Providers’ perceptions of Aboriginal palliative care in British Columbia’s rural interior

Heather Castleden PhD¹, Valorie A. Crooks PhD², Neil Hanlon PhD³ and Nadine Schuurman PhD²
¹School for Resource and Environmental Studies, Kenneth C Rowe Management Building, Dalhousie University, Halifax, NS, Canada, ²Department of Geography, Simon Fraser University, Burnaby, BC, Canada, and ³Geography Program, University of Northern British Columbia, Prince George, BC, Canada

Abstract
Aboriginal Canadians experience a disproportionate burden of ill-health and have endured a history of racism in accessing and using health care. Meanwhile, this population is rapidly growing, resulting in an urgent need to facilitate better quality of living and dying in many ways, including through enhancing (cultural) access to palliative care. In this article, we report the findings from a qualitative case study undertaken in rural British Columbia, Canada through exploring the perceptions of Aboriginal palliative care in a region identified as lacking in formal palliative care services and having only a limited Aboriginal population. Using interview data collected from 31 formal and informal palliative care providers (May–September 2008), we thematically explore not only the existing challenges and contradictions associated with the prioritisation and provision of Aboriginal palliative care in the region in terms of (in)visibility but also identify the elements necessary to enhance such care in the future. The implications for service providers in rural regions are such that consideration of the presence of small, and not always ‘visible’, populations is necessary; while rural care providers are known for their resilience and resourcefulness, increased opportunities for meaningful two-way knowledge exchange with peers and consultation with experts cannot be overlooked. Doing so will serve to enhance culturally accessible palliative care in the region in general and for Aboriginal peoples specifically. This analysis thus contributes to a substantial gap in the palliative care literature concerning service providers’ perceptions surrounding Aboriginal palliative care as well as Aboriginal peoples’ experiences with receiving such care. Given the growing Aboriginal population and continued health inequities, this study serves to not only increase awareness but also create better living and dying conditions in small but incremental ways.

Keywords: Aboriginal people, access to health care, inequalities in health and health care, palliative care, qualitative research, rural health care

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Introduction
Aboriginal peoples, who include Métis, Inuit and members of First Nations (formerly referred to as Indian Bands) in Canada, have numerous distinct cultures, yet they share common histories of colonialism involving marginalisation, exploitation and maltreatment (Castleden et al. 2008). They also face the challenge of coping with significant health inequities relative to the larger Canadian population (Waldram et al. 2006) and often lack recognition of their desire for self-determination and autonomy in terms of how they engage in both living and dying (National Aboriginal Health Organization 2002). At the same time, Aboriginal peoples are
now living longer and experiencing a higher incidence of chronic and degenerative disease such as diabetes and cancer and their related impairments (Assembly of First Nations 2005). As a consequence, their end-of-life stage may be protracted and require concentrated palliative support, which is often only accessible outside of their home communities and/or in institutionalised settings such as hospitals (Kitzes & Berger 2004, Gorospe 2006).

In recent years, there has been a rapid trend towards migration to cities and roughly 60% of Aboriginal Canadians now live in ‘non-isolated’ areas (National Aboriginal Health Organization 2002). Access to comprehensive and appropriate palliative care in Canada is difficult in both contexts: in rural settings, healthcare delivery is challenged by lack of resources (Crooks & Schuurman 2008); while in urban centres, palliative care is often divorced from the cultural norms and needs of Aboriginal peoples (Hotson et al. 2004, Allec 2005, Gorospe 2006, National Aboriginal Health Organization 2007). Yet at present, there is no Canadian standard for Aboriginal palliative care. Aboriginal peoples thus access the same set of services as do other Canadians – services that were not designed with sensitivity to cultural differences (Hotson et al. 2004, Altec 2005, Ellerby et al. 2006).

