‘Heated political dynamics exist . . .’: examining the politics of palliative care in rural British Columbia, Canada

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Abstract
Palliative care is delivered by a number of professional groups and informal providers across a range of settings. This arrangement works well in that it maximizes avenues for providing care, but may also bring about complicated ‘politics’ due to struggles over control and decision-making power. Thirty-one interviews conducted with formal and informal palliative care providers in a rural region of British Columbia, Canada, are drawn upon as a case study. Three types of politics impacting on palliative care provision are identified: inter-community, inter-site, and inter-professional. Three themes crosscut these politics: ownership, entitlement, and administration. The politics revealed by the interviews, and heretofore underexplored in the palliative literature, have implications for the delivery of palliative care. For example, the outcomes of the politics simultaneously facilitate (e.g. by promoting advocacy for local services) and serve as a barrier to (e.g. by privileging certain communities/care sites/provider) palliative care provision.

Keywords
Administration, Canada, entitlement, ownership, palliative care, politics, professional, qualitative, rural

Introduction
In developed nations, palliative care is typically delivered by a number of professional groups and informal providers across a range of settings. These settings include hospitals, community-based long-term care residences, and private homes. Having diversity in both care providers and sites of care is a strength of palliative care, as it enables provision to be responsive to a range of patient needs. This diversity can also pose challenges. One challenge comes from the need to seamlessly fit together the markedly different training and professional backgrounds that palliative care providers have. A second challenge comes from the fact that palliative care services do not operate in isolation but, as with other health services, are subject to larger decision-making processes (e.g. funding allocation, healthcare restructuring). Challenges such as these can have significant outcomes for providers’ abilities to deliver the best possible care to dying individuals and their families. As we demonstrate in this article, these challenges can result in the development of a ‘politics of palliative care.’ By this we are referring to the roles that decision-making power and control play in determining whether and how palliative care will be provided by specific people in particular places. The politics of palliative care can interfere with the compassionate delivery of palliative medicine and care, the enactment of best practice, and the facilitation of ‘good death’, and thus warrant attention.

The international health services literature has touched on a range of political-type issues and how they impact healthcare delivery. Significant attention has been given to the roles that politically influenced
or politically motivated decision making, particularly regarding service allocation, play in promoting tensions within and between various stakeholders. In the Canadian context, this research attention spans issues as diverse as the closure of health service sites,\textsuperscript{10} involvement of the public in health service decision making,\textsuperscript{11} impact of a shift to regionalized administration on health service delivery,\textsuperscript{12–14} and impact of health policy change on health service use,\textsuperscript{15} among other topics. This literature collectively demonstrates the roles that factors, such as power, influence, and geographic location, play in determining where health services are and are not delivered in Canada. Certainly, this is not a reality that is limited to the Canadian context. For example, a recent comparative study clearly demonstrated the highly impactful role of local and national politics in shaping the provision of community care in Britain and Finland.\textsuperscript{16} Health service studies that focus on issues such as these have placed their focus on community-level politics. However, the politics of health service delivery have been found to not rest solely at the community level. Issues such as aggression and conflict between professional groups,\textsuperscript{17,18} changes that increase the responsibilities of some provider groups and decrease those of others,\textsuperscript{19,20} and general demonstrations of ‘profession-centrism’\textsuperscript{21} can all bring about political displays of power and control between healthcare providers.

While the broad health services literature has focused on exploring community-level politics and the roles they play in shaping resource allocation and service delivery, little attention has been paid to those that ultimately shape palliative care delivery specifically. A notable exception is the scant literature focused on exploring community-level politics and the roles they play in shaping resource allocation and service delivery.\textsuperscript{12–14} Interestingly, rural places are also known for particular kinds of local politics due to their frequently reported tight-knittedness and strong sense of community spirit that promote involvement in local issues.\textsuperscript{30,31} Focus groups conducted with rural Canadians also found that rural residents believe they have unique perspectives on dying and the provision of palliative care.\textsuperscript{32} Thus, the rural context of this case study is central to our exploration of the politics of palliative care.

