

Core competencies in palliative care: an EAPC White Paper on palliative care education – part 1

The European Association for Palliative Care (EAPC) outlines what core competencies health- and social care professionals involved in palliative care should possess, in a consensus White Paper prepared by **Claudia Gamondi, Philip Larkin and Sheila Payne**

This White Paper follows on from a number of documents previously published by the European Association for Palliative Care (EAPC) that have addressed the issue of education and training for palliative care health professionals. It is widely recognised that palliative care is applicable across a range of healthcare settings, from tertiary hospitals to primary care. All healthcare professionals and workers should be able to provide appropriate palliative care and thus need to be trained to provide the highest possible standards of care in order to meet the challenging needs of patients and families, irrespective of diagnosis. Certain aspects of education and training are, by necessity, discipline-specific. However, there are clearly elements of palliative care training and core competencies for practice that are relevant to all professional groups involved in palliative care. This EAPC White Paper presents expert opinion on global core competencies for professional practice, irrespective of discipline, and is intended as a resource for practitioners and educators alike.

Role of the EAPC in education and training development across Europe

The Council of Europe's *Recommendation Rec (2003) 24 of the Committee of Ministers to member states on the organisation of palliative care*¹ highlights the need for structured programmes of education incorporated into the training of all concerned healthcare professionals. It stresses the necessity for all health- and social care professionals and workers involved in palliative care to be trained appropriately for their tasks in a concrete, insightful and culturally sensitive way.

The EAPC recognises the inherent value of shared learning across disciplines and that roles and functions within the delivery of palliative care may vary considerably across the EU, relative to the extent of service development and diversity of roles. Roles attributed to one discipline may be carried out effectively by professionals from a different clinical background.

To support sustainable and appropriate education for palliative care practitioners across Europe, the EAPC has commissioned task forces on education for nurses and physicians, psychologists, physiotherapists, social workers, chaplains, occupational therapists and those who work with children.² Further information on the work of each of these groups is available on the EAPC's website (www.eapcnet.eu). As part of this work, curricula for medicine, nursing and psychologists working in the field of palliative care are already available. Task forces for other professions (such as social workers) are currently working on curricula for their specific disciplines at a European level.

Key issues for education and training

This White Paper acknowledges the strategic shift in palliative care practice as an approach to care and that patients with progressive disease other than cancer face common challenges in their illness.³ Although the focus may differ globally (for example, the chronic illnesses of an aging population in Europe versus the HIV/AIDS pandemic in Africa), this White Paper contends that general palliative care must provide care for all, regardless of age, underlying condition or stage of the illness.^{4,5} Commitment to the principles of palliative

care means the healthcare practitioner should be fully aware of the internal and external factors that can impact on the patient's experience of service delivery, and act accordingly to ensure seamless care delivery as far as possible.

To prepare practitioners academically, the EAPC advocates a three-tier framework to palliative care, according to which all healthcare professionals receive education on the principles and practices of palliative care within their initial training, and those whose work is mainly focused on palliative care move to a specialist level of knowledge.

In keeping with international trends, the three levels are described as:

- Palliative care approach – intended as a way to integrate palliative care methods and procedures in general settings of care (such as internal medicine, elderly care, and so on)
- General palliative care – intended for professionals frequently involved with palliative care patients or acting as a resource person for palliative care in their setting of care, but for whom palliative care is not the main focus of their clinical practice (for example, primary care practitioners, oncologists, geriatricians, nurse practitioners and clinical nurse specialists)
- Specialist palliative care – intended for professionals working solely in the field of palliative care and whose main activity is devoted to dealing with complex problems requiring specialised skills and competencies.

Some countries have taken these levels and adapted them to their local situation. In some cases, levels have been subdivided to reflect national roles and responsibilities in service delivery. A good example is that of Switzerland.

Table 1 details the three levels of education described above; in that table, 'undergraduate' refers to a student undertaking their primary education in any healthcare discipline. 'Postgraduate' refers to a student who is qualified in their primary healthcare discipline and is now undertaking formal education in palliative care, which may be at a specialist level or in a discipline where palliative care may be a focus of work (for example, oncology or gerontology).

Core competencies for health professional education

An important document that underpins this White Paper is the article by Frenk *et al*

Table 1. Agreed levels of education currently adopted by the EAPC to reflect the scope and focus of professionals involved in the delivery of palliative care

Palliative care approach

A way to integrate palliative care methods and procedures in settings not specialised in palliative care. Should be made available to general practitioners and staff in general hospitals, as well as to nursing services and nursing home staff. May be taught through undergraduate learning or through continuing professional development

General palliative care

Provided by primary care professionals and specialists treating patients with life-threatening diseases who have good basic palliative care skills and knowledge. Should be made available to professionals who are involved more frequently in palliative care, such as oncologists or geriatric specialists, but do not provide palliative care as the main focus of their work. Depending on discipline, may be taught at an undergraduate or postgraduate level or through continuing professional development

Specialist palliative care

Provided in services whose main activity is the provision of palliative care. These services generally care for patients with complex and difficult needs and therefore require a higher level of education, staff and other resources. Specialist palliative care is provided by specialised services for patients with complex problems not adequately covered by other treatment options. Usually taught at a postgraduate level and reinforced through continuing professional development

published in *The Lancet* in 2010 on transformative education for the 21st century.⁶ The authors report on the findings of a global independent commission on the need to redesign professional health education. It argues for education, which strengthens leadership and produces 'enlightened change agents'. It argues for institutional collaboration, shared learning and curricula design, and the need 'to align the curriculum as an instrument of learning to achieve requisite competencies as the educational goal'.

