Short communication

Revisiting the use of ‘place’ as an analytic tool for elucidating geographic issues central to Canadian rural palliative care

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\textbf{ABSTRACT}

In 2010, Castleden and colleagues published a paper in this journal using the concept of ‘place’ as an analytic tool to understand the nature of palliative care provision in a rural region in British Columbia, Canada. This publication was based upon pilot data collected for a larger research project that has since been completed. With the addition of 40 semi-structured interviews with users and providers of palliative care in four other rural communities located across Canada, we revisit Castleden and colleagues’ (2010) original framework. Applying the concept of place to the full dataset confirmed the previously published findings, but also revealed two new place-based dimensions related to experiences of rural palliative care in Canada: (1) borders and boundaries; and (2) ‘making’ place for palliative care progress. These new findings offer a refined understanding of the complex interconnections between various dimensions of place and palliative care in rural Canada.

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1. Introduction

In 2010, Castleden and colleagues published a paper in this journal that aimed to explore the complex interconnections between place and palliative care in rural and remote settings. More specifically, they employed the concept of ‘place’ as an analytic tool for understanding the nature of palliative care from the perspective of formal and informal providers in a palliative care-poor area of rural British Columbia (BC), Canada. This analysis, summarized in Table 1, was based upon data collected during the pilot phase of a larger research project that has since been completed. In this short report we draw from the findings of the full, national research project in order to add two new components to the framework previously introduced by Castleden et al. (2010). In the following section, we provide a contextual overview of rural palliative care in Canada and a brief summary of the original paper before detailing the two new components. We conclude with a discussion of how this research contributes to a greater understanding regarding why place matters in the context of rural palliative care in Canada and beyond.

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2. Rural palliative care in Canada

Although varying definitions exist, ‘rurality’ is commonly understood as being a socially constructed phenomenon that applies to largely agricultural or resource-dependent regions/populations where the people themselves identify as being rural residents (Williams and Kulig, 2012). Often, the concept of rurality is relational, referring to spatial isolation and proximity from/to other places and services (Bourke et al., 2012). Rural Canada accounts for approximately 90% of the country’s total land mass and is home to approximately 6.3 million Canadians, about 19% of Canada’s total population (Statistics Canada, 2013). These rural communities are characterized as being rapidly aging (Public Health Agency of Canada 2006) and sparsely populated, and as such residents experience unique barriers in accessing health care services, which include both geographic and temporal connotations (Romanow, 2002).

Palliative care involves caring for people who are dying and their families by offering physical, psycho-social, and spiritual care and support. Despite access to palliative care being argued as a human right (Henteleff et al., 2011), great inequities exist in accessing this care (Giesbrecht et al., 2012; Maddison et al., 2011; Castleden et al., 2010; Exley and Allen, 2007). Eligibility for, access to, and availability of palliative care in many nations, including Canada, is largely dependent upon where one lives (Williams and
Table 1

<table>
<thead>
<tr>
<th>Sites of Care</th>
<th>Distance</th>
<th>Location</th>
<th>Aesthetics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local topography (i.e., mountainous region)</td>
<td>Lack of appeal for sights and sounds associated with institutional aesthetics (e.g., disinfectant, paging systems, alarm signals)</td>
<td>There is the desire for palliative care services to be local and easily accessible</td>
<td></td>
</tr>
<tr>
<td>Physical constraints (e.g., room size, technology needs) of physical sites of care can make it difficult to meet the emotional needs of dying patients</td>
<td>Place giving spaces to make them more “home-like” and appealing in the palliative context</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seasonality and weather patterns impacted participants</td>
<td>Family, friends, and others in the care recipient’s network create a desirable social aesthetic of familiar faces and voices at end-of-life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distance is viewed as an emotional construct (e.g., feelings of isolation intensified when care needs heightened)</td>
<td>Place was viewed as impeding the socializing process and desired social aesthetic</td>
<td></td>
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</tr>
</tbody>
</table>

Kulig, 2012). Therefore, an international need exists for more research to examine experiences of palliative care that can provide evidence of inequities to inform policy, particularly in geographically vulnerable regions like rural Canada.

3. Using ‘place’ as an analytical tool

For the pilot phase of a national-scale study aimed at examining issues of access to rural palliative care, 31 semi-structured phone interviews were conducted in 2008 with a diverse range of informal and formal palliative care providers in the West Kootenay-Boundary region of BC. During review of the pilot transcripts, various geographic issues emerged and their scope and scale were assessed through full thematic analysis. This analysis led to the identification of ‘place’ as an important analytic tool to garner a greater understanding of the geographic nuances of palliative care receipt/delivery in rural BC. Place is defined here in the broadest sense, encompassing aspects of both the physical (e.g., a material artefact or literal location) and the social (e.g., the ways people engage in place-making activities, have a sense of place, carry emotional attachments and attribute meanings to places) (Castleden et al., 2010). The four place-based thematic findings of the analysis were: (1) distance, (2) location, (3) aesthetics, and (4) sites of care. As Table 1 illustrates, social and physical dimensions of place emerged across each theme.

