"It's not necessarily the distance on the map...": Using place as an analytic tool to elucidate geographic issues central to rural palliative care

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ABSTRACT

Palliative care is intimately connected with place, yet little research has explored these relationships in depth, especially with respect to rural and remote settings. This paper uses multiple dimensions of the concept 'place' as an analytic tool to understand the nature of palliative care provision in a rural region of British Columbia, Canada. We draw upon primary data from formal and informal providers (n=31) to explore the social and physical place of rural palliative care. We unpack four highly geographic issues raised by participants, namely: (1) distance, (2) location, (3) aesthetics, and (4) sites of care. This analysis reveals a rich and complex experience of rural care-giving long overlooked in palliative care research and policy.

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1. Introduction

Geographers understand ‘rural’ in a number of ways. Cloke (2000) observes that ‘rurality’ is very much a socially and culturally constructed phenomenon, one which is often applied with reference to communities in areas that are agriculture- or resource-dependent, where people identify themselves as being rural residents, and where people display a lifestyle that is born from this rural identity. Issues of identity aside, much of the literature emphasizes what are seen to be the distinctive challenges of rurality, including limited service provision, remoteness from major urban centres, small population sizes, and minimal infrastructure (e.g., Iredale et al., 2005; Kearns et al., 2006; McCann et al., 2005). Rural health geography research has contributed much to this line of inquiry. For example, studies have documented place-specific barriers to gaining access to health and social care (e.g., Campbell et al., 2008; Hanlon et al., 2007), inequities in service provision (e.g., Hanlon and Halseth, 2005; Kenny and Duckett, 2004; Panelli et al., 2006), the relationship between rural lifestyles and health (e.g., Coast et al., 2006; King et al., 2006), and the health promoting or detracting nature of rural spaces (e.g., Conradson, 2005; Watkins and Jacoby, 2007). This research spans the broad sub-disciplinary streams of health (e.g., Edgeworth and Collins, 2006) and health care (e.g., Cloutier-Fisher and Skinner, 2006; Innes et al., 2005). Of particular interest to the present work, however, are more recent efforts to probe the ways in which social and emotional dimensions of lived space, and scalar relations of power, intersect in rural places to promote or deter from health and health care experiences (e.g., Shoveller et al., 2007; Skinner and Rosenberg, 2006).

Against this backdrop of rural health and health care, this paper seeks to shed light on palliative care, an often overlooked and undervalued component of health systems. Generally speaking, palliative care is about caring for people who are dying and their families. It involves the provision of supports to assist dying individuals with maintaining a quality-of-life/death across physical, psychological, practical, spiritual, disease management, death management, and grief domains (Ferris et al., 2002). Such care is offered across a range of sites, including nursing homes, acute care hospitals, respite facilities, and hospices, and by a range of providers, who can include family doctors, nurses, specialists, family members, community volunteers, and spiritual leaders, among others (Carstairs and Beaudoin, 2000; Prince and Kelley, 2006). Given the complexities involved in providing such care across these multiple sites and practices, a focus on palliative care by health geographers is much needed due to the increasing demand for such health and social care resulting from population aging (Davies and Higginson, 2004; World Health Organization, 31) to
of interest in ‘place’ and geographic location (Stjernsward et al., 2007) further warrants this research focus. Interestingly, such research also addresses Robinson et al.’s (2009, p. 256) recent observation that “a renewal of interest in ‘place’ and geographic location...should support further exploration of the influence of social and physical environments in rural settings on palliative care, and the involvement of a wider range of disciplines, such as human geography.”

We employ the core disciplinary concept of ‘place’ as an analytic tool for understanding the nature of palliative care provision in a rural region of British Columbia (BC), Canada from the perspective of formal and informal providers (n=31). In the broadest sense, place can be thought of as “bounded settings in which social relations and identity are constituted” (Cresswell, 2000, p. 582). This can be interpreted in many ways. Cresswell (1996) provides some direction to assist with further unpacking this concept which is so very fundamental to the discipline of human geography. More specifically, he contends that place can be usefully conceptualized in two ways: as both physical and social. Connotations of place as a material artefact, a literal location, and a setting for social relations reference its physical nature. Meanwhile, the ways in which people give meanings to places, engage in place-making activities, understand their place in social hierarchies, develop a sense of place, and create emotional attachments to places reference its social nature. Herein we explore the social place and physical place of rural palliative care through examining four highly geographic issues raised by the formal and informal providers interviewed: (1) distance, (2) location, (3) aesthetics, and (4) sites of care. Our specific objective is to draw on the diverse interpretations of both physical place and social place to advance our understanding of rural palliative care specifically and, more generally, to untangle the complex connections between place and health care.

