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Rural general practice and ethical issues. A rapid review of the literature

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ABSTRACT

Introduction. Key New Zealand ethical documents that describe appropriate ethical behaviour for doctors do not consider rurality and how this might impact on the practice of medicine. **Aim.** The aim of this study was to understand the literature on key ethical issues experienced by general practitioners in a rural context that might inform the development of a New Zealand agenda of rural medical ethics **Methods.** A rapid review was undertaken of three databases using a variety of key words relating to rurality, ethics, professionalism and medicine. Inclusion criteria were research articles focussing on the experience of doctors working in a rural healthcare setting, commentaries and narratives. The findings from the paper were synthesised and broad ethical categories created. **Results.** Twelve studies were identified that met the inclusion and exclusion criteria. Synthesis of the data revealed five ethical issues that predominately arose from living and working within communities. These ethical issues related to juggling personal and professional lives, managing friendships with patients, managing loss of privacy and anonymity, assuring confidentiality and practicing outside of comfort zones. **Discussion.** The majority of ethical issues arose from managing overlapping relationships. However, these overlapping relationships and roles are considered normal in rural settings. A tension is created between adhering to urban normative ethical guidelines and the reality of living in a rural environment. Professional ethical guidelines, such as those developed by the New Zealand Medical Council, do not account for this rural lived reality. Rural practitioners in New Zealand should be engaged with to progress a specific rural ethics agenda.

Keywords: general practice, medical education, medical ethics, New Zealand, rapid review, relationships, rural.

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Introduction

Medical ethics is a term that describes a set of moral principles and analytical framework.[1] These principles underpin professional ethical guidance that is generally developed by medical regulating authorities. The key ethical documents in New Zealand (NZ) that describe appropriate ethical behaviour are 'Good Medical Practice', published by the NZ Medical Council, and the 'NZMA Code of Ethics', published by the now defunct NZ Medical Association. Both documents provide guidance to the profession and its disciplinary bodies on what is considered normative doctor behaviour.

However, neither 'Good Medical Practice' nor the 'NZMA Code of Ethics' consider rurality and how it might impact on the practice of medicine. Additionally, the NZ Medical Council publishes a range of standards in particular contexts. Of these standards (as of May 2023) no standards mention rural ethical issues. In particular, neither the 'Safe practice in an environment of resource limitation' nor the 'Statement on providing care to yourself and those close to you' specify rural issues, despite both contexts being pertinent to the rural environment.

Urban centric medical ethics are likely to focus narrowly on the doctor–patient relationship and ignore the intersectionality inherent in living and working in rural areas.[2] This problematic one dimensional framing of medical ethics is likely to result in value judgments on rural practitioners who are considered to have 'breached' professional

WHAT GAP THIS FILLS

What is already known: There is little published literature on the ethical issues facing rural doctors. In particular, there is little to guide New Zealand rural general practitioners that takes into account the intersecting relationships in rural areas.
What this study adds: This rapid review highlights the major ethical issues that may be seen in rural areas.

guidelines. International literature has also pointed to the dearth of ethics resources providing guidance to rural practitioners as well as the lack of research into rural ethics.[3]

The aim of this study is to understand the key ethical considerations for medical practitioners in a rural setting. The primary purpose is to develop an educational resource tool for medical students. A secondary goal is to inform the development of a NZ agenda of rural medical ethics and to influence the development of appropriate guidelines and standards.

Method

A rapid review was undertaken to locate studies exploring ethical issues for medical practitioners in rural areas with the intention to create a resource for medical students. A rapid review is knowledge synthesis resulting from a simplified systematic review process.[4] In order to streamline the review process the literature search is limited, there are limited inclusion criteria, often one reviewer is used, quality appraisal is not normally carried out and a meta-analysis is not performed.[4] A rapid review was utilised, rather than a scoping review, due to the limited time available to develop an ethics resource and the availability of the first author who was undertaking this project as a summer studentship.

Within this rapid review three databases were searched – Medline (OVID), SCOPUS and CINAHL. There was no search for grey literature or unpublished studies.

The inclusion criteria were any original research article that was either partially or solely focusing on the experience of doctors working in a rural healthcare setting, within an Organisation for Economic Cooperation and Development (OECD) country and that described ethical issues. Exclusion criteria were first-person narratives, general commentaries or papers not in English. There was no limit on the date of publication or whether the research was qualitative or quantitative.