In this context, it has been judged useful to provide a consensus document reflecting the most important domains that are common across all professional groups. This White Paper proposes that these competencies are considered directly relevant to the delivery of high-quality clinical practice. Furthermore, they offer a framework for the development of palliative care education programmes and a common ground to present what is essential for robust palliative care education. However, although we suggest that core competencies may inform curriculum development, it is important that these competencies put forward by the EAPC are not seen merely as a tool for curriculum development per se. The importance of an open dialogue, which enables colleagues to learn from each other's perspective, is paramount to interdisciplinary teaching in palliative care.

The core competencies described in this White Paper are intended to be seen as

globally relevant to all who practice palliative care at the general level, irrespective of their discipline, and it may be helpful to read these competencies with reference to the *EAPC White Paper on standards and norms for hospice and palliative care in Europe*.^{4,5} They are deemed transferable across all care needed for people with life-limiting illnesses where palliative care may be appropriate, but are directed predominantly towards those who work in a generalist setting.⁷⁻⁹

Where used to inform curricula, the ten core competencies outlined in this consensus

document are essential to the development of any palliative care education programme.

A programme that excludes any of the competencies is unlikely to provide the required knowledge, skills and attributes

needed to understand and practice palliative care appropriately.

What competencies [...] are important for all practitioners, irrespective of their specific discipline?

Purpose of this White Paper

The purpose of this White Paper is to address the question: 'What competencies for clinical practice in palliative care are important for all practitioners, irrespective of their specific discipline?'

The White Paper aims:

- To provide guidance on the substantive competencies for all health- and social care professionals undertaking academic and/or clinical education in palliative care throughout Europe
- To describe core competencies specifically targeted towards practitioners offering a palliative care approach in their work and those working in general palliative care, in order to address the learning needs of the vast majority of healthcare professionals working with patients affected by life-threatening illness.

Given the somewhat confusing diversity in the way education levels are expressed in the EU curriculum documents that were reviewed (A, B, C or 1, 2, 3 or indeed sometimes both), any such alphabetical or numerical indicators have been omitted.

A resource for practitioners and educators

The White Paper will be a useful resource for:

- Professionals involved in palliative care teaching or training in European countries

- Stakeholders and decision-makers involved in medical or nursing education or in the training of other professionals involved in palliative care

- Professionals involved in the clinical field, particularly those with a responsibility for the continuing professional development of staff.

This White Paper is not intended to cover the competencies needed by specialists working in palliative care, or those confronted with complex palliative care situations that may need specialist advice, consultation or referral. Nor does it address the specific competencies needed by volunteers or family carers, which may be directed or managed by the healthcare professional.

In the first case, it is assumed that specialist practitioners would continually demonstrate these competencies through practice derived from higher education and training. In the second case, volunteers are important in the delivery of palliative care, but hold different responsibilities and have different education needs than healthcare professionals. In many countries, their role is not yet developed, and also their work is widely variable between different countries. It may be that, where volunteer roles and training exist, these competencies could be adapted to meet their needs. In relation to family carers, it would seem inappropriate to assess their competency to care in the ways defined in this White Paper, but it would be the responsibility of the healthcare professional to make a judgement on their ability to carry out care tasks under guidance and, where necessary, supervision.

Further, the competencies put forward in this White Paper are not intended to cover best practice guidelines of the individual professional disciplines (specified by national professional bodies) and they should be read and acted upon in accordance with the legal and clinical requirements of practice in each European country. The application of a palliative care philosophy to general clinical practice should be seen as integrative and supportive to existing patient care.

Applying a palliative care philosophy

The *EAPC White Paper on standards and norms for hospice and palliative care in Europe* identified core constituents that frame the application of palliative care principles and reflect the values underpinning best

Box 1. Core constituents of palliative care

- Autonomy
- Dignity
- Relationship between patient and healthcare professionals
- Quality of life
- Position towards life and death
- Communication
- Public education
- Multiprofessional approach
- Grief and bereavement

practice.^{4,5} Some of these constituents describe important skills, attitudes or professional approaches that need to be considered in the delivery of palliative care. These core constituents are usually delivered by an individual working in collaboration with other professions, applying their specific disciplinary understanding of the constituents to foster a better patient and family experience. These core constituents of palliative care are listed in Box 1 and frame the thinking behind the proposed core competencies in this White Paper. Understanding the importance of these concepts is essential to the successful application of the ten core competencies outlined here.

