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ORIGINAL PAPER

The three main competencies of every healthcare professional within palliative care – a descriptive study

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Abstract

Aim: The aim of this study was to describe the three main competencies that every healthcare professional working within palliative care should have, according to the perspective of another professional body working within palliative care. *Design:* A descriptive qualitative study. *Methods:* The data were collected from physicians, registered nurses, licensed practical nurses and professional stakeholders by means of an electronic survey in 2018. The data were analyzed using content analysis. *Results:* The three most important competencies of every healthcare professional working within palliative care were considered to be advance care planning; symptom management; and communication and psychosocial support for patients and their significant others. Advance care planning and symptom management were the main competencies expected from physicians. Symptom management and communication, psychosocial and existential support for patients and their significant others were the main competencies expected from nurses and practical nurses. *Conclusion:* The findings can be utilized in the education of palliative nursing and medicine to ensure a palliative approach and symptom management in an adequate time frame as well as communication and psychosocial and existential support. The findings offer clues for understanding the roles of the multi-professional team and for competence development through multi-professional continuing education within palliative care.

Keywords: healthcare professionals, palliative care, palliative medicine, palliative nursing, professional competence, qualitative research.

Introduction

Palliative care aims to improve the quality of life of patients and their significant others who face life-threatening illness. The care is provided through an active and holistic approach aiming to prevent and relieve physical, psychosocial and existential suffering (World Health Organization [WHO], 2020). Palliative care can last for a long time, even years. End-of-life care is part of palliative care and is timed to the immediate proximity of the supposed moment of death, i.e., to the last days or weeks (Radbruch & Payne, 2009).

Palliative care is a human right that should be available to everyone (Council of Europe, 2018). Therefore, palliative care should be integrated into the social welfare and healthcare system and thus, the development of the structures and processes on patients' paths are important to ensure equal access to palliative care, regardless of where patients live. Globally, there is, however, a need for a substantial expenditure to make palliative care available to everyone (Callaway et al., 2018; Connor, 2021). In the near future, the need for palliative care will increase worldwide due to the ageing population, increase in chronic diseases and cancer, and the likelihood of new infectious disease eruptions (Connor, 2021). Moreover, as a consequence of a needs-based shortage of healthcare professionals, there is also a deficit in palliative care educated personnel (Olsson et al., 2021; Saarto & Finne-Soveri, 2019; WHO, 2016). Therefore, the development of a structure of services alone is not enough, since there is a need to systematically develop the practice and education of palliative care to strengthen the competence of healthcare professionals within palliative care (Martins Pereira et al., 2021; Smets et al., 2018).

Previous studies have focused on the required palliative competencies of physicians (Mäenpää

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et al., 2021; Melender et al., 2020), registered nurses (Hökkä et al., 2020, 2021; Vihelä et al., 2020) and licensed practical nurses (Vattula et al., 2020) working within palliative care. Palliative patient care is carried out by a multi-professional team comprising physicians, registered nurses, licensed practical nurses and other members of social welfare and healthcare professionals. Therefore, recommendations for those working in diverse healthcare settings have included the competence requirements of each social welfare and healthcare professional group and core interdisciplinary competences, including continuing education opportunities within palliative care. The competence requirements within palliative care are broadly similar, but they are linked to the professional roles and responsibilities of each professional group member as well as the competence required at different levels of palliative care provision (Gamondi et al., 2013a, 2013b; Ryan et al., 2014).

Ensuring competence through palliative care education, together with the development of palliative care structures, are prerequisites that can enable equal and timely palliative care, regardless of the stage of the disease process (Hökkä et al., 2020; Melender et al., 2020) or the location of the patient's residence (Saarto, 2017; Saarto & Finne-Soveri, 2019). Moreover, a holistic approach and optimal quality in palliative care necessitate multidisciplinary expertise (Connor, 2021; Ryan et al., 2014; Salin et al., 2021). Effective collaboration with other members of a multidisciplinary team requires that each knows what competencies and responsibilities other team members have from the perspective of their professional role and responsibilities. Therefore, it is important to deepen the knowledge of other professions' expectations of the competencies of multidisciplinary team members, and to determine which of these competencies are seen as most important in providing person-centered and integrated palliative care.

Aim

This study aims to describe the three main competencies that every healthcare professional working within palliative care should have, according to the perspective of another professional body also working within palliative care. More specifically, the research questions were:

1) What are the three main palliative care competences required of every physician as perceived by registered nurses, licensed practical nurses and stakeholders?
2) What are the three main required palliative care competences of every registered nurse as perceived by physicians, licensed practical nurses and stakeholders?
3) What are the three main palliative care competences required of every licensed practical nurse, as perceived by physicians, registered nurses and stakeholders?

