community is one of several thousand in the U.S., and of tens of

thousands in the world, each possessing its own special characteristics and contours. What I will find there, that is shared in common with all rural communities, are good people working together to address the moral challenges presented by personal, professional, and societal moralities, including ethics problems. In that we can rejoice, share whatever each of us can bring to human survival, and flourish as we welcome these challenges and address them with all of our potential.

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