



Palliative Care: the final challenge

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Treatment across the life cycle is a hallmark of rural medicine. Although much attention is paid to the earliest stages of this cycle (obstetrical and newborn services for rural women), the other end of the cycle is equally important. Many of the same issues are at play when thinking about palliative care in rural communities: the desire to allow people to die as close to home as possible, and at home if possible; the importance of paying attention, not only to the patient but to their families and friends; the goal of not adding to the burden of illness (which may be significant) the indignity of transport away from home and family and from all that is familiar.

The leading causes of death — coronary heart disease, cancer and stroke — are well known to rural health care providers, with cancer in particular being the major diagnosis in patients requiring palliative care.

Such care has been developed as a specialty in many urban areas, but in many rural environments the resources are lacking to provide the same level of care. This should not be so, particularly since the need for expensive technology is less in a palliative care setting although the need for human resources correspondingly increases.

Currently, approximately 3.7 million Canadians are over the age of 65. By 2021 there will be 6.9 million Canadians in this age group. In 1991 Canadians older than 65 had a life expectancy of 18 years, 9 of which were expected to be disability free, with the remaining years including 3 years each of slight, moderate and severe disability.¹ These

projections may underestimate the actual situation in many rural regions that have a more elderly population than the average Canadian region.

The characteristics of palliative care are widely accepted and include an interdisciplinary and holistic approach that is focussed on quality of life and includes the involvement and support of the family. Care should be based on individual values and patient's wishes, and it should reflect best practices and integrate the community through the use of volunteers. In this issue of the Journal we publish personal reflections of two practitioners, who argue for the integration of palliative care into the "Jack of All Trades" armamentarium of rural physicians, and provide a host of practical tips.² This article is a good place to start (see page 253).

Unfortunately, in many communities palliative care is provided on an ad-hoc basis. The resources, both human and infrastructural, must compete with all the other imperatives on the rural health wagon. Nevertheless, more can and should be done. With strategic investment the opportunity exists to provide palliative care that is every bit as well organized, compassionate and appropriate, as any, anywhere. Rural communities will be strengthened, and those in need of these services will be the winners.

REFERENCES

1. Fisher R, Ross MM, MacLean MJ, editors. *A guide to end-of-life care for seniors*. Ottawa (ON): Population Health Directorate, Health Canada; 2000, p. 8.
2. Kelly L, O'Driscoll T. The occasional palliative care patient: lessons we have learned. *Can J Rural Med* 2004;9(4):253-6.