Methods

Design

A qualitative-based cross-sectional design was used in this study. The guidelines of the Standards for Reporting Qualitative Research (SRQR) were used in reporting this study (O'Brien et al., 2014).

Sample

This study was part of the EduPal (Developing Palliative Nursing and Medical Education through Multidisciplinary Cooperation and Working-life Collaboration) – project funded by the Ministry of Education and Culture. The study focused on physicians, registered nurses, and licensed practical nurses working at basic (A), special (B) or demanding special (C) levels of palliative care. The basic level (A) includes all social welfare and healthcare units in which end-of life care is provided for patients. At the basic level (A), one of the principal functions is to provide end-of-life care. Each hospital district with specially trained personnel provides special level (B) palliative and end-of-life care. At level C, palliative centers in university hospitals are specialized in palliative care, have an advanced level of educated professionals and offer only demanding palliative care (Saarto & Finne-Soveri, 2019). In addition, the survey stakeholder representatives from professional associations and patient organizations participated in the study.

Of the 272 participants, 64 were physicians, 131 were registered nurses, 55 were licensed practical nurses and 22 were stakeholder representatives. The age of the participants ranged between 19 and 66 years. The majority of physicians (92%), registered nurses (95%) and licensed practical nurses (98%) were female. All the physicians had completed their medical education before 2010, 69% of registered nurses and 62% of licensed practical nurses had completed their education before 2010. Representatives of the stakeholders were mostly from professional associations or patient organizations (84%) from the nursing district or other health organizations (16%).

Data collection

The data were collected between September and November 2018 from a convenience sample of physicians, registered nurses, licensed practical nurses and stakeholders using an electronic survey. The survey was designed on the basis of multi-disciplinary experts within palliative medicine (n = 2) and nursing (n = 1) and the European Association for Palliative Care (EAPC) recommendations of palliative care (De Vlieger et al., 2004; Elsner et al., 2013). An expert panel of palliative care nursing (n = 4) and palliative medicine (n = 3) professionals reviewed the survey. This is an independent study focusing on one open-ended question of the large data collected in the EduPal-project.

The recruitment of physicians (n = 149) and data collection, with two reminders to complete the survey, were organized via email with a contact person working within palliative medicine. The register of The Finnish Medical Association was used to obtain the email addresses of physicians with special competence within palliative medicine. The contact person of palliative nursing collaborated with the stakeholders of healthcare organizations (n = 150) to identify registered nurses and licensed practical nurses who worked at the basic (A), special (B) and demanding special (C) levels of palliative care. They were asked to forward the invitation letter and survey to the participants. Moreover, the stakeholders were invited to the study by sharing the survey link on the EduPal – project website and the project's Facebook page.

Data analysis

The analysis included the responses of participants to the question in which physicians had been asked to describe the three main competences of a registered nurse and licensed practical nurse in palliative care. Similarly, registered nurses had been asked to describe the three main competences of physicians and licensed practical nurses, while licensed practical nurses had been asked to describe the three main competences of physicians and registered nurses. Stakeholder representatives' answers were analyzed for their views of the three main competences of physicians, registered nurses and licensed practical nurses.

For analysis, the data was transferred from an Excel file to a Word file of 37 pages in total (Times New Roman font 12, line spacing 1). The data was analyzed by content analysis guided by the research question (Kyngäs, 2020; Vaismoradi et al., 2013). The first and second authors were responsible for the preliminary analysis. They read the material and conducted analysis independently, which was then refined and confirmed with all authors. Analysis of the data progressed from identifying open codes, combining open codes indicating the same content into subcategories, and then combining related subcategories into categories (Elo & Kyngäs, 2008) (Table 1). In addition, the presence of open codes in subcategories and categories was quantified (Kyngäs, 2020; Vaismoradi et al., 2013).

Table 1 Example of the analysis process, competence in communication, psychosocial and existential support of the patients and their significant others

Examples of open codes	Subcategory	Category
Empathy	communication with the patient and significant others	communication, psychosocial and existential support
Skill to encounter the patient		
Skill to encounter significant others		
Skill to discuss with the patient		
Skill to discuss with significant others		
Skill to listen to the patient		
Skill to listen to significant others		
Skill to provide psychological support to the patient	psychosocial support of the patient and significant others	
Skill to provide psychosocial support to the patient		
Skill to support significant others		
Skill to discuss about death and dying with the patient	existential support of the patient and significant others	
Skill to discuss about death and dying with significant others		

Results

The description of the competencies of every healthcare professional fell into five categories: competence in advance care planning; symptom management; communication and psychosocial support for the patient and significant others; multi-professional collaboration; and ethical and legal issues. The categories and subcategories are presented in Tables 2–4.