Recommendations provided by the Cochrane Rapid Review Methods Group were followed with study selection, data extraction and risk of bias assessment.[5] Papers located in the search were imported in the online software 'Covidence' (htpps://www.covidence.org). The first author then screened each article by title and abstract based on the inclusion and exclusion criteria. Papers that did not mention ethics in a rural context in their title or abstracts or were narratives or commentaries were excluded. The second author then verified the initial screening by reading the titles and abstract of the first 30 articles. The second screening involved reading the full text of remaining articles and selecting papers that were relevant to the research aim – to understand key ethical considerations in a rural setting. The second author verified the second screening by reading the final selected papers. Finally a manual search was undertaken using Google Scholar to locate any studies not identified in the databases that met the inclusion criteria.

Synthesis of the papers involved selecting the key ethical considerations and findings. These key findings were imported into an Excel spreadsheet. The data were compared across papers, and commonalities identified to generate broad ethical categories. The emerging broad ethical categories were discussed between authors and further refined. The papers were re-read to determine the final ethical categories and to provide supporting quotes. The mixed methods appraisal tool (MMAT) was used to provide a quality appraisal score and assessment of bias.[6]

Ethics approval was not required for this study as only previously published work was utilised.

Results

Description of studies

Five hundred and fifteen articles were identified using relevant subject headings and key words. The flowchart of the review process is outlined in Fig. 1.

The 12 studies identified in the rapid review were published between 1989 and 2020. Seven of the studies were qualitative, three were quantitative and two used both qualitative and quantitative methods. Nine studies were located in the United States (US), one in Canada, one in Sri Lanka and one in NZ. In six studies the participants were general practitioners/family physicians (GPs), four studies included both GPs and hospital specialists or other healthcare providers, and in two studies the participants were only hospital specialists or not defined. There were six studies that focused solely on rural practice, and the remaining six studies compared the experiences of rural and urban practices. Two studies only included female doctors as participants and the remaining 10 studied both genders. The key findings of each paper are presented in Table 1.

Ethical issues

The synthesis of the data revealed a number of ethical issues specific to the rural context. These ethical issues arose primarily because rural doctors are 'living where people are not strangers' (see the report by Spenny and Elsbury,[7] p. 186). While all doctors have a duty to care for the health