British Columbia (BC), Canada’s most westerly province, is home to approximately 196 000 Aboriginal peoples representing no less than 30 distinct cultural groups. Palliative care services in the province are located unevenly, with most team-based and specialised care offered in larger urban centres (Cinnamon et al. 2008). General practice physicians provide the bulk of palliative care (Canadian Institute for Health Information 2008) and most BC communities do have reasonable access to non-specialised care (Pong & Pitblado 2005, Watson et al. 2005). The province’s Ministry of Health recognises that current access to palliative care is inadequate for many citizens and that this must be addressed (British Columbia Ministry of Health 2006). There are, in fact, calls to enhance palliative care in general across the country (Health Canada 2005).

Acknowledgement of the cultural, linguistic and ethnic diversity of BC’s residents has yet to translate into a strengthened approach to palliative care. In 2006, the BC Ministry of Health released a framework on palliative care that prioritises administration, accessibility and co-ordination, but neglects to mention, for example, the specific needs of non-urban communities and has only limited acknowledgement of the need to offer culturally sensitive care to all citizens. Admittedly, the framework is a starting point and not an actual blueprint for how care should be provided; however, the lack of attention to cultural sensitivity at this stage may prevent the prioritisation of this issue into guidelines for service providers. BC is not alone in this regard. Numerous studies have pointed out challenges palliative care administrators and providers face in either prioritising or providing culturally sensitive care in general (Hall et al. 1998, Gatrad & Sheikh 2002, Owens & Randhawa 2004, Kemp 2005, Thomas et al. 2008) and for Aboriginal peoples specifically (Kaufert & Lavallee 1999, Kitzes & Domer 2003). Research is thus needed not only to document further challenges but also to identify ‘ways ahead’ in terms of delivering more culturally sensitive palliative care.

The study

In this article, we present the findings of a qualitative case study examining palliative care services and provision in the rural interior of BC. The purpose is to explore current realities, particularly the challenges of delivering culturally sensitive and safe palliative care for Aboriginal peoples in a rural area where they form only a small minority of the local population. This is a much needed contribution to the Aboriginal palliative care literature as research has traditionally focused on care provision in reserve communities, urban settings and places that have sizeable Aboriginal populations (e.g. Hotson et al. 2004, Allec 2005, Gorospe 2006). Our specific objectives are to: (1) thematically explore the challenges inherent in prioritising and providing culturally sensitive palliative care to the region’s Aboriginal minority population; (2) identify elements that are necessary for further enhancing such care; and (3) consider the implications of our findings for service providers and administrators in the region and in other communities that are home to small Aboriginal populations.

Case study site overview

The West Kootenay-Boundary (WKB) region of BC is a lightly populated and widely dispersed region of small towns and cities. The analysis presented in this article focuses on three such communities: Trail, Nelson and Castlegar. These communities were selected for this qualitative case study based upon the findings of a detailed spatial analysis aimed at identifying regions of rural BC that have limited access to palliative care (Cinnamon et al. 2009). Trail is the largest of the communities, with a population of 18 131 (Statistics Canada 2002) and participants characterised it as being a ‘blue collar, one-company town’. It is also home to the WKB regional hospital. Nelson has a population of 9585 (Statistics Canada 2002) and is characterised as being an artistic community where a number of holistic and alternative health therapies are practised. Finally, Castlegar is home to 7610 residents (Statistics Canada 2002) and described as the
‘crossroads of the Kootenays’ given its centralised location in the region. Basic health services were available in all of the case study communities, including local access to family doctors, nurses, pharmacists and clinics. Each town had its own volunteer hospice society and there were eight designated palliative care beds between them in extended care facilities and the regional hospital, with supported home-based care also available.