The three main required competences of every physician

The three main palliative care competences of every physician were advance care planning, symptom management, and communication and psychosocial

support for patients and significant others: *"Good symptom management, ability to provide advance care planning on end-of-life care, psychosocial competence"* (Registered nurse 3). *"Pain relief, taking into account the patient's wishes and will, listening and supporting significant others"* (Licensed practical nurse 16). *"Assessment of palliative and end-of-life care requires decision making. Principles for limitations of care in palliative and end-of life care"* (Stakeholder representative 21). Moreover, stakeholder representatives highlighted that every physician should have a holistic approach to patient care, especially competence to assess and manage physical, psychosocial and existential suffering: *"A holistic approach to care: taking into account physical, psychological, social and existential needs"* (Stakeholder representative 21).

Registered nurses and stakeholder representatives emphasized that advance care planning is the most important competence of every physician. Licensed practical nurses, for their part, highlighted communication and psychosocial support for patients and their significant others as being the most important competence of every physician (Table 2).

Table 2 Main competencies of palliative care of physicians as perceived by registered nurses, licensed practical nurses and stakeholder representatives

Physician competence – categories and subcategories		
Registered nurses (n = 131, 407 original expressions)	**Licensed practical nurses (n = 55, 187 original expressions)**	**Stakeholder representatives (n = 22, 129 original expressions)**
Advance care planning, f = 139 care approaches made in advance, f = 109 goals of care and treatments, f = 16 palliative care needs assessment, f = 14	**Communication and psychosocial support, f = 75** psychosocial support, f = 31 communication with the patient and significant others, f = 22 encountering the patient and significant others, f = 20	**Advance care planning, f = 55** care approaches made in advance f = 27 palliative care needs assessment, f = 19 basic principles of palliative care for children, f = 9
Symptom management, f = 132 pain management, f = 75 management of other symptoms, f = 41 medication, f = 16	**Symptom management, f = 63** pain management, f = 54 management of other symptoms, f = 9	**Communication, psychosocial and existential support, f = 30** psychosocial support, f = 18 communication with the patient and significant others, f = 5 encountering the patient and significant others, f = 5 recognizing existential suffering, f = 2
Communication and psychosocial support, f = 92 communication with the patient and significant others, f = 56 encountering the patient and significant others, f = 22 psychosocial support, f = 9 psychological support, f = 5	**Advance care planning, f = 31** care approaches made in advance, f = 28 palliative care needs assessment, f = 3	**Symptom management, f = 25** management of other symptoms, f = 13 pain management, f = 9 medication f = 3
Multiprofessional collaboration, f = 38 ability to work in a multiprofessional team, f = 23 consulting skills, f = 15	**Multiprofessional collaboration, f = 11** ability to work in a multiprofessional team, f = 10 consulting skills, f = 1	**Multiprofessional collaboration, f = 15** consulting skills, f = 9 ability to work in a multiprofessional team, f = 6
Ethical and legal issues, f = 6 ethical behavior f = 4 dignity for patients, f = 2	**Ethical and legal issues, f = 7** dignity for patients, f = 6 ethical behavior, f = 1	**Ethical and legal issues, f = 4** dignity for patients, f = 2 ethical behavior, f = 2

f – frequencies

The three main required competences of every registered nurse

The three main competences of every nurse in palliative care as perceived by physicians were symptom management, communication and psychosocial support for patients and their significant others, and advance care planning: *"Realizing fully what palliative and end-of-life care means, supporting patients in discussion related to advance care planning, effective symptom management, encountering patients and significant others, listening and being alongside the patients"* (Physician 22). Communication and psychosocial support for patients and significant others, also including alleviating existential suffering, was the main competence of registered nurses as perceived by licensed practical nurses, followed by competence in symptom management: *"I would emphasize*

existential questions, pain management and interaction" (Licensed practical nurse 33). Stakeholder representatives, for their part, highlighted the competence of registered nurses in advance care planning, and communication and psychosocial support for patients and their significant others. Besides licensed practical nurses, stakeholder representatives regarded multi-professional collaboration as a third important competence for every registered nurse working within palliative care: *"It is also necessary to psychologically support significant others, if necessary, in cooperation with the professionals of social services"* (Stakeholder representative 5) (Table 3).

The three main required competences of licensed practical nurses

Communication and psychosocial support for patients and their significant others followed by symptom management and advance care planning were regarded as the main competencies of licensed practical nurses as perceived by the physicians. Among the registered nurses, symptom management was mentioned most often as a key competence of licensed practical nurses: *"A licensed practical nurse should recognize the most common symptoms and know how to treat them"* (Registered nurse 83).