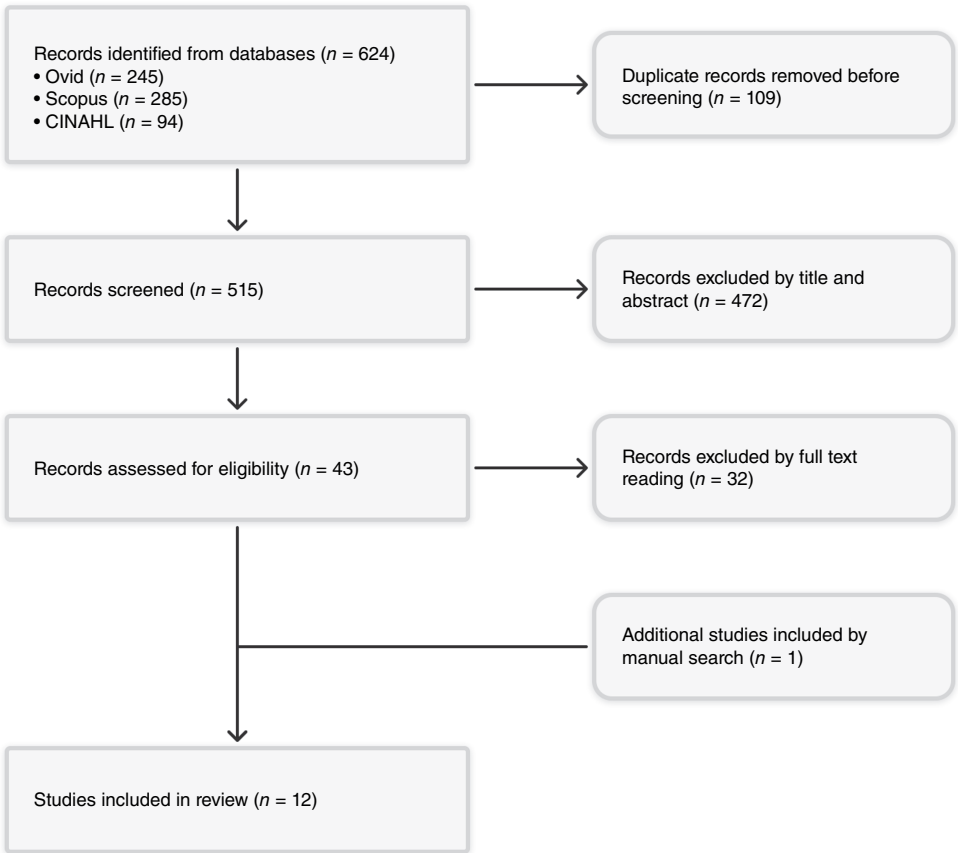

Fig. 1. Flowchart of screening process.

of their communities, rural doctors in the studies appeared to express a stronger sense of duty than urban doctors. This was felt to be a product of the fact that caring for a smaller community meant that rural doctors had more frequent contact with their patients and therefore developed more personal relationships with their patients. For example, rural doctors in the studies discussed how their patients were the local mayor, school principal, restaurant owner, supermarket worker and so on. Furthermore, some rural doctors grew up in their communities, therefore these personal relationships already existed. Examples given in the studies included how their patients were their family, family friends, an old primary school teacher or old school friend.

> Living where people are not strangers, … there is an atmosphere of trust. (p. 186)[7]

> To me, … it is not a job, it is not a business position, it is a vocation … I am a member of my community and as such I've got certain responsibilities to my patients and my community [to provide a service]. (p. 87)[8]

This strong sense of vocation and being embedded within communities, as well as a context of limited resources, created five ethical challenges. These related to juggling personal and professional lives, managing friendships with patients, managing loss of privacy and anonymity, assuring confidentiality and practicing outside of comfort zones.

Juggling personal and professional lives

In general, doctors had to juggle the demands of their personal and professional lives. Rural doctors, in particular, expressed the view that the demands of their personal life (such as being a parent, partner or friend) strongly competed with the demands of their professional life, especially as a female or junior doctor. Rural doctors reported having a strong sense of duty to care for their communities that often outweighed their sense of duty to their personal lives.

> I wish, I wish, I wish that I could figure out a way to do less work and more in my family life without making my patients feel like they're not important to me, because that's what winds up happening when I say I'm going to take time with my family. (p. 249)[9]

> You feel like you are always letting one part of you down. (p. 5)[10]

A number of the studies discussed how rural doctors were often working in settings with poor access to resources and workforce. As a result, the impact of prioritising their

Table 1. Summary of studies.

Author and date	Title	Methods	Setting	Aim	Key findings	MMAT score
Stutzman *et al.* (2020)	Support for rural practice: Female physicians and the life–career interface	Qualitative semi-structured interviews	20 female physicians in their rurally focused family medicine residency in Northwest USA. Age range was 31–59 years and participants were 1–25 years post-residency. Rural defined as Rural–Urban Commuting Area codes 4–10.	To capture the meaning and common features, or essences, of an experience or event, in particular the lived experience of female physicians practicing in rural areas in the north-west region of USA.	Participants perceived that the blurring of professional and personal boundaries can be positive. However, they also acknowledged that it can be negative, for example, patients attempting to contact participants by going to their home. There was an acknowledgement of professional isolation, for example, newer physicians performing skills for the first time on the basis of being physically far away from other doctors.	5/5
Phillips *et al.* (2016)	Rural woman family physicians: Strategies for successful work–life balance	Qualitative semi-structured interviews	25 female family physicians practicing in rural communities in the USA. Age range was 34–55 years. 95% of participants identify as Caucasian. Rural defined as Rural–Urban Commuting Area level of seven or higher.	To better understand the personal and professional strategies that enable women in rural family medicine to balance work and personal demands and achieve long-term career satisfaction.	Most participants reported working more than their desired work hours in response to the community's needs. Participants reported having to have supportive partners to allow them to be more available for their patients. Most participants related to the statement 'I feel guilty when I am not available for my patients.' Participants also mentioned a lack of privacy, with patients calling them at home after hours or on vacation.	4/5
Kirchhoff *et al.* (2014)	Rural and urban primary care physician professional beliefs and quality improvement behaviours	Quantitative survey with dichotomised responses to indicate complete endorsement of a particular behaviour/attitude	A survey of 1891 primary care physicians of whom 9.3% were practicing in rural areas within the USA. Rural defined as Rural–Urban Commuting area codes 4–10.	To evaluate whether primary care physicians from urban and rural practices differed in attitudes and behaviours related to quality improvement activities, patient relationships and professionalism/self-regulation.	Rural physicians were more likely to discuss the cost of healthcare, prescribe a brand name the patient requested, treat uninsured patients without charging them and have a financial relationship with their patients. Rural physicians were more likely to be aware of incompetent colleagues and less likely to report them.	5/5
Brooks *et al.* (2012)	Management of professional boundaries in rural practice	Qualitative. Semi-structured interviews	12 rural family physicians. 67% aged over 40 years. 33% female. Rural defined as populations of 900–18 000.	To explore the management of professional boundaries, including dual relationships, by rural family physicians.	Participants reported struggling with professional boundaries and negotiating their roles in communities. However, participants also reported advantages in rural practice with opportunities to serve their communities in multiple roles. Rural practice was seen as a vocation.	5/5