Understanding 'competence'

Competency is complex to define. Conceptually, there are two approaches to defining it: the first defines a competence as an ability to perform a task; the second describes the competences in terms of a wider concept, considering both a set of dimensions necessary to produce a performance and the performance itself. According to this second approach, a demonstrable and measurable set of attributes (knowledge, skills and behaviours) can be reasonably expected of a practitioner following a prescribed course of theoretical and clinical learning.¹⁰ Although there is a significant range of definitions of competency,¹¹ there are a number of key questions that need to be asked before competence is applied. Some of these key questions are listed in Box 2.

Given the variation in palliative care service provision across Europe and the need to provide a clear and meaningful definition of competence in this White Paper, we propose that the definition offered by Parry (see

Box 2. Key questions on competency in palliative care

- What is the current position of palliative care within the national health system?
- What is the capacity of the individual to achieve competency in palliative care?
- What resources are available to enable the individual to learn and practice skills?
- Are baseline standards available against which competency can be determined?

Box 3. Definition of competency¹²

'A competency is: a cluster of related knowledge, skills and attitudes that affects a major part of one's job (a role or responsibility), that correlates with performance on the job, that can be measured against well-accepted standards, and that can be improved via training and development'

Box 3)¹² may be the most cohesive and easily transferable across national settings. A fuller description of competency by Stoof *et al* points to the need for critical thinking, the ability to problem-solve and predict outcomes, to plan ahead and to use judgement and wisdom in devising the intervention and evaluation of care.¹¹ None of these are mutually exclusive and should be considered as interdependent in the development of the competency of an individual. The core question of those involved in training and education should be: 'What is my expectation of the learners following this education programme and how well equipped are they now to carry out the duties expected of them?'

Understanding core competency

Palliative care is, by the nature of its practice, collaborative. Patients affected by a life-threatening illness and their families present a variety of palliative care needs. Collaborative practice between professions is an established standard of care for meeting those needs. This is clearly demonstrated by the WHO definition of palliative care, which is commonly accepted as the gold standard across Europe.³ The weaving and blending of the specific skills offered by distinct professional groups has been shown to provide better outcomes for patients and their families in receipt of palliative care services.¹ How these multidisciplinary teams have evolved in

different European countries reflects the diversity in the levels of development of palliative care. The UK model of a large interdisciplinary team of practitioners (physician, nurse, social worker, psychologist, chaplain, physiotherapist, occupational therapist, complementary and supportive therapist) may be inspirational, but certainly not essential to the delivery of good palliative care. In some countries, roles adopted by one discipline may be the remit of another; for example, the emotional support provided by psychologists in one country may be provided by social workers in another, depending on their training and role functions. At the core of good collaborative practice is the ability to understand and respect boundaries of practice, to know when and how to refer for expert advice and intervention where necessary, and to ensure a meaningful communication flow of relevant information through the team, in order to provide quality care for the patient and family. One of the challenges of collaborative work is to share a common philosophy of care and common goals.

Describing core competencies

The *EAPC Atlas of Palliative Care in Europe* showed a wide variety of palliative care development in the different European countries, which were due, at least in part, to varying interpretations of underlying concepts.² Following this, the *EAPC White Paper on standards and norms for hospice and palliative care in Europe* provided a consensus on basic terminology and standards in palliative care delivery.^{4,5}

Similarly, for education in palliative care, it is argued that different models are used in different countries, reflecting different levels of recognition of palliative care as a distinct clinical practice. The core competencies outlined in this White Paper should be considered as a means to share a common language for palliative care practice and education in Europe. In respecting boundaries, roles and responsibilities for specific disciplines, it is acknowledged that there are some aspects of competence in practice that transcend disciplines and would be expected of any practitioner working in the field of palliative care, irrespective of their professional field and role.

Having a set of core competencies has the potential to strengthen the impact of palliative

Box 4. The ten core competencies in palliative care

- | | |
|--|--|
| 1. Apply the core constituents of palliative care in the setting where patients and families are based | 7. Respond to the challenges of clinical and ethical decision-making in palliative care |
| 2. Enhance physical comfort throughout patients' disease trajectories | 8. Practise comprehensive care co-ordination and interdisciplinary teamwork across all settings where palliative care is offered |
| 3. Meet patients' psychological needs | 9. Develop interpersonal and communication skills appropriate to palliative care |
| 4. Meet patients' social needs | 10. Practise self-awareness and undergo continuing professional development |
| 5. Meet patients' spiritual needs | |
| 6. Respond to the needs of family carers in relation to short-, medium- and long-term patient care goals | |

care, to the extent that it presents a framework that separates it from other allied areas of clinical care – such as oncology, gerontology, neurology or internal medicine. This does not mean that the core competencies that we suggest in this White Paper do not have any resonance in other clinical fields, but rather that a practitioner in the field of palliative care must be able to demonstrate them.