Sinixt (Aboriginal) people, identified as the original inhabitants of the WKB region, were declared extinct by Canada’s federal government in 1956, something that lingers in the collective memories of people in the region. Despite this, people claiming Sinixt identity recently filed a land claim to access their traditional territory through the Canadian court system. The government’s declaration of extinction aside, people identifying as Aboriginal do live in the WKB. According to Statistics Canada (2006), there were 450 Aboriginal people living in Trail, 300 in Nelson and 275 in Castlegar, a total of 1025 of the 2000+ people reporting Aboriginal identity in the region (reporting Aboriginal identity on the Canadian census tends to under-represent actual numbers of Aboriginal people). However, there are no local Aboriginal reserves or treaty lands in the immediate vicinity of the WKB. Thus, in comparison to the surrounding communities in BC’s interior, the region has a relatively limited Aboriginal population.

Methods

The findings presented here contribute to a larger study focused on palliative care in BC’s rural interior. The overall goal of the larger study was to examine palliative care service provision in this region and explore the potential for providing more regionalised care – specifically through the creation of secondary palliative care hubs – by determining localised barriers and facilitators to such service delivery. In order to do this effectively, consulting with local formal (e.g. paid health service workers) and informal (e.g. family caregivers, pastors, volunteers) palliative care providers was a necessary step so that we might better understand how palliative care is currently being provided. In 2008 (May–September), we conducted one-on-one phone interviews (n = 31) with a range of formal and informal palliative care providers in the WKB region.

Participants were recruited using a purposeful strategy in order to maximise diversity across communities in the WKB region and occupations. An initial group of potential participants was contacted using networks held within the investigative team. Calls for participants were also placed on the electronic listserves of key associations. Further recruitment occurred through reviewing employee listings for the regional health authority and health service sites (e.g. the regional hospital), through targeted internet searches and snowball sampling. In total, 40 people were contacted, 31 of whom ultimately took part in the study. These participants provided a range of palliative care services in the WKB region (see Table 1). While many provided services in multiple communities, they identified their main community of practice to be Nelson (n = 5); Trail (n = 11); and Castlegar (n = 13). Two participants were providers in northern BC who had expert knowledge of the state of rural palliative care provision throughout the province. The research team agreed that their input would provide an important comparative perspective between regions. On detailed analysis, rather than contrasting to participants in the interior, their responses were complementary and thus integrated into the data set.

Phone interviews lasted 1.5–2 hours and were conducted by the lead author in order to enhance consistency. A semi-structured guide was used that covered: experience with palliative care; community descriptions; community health and healthcare priorities and challenges; community need for palliative care and existing availability; community palliative care challenges; and the secondary palliative care hub approach. With the exception of a series of 21 short Likert scale questions asked at the end of the interview about the hub approach, the questions posed were open-ended and, as is the nature of semi-structured interviewing, participants were also asked to share with us any other information they felt was relevant but not addressed in the interview. Procedures for obtaining informed consent and all other aspects of the study were reviewed and approved by the Office of Research Ethics at Simon Fraser University and the Interior Health Authority.

Analysis

Interviews were digitally recorded and transcribed verbatim. All transcripts were entered into NVivo® (qualitative data management software, Doncaster, Victoria, Australia) and thematic coding ensued. To guide the

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<tr>
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<td>6</td>
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<td>Hospice/palliative care volunteer</td>
<td>5</td>
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<td>Other</td>
<td>4</td>
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<td>2</td>
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<td>Pastor/minister</td>
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<td>Hospice society worker</td>
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<td>Allied healthcare professional</td>
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<td>Family caregiver</td>
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Table 1 Participants’ roles in palliative care service provision
Asian people commented: as having a largely white population. One participant vision; contradictions in perceptions of this provision; visibility of and access to culturally sensitive service pro-

lierative care for Aboriginal residents in the WKB: the

tified three major themes regarding the provision of pal-

liative care was not a focus of the larger study, nor was it intended as an analytic issue. However, as data collection began, it became clear that 'perceptions of culture' was an important topic that warranted further analysis, particularly in relation to Aboriginal peoples and access to/use of palliative care in the WKB. We iden-
tified three major themes regarding the provision of pal-

liative care for Aboriginal residents in the WKB: the visibility of and access to culturally sensitive service pro-

vision; contradictions in perceptions of this provision; and the necessary elements for providing culturally sen-
sitive care. These themes are elaborated upon below.