(*Continued on next page*)

Table 1. (*Continued*)

Author and date	Title	Methods	Setting	Aim	Key findings	MMAT score
Meidema (2009)	Crossing boundaries: family physicians struggles to protect their private lives	Qualitative interviews utilising a collective case study approach	48 family physicians across the province of New Brunswick, Canada. Half of the participants were practicing rurally. There were more male (63%) than female participants. Mean age was 50 (male) and 43 (female) years. Rural not defined.	To explore the tensions between professional and personal boundaries and how they affect the work and private lives of family physicians.	Rural physicians frequently brought work home and fielded calls at home related to patient care. Rural physicians often met patients when shopping or participating in community activities. Rural physicians reported patients showing up at homes for consultations and advice and calling their family members to gain after-hours access or asking for advice in the supermarket. Some rural physicians report not being able to 'take their white coats off' in the community because patients do not respect professional boundaries.	5/5
Senarathna *et al.* (2008)	Personal and professional challenges in the management of deliberate self-poisoning of patients in rural Sri Lanka: a qualitative study of rural hospital doctors experiences and perceptions	Qualitative semi-structured interviews	15 doctors from rural hospitals in North Central Province, Sri Lanka. Rural defined according to the Sri Lankan Ministry of Health categorisation of hospitals – base, district peripheral units and village classified as rural.	To explore the experiences and perceptions of primary care rural Sri Lankan hospital doctors towards treating self-poisoning patients.	The behaviour and expectations of hospital staff and community influenced the treatment of self-poisoning and was considered a barrier to optimal decision making. Inappropriate behaviour and high expectations of patients and relatives, who were often from the same village as doctors, produced a sense of extra pressure leading to more hospital transfers even though the case could have been managed in rural hospitals. There was a lack of resourcing to support the professional development of rural doctors and they often had to perform tasks outside of their training.	5/5
Chipp *et al.* (2008)	Adaptations to healthcare barriers as reported by rural and urban providers	Quantitative survey	1546 participants, including family physicians and non-medical health providers, in rural and urban Alaska and New Mexico. Rural defined as community size <15 000.	To explore adaptations made by healthcare providers in their daily practice in Alaska and New Mexico with an array of population densities.	Rural healthcare providers were more likely to be involved in community events, safeguard client confidentiality and adjust treatment styles than urban providers. Participation in community events was felt to be important as it maintained participants status as insiders and improved the communities willingness to form a therapeutic alliance with them.	5/5
Roberts *et al.* (2007)	Ethical disparities: Challenges encountered by multidisciplinary providers in fulfilling ethical standards in the	Quantitative survey	1558 multi-disciplinary medical and behavioural care providers across rural and non-rural areas of Alaska and New	To determine whether healthcare providers report greater difficulty for rural than urban residents and for ethnic minorities in four areas of ethical relevance: attaining	Rural healthcare providers reported more difficulties across all ethical practice issues and types of patients. Rural providers reported more frequent problems in caring for minority patients than urban areas for three of the ethical practices, confidentiality,	5/5

(*Continued on next page*)