Stakeholder representatives, for their part, considered advance care planning as the main competence of every licensed practical nurse. Besides symptom management and advance care planning, also registered nurses and stakeholder representatives perceived communication and psychosocial support for patients and their significant others as important competencies of licensed practical nurses: *"Non-verbal communication, presence and conversation skills"* (Nurse 117). *"Encounters the patient and significant others with dignity, takes into account individual situations, and creates a positive interaction atmosphere"* (Stakeholder presentative 17) (Table 4).

Table 3 Main competencies of palliative care of registered nurses as perceived by physicians, licensed practical nurses and stakeholder representatives

Registered nurse competence – categories and subcategories		
Physicians (n = 64, 246 original expressions)	**Licensed practical nurses (n = 55, 147 original expressions)**	**Stakeholder representatives (n = 22, 114 original expressions)**
Symptom management, f = 108	**Communication, psychosocial and existential support, f = 55**	**Communication and psychosocial support, f = 40**
management of other symptoms, f = 63	encountering the patient and significant others, f = 29	encountering the patient and significant others, f = 12
pain management, f = 31	communication with the patient and significant others, f = 17	communication with the patient and significant others, f = 14
medication, f = 14	psychosocial support, n = 7	psychosocial support, f = 14
	relieving existential suffering, n = 2	
Communication and psychosocial support f = 78	**Symptom management, f = 45**	**Advance care planning, f = 32**
communication with the patient and significant others, f = 33	pain management, f = 30	basic knowledge and skills of palliative care, f = 17
encountering the patient and significant others, f = 28	medication, f = 10	provision of palliative nursing care, f = 11
psychosocial support, f = 17	management of other symptoms, f = 5	awareness of care approaches, f = 4
Advance care planning, f = 39	**Multiprofessional collaboration, f = 32**	**Multiprofessional collaboration, f = 22**
basic knowledge and skills of palliative care, f = 28	ability to work in a multiprofessional team, f = 28	ability to work in a multiprofessional team, f = 20
awareness of care approaches, f = 11	consulting skills, f = 4	consulting skills, f = 2
Multiprofessional collaboration, f = 21	**Advance care planning, f = 10**	**Symptom management, f = 18**
ability to work in a multiprofessional team, f = 17	awareness of care approaches, f = 6	management of other symptoms, fr = 12
consulting skills, f = 4	provision of palliative nursing care, f = 4	pain management, f = 3
		medication, f = 3
	Ethical and legal issues, f = 5	**Ethical and legal issues, f = 2**
	dignity for the patients, f = 5	ethical behavior, f = 2

f – frequencies

Table 4 Main competencies of palliative care of licensed practical nurses as perceived by physicians, registered nurses, and stakeholder representatives

Licensed practical nurse competence – categories and subcategories		
Physicians (n = 64, 196 original expressions)	**Registered nurses (n = 131, 410 original expressions)**	**Stakeholder representatives (n = 22, 65 original expressions)**
Communication and psychosocial support, f = 76 communication with the patient and significant others, f = 41 encountering the patient and significant others, f = 22 psychosocial support, f = 13	**Symptom management, f = 146** management of other symptoms, f = 80 pain management, f = 66	**Advance care planning, f = 22** provision of palliative nursing care, f = 12 basic knowledge and skills of palliative care, f = 6 awareness of care approaches, f = 2 palliative nursing care needs assessment, f = 2
Symptom management, f = 61 management of other symptoms, f = 47 pain management, f = 14	**Communication and psychosocial support, f = 128** communication with the patient and significant others, f = 65 encountering the patient and significant others, f = 33 psychosocial support, f = 30	**Communication and psychosocial support, f = 20** communication with the patient and significant others, f = 11 encountering the patient and significant others, f = 9
Advance care planning, f = 39 provision of palliative nursing care, f = 14 basic knowledge and skills of palliative care, f = 12 awareness of care approaches, f = 11 palliative nursing care needs assessment, f = 2	**Advance care planning, f = 95** provision of palliative nursing care, f = 78 awareness of care approaches, f = 13 palliative nursing care needs assessment, f = 4	**Symptom management, f = 14** management of other symptoms, f = 7 pain management, f = 7
Multiprofessional collaboration, f = 20 ability to work in a multiprofessional team, f = 11 consulting skills, f = 9	**Multiprofessional collaboration, f = 38** ability to work in a multiprofessional team, f = 34 consulting skills, f = 4	**Multiprofessional collaboration, f = 7** ability to work in a multiprofessional team, f = 5 consulting skills, f = 2
	Ethical and legal issues f = 3 ethical behavior, f = 2 coping at work, f = 1	**Ethical and legal issues, f = 2** ethical behavior, f = 1 coping at work, f = 1