Visibility/invisibility

Participants described the WKB as having a very differ-

ent ethnic composition in contrast to other regions of the province. While BC has substantial Aboriginal and immi-
ger populations, participants viewed the WKB as having a largely white population. One participant commented:

[The region] would be mostly, I'm going to say, white Anglo Saxon communities. There's very few black or dar-

ker skinned, Afro-American people, very few... Oriental or Asian people...you know, fairly mono-cultural.

Participants did, however, identify three distinct cultural groups as having settled in the region: Russian Dukhabors; Italians; and Portuguese. These were the groups reported as being visible in palliative care sites.

Participants had varied responses about the presence of Aboriginal peoples in the region, ranging from reporting that there were 'none' to 'some'.

The original group that was here, the Sinixt, were declared extinct. But they still exist in small numbers, and they don't think they're extinct.

Clearly, the statistics reported above demonstrate the presence of Aboriginal peoples in the WKB. Interest-

ingly, a few participants noted that there has been an emerging trend of 'coming out' among Aboriginal peo-

les. Long-standing racism has historically led many Aboriginal people to avoid self-identifying in order to avoid substandard care (Browne & Fiske 2001). One par-

ticipant explained:

There is definitely a lot of Métis people, and in fact the population of Métis people [in the region] increased by 48% since 2001 to 2006... the most obvious [reason for this] is increased confidence and cultural pride.

However, this increase in self-identifying as Aborigi-

nal did not seem to translate into participants having a heightened awareness of the presence of Aboriginal peo-

ples in the region generally, or as recipients of palliative care services specifically.

When participants described whom they actually saw in the palliative care beds in institutionalised settings, they identified mainly white people.

I see mostly white faces. They may have...some other back-
ground that comes out in their speech, but white faces gen-

erally.

It was also suggested that middle-income earning white people were the most likely to use palliative care because it was more culturally accessible to them. Participants further suggested that cultural minorities in the region such as Aboriginal peoples were more likely to 'take care of their own'. This could be due to lack of awareness of local palliative care services, or due to factors such as (un/intentional) exclusion from such provision or being invisible to formal care providers due to being cared for in private home spaces. Furthermore, the seeming invisibility of Aboriginal peoples specifically may, in part, be linked to the stereotyping of physical characteristics. As one participant explained:

There's [Aboriginal] people that are lighter skinned, and they are... half. There's a whole large group that are half, intermix or whatever. So I can't identify them.

In this instance, appearance was being relied upon as an indicator of Aboriginal identity rather than on, for example, the presence of local cultural events or organi-
sations.

Contradictions

How participants approached palliating clients of differ-

ent cultural backgrounds was inconsistent. Some
reported that service provision was delivered on an individual basis and that it ‘boils down to each individual family’. Others suggested that cultural differences were set aside so that clients received equal access and care. One participant went so far as to say:

When [you’re] going as a hospice worker you don’t have any prejudice – I don’t and nobody does – about their culture and religion.

Statements from other participants, however, contradict this characterisation of care. For example:

Just recently actually there has been a patient who went in to receive services and was racially attacked and the physician was using terminology, ‘You people are always,’ you know just over generalized comments, and using [an] elevated voice to... ensure that they’re heard, and the patient left with little dignity... that person has some chronic and acute health issues, and requires regular contact with health services, and is now feeling very, very distrustful, and scared to... even enter the building.

Other participants also acknowledged that clients presenting with mental health problems, a history of substance abuse, obesity, low socioeconomic status and/or homelessness have been subject to unequal treatment.