Development of the EAPC core competencies in palliative care

The process of developing these core competencies was initially undertaken by the authors of this White Paper.

In Step 1, existing curricula (both those currently offered by the EAPC and those available or being used in EU member states) were reviewed, collated and compared for similarities and differences in terms of language transcending the role and function of a specific profession. For example, item 2 of the proposed competencies ('Enhance physical comfort during the patient's journey') was taken from a current set of professional competencies being developed in Ireland; it was considered more reflective of a global approach by a number of professional groups to patient care than 'symptom management in palliative care', which would clearly be meaningful for physicians and nurses but possibly less for other professions. These items then formed the basis of the core interdisciplinary competencies proposed.

In Step 2, the draft competencies were sent to an interdisciplinary group of experts from both academic and clinical backgrounds who were asked to review, comment on and revise

them. A revised draft was then submitted to the EAPC Board of Directors for final approval.

Although the order of competencies as listed in this White Paper is not intended to be chronological, it is agreed that an understanding of the core principles of palliative care should act as the foundation upon which other competencies may be developed; it is, therefore, presented first.

Ten core competencies in palliative care

Box 4 lists the ten EAPC interdisciplinary core competencies in palliative care, which are numbered from one to ten. These core competencies will be described in detail in part 2 of this article, in the next issue of the *European Journal of Palliative Care*.

Declaration of interest

The authors declare that there is no conflict of interest.

Acknowledgements

The authors would like to thank the experts who invested time and effort to review this White Paper: Inger Benkel, Karl Bitschnau, Marilène Filbet, Mai-Britt Guldin, Christine Ingleton, Saskia Jünger, Don Tullio Proserpio, Lukas Radbruch and Esther Schmidlin. The authors would also like to thank the Board of Directors of the European Association for Palliative Care for its participation in the review of the document.

References

1. Council of Europe. *Recommendation Rec (2003) 24 of the Committee of Ministers to member states on the organisation of palliative care*. [www.coe.int/t/dg3/health/Source/Rec\(2003\)24_en.pdf](http://www.coe.int/t/dg3/health/Source/Rec(2003)24_en.pdf) (last accessed 12/12/2012)
2. Centeno C, Clark D, Lynch T et al. *EAPC Atlas of Palliative Care in Europe*. Houston: IAPC Press, 2007.
3. World Health Organization. WHO Definition of Palliative Care. www.who.int/cancer/palliative/definition/en/ (last accessed 12/12/2012)
4. Radbruch L, Payne S, Bercovitch M et al. White Paper on standards and norms for hospice and palliative care in Europe: part 1. *European Journal of Palliative Care* 2009; **16**: 278–289.
5. Radbruch L, Payne S, Bercovitch M et al. White Paper on standards and norms for hospice and palliative care in Europe: part 2. *European Journal of Palliative Care* 2010; **17**: 22–23.
6. Frenk J, Chen L, Bhutta ZA et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. *Lancet* 2010; **376**: 1923–1958.
7. Higginson IJ. Health care needs assessment: palliative and terminal care. In: Stevens A, Raftery J (eds). *Health Care Needs Assessment 2nd Series*. Oxford: Radcliffe Medical Press, 1997.
8. Janssen DJ, Spruit MA, Wouters EF, Schols JM. Daily symptom burden in end-stage chronic organ failure: a systematic review. *Palliat Med* 2008; **22**: 938–948.
9. Murray SA, Kendall M, Boyd K, Sheikh A. Illness trajectories and palliative care. *BMJ* 2005; **330**: 1007–1011.
10. Whitty G, Whilmott E. Competence-based teacher education: Approaches and issues. *Cambridge Journal of Education* 1991; **21**: 309–320.
11. Stoof A, Martens RL, van Merriënboer JG, Bastiaens TJ. The boundary approach of competence: a constructivist aid for understanding and using the concept of competence. *Human Resource Development Review* 2002; **1**: 345–365.
12. Parry SB. The quest for competences: competency studies can help you make HR decision, but the results are only as good as the study. *Training* 1996; **33**: 48–56.

Claudia Gamondi, Palliative Care Physician, Palliative Care Department, Oncology Institute of Southern Switzerland, Ticino, Switzerland; Philip Larkin, Professor of Clinical Nursing (Palliative Care), School of Nursing, Midwifery and Health Systems, University College Dublin and Our Lady's Hospice and Care Services, Harold's Cross, Dublin, Ireland; Sheila Payne, Professor and Director, International Observatory on End of Life Care, Lancaster University, UK

Core competencies in palliative care: an EAPC White Paper on palliative care education – part 2

In the second part of this consensus White Paper issued by the European Association for Palliative Care (EAPC), **Claudia Gamondi, Philip Larkin** and **Sheila Payne** describe in more detail the ten core interdisciplinary competencies in palliative care

This article follows on from part 1 published in the previous issue of the *European Journal of Palliative Care* and looks at the ten core interdisciplinary competencies in palliative care in more detail. For each competency, a short description of its rationale and focus is followed by a list of its constituents. Each constituent may be relevant to more than one competency, but, for clarity, it has been placed where its impact is likely to be the most evident.