4. Study overview

The current analysis is based upon the findings of the data collected during the qualitative research stage of a new, large mixed-methods study that is national in scope and to which Castleden and colleagues’ (2010) pilot analysis contributes. The specific aim of the new study was to identify rural Canadian communities that are in need of, and are highly suitable for, expanding their palliative care service provision through creating a geographic siting model. Site selection for qualitative interviews was based upon spatial analytic results from previous stages in the larger research process (for more information on the spatial analysis, see Crooks et al., 2011). Contextual information was gathered on the model’s 20 most highly ranked palliative care-poor communities across Canada, and through careful case study identification, four sites were purposely selected for the qualitative stage: (1) Lloydminster, Alberta/Saskatchewan; (2) Thompson, Manitoba; (3) Fort Frances, Ontario, and; (4) Happy Valley-Goose Bay, Newfoundland & Labrador (see Fig. 1).

4.1. Data collection

From February to September 2014, forty semi-structured phone interviews were conducted with formal (n=34) and informal (n=6) palliative care providers and administrators in each of the four communities (n=10/community). The formal provider participants came from diverse occupations (see Table 2). Similar to the original pilot study, interviews asked about participants’ experiences with palliative care provision; community descriptions; community health and health care priorities and challenges; community need for palliative care and existing availability; and their perspective on the siting model approach. All interviews were digitally recorded, transcribed verbatim, and entered into NVivo™ software for coding.

4.2. Analysis

During the interviews, it became apparent that place, in both
the physical and social sense, was found by participants to shape their palliative care experiences. As such, the original framework developed by Castleden and colleagues (2010) was reviewed with our newly completed dataset, and thematic analysis ensued. Thematic analysis involves segmenting and reconstituting data to facilitate the search for patterns of experiences, whereby the result is a description of those patterns (Ayres, 2008). By contrasting against Castleden and colleagues’ (2010) framework, five random transcripts were reviewed and a thematic coding scheme was developed to encompass the main geographic and/or place-based themes found to be central to the participants’ discussions. After coding five additional transcripts, the scheme was reviewed and refined, and then the entire data set was coded accordingly. To enhance consistency, the first author led all steps of the coding and analysis process. Multiple investigators were involved in each step to provide feedback and enhance interpretations, thus contributing to the reliability of the findings.

5. Findings

Our analysis confirms Castleden and colleagues’ (2010) existing findings that distance, aesthetics, location, and sites of care are central to the social and physical place of palliative care in rural Canada, but also reveals two new place-based dimensions: (1) borders and boundaries; and (2) ‘making’ place for palliative care. These dimensions are summarized in Table 3 and examined below.

5.1. Borders and boundaries

Provincial and jurisdictional borders were found to shape participants’ experiences of palliative care, which is an issue we explore in a full analysis elsewhere (see Giesbrecht et al., 2016), but...
which also makes a meaningful addition to Castleden and colleagues’ (2010) framework. For example, the provincial border was found to be a major issue in Lloydminster as this community has the unusual location of straddling two provinces (Alberta and Saskatchewan), but is actually incorporated as a single city. Referring to their greatest challenges, this participant stated it was: “The fact that we’re on the Saskatchewan/Alberta border… there’s a lot of arguments between the two [provincial health] ministries to decide where the money goes” (L-08). Jurisdictional borders, particularly those defining health authorities within provinces, were also impactful. Participants described differences in funding, services, and supports available as you move from one jurisdictional authority to another: “I’d like for everybody to be able to receive the same types of services… we will pay for their ambulance bill… but another health authority doesn’t” (H-01). Participants emphasized the desire for a healthcare system that facilitates information sharing across health authority borders, particularly for those residing and working nearby.

Socially, professional and cultural boundaries were found to shape participants’ experiences by geographically distinguishing binaries between groups (e.g., us/them; here/there; included/excluded). Categorization of formal provider occupations (e.g., specialists, physicians, nurses) results in professional boundaries, whereby each worker is responsible only for her/his own specialty. Some participants expressed frustration with this, stating a major challenge being the lack of communication between professionals and a need for more coordination: “what we are missing is a coordinated palliative care program… every service is providing palliative care, but there is no coordination or no organization of it into a program” (F-04). Participants also commented on the differences in cultural practices, norms, and behaviours that resulted in invisible boundaries being drawn that shaped access to culturally meaningful palliative care.

### 5.2. ‘Making’ place for palliative care progress

In all four communities, participants described steps being taken to ‘make place’ for palliative care. Many expressed the need for more, and development of, new spaces in existing hospitals dedicated to palliative care: “We’ve recently added on a palliative care room and renovated the other… we used to have two palliative care rooms, we now have three” (L-01). Another describes: “Within the hospital community, they’re really looking towards expanding palliative care rooms... and so the desire is there to move forward” (F-08). Some participants also shared how they were actively engaged in creating more public awareness on palliative care and the local services available by developing various knowledge-based materials to, in part, enhance awareness of these existing spaces. One participant explains: “I set up a palliative care information booklet for our department with two other nurses because some of our clients are… illiterate... and some people just don’t understand the medical jargon” (H-09). Other participants shared examples of tool kits and brochures that were recently created in order to target and inform populations about local services.