Table 1. (*Continued*)

Author and date	Title	Methods	Setting	Aim	Key findings	MMAT score
	care of rural and minority people		Mexico. Rural defined as community size <15 000.	treatment adherence, assuring confidentiality, establishing therapeutic alliance and engaging in the informed consent process.	informed consent and treatment adherence, with confidentiality being the most frequent.	
Spenny and Ellsbury (2000)	Perceptions of practice among rural family physicians – is there a gender difference?	Quantitative and qualitative survey with closed and open ended questions	63 randomly selected board-certified family physicians in rural towns of the north-western US including Idaho, Montana and Wyoming. Responses included 26 females and 37 males. Rural defined as community size <10 000.	To describe the differences in perceptions of rural practice between male and female physicians in rural practice.	Relatively greater portions of women raised concerns about the lack of privacy. Examples include being unable to escape patient phone calls unless leaving town and the communities unrealistic expectations of being on call for 24 h. However, it was also seen as a positive to be an integral member of the community.	4/5
White *et al.* (1994)	Can one be a good doctor and have a sexual relationship with one's patient?	Qualitative focus group	27 New Zealand general practitioners in six focus groups. Uncertain percentage of rural general practitioners. Rural not defined.	To understand the meaning for general practitioners of social and sexual conduct with patients.	Participants agreed that it was impossible to avoid social contact with patients in a rural or small town where all the residents were potentially friends.	3/5
Ullom-Minnich and Kallail (1993)	Physicians strategies for safeguarding confidentiality: the influence of community and practice characteristics	Survey including multiple choice and open ended questions	510 family physicians in Kansas, US. Rural defined by community size less than 5000 or 5000–20 000.	To determine the influence of practice characteristics on safeguarding confidentiality.	Small community size was the most objective variable that influenced patient privacy. Family physicians in smaller communities reported having more than 5% of their patients as friends or family, some outside interaction with more than 5% of their patients and more than 5% would interact with a person who knew their patients but were not connected to the physician's office (eg disclosures to family, third-party payers or consultants).	4/5
Badger (1989)	Reporting of child abuse: Influence of characteristics of physician, practice, and community	Quantitative survey	120 Alabama, US paediatricians and family physicians. Rural defined as community size <10 000.	To investigate the relationship between the community, physician and practice characteristics of reporting behaviour.	Solo and rural physicians were the most concerned about the effect of reporting on their relationship with their patients. Rural physicians were more concerned that a report would result in making the child angry and were most concerned about their lack of skills in abuse detection. The community (rural, small, urban) in which the physician practiced appeared to dictate the tolerance threshold for abuse recognition and the acceptability of seeking outside intervention.	3/5

personal lives was noted to potentially cause harm to their patients.

> I'm not sure that I can continue to deal with situations where it's on me to [decide] about taking my sick child out of childcare or shutting down a clinic for a whole day and having patients be out of luck. (p. 249)[9]

Conversely, prioritising their professional lives would impact on their personal lives, including free time.

> There are always emergencies and unpredictable things coming up. Almost every week I'm working some free overtime. (p. 287.e2)[11]

Some solutions to managing the tension between personal and professional lives, suggested in the studies, included being flexible about the expectations of a good work and home life,[10] establishing clear boundaries with patients[10] and finding a partner that is understanding and supportive of the demands of the career as well as a partner that prioritises the doctors career over their own.[9,10] Two of the studies highlighted that although tensions existed between personal and professional lives there was an abundance of rewards that accompanied being a rural doctor as well as parent, partner and friend.[9,10]

Managing friendships with patients

As rural doctors are 'living where people are not strangers' there appeared to be a blurring between the boundaries of being a patient and being a friend. While a participant in one study stated that 'clearly you cannot be friends with your patients',[8] the majority of studies reported on how rural doctors did make and maintain friendships with patients.