The ten core competencies

1. Apply the core constituents of palliative care in the setting where patients and families are based

Palliative care should be delivered in the place of the patient/family's choice, adapting to that environment as necessary. When this is not possible, advice should be given on alternative options. Most palliative care can be dispensed in generalist/non-specialist settings. Adaptation is key to the successful integration of palliative care principles, but it should be the palliative care professionals who adapt, rather than patients and families making significant changes to their life circumstances.

Palliative care professionals should be able to:

- 1a: Understand the meaning of life-limiting and life-threatening illness
- 1b: Apply the principles of palliative care, which affirm life and offer a support system to help patients live as actively as possible until death, focusing on quality of life and help for families during illness
- 1c: Understand the significance of the physical, psychological, social and spiritual issues that affect people with life-limiting conditions and their families

- 1d: Recognise the values, beliefs and culture of patients and families
- 1e: Demonstrate the ability to incorporate the palliative care approach as early as is appropriate
- 1f: Recognise patients' and families' needs for appropriate comprehensive care in the dying phase and provide such care.

2. Enhance physical comfort throughout patients' disease trajectories

Physical comfort represents an essential component of quality of life for people with a life-limiting illness and their families. A tailored plan of care should include anticipation, assessment, treatment and re-evaluation of the physical symptom burden all along the disease trajectory.

Palliative care professionals should be able to:

- 2a: Demonstrate a clinical practice that promotes the prevention of suffering, whatever their level of experience is
- 2b: Demonstrate the ability to actively support patients' well-being, quality of life and dignity
- 2c: Implement the assessment of physical symptoms and well-being into routine clinical work
- 2d: Anticipate potential complications, which may exacerbate suffering, and prepare a responsive care plan
- 2e: Offer excellence in end-of-life care regardless of the setting.

3. Meet patients' psychological needs

All palliative care professionals need to have an understanding of patients' psychological needs and should be able to offer a supportive intervention according to their discipline and

skills. Good psychological care requires sound case assessment skills, sensitive questioning skills and clinical discernment (for example, if a patient requires referral to psychological services). It is recognised that not all patients and families require a formal counselling intervention. Good communication skills are essential to meet patients' psychological needs. The ability to know when to refer and to whom is essential.

Palliative care professionals should be able to:

- 3a: Acknowledge patients' emotions and support them sensitively
- 3b: Foster patients' coping mechanisms
- 3c: Provide a diagnosis, care plan and, when appropriate, an intervention applied systematically and skillfully, with ongoing evaluation of patients' psychological and psychiatric symptoms, considering their prognosis, personal wishes and the environment in which they live.

4. Meet patients' social needs

A life-limiting illness impacts on the interpersonal relationships of patients and families, who need additional resources (both internal and external) to be able to maintain good quality of life. Patients' concerns over relationships, finances, housing and personal affairs can challenge the practitioner to provide optimum care in the clinical setting. Again, understanding when and how to refer patients for specialist help is key.

Palliative care professionals should be able to:

- 4a: Appreciate the social context of patients and families and its impact on their experience of receiving palliative care
- 4b: Provide patients with information about available benefits and entitlements from health- and social care
- 4c: Enable patients to manage personal affairs as necessary.

5. Meet patients' spiritual needs

Life-limiting illness can provoke questions about deeper existential issues, such as the meaning of life. Spiritual care should be integral to palliative care provision. Spiritual needs may or may not be addressed through a religious practice. Being able to raise spiritual issues in a supportive and caring environment may help patients, and a willing healthcare professional can provide them with the opportunity to do so. Healthcare professionals should have the confidence to discuss

spiritual issues with patients and families if desired. Referral to an appropriate spiritual advisor may also benefit patients and families.

Palliative care professionals should be able to:

- 5a: Demonstrate the reflective capacity to consider the importance of spiritual and existential dimensions in their own lives
- 5b: Integrate the patients' and families' spiritual, existential and religious needs in the care plan, respecting their choice not to focus on this aspect of care if they so wish
- 5c: Provide opportunities for patients and families to express the spiritual and/or existential dimensions of their lives in a supportive and respectful manner
- 5d: Be conscious of the boundaries that may need to be respected in terms of cultural taboos, values and choices.

6. Respond to the needs of family carers in relation to short-, medium- and long-term patient care goals

Patient care should incorporate family carers, taking into account their local environment, healthcare system and, of course, their relationships with healthcare professionals who are now part of their lives. Family carers are often the providers of care and the link between patients and professionals. It is essential that their role is supported and enhanced wherever possible, and that the challenges and potential conflicts of caring are acknowledged and addressed appropriately, including referral for specialist guidance as needed. This support should extend into the early bereavement phase. Professionals' ability to seek expert advice is essential.