2. Research techniques and methods

The present analysis contributes to a larger study that aims to examine the provision of palliative care services in a rural region of BC’s interior and specifically explore the potential for providing care through creating secondary palliative care hubs by determining localized barriers and facilitators to this approach to service delivery. The area of focus for our case study, the West Kootenay-Boundary (WKB) region, was identified through a series of spatial analyses run to determine which rural areas in the province are underserviced with regard to palliative care and could benefit the most from the establishment of a secondary hub (see Cinnamon et al., 2008; Crooks et al., 2009). The WKB region is topographically depicted in Fig. 1. We describe this region in greater detail in the section that follows. In order to understand the potential barriers and facilitators to siting service hubs we conducted interviews with formal (e.g., nurses, family doctors, administrators, hospice society administrators) and informal (e.g., pastors, family caregivers, hospice volunteers) palliative care providers in the WKB region across the formal (for-profit), voluntary (non-for-profit) and informal (volunteer) sectors. A total of 31 interviews were completed in the summer of 2008. These interviews yielded important data beyond the scope of the hub approach and its barriers and facilitators, some of which are examined herein.

Interview participants were recruited from three specific proximal communities in the WKB region, Nelson, Trail, and Castlegar, in a purposeful fashion in order to get as much diversity as possible in occupational groups. Recruitment first proceeded by using the investigators’ networks to contact potential participants. Next, calls for participants were circulated to key associations and were placed on electronic listservs and newsletters. Our final steps were to undertake targeted internet searches, to review employee listings for health service sites and the regional health authority, and to snowball out from existing participants. In total 40 people were invited to participate in an interview, 31 of whom ultimately accepted. Numerous distinct informal and formal palliative care provider groups are represented in the sample: nurses (n=7), family doctors (n=2), allied health care professionals (n=2), health care administrators (n=6), hospice society workers (n=2) pastors (n=2), hospice/palliative care volunteers (n=5), informal caregivers (n=1), and others whose jobs involve providing palliative care (n=4). Although many of the

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1 The procedure for recruiting participants, obtaining consent, and all other aspects of the study were reviewed and approved by the Department of Research Ethics at Simon Fraser University and the Interior Health Authority.
respondents provided care across a number of communities in the WKB region, five identified Nelson, 11 identified Trail, and 13 identified Castlegar to be their main community of practice.

To enhance the consistency of data collection, all interviews were conducted by a single investigator (the first author). As this investigator was not situated in the WKB region all interviews were conducted by phone. The interviews typically lasted for 1.5–2 h. Participants were sent detailed information about the study prior to speaking with the interview, including a consent form they signed and returned in advance of the conversation. Phone interviews were organized using a semi-structured guide of open-ended questions which inquired into: community descriptions; community health and health care challenges and priorities; experience with palliative care provision; palliative care service availability and need; and the secondary hub approach. At the end of each interview a series of 21 Likert scale questions were posed that probed specific issues regarding the hub approach and also issues of distance from and access to existing palliative care services.

Interviews were digitally recorded and, upon completion, were transcribed verbatim and entered into NVivo 8™, a qualitative data management program. Following the completion of data collection coding ensued using a thematic approach. To do this a meeting of the investigative team was held after independent transcript review in order to identify issues to be probed using thematic analysis. Five analytic issues were identified for thematic analysis, and their subsequent coding and interpretation were confirmed across investigators in order to strengthen the analytic process and thus the quality of the interpretation. The five major analytic issues are: (1) aboriginal palliative care in the WKB region; (2) the local politics of palliative care; (3) health service and administration issues; (4) visioning for the secondary palliative care hub; and (5) geographic issues relevant to giving palliative care. Thematic analysis involves categorizing coded data to each of these five analytic issues were created and applied to forms they signed and returned in advance of the conversation. Thematic analysis, and their subsequent coding and interpretation forms the basis of the present paper. Organizational codes specific to each of these five analytic issues were created and applied to the dataset. After coding was completed thematic analysis was employed. Thematic analysis involves categorizing coded data based upon patterns within a dataset and comparing these patterns to existing literature and the study purpose (Arnonson, 1994). The employment of this analytic technique resulted in the identification of four main geographic themes central to the respondents’ discussions which, when compared against the relevant human geography literature, led to the identification of place as an important analytic concept to be employed when attempting to come to a greater understanding of their nuances.