**Methods**

The case study methodology is employed when researchers want to achieve an in-depth understanding of a particular issue and its relevant context.\textsuperscript{33} In this study we – a team of four health geographers with expertise in spatial and qualitative methods – employed an instrumental case study design\textsuperscript{34} to explore how barriers and facilitators to rural palliative care delivery play out in practice, and the implications they may hold for enhancing service delivery. The overall study aim was to explore the potential for enhancing rural palliative care delivery in British Columbia using a hub approach.\textsuperscript{35} In summer 2008 interviews ($n=31$) were conducted with formal (i.e. paid providers who typically have formal training)
and informal (i.e. unpaid providers, such as volunteers and family caregivers) palliative care providers in three communities that comprise the geographically bounded case study. In case studies, initial analyses are typically conducted in order to thoughtfully select the area of focus.36,37 Consistent with this approach, the WKB was selected for qualitative data collection as it was determined to be an underserviced rural area with regard to palliative care through a series of spatial analyses conducted earlier using health service and population data.38 After further spatial analysis, the region was also found to be highly suitable for enhancing its palliative care services.39 This made it an ideal location in which to explore barriers and facilitators to rural palliative care enhancement.

**Case study context**

Context is integral to designing and interpreting the results of case studies,40 and the present study is no exception. The geographic distribution of and relationships between communities in the WKB region are important contextual elements. The WKB is located in the province’s interior and has a number of small towns and cities that are widely dispersed across the region’s mountainous terrain (see Figure 1). Guided by the findings of our spatial analyses, three specific communities were selected as the focus of this case study: Castlegar, Nelson, and Trail. These communities have strong and distinguishing identities, due in part to historical patterns of migration and economic investment, which are recognized throughout the region. Trail is a ‘working-class’ resource center with the largest population of the three communities. Castlegar is the smallest, and is centrally located in the WKB. Nelson is known for attracting more ‘alternative-minded’ residents and activities (e.g. craft industries, artists). In addition to differences in local culture, there are also long-standing animosities between the three communities concerning ‘who gets what’ (e.g. the airport in Castlegar, the regional hospital in Trail) that are an important aspect of the spatial organization (and politics) of health services in the WKB.

Like most Canadian provinces, British Columbia has decentralized many responsibilities for healthcare governance to regional health authorities. However, the provincial government retains primary responsibility for overall funding allocations and regulation of regional health authority performance.41 Thus, the provision of palliative care is highly varied throughout the province. Rural palliative care has not been the focus of systematic planning and development either before or after decentralization.38,42 This is evidenced in the WKB by a dearth of palliative-focused services in many of the communities served by the regional health authority. For instance, there is no freestanding hospice, and fewer than ten beds have been designated for palliative care across the three communities. The WKB presents several challenges to health service organization and delivery, including for palliative care,
that compound the issues brought on by decentralization due to its small rural settlements dispersed over mountainous topography. For example, the region’s mountainous terrain limits timely movement between palliative care sites, particularly in the winter months.43

Recruitment

After obtaining ethical approval for the study from Simon Fraser University and the Interior Health Authority, a purposeful recruitment strategy was employed to identify potential phone interview participants from the three communities. This strategy was selected in order to maximize diversity in respondents’ locations of practice/residence and occupations. Potential participants were first contacted using our existing networks. Next, calls for participants were placed on listservs run by relevant organizations operating in the WKB. Calls for participants were also circulated through snowball sampling from existing participants (i.e. asking participants to suggest others who might be willing to speak with us), by reviewing employee listings for local health service sites, and through targeted internet searches.

In total 40 people were invited to participate in a phone interview, 31 of whom ultimately took part. Their occupations are summarized in Table 1. Participants identified their main community of practice/residence to be: Trail (n = 11), Nelson (n = 5), and Castlegar (n = 13). Many of the formal providers interviewed practiced across the three communities despite being based out of one. Two participants were based in rural northern British Columbia. Both of these participants had great familiarity with the state of rural palliative care across the province, and directly asked to participate in the study. After careful consideration it was determined that their input could provide an important comparative perspective, and useful context at the very least, and so they were interviewed. Their responses were found to complement those of the WKB respondents and were integrated into the dataset, rather than kept distinct for comparative purposes.