Palliative care professionals should be able to:

- 6a: Recognise and support family carers in their tasks as care-givers, identifying those who may be at risk of experiencing undue distress or burden
- 6b: Acknowledge family carers' decisions in relation to paid employment and the implications of relinquishing such roles
- 6c: Recognise other roles of, and demands on, family carers (who may, for example, also care for children or other people)
- 6d: Offer to family carers psychological and emotional support separate from that offered to patients, where necessary
- 6e: Foster family carers' ability to interact with different healthcare professionals

Understanding when and how to refer patients for specialist help is key

- 6f: Develop strategies within the care team to manage family conflicts
- 6g: Facilitate short-term bereavement counselling if considered appropriate
- 6h: Identify complex bereavement needs and refer as appropriate.

7. Respond to the challenges of clinical and ethical decision-making in palliative care

Palliative care professionals face challenging ethical and moral dilemmas, including questions around hydration and nutrition, sedation, physician-assisted suicide and/or euthanasia. Many of the skills needed to address these dilemmas are taught during

professional training and it is, therefore, the application of these skills in the palliative care context that is important. However, certain areas of practice (for example, the use of palliative sedation as proposed

by the EAPC¹) may require additional knowledge and training. It is deemed the responsibility of each practitioner to ensure that they hold the necessary competency to address the ethical challenges posed by current palliative care practices. Equally, all practitioners should have a thorough understanding of their own professional code of practice and how that relates to the delivery of palliative care. The EAPC has issued a range of position papers and consultation documents on these challenging issues, which provide guidance to professionals in the assessment of complex ethical situations.

Palliative care professionals should be able to:

- 7a: Act in respect of bioethical principles, national and international legal frameworks and patients' wishes and values
- 7b: Foster patients' autonomy, in balance with other ethical principles such as benevolence, non-maleficence and justice
- 7c: Support patients to express their preferences and wishes about their care and treatments during the disease trajectory
- 7d: Enable patients, families and carers to be part of the decision-making process
- 7e: Be aware that the most appropriate ethical care may not always coincide with patients' wishes and preferences.

8. Practise comprehensive care co-ordination and interdisciplinary teamwork across all settings where palliative care is offered

To provide continuity of care between different clinical services and places of care, it is necessary to ensure that there is a clear pathway delineating the specific roles of team members and the responsibilities for the co-ordination of care, and acknowledging the actual and/or potential contributions of others to the care of patients and families. We recognise the important role that volunteers can play in the co-ordination of care. Interdisciplinary learning also contributes to a better understanding of responsibilities, roles and functions.

Palliative care professionals should be able to:

- 8a: Provide all necessary support during patients' transitions between care settings
- 8b: Foster interprofessional teamwork
- 8c: Be able to identify the responsibilities of the different team members in the planning and delivery of care to patients and families
- 8d: Strengthen, where feasible, the role of volunteers in the supportive care of patients and families
- 8e: Offer to patients and family carers the most appropriate model of care in relation to their current palliative care needs.

9. Develop interpersonal and communication skills appropriate to palliative care

Effective communication skills are essential to the application of palliative care principles and to the delivery of palliative care. They are particularly important when bad news need to be broken, when difficult decisions regarding treatment continuation or withdrawal need to be made, when circumstances are ambiguous or uncertain and when strong emotions and distress arise.

Palliative care professionals should be able to:

- 9a: Demonstrate ways of building a therapeutic relationship with patients and family carers
- 9b: Foster greater communication within the team and with other professional colleagues
- 9c: Choose appropriate methods of relating and interacting according to age, wishes and intellectual abilities, verifying the understanding of decisions taken
- 9d: Interpret the different types of communication (for example, verbal, non-verbal, formal and informal) of patients and family carers appropriately
- 9e: Use guidelines for breaking bad news, where available

Ways to strengthen resilience and prevent burnout should be identified

- 9f: Adapt language to the different phases of the illness, be sensitive to cultural issues and avoid the use of medical jargon
- 9g: Support people's informed decisions regarding the level of information they wish to receive and share with their family
- 9h: Pace the provision of information according to the preferences and cognitive abilities of patients and family carers.

10. Practise self-awareness and undergo continuing professional development

Continuing professional development, the requirements of which are usually defined by each professional discipline, should be an integral part of clinical practice. Opportunities to acquire further knowledge should be sought where available. Part of this learning should be about self-awareness (for example, knowing how to develop safe practice; understanding the limits of one's own skills and abilities; and knowing when referral is in patients' and families' best interest). The impact, on the healthcare professional, of caring for people with life-limiting illness should be acknowledged and ways to strengthen resilience and prevent burnout should be identified. This may be achieved through structured or informal peer supervision strategies.