3. Contextual overview

Before moving on to discuss the analytic findings, some context is required in order to assist with their interpretation. An important part of this context pertains to the case study region of focus itself. The WKB region is situated in BC’s interior and is home to a limited number of relatively isolated service centres. This dispersion is due in part to the terrain and topography of the area, which is rugged, mountainous, and dotted by lakes and rivers. These landscape features can make travel in the region dangerous in winter weather and generally lengthy due to roads that must wind around water bodies and mountains. The main industry is primary resource extraction, with a focus on mining, timber, and hydroelectric development. The region’s population was characterized by participants as being relatively homogeneous, with large numbers of people of Russian Dukhabor, Italian, and Portuguese ancestry residing in the three case study communities and few visible or linguistic minorities, new immigrants, or Aboriginal peoples. The three specific communities of focus within the region are quite distinctive. Castlegar is the smallest, home to just over 7500 residents (Statistics Canada, 2002), and was characterized as an ideal central location for regional health services even though the regional hospital had not been sited there. Trail is the largest of the three communities, housing just over 18,000 people (Statistics Canada, 2002). It hosts the regional hospital which offers some tertiary care and was characterized as a ‘one-company’ town due to a large nickel mining company located there. Nelson has just over 9500 residents (Statistics Canada, 2002) and was frequently characterized as having a sizeable artistic and ‘alternative-minded’ community.

The provision of palliative care services in BC can generally be characterized as inconsistent. The regionalization of health service decision-making through the establishment of five regional health authorities in 2001 has led some regions to prioritize palliative care provision, while others have not (Crooks, 2009). Health authorities in the most populous areas have developed (and in some instances inherited from before their inception) significant numbers of palliative care units in hospitals, hospice residences, and diverse practice teams. Conversely those serving the expanses of rural and remote territories in the province have yet to put in place, for the most part, extensive palliative care service infrastructure (Cinnammon et al., 2008) due to differing priorities and the lack of economies of scale. The lack of palliative care service provision in rural areas in general, and including that which is rural-centric (i.e., created specifically for rural communities), is not a BC-specific problem and in fact has been identified across the international literature as a significant challenge (e.g., Robinson et al., 2009; Wilson et al., 2006). Despite this, there are some dedicated palliative care services available in the three communities of focus. Several health care clinics are present, which means that family doctors are available to those on patient rosters, and Canadian family doctors who practice in rural areas typically take on more palliative care provisioning in their workloads than do their urban counterparts (Pong and Pitblado, 2005). While there is no freestanding hospice in the region, there are approximately eight beds designated for palliative care across the three small hospitals and extended care homes in the communities of focus. Finally, some of the formal health service providers interviewed had taken palliative care care modules in their training, but the overwhelming majority were generalists who, as part of their practice, were involved in providing palliative care.

4. Findings: exploring the ‘place’ of rural palliative care

We identified four major geographic themes that participants evoked when discussing the realities of palliative care provision in the WKB region. As noted above, these themes are: distance, location, aesthetics, and sites of care. In unpacking these concepts it became clear that ‘social place’ and ‘physical place’ implicitly informed respondents’ discussions of these geographic features of rural palliative care and thus they were adopted as analytic tools to push forward the interpretation of the findings. These issues, as they relate to rural palliative care in the WKB region, are elaborated upon in the remainder of this section.