> I had a close friend of mine who had an ovarian mass and I found out it was benign and I was almost crying when I found out and trying to keep that in check and still be the doctor … and, thank goodness, it was good news. (p. 1094)[8]

> I see a number of people [that] I consider friends … as a physician. (p. 1093)[8]

While White *et al.*[12] suggested that if a doctor developed a friendship with a patient, they would transfer care to a colleague, other studies stated that in rural communities, rural doctors often did not have other colleagues to transfer their patients' care to. This meant that rural doctors had to choose between accepting the harms of treating a family member or friend or the harms of refusing to provide medical care. One consequence of this was that that rural doctors sometimes had to limit the amount of friendships that they pursued or live in neighbouring towns.[8]

Managing loss of privacy and anonymity

For those doctors that did live in the rural areas in which they practiced there was a loss of privacy and anonymity that did not occur (to the same extent) in urban locations. For example, participants in the studies mentioned how patients often asked for medical advice at the supermarket, shopping mall, parking lots, restaurants, community events and even at their children's sports games. For some participants it felt that they could 'never take their white coats off'. These encounters did not appear to 'bother' many of the participants (especially senior rural doctors) and some strategies were suggested such as asking patients to make an appointment in office hours.[8] However, more intrusive encounters did invade their privacy. For example, some patients attempted to contact rural doctors after-hours by calling their personal phone number or the personal phone numbers of their parents or secretaries.

> Everyone knew us, everyone knew our parents. They would call my parents' house [saying] we would like to make an appointment. (p. 287.e3)[1]

> You can't go anywhere without seeing somebody [that] you've seen professionally. (p. 1093)[8]

There appeared to be a trade-off between rural doctors duty to care for their communities and their right to privacy and anonymity. In particular, to manage the community's expectations to 'be the doctor' both by being available for 24 h a day, 7 days a week and by merging/blending their more private personal persona with their more public professional persona. Some studies found that this ethical dilemma was more challenging for females[7] and junior rural doctors.[11]

Assuring confidentiality

In rural practices, there appeared to be more opportunities for breaching doctor–patient confidentiality. This related to the greater proportion of patients that were family, friends or acquaintances of the rural doctors.[13–15] One study found that 29% of rural practices reported that more than 5% of their patients were family or friends of the doctor or their staff, and 36% reported that more than 5% were acquaintances of the doctor or their staff.[15] However, one study also suggested that rural doctors were well aware of the risk of breaching confidentiality and took active steps to safeguard patients' confidentiality.[13] Another study highlighted that safeguarding confidentiality in rural areas could impact on suspected child abuse reporting.[16]

Practicing outside of comfort zones

Rural doctors reported that there were less opportunities to learn and practice new clinical skills with adequate

supervision. One example was a senior rural doctor who stated that she often performed clinical procedures on patients without adequate practice or supervision.[10] Another example was a junior rural doctor who recalled choosing to intubate a dying patient without supervision and despite it being out of his scope of practice.[17] Senarathna *et al.* also suggested that managing patients and providing treatment was often coloured by the expectations of communities.

As previously noted, rural doctors in the studies reported relatively more workforce pressures and fewer resources in comparison to urban doctors. This meant that, often regardless of their experience, the harms of not performing a procedure outweighed the harms of performing it without adequate experience or supervision.

> It's just that you have to trust yourself and then you have to know that whatever is going to happen, no one else is going to be there, so you just have to do it. (p. 6)[10]

There was no evidence in the studies that rural doctors had a lack of clinical competence or did not provide good quality health care. One study found that rural doctors were significantly more enthusiastic about participating in quality improvement courses than urban.[18] Solutions suggested to develop new clinical skills in rural settings were to have diversity in age and a good learning environment, so that doctors can have adequate support and supervision from their colleagues.[8]

Discussion

This rapid review found that doctors working in rural areas experienced at least five ethical dilemmas that were distinct in comparison to doctors working in larger urban areas. These ethical dilemmas arose predominately from a rural context in which rural doctors are part of the communities in which they work as well as these communities having more limited resources. Nelson *et al.*[3] described the rural context, in relation to a rural ethics agenda, as being the unique socioeconomic, cultural and geographical characteristics of rural communities. They listed a number of characteristics that could shape rural healthcare issues. These contextual characteristics included limited economic resources, reduced health status, limited availability and accessibility of healthcare services, cultural and personal values, caregiver stress and dual and overlapping professional and patient relationships. A number of these contexts were described in the rapid review. However, it was the overlapping relationships that appeared to give rise to the majority of rural issues in this review. This inclusion of intwined relationships involving places and communities is consistent with broader theoretical frameworks of rural ethics.[19]