Palliative care professionals should be able to:

- 10a: Engage in lifelong educational activities to maintain and develop their own professional competencies
- 10b: Practise self-awareness, being conscious of their personal strengths, frailties, and moral and spiritual beliefs
- 10c: Recognise early signs of burnout and seek appropriate help
- 10d: Act as a resource to others in the team
- 10e: Be aware of the needs of colleagues who are in distress but are unaware of the impact this can have on themselves and on those they care for.

Desired outcomes and behaviours

The overall outcome of implementing these ten core competencies should be a better experience for patients and families. In terms of behaviours, the aim is to see healthcare professionals grow in confidence so that they are able to anticipate palliative care needs, respond effectively, and understand their own limitations and the need to seek help. A future development of this work would be to ensure

that outcomes and behaviours clearly reflect the expectations of the regulatory bodies who govern the clinical practice of each discipline (medicine, nursing, social work, etc) in every European country.

How to provide interdisciplinary learning in palliative care

The core components of quality palliative care education have been addressed in various EAPC publications – which, so far, have always reflected the needs of specific disciplines. Many of these components can equally apply to any education programme designed to address interdisciplinary learning needs.

Although the evidence for, and evaluation of, interdisciplinary learning are relatively scarce,² and the development of interdisciplinary curricula challenging, the benefits in terms of role appreciation and knowledge acquisition are compelling. However, at generalist level, it is acknowledged that interdisciplinary learning may not be achievable, and that integrating palliative care principles into the core curricula of each specific discipline may be more advantageous. At specialist level, interdisciplinary learning has noted benefits and there are learning models that incorporate shared and discipline-specific learning.^{3,4}

We think that the following elements, detailed in the five paragraphs below, should be part of any education programme that has shared learning content across professional groups – however this list is not exhaustive.

Using appropriate adult-learning teaching methods and concepts, including single, discipline-specific learning where necessary

All professionals should learn the principles of good communication. Similarly, they should all learn the principles of good symptom management. However, physicians and nurses may require further in-depth training in the latter.⁵⁻⁷ Social workers and psychologists may require advanced skills to respond to the specific needs of family carers.⁸

Using an interdisciplinary team of educators, comprising both clinicians and academics, to dispense the education programme

An education programme dispensed by healthcare professionals from different backgrounds is more likely to teach students the core skills needed in the delivery of care,

such as negotiation, clarification, precision, context-setting and evaluation skills. Using real casework from clinical practice and involving practitioners in the planning, delivery and evaluation of the academic programme strengthens its intrinsic value. Teaching palliative care is as much about getting students to reflect on their personal attitudes, beliefs and behaviours as about enhancing their skills and knowledge.^{9,10}

Consider the possibilities that modern learning technologies offer

It is advisable that continuing education should be based on different learning modalities.¹¹ There is evidence that using digital learning tools – for example, videoconferences – can enhance the understanding of palliative care theory and its application to practice.^{12–14} E-learning enables students to learn at their own pace and use an array of resources that would not be available to them in the classroom setting.¹⁵

However, in palliative care education, online learning does not meet students' needs for practical training, particularly training in the skills required for sensitive communication and interprofessional interaction. Further, the EAPC acknowledges that access to e-learning may vary considerably across Europe. In order to support the development of palliative care education, we would encourage shared learning opportunities across countries.

A mixed learning approach, where certain aspects of the programme are taught in the classroom, may be the best solution. This also supports a camaraderie that can be beneficial to students, who learn about the world views of fellow students from different professional backgrounds. Whether outside the classroom or beside the online programme, informal discussion between students can be fruitful in terms of learning.

Encourage clinical placements

The importance of being able to link theory to practice is essential in all clinical learning programmes.¹⁶ Students need the opportunity to refine and hone skills learnt in theory in a safe and supportive learning environment, which encourages self-reflection and critical thinking. Clinical placements offer the student time to experience practices that are different from their own. In some cases, if students are required to undergo a

competency-based assessment and facilities are not available in their own work setting, the assessment can be carried out while the student is working in an environment conducive to good practice.

Palliative care can be taught and learnt in a number of settings, including accident and emergency departments and intensive care units. With appropriate support, a placement in a non-palliative care setting may be of equal benefit to a placement in a specialist palliative care setting. Learning from other settings is a valuable way of determining the quality of one's own work and spotting opportunities for service improvement at a local level.

Provide a proper evaluation of the quality of the education programme

It is essential to offer evidence for the successful outcome of the education programme, not only for the funders, but also for the future marketing of the programme and its viability.¹⁷ It is important that the views of the different disciplines are represented in any evaluation and that, if core concerns are identified, these are addressed in the planning for the next programme. Key to the evaluation, however, is the extent to which interdisciplinary learning has benefited students and how they will be able to translate it into practice in the future.