4.1. Distance

Physical distance between palliative care services and users, or between in-home care providers and clients, was repeatedly identified among participants as a major factor in terms of accessing services in the WKB region. “It’s not necessarily the distance on the map, it is the actual reality of the roads.” On top of
that, the region’s physical terrain and winter weather were reported to sometimes negatively affect people’s abilities to drive the required distance to access basic services, palliative or otherwise. “We don’t even have milk sometimes in the [grocery] store... the trucks can’t get through... the roads are blocked because there’s been an avalanche... A lot of people... try to avoid travelling on a regular basis on those roads in the winter, because it is not very smart.” While the time required to travel to certain services may be comparable to some urban areas, the actual distance travelled is significantly more, often at higher speeds. One participant noted: “It’s a long way [to the regional hospital], it’s a half an hour, which is a long way here. I know for the city it isn’t.” Seasonality, weather patterns, and topography thus all had an impact on how participants understood the physical place, and especially how it relates to geographic accessibility, of palliative care in the WKB, and particularly as these factors impacted upon perceptions of distance to/from services or providers.

As participants discussed issues of physical distance and proximity to services it became clear that the issues being raised were imbued with social meanings and understandings of many things, including place. For example, distance was often applied as an emotional construct. In particular, participants commented on how informal caregivers (typically family members) located in communities removed from palliative care services experienced intensified feelings of geographic isolation when abrupt changes in the care recipient’s health status took place. When such changes occurred without warning people sometimes became acutely aware of, if not even distressed about, the physical distance to formal care, or between providers and their homes. At the other end of the spectrum, many participants spoke of their own or others’ feelings of having been distanced from what was going on with a palliative family member (e.g., involvement in decision-making) due to geographic separation. Participants emphasized the importance families placed on ‘being there’ for their dying loved one. When services were not available locally, the distal isolation can be overwhelming. Finally, the costs associated with dying can also impact the social place of a client and his or her family. “Every time you leave town, it costs and, you know, you have to stay overnight and you have to eat and you use the phone to phone your family and so you’re accruing phone bills.” For some, accessing palliative care services can create insurmountable distances due to the financial burden alone. From these examples it can be seen that the social place of distance as it relates to palliative care brings about different kinds of readings, including emotional and financial ones.

4.2. Location

As a physical place, the WKB region’s location in BC presents challenges in terms of accessing palliative care services. The region’s weather and its resulting challenges can seem insurmountable when compared with the more moderate climate found along BC’s southern coast, which is the province’s most populous region. Moreover, there was general agreement that these challenges were somewhat ‘invisible’ in those physical locations where decision-making took place, namely the province’s capital (Victoria) or the regional health authority centre (Kelowna). “Decision makers should take a drive through the interior and preferably in January and should get a sense of the distances involved, the mountain passes, and the snow conditions.” In fact, the southern coastal region was often referred to as an out-of-place location for decision-making not only about the WKB but the interior and north more generally. “Our access to [palliative services] is, well, weather dependent and so it’s very easy for the people sitting in the ivory towers of... Victoria to look at numbers only and not at distance, not at climate.” At the same time, participants also recognized that while the WKB region was large, the population of the area was not. Thus, participants acknowledged the need to ‘make do’ with certain differences in services due to the combined effects of the region’s size, small population, and geographic location. Despite this, there was a strong sense that “interior people are every bit as worthy of that [high] level of care as coastal people.”

Participants reported that WKB residents’ social locations mattered in terms of whether or not they were aware of palliative care service provisioning. “I think palliative care is available if you go hunting for it.” Social capital, cultural identity, socio-economic status, age, and ability were all identified as factors influencing people’s abilities to become informed about and partake in the services available in the region. At the same time, participants also noted that the rural location of the WKB region both necessitated and promoted resourcefulness on the part of the people living there. Participants referred to their own and other communities in the WKB as being ‘very tight knit’ with ‘incredible volunteer base[s]’ and “very generous people... who are really genuinely concerned about the community.” People could draw upon such connections when wanting to become familiar with local or regional service availability. While participants recognized the community-based cohesion, they were also cognizant of cross-community tensions that exist due to socio-political and locational factors. “The politics of the Kootenay Boundary are quite unique to the province of British Columbia. [laughter] None of the communities get along very well.” In fact, participants identified socio-political influences, rather than physical geographical factors, as having played a major role in determining the ultimate locations of health services, including those specific to palliative care, in the WKB.