Interestingly, those participants who did recognise the existing Aboriginal population presented contradictory statements about where Aboriginal people go to die or be cared for while dying. Some participants suggested that Aboriginal peoples did not choose to stay in the region to die. Rather, as one participant explained:

[Aboriginal people] go back where they came from... I’ve seen it happen a couple of times where the services become increasingly difficult to access, and they just they return to the place familiar to them...we don’t keep them here... But there’s definitely a pattern in this community where [Aboriginal] people leave the community.

Other participants presented opposite views, as noted in the following:

Some who have been associated with a reserve will go back, but most don’t.

The incongruity of these two viewpoints suggests that much still remains to be understood about Aboriginal peoples’ ways of receiving palliative care and dying in the WKB region.

Participants typically resorted to making generalisations about different cultural groups when asked to discuss cultural needs in palliative care, although often with qualifying statements. For example, in the context of access to palliative care, access was seen as equal but that not all groups were interested in using such services.

The traditional Canadian family [is] probably more receptive to palliative care services than some of your more ethnic minority groups are...they may not be as open to that level of service when it’s offered to them... So I don’t think there’s any denial of access. I think it’s just whether the recipients are receptive to what’s being offered.

This statement suggests there may be a need for better understanding of the wants and needs of cultural groups in the region.

In the specific context of Aboriginal palliative care, generalisations and assumptions were made, as can be seen in the following statement:

I think they’re getting more tuned to what their past spiritual practices were and so I think that’s helpful. You know, like they now do smudging and all that sort of thing, which I don’t think they did in the past, or certainly not that we knew of.

First, there is a generalisation that Aboriginal peoples smudge, that is the burning of traditional medicines (e.g. cedar; sage; sweet grass) to cleanse, as a form of spiritual practice; meanwhile not all Aboriginal peoples adhere to traditional belief systems (Kelly & Minty 2007). Second, there is an assumption that spiritual practices have not consistently occurred in the region, whereby more reasonably – given the negative colonial policies and practices most Aboriginal peoples have experienced – these practices have not been made visible to health service providers (Brown & Fiske 2001). At the same time, an important acknowledgement is made that recognises providers have not always been aware of the cultural needs of Aboriginal clients in the region.

Necessary elements

Participants identified several ‘necessary elements’ for providing culturally safe Aboriginal palliative care in the WKB region. Due to an expressed lack of awareness regarding cultural differences in death and dying, they spoke with some frequency about the need for training to meet their desire for providing care with cultural competence.

Do we culturally understand the differences in the way people approach death? I’m not sure any of us have had, in this area, very much training or exploration of that.

Such lack of training may lead to cultural misunderstandings:

I’m sure some different cultures might be misread with regard to managing their pain or supporting the family, those kinds of issues.

Those participants who did have experience with palliating Aboriginal clients suggested that differences in how both care and dying were experienced were based
on differing worldviews. A participant attempted to articulate this difference:

They are very ‘in the moment’. I don’t know if that’s a cultural thing.

The participant alludes to the possibility of experiencing life and death in a particular way, attributing it to a cultural phenomenon, while also expressing uncertainty in her statement about how to make sense of such difference. However, some participants did not see the need for training in cultural sensitivity.

The [Aboriginal] people who do live here have more or less adapted to our – for the lack of a better word – white man’s ways. They live within the community. They have amalgamated. They’re in the melting pot.

Alternatively, experiences of prejudice, discrimination and racism may have led many Aboriginal peoples to suppress their Aboriginal identity in public spaces (Browne & Fiske 2001). This last point further reinforces the need for training in how to provide culturally safe palliative care to the region’s Aboriginal population, which some participants indicated would lead to greater access to health care for this and possibly other marginalised groups.