Data collection

Formal and informal palliative care providers interested in participating in an interview were sent detailed information about the study along with a consent form that they completed and returned prior to the phone interview. Interviews lasted on average 1.5–2 hours. All interviews were conducted by a single interviewer, the second author, in order to enhance consistency. Interviews were conducted by phone as the interviewer was not based in the case study region; face-to-face interviewing was not possible due to financial constraints. Although nuances, such as facial expressions, may have been missed because interviews were not conducted in-person, the cost effectiveness of phone interviewing was ultimately what made the study feasible. Feasibility is, in part, why phone interviewing is becoming a common method of qualitative data collection, but also because it is known to yield high-quality data.44 During the interviews participants were asked open-ended questions about: their experience with providing palliative care; community descriptions; community healthcare and health challenges and priorities; community need for palliative care and existing availability; and enhancing service delivery. They were also asked a series of 21 Likert-scale questions at the end of the interview that probed in more detail the service hub approach.

Analysis

Interviews were digitally recorded and transcribed verbatim. The data were managed using the N8™ software program. The first step in the analysis was for each of us to conduct independent transcript reviews. We next held a team meeting in order to identify issues emergent from the dataset that warranted analysis. Five meta-themes were identified: (1) the role of place in rural palliative care provision; (2) Aboriginal-focused palliative care; (3) health service administration; (4) visioning for secondary rural palliative care service hubs; and (5) the politics of palliative care. The focus of this article is exclusively on this last theme. A thematic approach to the analysis was then undertaken.45 To do this a coding scheme was collaboratively developed to organize the dataset. The second author then undertook the coding. Coding extracts relevant to the meta-theme were next shared between the first and second authors, who created an interpretive matrix to guide the thematic analysis of the findings.46 One axis characterized the levels of politics identified in the dataset, while the other contained three crosscutting themes. The cells of the 3 × 3 matrix were then

Table 1. Participants’ roles in palliative care service provision

<table>
<thead>
<tr>
<th>Role/occupational group</th>
<th>Number</th>
</tr>
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<tbody>
<tr>
<td>Nursing</td>
<td>7</td>
</tr>
<tr>
<td>Healthcare administrator</td>
<td>6</td>
</tr>
<tr>
<td>Hospice/palliative care volunteer</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
</tr>
<tr>
<td>Family doctor</td>
<td>2</td>
</tr>
<tr>
<td>Pastor/minister</td>
<td>2</td>
</tr>
<tr>
<td>Hospice society worker</td>
<td>2</td>
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<tr>
<td>Allied healthcare professional</td>
<td>2</td>
</tr>
<tr>
<td>Family caregiver</td>
<td>1</td>
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populated with findings unique to each. Confirmation was sought from all investigators concerning the interpretation of the findings. This collaborative approach to data coding and interpretation in the analytic process strengthens the credibility and integrity of the results and enhances overall rigor.47

In terms of the presentation of the analytic findings in the remainder of the article, while all participants offered insights into the politics of palliative care, we have carefully selected quotation extracts that best illustrate particular political dimensions. This procedure is in keeping with standard qualitative data interpretation.48 We do not give any identifying information for quotes as the WKB region is small, and the provision of palliative care in the region is even smaller, and so the risk of identifying participants is high should descriptors such as occupation or location be used. Finally, the quote extracts are substantial in size as they are intended to give readers the opportunity to ‘hear’ participants’ voices, thereby maintaining the richness of the data.48