4.3. Aesthetics

In our conversations with formal and informal palliative care providers, participants frequently discussed the actual physical places where people die in the WKB, thus invoking the concept of place aesthetics. First, their descriptions invariably referred to how things looked in particular settings, such as artwork, furniture, room characteristics (e.g., wall colours), as well as smells and sounds. There was some criticism regarding the place aesthetics of the publicly-funded palliative care beds, particularly those housed at the regional hospital. “I’m not satisfied with the rooms at all. The care [and] the nurses are fine, but it’s pretty awful to be going to such a barren room and those are your last days.” At the same time there was also praise for the local fundraising efforts undertaken to renovate and redecorate these spaces in the future. Participants also drew aesthetic comparisons across sites, such as between the home and institutional settings, in accentuating the importance of place familiarity. This point was sometimes made in order to draw attention to the lack of appeal for those sights and sounds associated with institutional aesthetics (e.g., disinfectant, paging systems, alarms, lighting). The respondents made it clear that the physical aesthetics of care spaces in the WKB were necessary components of comprehensive formal palliative care service provision.

The creation of a social aesthetic in places where people receive palliative care also emerged as a key variable amongst participants’ discussions. As a respondent explained: “You can die in a corner and still die or you can die in a nice, comfortable, cozy bed with your own Afghan on top of you and your family around you.” Having friends, family, and other loved ones in-place during the end stages of life was central to creating what many respondents viewed as a desirable social aesthetic of familiar faces and voices,
in short, to die a good death.² Not surprisingly, this can be of great value to those sharing in the dying experience as well: “When you read the ‘obits’, you’ll often find that line in it, that says ‘he died surrounded by family and friends’ and it is so important for the family to be able to say, ‘we were there’.” Some care sites were described as either promoting or preventing the creation of a desired social aesthetic. Although there are no hospice houses in the WKB region, a number of participants explained that they are a “good place to die” for many reasons including that they promote the gathering of friends, family, and others to support and celebrate the dying individual. On the other hand, hospitals, despite having some dedicated palliative care beds, were seen as impeding the socializing process and its desired social aesthetic. One participant described such a room in the following way, “the actual room itself, where the hospital bed is, is very, very small... There might be room for two chairs, and then the nurse has to come in, and then everybody has to move, the chairs have to be moved. It is unbelievable.” Participants observed that people wanted to die in physically and socially aesthetically pleasing places, and were willing to pay out-of-pocket for this, when available and financially viable, if necessary.

4.4. Sites of care

The literal sites of palliative care across the three case study communities were generally the same: family homes, extended care facilities, and the WKB regional hospital. Participants quickly identified the importance of the local for what could be termed ‘compassionate’ palliative care. “Palliative care...[has] to be set locally, where people could access it easily and not like my friend, [driving from one rural community to another] to see her mother. When she got there, her mother had died.” As we noted above, the reality of rural locations has meant that travel is almost always required to access sites of care. One of the issues informing this is that palliative care in the WKB was typically delivered from multi-purpose health service sites (e.g., hospitals) and did not exist independent of them. “I recognize that it’s difficult to separate palliative care, physically very far from where other levels of care are being given.” Out of recognition that there is ‘only one chance to die right’, participants were able to draw on existing experiences in order to articulate their desires for local sites specifically for palliative care. Their collective vision included offering choice regarding the site at which care was to be given and an environment that allows for “being able to live through the dying process—that would be my total vision for a palliative care [site].”

When inter-professional politics surfaced within and between care sites, providing compassionate palliative care sometimes proved to be a challenge. For example, some participants explained that different provider groups practicing at the same site had care practices which clashed and at times did not prioritize a ‘good death’ for clients. Participants also spoke with frequency about the challenges associated with meeting the emotional needs of dying clients within the physical constraints of formal care sites. For example, while there are two dedicated rooms for palliative care in the WKB regional hospital, these numbers do not warrant full-time palliative care providers. Further, the palliative care unit is adjacent to an acute care department and thus staff are required to serve both units throughout their shift, making the social interactions across these two spaces difficult given their drastically different purposes. “I really think that there has to be a physical separation from acute care, and I’m thinking of the care professionals for whom it is intensely difficult to move from an acute care situation into a palliative care situation, and then back again, within minutes...it is so easy to treat a palliative patient as an acute patient.” Finally, the socio-cultural aspects of palliative care were distinguishable between public and private sites of care. For example, participants’ cultural readings of palliative care sites indicated, for the most part, that ethnic minorities were largely invisible in public (institutional) care sites and were thought to utilize private (home) sites with family members providing the bulk of care³.