Participants were asked to describe the ideal location for receiving palliative care. Typically, their responses indicated that death should occur in a place determined by the client, whether that was in the person’s home or an institutional setting, and that this is a necessary element for providing the best care possible. Based on their experiences, most described a home-like environment as being idyllic, and a freestanding hospice house as being their vision for palliative care in the region. When thinking about the ideal palliative care scenario for Aboriginal clients, one participant noted that it would be:

[Very important that palliative areas are physically non-threatening or [as] least institutionalized as possible just because of the residential school experience…and to end your life in a building that may look like that could…really trigger some emotional stuff.]

Considering the necessary elements for providing culturally safe Aboriginal palliative care, this comment serves as a reminder that hospitals and long-term residential care units run the risk of presenting more damage than benefit in light of the colonial legacy of institutional settings for Aboriginal Canadians.

Participants often explained that they had to make do with whatever existing resources they had available in order to accommodate Aboriginal peoples (and people from other cultural minorities) into their practice. They were, however, able to make suggestions about how best to allocate new resources dedicated to enhancing Aboriginal palliative care in the region. One suggestion was to make more of an effort to (re)connect dying Aboriginal peoples with their homelands. While many Aboriginal peoples no longer reside in their traditional territories, having a connection to one’s homeland remains innately important (Castleden et al. 2009b). It was explained:

A person [who] is getting sick and they know where they’re from…but they don’t really want to go to that place, because they don’t have any connections, they don’t know anyone. They don’t really want to go there to die, but they’d like a connection. That soil can be used in ceremony and the medicine of that soil can be taken advantage of.

Here, the suggestion was to present Aboriginal palliative care clients with soil from their home territory. Participants who were either Aboriginal themselves or were actively involved with the region’s Aboriginal population identified a number of similar necessary elements in their visions for Aboriginal palliative care. These included having an appropriate physical location and care space, being in close proximity to natural surroundings, being able to practice ceremonial activities while receiving care, having access to traditional foods and the use of traditional medicines. Clearly offering culturally sensitive care practices such as those described requires dedicated resources and thus serves as a necessary element to providing Aboriginal palliative care in the region.

Discussion

Recent studies indicate that the under-utilisation of health services by cultural minorities is often due to cultural and conceptual differences in how health is understood and achieved, as well as systemic barriers, which are embedded within service systems (Mulvihill et al. 2001, Fung & Wong 2007). It is thus likely that these factors also affect Aboriginal peoples’ use of palliative care in BC’s interior. Research suggests that attention must be given to overcoming barriers and understanding differences in useful ways in order to facilitate equitable access to health services. For example, having minority representation among health professionals, linguistically accessible health education materials, language interpretation and cultural competence training for healthcare providers are recommended interventions (Beach et al. 2005, Price et al. 2005, Gozu et al. 2007).

From the data, four ‘necessary elements’, which can serve as interventions to enhance the provision of palliative care for Aboriginal clients, are identified: (1) allocating resources to establish strategies such as culturally specific practices (e.g. smudging) that will facilitate experiencing a good death; (2) providing culturally safe care that supports people in claiming and embracing their
Aboriginal identity at end-of-life; (3) giving care in spaces that do not re-institutionalise Aboriginal people; and (4) offering training to formal and informal service providers regarding cultural practices in death and dying. These necessary elements build upon and contribute to the vision for palliative care set out by the National Aboriginal Health Organization (2002, 2007).

The findings point to the fact that both the region’s ‘rurality’ and the presence of a marginal Aboriginal population are highly relevant to how participants discussed palliative care. The few studies of Aboriginal palliative care practices have largely taken place ‘on reserve’ where Aboriginal peoples share a common cultural identity or in urban settings where they are often removed from their cultural norms and needs. The WKB region thus presents an atypical case. There are individuals with Aboriginal identity in the region, but the relative homogeneity of the white population renders cultural differences invisible at times – when a Métis person does not ‘look Aboriginal’ – and visible at other times – when someone’s cultural practices do not fit the norm. This situation presents numerous challenges for formal and informal palliative care providers alike, who must be attuned to the importance of unique and different cultural practices while at the same time must avoid generalisations or assumptions about individual needs or desires.