Participants described undertaking various initiatives that made a social place for palliative care in local dialogues, with the hope of increasing awareness and knowledge, and raising its profile to a community-recognized priority. For example, some participants described the development of volunteer groups aimed at advancing local palliative care. One participant describes how, “we trained a lot of volunteers and we had updates and meetings and we raised money and awareness by doing different activities in the community” (F-07). Participants also expressed the desire for more knowledge, education, and training on palliative care, thinking that such initiatives can work towards creating an expanded social place for palliative care in the community. One participant explained how they recently developed a program and is working towards having mandatory palliative care education for all local healthcare providers. Others stated their willingness to undertake more training, but due to the distance and time required to travel from their rural communities to larger centres where workshops often take place, they faced access barriers.

### 6. Concluding discussion

Our findings confirm the importance of the original framework introduced by Castleden and colleagues (2010), but also highlight the need to broaden it to include the two new place-based dimensions of borders and boundaries and ‘making’ place for palliative care. While these dimensions may not be new to palliative care research, they are new to our previously-published framework. As such, the inclusion of these new findings is significant as it generates a more robust framework to offer researchers interested in considering the social and physical place-based dimensions of not only rural palliative care, but various other healthcare services across a range of diverse geographical settings.

The participant perspectives garnered here have brought to our attention that borders and boundaries shape experiences of rural palliative care, which contributes to understandings on the diverse ways in which everyday lives are shaped by border/boundary binaries distinguishing between ‘us/Them’, ‘here/there’, and ‘included/excluded’ (Newman, 2006; Wastl-Walter, 2011). Our findings also acknowledge the notion of ‘place making’ in the context of rural palliative care and contribute a greater understanding

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**Table 3**

New findings – revisiting the use of ‘place’ as an analytical tool.

<table>
<thead>
<tr>
<th>Borders/boundaries</th>
<th>‘Making’ place for progress</th>
</tr>
</thead>
</table>
| **The physical place of palliative care** | • Development of new spaces dedicated to palliative care is currently underway  
• Materials, such as a palliative care tools kits, information booklets, and brochures are being created to increase local knowledge and awareness  
• Various initiatives are underway to bring palliative care into the local dialogue, allowing it to become more visible, and thus more of a local priority  
• The desire for more education and training exists to advance knowledge and awareness of palliative care |
| **The social place of palliative care** | • Provincial borders create major barriers in continuity of care  
• Jurisdictional borders create differences in funding and resulting palliative care access and services available  
• Development of new spaces dedicated to palliative care is currently underway  
• Materials, such as a palliative care tools kits, information booklets, and brochures are being created to increase local knowledge and awareness  
• Various initiatives are underway to bring palliative care into the local dialogue, allowing it to become more visible, and thus more of a local priority  
• The desire for more education and training exists to advance knowledge and awareness of palliative care |

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regarding the active role community members play in the advancement of palliative care - a healthcare service that is often overlooked and undervalued (Castleden et al., 2010; Canadian Medical Association, 2015). The place making actions of participants across four palliative care-poor rural communities generate the space needed for palliative care to become visible, accessible, and more of a priority in rural Canadian communities.

We consider it important to reflect on why the two new framework dimensions shared here did not emerge in the original pilot study run by Castleden and colleagues (2010). Conceivably, it may simply be because we cast our net wider in the four case studies, each with different socio-economic, demographic, and cultural circumstances. Including an increased diversity of perspectives from residents in very different rural Canadian communities is likely to give rise to new thematic findings. But more likely, these themes did not emerge originally as the pilot study was not undertaken using a comparative approach. Although participants came from three nearby communities, the communities were heavily linked in terms of resource sharing and the geographic nuances of the region. It was through comparing and contrasting perceptions and perspectives from multiple diverse communities that the additional framework dimensions reported on here were given light. In revisiting our pilot data with these new dimensions in mind, it is now clear that these two new dimensions did apply to that case study region even though they did not emerge in our initial rigorous thematic analysis.

Taken together, our findings contribute to a greater understanding regarding why place matters in the context of rural palliative care in Canada, and likely elsewhere. Building upon existing research (Bender et al., 2009; Andrews and Moon, 2005; Cummins et al., 2007), we contend that acknowledging the social and physical dimensions of place can provide healthcare administrators and planners with a nuanced, rich, and complex understanding of rural palliative care. This, in turn, has the potential to facilitate the creation of more equitable and accessible palliative care supports for all Canadians. Beyond Canada, this research offers a unique framework to examine the significant connections between place and healthcare in any international context.

References