5. Discussion

An interesting phenomenon is taking place across the Canadian landscape with respect to population demographics: the country is seeing a ‘grey ing’ of the rural population as it ages-in-place and a migratory inflow of urbanites seeking out a rural lifestyle. As a matter of course, the pressure placed on formal, informal, and voluntary sector providers to service these older populations has been on the rise in these communities. Thus, while it is true that there is an impetus for research that addresses rural health issues across the life span, end-of-life and palliative care issues are in need of particular attention (Robinson et al., 2009). A case in point within the WKB region, and one that drew national headlines, was the ‘Albo Story’ wherein a husband and wife, married nearly 70 years, were separated upon receiving palliative care due to the provincial ‘first available bed’ policy. This policy dictates that those in need of and eligible for publicly funded residential care must take up the first bed available in their region within 48 h of notification regardless of whether or not it is in their preferred care site or at a distance from loved ones (BC Ministry of Health, n.d.). They may later request a transfer to a more desirable facility should a bed become available there. While Al Albo remained in the local area hospital for treatment, Fanny Albo was sent to a long-term care facility 100 km away from him. She died 2 days later. Her husband then died within 2 weeks of her death (CBC, 2006). Their story is indicative of a devaluing of the social and physical nuances of place identified in the findings section, which when considered can assist with facilitating a ‘good death’, and also of the place of palliative care in general in the WKB.

The ‘rural idyll’, a widely accepted and utilized concept in geography (Little and Austin, 1996), encompasses a number of key elements, including: tight-knit families, a strong sense of community, and a pace of life that is well distanced, both socially and physically, from urban life. Our findings suggest that the public notion of the rural life in its idealistic fashion is contradicted by the rural death, at least through the lens of the formal and informal care providers interviewed for this study. In the WKB region the sense of solitude afforded to life in the rural idyll can become a sense of isolation for those who are approaching end-of-life (e.g., when sent to a distant site of care that prevents the establishment of a desired social aesthetic), and the caring nature of rural communities can be replaced with care providers having to negotiate a seemingly compassionless system (e.g., when care providers must work in an environment that does not facilitate best

² See McNamara (2003) for a detailed discussion on the concept of creation of a social aesthetic for a ‘good (enough) death’ in the palliative care literature.

³ Castleden et al. (in review) provides a detailed discussion regarding perceptions of culture amongst formal and informal palliative care providers in the WKB region.
practice). Such findings about the contradictions in rural life and rural death would not have come to the fore had we not explicitly employed place as an analytic tool in the present study.

Parallels can be drawn between our findings and the rural health geography literature. As stated in the Introduction, rural places serve as important contexts in health/health care research. Here we contribute to critical analyses concerning social space and power relations in rural places by exploring the socio-emotional nature of distance, socio-economic location of clients and their carers, as well as the socio-political hierarchies inherent in various sites of care. Importantly, our findings support Skinner’s (2008) analysis regarding the paradox of rural voluntarism. Skinner suggests that rural community members often volunteer not because they want to but because there is perceived to be no alternative. In such circumstances, the pressure to volunteer can extend to already overextended formal care providers. As one participant in our study revealed: “More and more now we're getting physicians willing to give out their [home phone] numbers...because as our services are reduced... I guess it’s [pause] not that we’re volunteering but we’re utilizing one another more I suppose.” This raises the notion of choice concerning rural voluntarism as it pertains to palliative care. Despite the changing demographic of rural communities, health care cuts have resulted in the closure of several small rural hospitals throughout BC. Consequently, participants across service sectors commented that they had to endure the shrinking human, financial, and material resources made available to them. There was substantiated concern that rural residents were ‘falling through the cracks’ of a neoliberal health care system, particularly in terms of palliative care—which is when more intensive services are typically needed—and, quite interestingly, they explained the outcomes of this using the geographic concepts reported on herein.4