Although this challenge is not unique to the region, the way it plays out in this particular place is clearly informed by the presence of a minority and heterogeneous – in that they do not share a common identity or live on the same reserve – Aboriginal population. Interestingly, the rurality of the location can offer ways to provide culturally safe and sensitive care that may not be available in more populated urban centres. For example, care providers in the WKB region are in a position to draw upon the strengths of rural communities, which in Canada are often described as ‘tight-knit’ and as places where neighbours care for one another. Furthermore, the lack of specialists practicing in the region may result in clients receiving palliative care from longer-term healthcare providers who may have a better sense of their personal and cultural histories thus enhancing the continuity of care provided. However, this is not to say that physical and social barriers to accessing quality palliative care are absent (Castleden et al. 2010).

Where Aboriginal palliative care should take place, and by whom, are particularly important concerns in the context of Aboriginal peoples’ interactions with the Canadian healthcare system, given the legacy of mistrust resulting from the colonial encounter. Considering the similarity of colonial histories in Australia and New Zealand (Anderson et al. 2006, Smylie et al. 2006), there is value in linking with research in these regions (see, for example, McGrath et al. 2006, 2007, McGrath & Phillips 2008). If, as the participants in this study indicate, Aboriginal peoples take care of their own, then perhaps creating a model that, in essence, forces inclusivity is not the appropriate solution. Rather providers and policymakers should seek direction from representatives from these cultural groups about how/if there is something that could be done differently from current practices of service delivery.

**Implications for service providers**

Palliative care service providers in the region must more actively consider the presence of a small and not always ‘visible’ Aboriginal population. Such a challenge is not uncommon for rural care providers, whose practice often requires them to become ‘expert generalists’. But while providers in rural settings often pride themselves on their resiliency and resourcefulness, most would also call for much greater administrative support and opportunities to consult with peers and other health providers when faced with challenging or unfamiliar circumstances. In the context of this paper, this may include providing formal opportunities to dialogue across collegial and professional groups about strategies for enhancing culturally accessible palliative care in the region in general, and for Aboriginal peoples specifically. With respect to offering training for service providers regarding cultural practices in death and dying, developing capacity and recruiting formal and informal Aboriginal palliative care providers is a logical extension to facilitate culturally safe spaces and culturally competent care. A recently published report on Aboriginal-focused palliative care in rural BC suggests there is strong interest from Aboriginal communities to do so (Castleden et al. 2009a).

The presence of regional health boards in BC provides a potential platform from which to organise efforts to enhance capacity, through the provision of planning meetings, conferences, networking opportunities and educational sessions emphasising cultural issues in delivering palliative care. Such initiatives could connect rural and small town providers with those from elsewhere in the region and beyond who have particular expertise that is needed locally, including with regard to caring for Aboriginal peoples. Ideally, a regional approach to cultural capacity building would acknowledge the skill and dedication of local palliative care providers, and provide a forum for a meaningful two-way exchange between generalists and specialists.

**Conclusion**

In this article, we have explored formal and informal palliative care service providers’ perceptions of culture
differences in a rural Canadian setting that is regarded as lacking in cultural diversity. Specifically, we examined their experiences with delivering palliative care to Aboriginal peoples who form only a small minority of the regional population. We found that the visibility of and access to culturally sensitive service provision led to contradictions in perceptions of this care. We subsequently identified a number of necessary elements for providing palliative care that were sensitive to the histories and cultures of Aboriginal peoples. This analysis begins to address a substantial gap in the palliative care literature concerning Aboriginal peoples’ experiences with receiving such care. That people with Aboriginal identity experience significant health disparities in contrast to other Canadians (Health Canada 2008) and that they are the fastest growing population in Canada (Abele 2004) suggests an imperative to engage in such studies in order to create better living and dying conditions for the descendants of Canada’s original inhabitants.

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