**Results**

Thematic analysis of the interviews revealed three levels of politics taking place regarding palliative care in the WKB: inter-community, inter-care site, and inter-professional. Three themes were found to crosscut these levels. Firstly, the issue of ownership was frequently raised by participants. The notion of patient ownership is often discussed in the health services literature (e.g. Drazen;49 Andrews50), wherein it describes ‘the philosophy that one knows everything about one’s patients and does everything for them…and [it] is fundamental when facing critical patient care decisions’ (Van Eaton:51 p.230). As is shown in this section, the notion of ownership also extends to other levels, wherein, for example, palliative care service sites demarcate ownership over existing resources. Secondly, participants expressed a sense of entitlement to palliative care resources, and particularly towards the allocation of new resources, across all three levels of politics. A number of different rationales, which are discussed below, were shared in order to justify notions of entitlement. Finally, healthcare administration was widely discussed as a key component of the politics of palliative care. Specifically, the regional health authority’s decision-making processes were perceived to be politically motivated when it came to decisions that left one community, site, or group with more or less resources than the others. While there is clear overlap between the levels of politics identified and the themes that crosscut them, we tease them apart in the presentation of the findings below in order to illuminate the true scope of politics of palliative care operating in the WKB.

**Inter-community politics**

**Ownership.** Recent healthcare reform in British Columbia has led regional health authorities to close many care sites, thus impacting the availability of healthcare, including palliative care. Communities in the WKB have experienced a palpable sense of loss of ownership as services were taken away: ‘…it’s very hard because for me, and quite a few of us in town, we were devastated when we lost our hospital, and you’re left with a really bitter [taste].’ In the WKB, this reform has left some communities frustrated with the regional health authority for designating Trail as the host community for the regional hospital. As a participant explained: ‘That’s been the argument in [the WKB] all the time. You know, well, Trail isn’t in the geographic centre, and Castlegar is. We should have the regional hospital there.’ Participants expressed concern regarding political and economic biases in the regional health authority’s decision-making processes. These biases were thought to hold important implications for determining which communities will ultimately hold ownership for various palliative care services, including the local benefits this bestows upon them (e.g. high potential spatial access). Another concern is the seeming lack of a geographic rationale for locating services in Trail, particularly as some of the WKB’s designated palliative care beds are hosted by the regional hospital, thus determining where people can access such care.

**Entitlement.** Participants explained that local administrators commonly make and justify arguments for where new palliative care services or resources should be located, based either on the notion that a lack of existing resources in a community warrants entitlement to future ones, or that the presence of existing resources in a community warrants entitlement for future ones. In the case of the WKB, the former rationale serves to justify why Castlegar and Nelson are entitled to new localized palliative care resources to compensate for existing service gaps, while the latter rationale serves to justify ‘stockpiling’ all available and future resources in Trail to enhance its existing services. Clearly, these rationales are highly contradictory. It was also noted that some healthcare administrators and palliative care providers are quite resigned to thinking they will not receive further resources despite feelings of entitlement to them. For example, a participant explained that if ‘the [regional health authority] was to say that [a new service was] going to be in Trail—which is the most likely place that they would put it…because that’s where the regional hospital [is]…- Nelson would just go ‘Oh, oh well. That’s the way it is, that’s the way it’s always been’.’ Regardless of the rationale for why a community perceives itself to be entitled to more resources,
there was acknowledgement that a sense of entitlement may not translate into acquiring additional local palliative care resources.

**Administration.** Offering a full suite of palliative care services in all rural communities is not fiscally possible; participants appreciated that the regional health authority had to make difficult allocation decisions because of this reality. A participant commented: ‘I know some of our community administrators would say they’d prefer to see a budget divvied up [by service] and just let us [palliative care providers] do our thing... and that doesn’t always work.’ Comments such as this show awareness for the types of challenges faced by administrators. However, there is also an awareness that past administrative decisions are now contributing to present inter-community politics, including tensions regarding which community hosts palliative care services and sites. It was observed by a number of participants that: ‘There is so much animosity between Nelson and Trail particularly, that again, it [decision-making] becomes extremely dysfunctional... and so, people make decisions... that aren’t made for reasonable reasons, it becomes extremely emotional.’ These tensions are exacerbated when top-down decisions are made that leave resource-poor communities criticizing the regional health authority for not meaningfully consulting with local providers and administrators. When reflecting on this reality, a participant explained that the regional health authority ‘sometimes tends to impose things on [communities], and that’s not always well accepted. I think we would do much better if we could work from the grass roots up... It’s not going to be perfect for anybody, but everybody has some investment in it.’ Although community-based administration may allow for locally responsive service delivery, there was broader recognition that administration is challenging and may require resources that are beyond the capacity of individual communities.