This study responds to the need for more scholarly engagement with the geographic concept of place as an analytic tool has benefited this work given the richness of the findings. While geographers typically use key concepts such as place, scale, or space as a backdrop or to frame a study, they have not consistently applied these concepts as analytic devices. Doing so helps to reinforce and scrutinize the geographic aspects of a particular phenomenon, in this case the roles that the physical and social place of palliative care play regarding distance, location, aesthetics, and sites of care in a rural region. It also strengthens the contributions that the discipline can make in terms of how we apply a ‘geographic lens’ to datasets, noted by the excerpt from Robinson et al. (2009) quoted in the Introduction. As such, we encourage health geographers and others to further engage with core disciplinary concepts as analytic tools, which can both serve to expand on rural palliative care research specifically and aid in better understanding how geographic issues interface with health care provision or health in places more generally.

6. Conclusion

This paper has broadly focused on ways in which health geographers understand and contribute to the issue of rural palliative care. We ask: how does place matter with respect to palliative care in BC’s WKB region? In doing so we differentiated between physical and social place and illustrated that the two affect delivery of rural palliative care in different ways. We were especially interested in the unique social aspects of how rural environments impact on delivery of palliative care. Four geographic themes emergent from the dataset allowed for exploration of this issue, namely: distance, location, aesthetics, and sites of care. As the interviews unfolded, an interesting phenomenon was revealed: the four geographic themes that we sought to analyze through the lens of their physical and social place were found to be inter-connected. For example, distance to care resulted from location; location gave rise to unique and definitive aesthetics; aesthetics shaped perceptions of sites of palliative care; and the extent of palliative local care sites is a function of distance from major centres of population.

In this paper, we have revealed many of the complexities of place and its relationship to palliative care. There has been little prior theoretical or applied research in this area, thus, our discussion raises salient issues such as whether the idyll of rural living is negated by the reality of the rural death—which may be negatively affected by distance—or lack of services. Likewise the spectre of solitude in rural regions is transformed into isolation in terms of access to health services. And finally, in this revisiting of romantic ideals, voluntarism is recast as necessity rather than solely altruism. By uncovering such complexities a number of avenues worthy of further exploration have been opened up. For example, aesthetics—including sights, smells and sounds associated with a particular place—have received little attention as facets of palliative care, yet participants were strongly aware of their influence. Rooms were described as ‘barren’ whilst the concept of dying ‘surrounded by family and friends’ with all that this evokes was promoted. Aesthetics were also strongly tied to the perception of quality of the sites of palliative care and by implication their response to the palliative care facility. Such findings point to the potential wealth of information to be gleaned from further exploring the aesthetics of rural health care sites. Scholars and palliative care providers alike can employ the social and physical dimensions of place as an additional tool for making sense of how people make choices in their preferred locations of death, and particularly in recognizing that place-based variables likely intersect with other personal factors such as ethnicity, culture, gender, and socio-economic status. The above analysis has pointed to some of these intersections. Certainly, our analysis has also demonstrated that the role of structural factors in informing ‘choice’ are also highly relevant, such as whether or not care can be delivered in a desired location.

The emphasis in this study on socio-emotional costs of rural life in the context of palliative care is unique in the geographical literature. It develops a distinct analytic approach focused on place and grounded specifically in examinations of distance, location, aesthetics and sites of palliative care. Thus, this paper serves an initial foray into analyzing an under-theorized aspect of health services delivery using such a unique analytical lens. We anticipate that this four-pronged analysis of space could usefully be extended to other areas of health services research. In addition, we foresee continued refinement of place analytics (or even those which employ other core geographic concepts as analytic tools) with respect to delivery of palliative care in rural and remote regions.

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4 In a recent report by the Canadian Institute for Health Information (2007) on Health Care Use at the End of Life in Western Canada, the average cost of health services during the last two years of life varied from an average of $2000 for those who were generally independent to an average of $158,000 for those who were largely dependent on the health service system in terms of complexity and volume. It is important to note that these figures are those that are carried by the system and they do not include things such as the personal out-of-pocket costs to access care or to visit a care recipient staying elsewhere, including transportation and time off of work.
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