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The Patient Beyond the Postal Code

You can tell who drove the farthest by the way they walk in. There's a stiffness in the shoulders, a quiet fatigue in the eyes—not just from illness, but from the road. They come from hours away: northern farms, lakeside towns, remote communities where cancer care is out of reach. Some arrive in borrowed cars or community transport vans. Others scrape together enough for a motel room.

Each file tells a story—not just of illness, but of distance and isolation. The burden of geography lingers quietly between the lines of every appointment. Behind every chart is a quiet account of sacrifice: missed workdays, gas receipts, empty hotel beds, and long, relentless drives to reach the treatment that might save a life. Long drives and longer silences, traded for a chance at staying alive.

I learned the weight of distance while working in Barrie, Ontario—a regional cancer centre that offers care to many, yet lies far from the hearts of the communities it serves. In quiet exam rooms and crowded waiting areas, it became clear: for rural patients, the journey doesn't begin with treatment. It begins with a map.

In rural Canada, geography is more than landscape—it is fate. Radiation therapy, with its daily demands over weeks, asks too much of those living too far away. The road becomes part of the illness: long, costly, and unforgiving. For some, it delays care. For others, it denies it. The choice isn't between treatment options—it's between treatment and everything else: work, family, stability. And too often, those choices are made in silence, unnoticed by a system that was never built to see the journey behind the appointment.

This is not just a local issue. The burden of cancer among rural Canadians is well-documented, marked by later-stage diagnoses, reduced access to guideline-concordant care, and elevated cancer-related mortality rates [1]. A population-based study found that breast cancer patients who lived farther from treatment facilities were significantly less likely to receive radiation therapy, even when clinically indicated—highlighting how geography can dictate not only access, but outcomes [2].

These disparities persist across other cancer types. Rural patients—particularly those from Indigenous or low-income backgrounds—experience higher rates of treatment nonadherence and poorer survival [3,4]. In many regions, radiotherapy remains concentrated in urban centres, leaving rural communities to navigate longer travel times, limited transportation infrastructure, and the emotional and financial toll that comes with them [5,6]. Some parts of the country have become what researchers call "radiotherapy deserts"—entire areas with virtually no access to essential services like palliative radiation [7].

But if we want to move beyond patchwork solutions, we must first ask: *why do radiation deserts exist in the first place*?

The answer lies not only in population density or economic feasibility, but in the deep-rooted prioritization of centralized, urban-based care delivery models—models shaped by funding

structures, workforce distribution, and historical underinvestment in rural infrastructure. Technology is rarely the limiting factor; policy and political will often are. A lack of rural representation in policy planning perpetuates a cycle where those most affected remain unheard. The health system, designed for efficiency in dense settings, struggles to flex for the dispersed. It's a system optimized for averages—not outliers.

These inequities aren't theoretical. They unfold every day in cancer centres across Canada, including the one where I volunteered. I saw patients arrive weary before treatment even began. I met caregivers running on little more than commitment and caffeine, catching moments of sleep in vinyl chairs. I listened as families described the juggling act of missed shifts, childcare, long drives, and financial stress. Even the most compassionate healthcare teams could only do so much within a system never built with rural realities in mind.

The social determinants of health shape every part of the cancer journey, yet they remain under-addressed in national cancer strategies. When we speak of equity in cancer care, we must ask: who are our systems built for—and who continues to be left behind?

There are tangible, well-studied solutions: expanding regional satellite cancer centres and deploying mobile oncology units can bring care closer to where patients live, substantially reducing the need for long-distance travel [8]. But to avoid repeating history, these must not be seen as isolated fixes. They must form part of a systemic redesign that explicitly addresses the root causes of access deserts: uneven distribution of healthcare workforce, fragmented federal-provincial coordination, and the invisibility of rural patients in urban-centric planning processes.

Travel and lodging reimbursement programs, such as the Ontario Northern Health Travel Grant, offer critical support but must be streamlined and made more accessible, especially for patients facing financial precarity or who cannot afford the delays of current reimbursement systems [9,10].

Additionally, flexible treatment models—such as hypofractionated radiation regimens that reduce the number of treatment sessions—can significantly lower the travel burden without compromising care [11,12,13]. Consolidated appointment scheduling and expanded virtual care options also hold promise, but only if rural patients have access to reliable broadband and the tools to participate [14,15].

Still, innovation without inclusion falls flat. Beyond infrastructure, there is a deeper call: to *listen*. To involve rural patients, providers, and community leaders in the co-design of cancer care systems. Because no policy written in a boardroom can truly capture the lived experience of a four-hour drive home after a round of radiation therapy.

Volunteering in Barrie taught me that compassion in cancer care must extend beyond the exam room. It must travel the same roads as the patient. It must recognize the miles walked before and after each appointment. And it must advocate for a system that meets people where they are—not just geographically, but emotionally and socially, too.

Though I'm early in my training, I know this much already: I want to practice medicine that honours the full weight of a patient's journey. Not just the clinical story, but the geography, the barriers, the strength it takes to show up. And I want to be part of building a system where proximity no longer determines access to care.

Because care should not live at the end of the road—it should rise to meet those still on it.

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