**Inter-site politics**

**Ownership.** Paralleling the community-level politics, conflict between care sites across and within communities is also taking place in the WKB. The need for patients to receive care in a particular site creates tensions between care sites because ‘owning’ a patient also means receiving the subsequent funding for that person’s care. Care sites all want access to financial resources and so any sense that patients are being referred to sites due to partiality, nepotism, or any other reason is controversial. For example, it was noted that physicians may favor one care site over another for referral, which can cause tensions between facilities. The fall-out of this can negatively impact palliative care recipients and their families. Politics and power struggles also play out between care sites in instances where professional committees convene to determine palliative bed allocation. For example, it was explained that: ‘There is a committee that meets and provides services, particularly to the [palliative care] beds that are in [privately funded long-term care facility], that decides who can go there. So there’s a couple of physicians that have a special interest. There’s a lot of politics that goes on.’ It is interesting to note that in this extract the participant explicitly refers to this situation as causing, or exacerbating, the politics of palliative care.

**Entitlement.** Participants explained that care sites in the WKB are pitted against one another when forced to make claims of entitlement to palliative care funding and resources. This particularly happens when allocating funds between private home-based care and institutional settings. It was further explained that while the home is (theoretically) prioritized as a site of palliative care, reforms have left home care workers limited in the number of hours of service they can provide and the range of tasks they are permitted to do. This is making it less realistic for families to use the home as a care site and more likely for them to rely on the hospital. Many participants were frustrated by this: ‘If people want to palliate at home, we should do everything we can to keep them there. Unfortunately it’s very difficult in [the WKB] to keep people at home because we don’t have enough services to keep them at home. So it’s kind of like mixed messages, we want to keep them at home, that’s [the regional health authority] goal, but we just don’t have enough resources to actually do that.’ Given this, many participants argued that home care services, particularly those that enable the home to be a site of care, were entitled to receive renewed palliative care funding and training opportunities.

**Administration.** At present, funding for palliative care is divided between care sites (e.g. home care versus institutional care) and there is a lack of political will to create a shared budget across them. This frustrated some participants, as it was acknowledged that creating a shared budget may, in fact, reduce territorialism and notions of ownership. An outcome could be that providers could have more focus on care rather than issues of ownership and entitlement. As a participant explained: ‘There has to stop being a dividing line between the acute care budget and the residential care budget and the community care budget. How ever we fund palliative care, it has to be out of a shared pot, because palliative care happens in all those areas and so to say “This is mine, and this is mine, and this is mine” is what fragments it and then nobody wins, and nobody has enough resources.’ Institutionalized administrative structures also create politicized tensions. For example, while the bulk of palliative care patients receive...
care in the home at some point, hospital rounds are only for people receiving on-site care. This leaves home-based and medically intensive patients in long-term care facilities beyond the reach of this expertise. It was also revealed that a shift in the place from where home care administration happens (i.e. out of the hospital and into a community office) has enhanced the perceived divide between home and institutional care. A participant who works out of this office explained that s/he was ‘much more involved in the hospital’ when the office was based there, and favored its return to there.

Inter-professional politics

Ownership. Rural family physicians typically provide patient care from birth to death. While there are many benefits to having this long-standing relationship, it can also create a sense of patient ownership. It was explained that this sense of ownership, in turn, may minimize physicians’ help-seeking behaviors as individuals move from ‘patients needing treatment or cure’ to ‘palliative patients in need of pain and symptom management’. A participant reflected on this issue, explaining that ‘in terms of referrals…there [is], a little bit of, sort of territorialism… Historically in our area, many of the physicians have… just wanted to look after their own clients, or their own patients.’ It was further observed that personality conflicts between providers can confound decision-making regarding symptom management or when giving up oversight of a patient. As this participant explained, such situations become politically charged: ‘We had a nurse…[who] had quite a high level of [palliative care] expertise but there was politics there as well, in that the nurses from home nursing care, who had historically always been the people who were right up on things for palliative care, didn’t want to refer to [this person], didn’t want to consult with [this person]… I think the home care nurses were threatened. They didn’t like somebody coming in and telling them… how to do pain and symptom management.’ In this case, having one provider with ownership of more specialized palliative care expertise created tension among the team within which s/he was situated, thereby creating or exacerbating a politics of palliative care.