Conclusions

The ten core competencies presented in this White Paper are based on the key principles that working in partnership as a team, sharing discipline-specific skills with colleagues and having a willingness to learn from each other will improve the overall outcomes of palliative care for patients and families. The proposed competencies are intended to complement skills and attitudes the healthcare professionals have already acquired through clinical practice. In this way, it is hoped that they will be able to integrate their new competencies into daily practice.

As with any competency, the degree to which the ten palliative care competencies may be achieved depends as much on the professional's own view of how competent they are as on how they are perceived by others. Competencies should never be seen as a tool to judge practitioners, but rather as a benchmark that all should aspire to reach over time. Further, we reiterate the importance of

developing competencies appropriate to the level of palliative care service provision in each European country. Some aspects of a competency may initially be aspirational, and fully achievable only once palliative care services have developed. We nonetheless propose that the ten core competencies identified in this White Paper may assist in scoping the roles and responsibilities of palliative care teams as they strive to provide care within different healthcare systems.

Acknowledgements

The authors would like to thank the experts who invested time and effort to review this White Paper: Inger Benkel, Karl Bitschnau, Marilène Filbet, Mai-Britt Guldin, Christine Ingleton, Saskia Jünger, Don Tullio Proserpio, Lukas Radbruch and Esther Schmidlin. The authors would also like to thank the Board of Directors of the European Association for Palliative Care for its participation in the review of the document.

References

1. Cherny NI, Radbruch L. European Association for Palliative Care (EAPC) recommended framework for the use of sedation in palliative care. *Palliat Med* 2009; **23**: 581–593.
2. Singh H. Building effective blended learning programs. *Educational Technology* 2003; **43**: 51–54.
3. Taylor J, Swetenham K, Myhill K *et al*. IMhPaCT: an education strategy for cross-training palliative care and mental health clinicians. *Int J Palliat Nurs* 2012; **18**: 290–294.
4. Zwarenstein M, Goldman J, Reeves S. Interprofessional collaboration: effects of practice-based interventions on professional practice and healthcare outcomes. *Cochrane Database Syst Rev* 2009: CD000072.
5. Mason SR, Ellershaw JE. Preparing for palliative medicine: evaluation of an education programme for fourth year medical undergraduates. *Palliat Med* 2008; **22**: 687–692.
6. von Gunten CF, Mullan P, Nelesen RA *et al*. Development and evaluation of a palliative medicine curriculum for third-year medical students. *J Palliat Med* 2012; **15**: 1198–1217.
7. Wee B, Hillier R, Coles C *et al*. Palliative care: a suitable setting for undergraduate interprofessional education. *Palliat Med* 2001; **15**: 487–492.
8. Bosma H, Johnston M, Cadell S *et al*. Creating social work competencies for practice in hospice palliative care. *Palliat Med* 2010; **24**: 79–87.
9. Jünger S, Payne S. Guidance on postgraduate education for psychologists involved in palliative care. *European Journal of Palliative Care* 2011; **18**: 238–252.
10. Kizawa Y, Tsuneto S, Tamba K *et al*. Development of a nationwide consensus syllabus of palliative medicine for undergraduate medical education in Japan: a modified Delphi method. *Palliat Med* 2012; **26**: 744–752.
11. Centeno C, Clark D, Lynch T *et al*. *EAPC Atlas of palliative care in Europe*. Houston: IAPC Press, 2007.
12. McConigley R, Aoun S, Kristjanson L *et al*. Implementation and evaluation of an education program to guide palliative care for people with motor neurone disease. *Palliat Med* 2012; **26**: 994–1000.
13. Pulsford D, Jackson G, O'Brien T, Yates S, Duxbury J. Classroom-based and distance learning education and training courses in end-of-life care for health and social care staff: A systematic review. *Palliat Med* 2013; **27**: 221–235.
14. van Boxell P, Anderson K, Regnard C. The effectiveness of palliative care education delivered by videoconferencing compared with face-to-face delivery. *Palliat Med* 2003; **17**: 344–358.
15. Ellman MS, Schulman-Green D, Blatt L *et al*. Using online learning and interactive simulation to teach spiritual and cultural aspects of palliative care to interprofessional students. *J Palliat Med* 2012; **15**: 1240–1247.
16. Dando N, d'Avray L, Colman J, Hoy A, Todd J. Evaluation of an interprofessional practice placement in a UK in-patient palliative care unit. *Palliat Med* 2012; **26**: 178–184.
17. Haugen DF, Vejlgård T. The Nordic Specialist Course in Palliative Medicine: evaluation and experiences from the first course 2003–2005. *Palliat Med* 2008; **22**: 256–263.

Claudia Gamondi, Palliative Care Physician, Palliative Care Department, Oncology Institute of Southern Switzerland, Ticino, Switzerland; Philip Larkin, Professor of Clinical Nursing (Palliative Care), School of Nursing, Midwifery and Health Systems, University College Dublin and Our Lady's Hospice and Care Services, Harold's Cross, Dublin, Ireland; Sheila Payne, Professor and Director, International Observatory on End of Life Care, Lancaster University, UK