One problematic issue, in dichotomising a rural and urban context, is that the rural context is often defined in deficit terms or in comparison to an urban norm.[2] This urban norm extends to a deficit approach to rural ethics.[19] Fors[20] describes this as a 'geographical narcissism' in which it is assumed that there is a continuum from urban to rural and that rural settings have a lower status. Similarly Roberts *et al.*[21] refers to geographical narcissism as a 'metronormativity' resulting in a form of oppression in which rural values are ignored. The urban ethical norm of having separate professional and personal lives is challenged in a rural setting. As seen in this rapid review, overlapping relationships and roles are normal and common for rural doctors and require some degree of juggling. Crowden[22] highlights how it is likely impossible for someone to be anonymous in a rural town. This lack of anonymity arises because a rural presence involves sharing the same social space as others.[2]

Sharing the same social space will inevitably give rise to friendships and the challenge of providing care to someone who is a friend or close acquaintance or a distant family member. Some authors have suggested that it is extremely difficult to keep separate relationships in rural and remote areas unless the physician has very few friends or few patients.[23] The findings from this review likewise demonstrated that many rural doctors managed friendships with patients and that these friendships were valued and added meaning and depth to the patient relationship. One of the challenges in disengaging from multilevel relationships, as suggested by urban ethical norms as a way of avoiding providing care to friends, is that this may produce a less productive clinical environment overall[3] and lead to poorer access to care, as suggested in the findings.

The findings in this review also highlighted urban privilege in regards to healthcare resourcing. The inequity in distribution of the healthcare workforce and training resulted in doctors undertaking procedures in which they had little training or supervision. It cannot be expected that all services are available in rural and remote locations. However, the lack of services does result in a double jeopardy for rural doctors where the harm of not undertaking a procedure is balanced against the harm of undertaking a procedure in which the doctor has inadequate training or supervision. One ethical approach to practicing outside of scope is to be reflective and aware of one's incompetence but be prepared to be of use.[2]

The majority of ethical issues seen in this study reflect a tension between adhering to urban normative ethical guidelines and the reality of living in an environment where people are not strangers. While only one of the studies was based in NZ it is likely that the broader findings would apply to the NZ context. In particular we note that core Māori values are intrinsically relational and reciprocal.[24] Professional ethical guidelines, such as those developed by the NZ Medical Council, do not account for this rural lived reality. As a result, doctors are drawn into a '*gemeinschaft–gesellschaft* gavotte' as they try to reconcile

their experience of rural society with the standards of the profession.[25]

While this study did highlight a number of ethical issues it also presented some solutions to those issues, such as being flexible with home and work life, preemptive boundary setting and actively safeguarding confidentiality. These solutions reflected pragmatic adaptions to urban bureaucracies.[2] In addition, some of the papers alluded to a virtuous ethical approach, for example those participants who discussed rural health as a vocation or having a sense of obligation and responsibility to their patients. Taking a virtuous ethical approach means focusing on the goals of rural health, most notably improving access to health care.[22] Rural doctors should be sensitive to the obligation to act from the virtues of rural health practice in situations of boundary crossing and need to develop a rural ethical sensitivity beyond what is normally practiced in urban centres.[22]

There are a number of weaknesses with this study that reflect the rapid review method. It is unlikely that the complete literature was examined, and the included studies were not critiqued for their weaknesses beyond an appraisal score. This review focussed on the ethical issues faced by rural GPs and related literature that applied to other rural health professional groups were not included which might have had some relevance. Likewise broader ethical issues that pertained to rural general practice, such as funding and resource allocation, were not examined fully. Another weakness included differing definitions of rurality used in the papers, making it difficult to make a direct comparison to the NZ context, as well as an absence of Indigenous peoples' voices in the literature. Finally, our search terms did not result in inclusion of many studies relating to telehealth. The papers that we did locate involved urban clinicians providing telehealth services rather than the lived experience of rural clinicians or papers that focussed on ethics relating to access barriers or generic issues around confidentiality.

This rapid review has demonstrated that there are unique ethical challenges in rural areas that arise from the context of intersectionality. The evidence suggests that ethical guidelines need to account for this rural context. Medical educators and the NZ Medical Council should engage with rural practitioners in order to progress a rural ethics agenda.

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Data availability. The data that support this study will be shared upon reasonable request to the corresponding author.

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