Entitlement. There was an underlying sense held by some participants of being entitled to provide palliative care to patients because of the experience, expertise, and relationships they have built up over time. This was true regardless of whether or not they had received formal training in this area of practice. Contrary to this, it was observed that in some instances specialized credentials are used to usurp first-hand experience. In such cases credentials are used as a form of entitlement to oversee a patient’s care. Having to work where some providers have specialized training and others do not, and some have lengthy hands on experience and others do not, has resulted in an environment that one participant described as ‘very political’. The long-standing hierarchy that exists among medical professions was reported to be in force in the WKB. As one participant explained, this hierarchy can negatively impact working relationships, including access to information between professional groups: ‘It’s hard to get into the “doctor world” to really know what’s going on… doctors are very territorial…and it’s one of those sort of “group phenomenon” things that if you’re different…it makes it very difficult…’ It was commonly reported that tensions between provider groups are exacerbating conflicts over who is entitled to make which palliative care decisions, and who holds the ability to overrule others’ decisions.

Administration. Political will has a major impact on the allocation of funding for palliative care services in the WKB. At present, service coverage is thought to be insufficient and limited. Those services that are available are constantly at risk of further cuts from a top-down regional health authority administration. Many providers perceive the health authority to be making arbitrary decisions based on ‘back-room’ politics. For example, the cutting of a palliative care nursing position was attributed to professional and administrative politics. This cut was seen as a significant loss to communities’ palliative care provisioning: ‘[The nurse] still has such a passion for palliative care and pain and symptom management, and so much expertise to give, but the [regional health authority] is not amenable to having a pain and symptom management nurse…[it was] the politics of [name of regional administrator]…not wanting to apply funding there.’ To prevent similar situations from happening again, it was explained that transparent and frequent communication between professionals, sites of care, and communities will be critical to assuaging the politics of palliative care. Using a common analogy, a participant described this desired situation as letting ‘the right hand…[know] what the left hand is doing.’

Discussion

Thematic analysis of interviews conducted with formal and informal palliative care providers has revealed three levels of politics at play in the WKB region. Inter-community politics highlight struggles regarding service allocation and funding, inter-site politics draw attention to issues of local resourcing and its distribution, while inter-professional politics bring to light challenges associated with collaborative practice and professional hierarchies. Three crosscutting themes were found to characterize how these politics play out
with regard to palliative care: ownership, entitlement, and administration. These themes reveal common factors that promote politics at all levels. Regarding ownership, politics commonly emerged due to observations of others having access to resources or decision-making power above and beyond what some do. These observations were then leveraged as a justification for why additional palliative care resources or decision-making power was needed for the relatively deprived group, site, or community. While the uneven distribution of resources or decision-making power was a factor promoting politics around ownership, historical precedents were more frequently discussed in relation to entitlement. If a community, site, or group was favored in the distribution of palliative care resources or decision-making power, over time it was expected that that this would continue, while others used this same rationale to justify why they were entitled to benefit from future allocations. Finally, structural aspects surrounding the organization and practice of services were frequently cited as administrative factors that, in turn, reinforced or promoted the politics of palliative care in the WKB. These findings reveal how complex and interrelated various levels of politics in palliative care can be. They also serve to extend the more traditional focus placed solely on inter-professional politics in the palliative care literature, as explained in the introductory section.

