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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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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/communities 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
Original findings from *Author* and colleagues (2010).

	Distance	Location	Aesthetics	Sites of care
The *Physical* Place of Palliative Care	• Physical distance between palliative care providers and care recipients identified as a major barrier to service access • Seasonality and weather patterns impacted participants' travel across vast distances	• Local topography (i.e., mountainous region) created challenges in accessing palliative care services • Such challenges were perceived to be 'invisible' to those in the physical locations were palliative care policy decisions are made	• Lack of appeal for sights and sounds associated with institutional aesthetics (e.g., disinfectant, paging systems, alarm signals) • Praise given to renovating and redecorating spaces to make them more 'home-like' and appealing in the palliative context	• There is the desire for palliative care services to be 'local' and easily accessible • Palliative care needs to offer choice regarding the site of care and providing an environment that allows for care recipients' comfort and enjoyment
The *Social* Place of Palliative Care	• Distance is viewed as an emotional construct (e.g., feelings isolation intensified when care needs heightened) • Concerns that spatial distance between family members leads to feelings of social distance and the lack of involvement in decision-making	• Cross-community tensions exist due to socio-political and locational factors • Citizens' social locations matter in terms of whether or not they are aware of palliative care provision	• Family, friends and others in the care recipient's network create a desirable social aesthetic of familiar faces and voices at end-of-life • Hospital settings were viewed as impeding the socializing process and desired social aesthetic	• Inter-professional politics can pose a challenge to providing palliative care • 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

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 were 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

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