In this qualitative case study we set out to explore how barriers and facilitators to palliative care delivery play out in practice in the WKB, and the implications they may hold for enhancing service delivery. The politics of palliative care was not initially an issue of focus. However, upon review of the transcripts it was revealed that inter-community, inter-site, and inter-professional politics can act as important barriers and facilitators to care delivery. For example, they act as a barrier through creating a trickle-down effect, whereby rifts and tensions can ultimately negatively impact patients and their families (e.g. by limiting choice) and providers (e.g. in having to negotiate fractured professional relationships) alike. At the same time, they can act as a facilitator by pushing some palliative care providers and others into playing advocacy roles, thus raising awareness of palliative care issues and needs in the WKB. Such findings demonstrate the importance of understanding and seriously taking into consideration the ‘political dimensions’ of palliative care in a particular community or region prior to enhancing services. This is something that researchers and decision makers alike must address when taking up the recent calls to develop new models and modes of palliative care for rural areas (e.g. Robinson et al.,27 Wilson et al.,28 Crooks and Schuurman29). By voicing the politics of palliative care at play in the WKB during their interviews, and particularly when not prompted to do so, the participants were, in effect, conveying this very message.

The process of enhancing rural palliative care services may provide communities, sites, and professional groups with the opportunity to resolve political tensions that have arisen over time due to struggles over access to decision-making power, as well as human, financial, and material resources. Specific strategies for doing this identified by the participants include: making administrative decision-making more transparent; co-locating different professionals or professional groups in proximal offices; consulting with stakeholders when making significant system and service changes; creating clear guidelines for how patient referrals are to take place; and putting local resources in place that are needed to meet regional priorities (e.g. having adequate home care support). Several of these same strategies appear elsewhere in the palliative care literature, thus suggesting that they have relevance beyond the WKB. For example, as noted in the introduction, other studies have demonstrated the potential benefits of having palliative care providers’ offices located close to one another. Doing so provides opportunities to enhance communication and inter-professional collaboration.8,26 Existing research also offers strategies not specifically identified by the participants that may also assist with mollifying some of the politics of palliative care taking place in the WKB and elsewhere. Giving providers clear role definitions,1 developing a shared culture of palliative care in the region,24 and providing opportunities for cooperation between formal and informal palliative care providers9 are all examples of strategies discussed elsewhere. Interestingly, it has also been suggested that the concept of ownership can be used in a positive way to enhance palliative care. This can happen when providers, sites, and/or communities can create a sense of collective ownership over their goals.2 Finally, it has been noted that at the inter-site and inter-community levels, lessening the complexity of palliative care arrangements may also serve to remedy service challenges;8 this, in turn, may lessen tensions and ultimately political struggles over decision-making power.

**Implications for palliative care practice and delivery**

Politics are a pervasive feature of healthcare, and this study suggests that rural palliative care is no exception. Turf, territory, ownership, and competition were common tropes used to describe conflict between health professions, organizations, and communities within the rural and regional context. In the WKB, the establishment of a regional health authority governance
framework provides a platform by which the resolution of various competing interests can be achieved through greater attention to local input and conditions, but in no way mollifies the potential for conflict. Lines of accountability, funding flows, program development, and organizational structures must ultimately work within the confines of finite resources, but with the goal of maximizing support within a given jurisdiction for those in need of care, their families, and informal support networks. At the level of practice, there is likewise a need for recognition of, and respect for, the talents and capacities of others in the field. This may help to avoid the ‘game-playing’ that can happen between palliative care professionals who have negative perceptions of others’ work and skills, thus creating tension and politics. Even more critically, however, providers must ‘buy-in’ to the notion that more will be achieved by working toward shared goals, and that this almost inevitably entails compromise and accommodating collective interests at the expense of individual ones. Doing so may overcome some of the politics reported herein, along with the aggression and ‘profession-centrism’ reported in others’ research.

We expect that the implications for palliative care practice and delivery shared here, along with the findings communicated above, are likely to have relevance to other places that share a similar context to the case study region. Perhaps most obvious is the case of rural Australia, where isolation and distance are comparable to the rural Canadian context. Both countries are facing an increasing demand for palliative care along with population aging and the movement of retirees from the city into the countryside that is amplifying the pressing need to enhance rural services. Given these parallels, the levels and types of politics of palliative care at play in rural regions of both countries are likely to have similarities, and so the strategies identified to remedy the politics may also be applicable to both jurisdictions.

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