f – frequencies

Discussion

The aim of this study was to describe the three main competencies required of every healthcare professional within palliative care, from the perspective of other professional groups. Mostly, similarities were found when comparing the competence areas that every physician, registered nurse and practical nurse needs when providing basic palliative care in any social welfare and healthcare setting. The three main competencies emphasized were advance care planning, symptom management, and psychosocial support for patients and their significant others, which all need special attention in order to ensure quality person-centered palliative care (Olsson et al., 2021). It is also worth noting that although these competencies were based on the professional boundaries, roles and responsibilities of each professional group member, there was still some variation in these competencies within and between professional groups.

The results are largely congruous with those found in previous research regarding the competencies of physicians working at the general level (Melender et al., 2020). Especially patients and their significant others have been found to appreciate the competencies of physicians in advance care planning, psychosocial support (Mäenpää et al., 2021) and empathic and person-centered encounters (Oishi & Murtagh, 2014). Moreover, the results confirm the importance of registered nurses' and licensed practical nurses' competencies, particularly in symptom management, as well as when supporting, encountering and interacting with palliative patients and their significant others (Hökkä et al., 2020, 2021; Vattula et al., 2020; Vihelä et al., 2020). Besides multiprofessional collaboration, it is worth noting that existential, ethical and juridical questions in conserving the dignity of patients have become increasingly important for all social welfare and healthcare professionals working in various palliative care settings. This is a result of an increasingly diverse array of palliative patient competencies in advance care planning (Hökkä et al., 2020, 2021; Melender et al., 2020; Östlund et al., 2019; Ryan et al., 2014; Vattula et al., 2020; Vihelä et al., 2020).

According to the results of this study, it is important that every member of the multi-professional team understands the crucial role of advance care planning. Moreover, physicians should have the competence

to make decisions about advance care planning according to the best interests of patients, and in collaboration with them, as well as with their significant others if possible (Melender et al., 2020). The finding that communication and psychosocial support for palliative patients and their significant others is a key competence of every healthcare professional was in line with recommendations and previous research. However, more attention needs to be paid to the competence of every member of the multi-professional group when it concerns holistic palliative care, including identifying existential needs and relieving existential suffering. (Gamondi et al., 2013a; Hökkä et al., 2020, 2021; Melender et al., 2020; Ryan et al., 2014.) Moreover, emotional sensitivity is needed when dealing with difficult thoughts and feelings together with palliative patients and their significant others (Hökkä et al., 2020; Melender et al., 2020; Östlund et al., 2019). In particular, cultural competence, religion literacy and empathy, the ability to listen and interact in a manner appropriate to the situation are emphasized when confronting different kinds of palliative patients and significant others (Givler et al., 2022; Saarelainen et al., 2020; Suikkala et al., 2021).

Multi-professional collaboration was found only among the three main competences of nurses, according to the views of related caregivers and stakeholder representatives. In addition to professional related competences, the importance of multi-professional collaboration is increasing further in timely and appropriate palliative care to improve the quality of life of patients and their significant others (Suikkala et al., 2021). The majority of palliative patients are treated at the basic level in care homes and inpatient wards of community health centers and hospitals, where each member of the multi-professional team should have an adequate amount of competence to provide holistic palliative care (Saarto & Finne-Soveri, 2019). This sets requirements for both undergraduate and continuing education in relation to the core palliative care that is necessary in practice and with which each healthcare professional working in the field of palliative care applies their competence based on their professional position. In particular, education within palliative care is needed to strengthen the competence of those social welfare and healthcare professionals who work in long-term care, such as residential homes for senior citizens (Gamondi et al., 2013a; Smets et al., 2018).

It is important that employers and all professionals involved in a palliative care team know the core professional competencies and responsibilities of members of their multi-professional team to ensure seamless and effective multi-professional collaboration in providing a high quality of palliative care. It is also important that every member of a multi-professional team working either in a social welfare or healthcare setting knows how to utilize the expertise and competencies of other team members in patient-centered palliative care (Hökkä et al., 2020; Melender et al., 2020; Oishi & Murtagh, 2014; Ryan et al., 2014; Sousa & Alves, 2015). This highlights competency management as a key issue in producing quality palliative services by offering continuous professional development opportunities to develop within palliative care competence and thus, enhance the career path within palliative care.

Palliative care for children and adolescents was rarely mentioned. However, it is important that every member of a multi-professional palliative care team has the competence to encounter and support children as well as relatives, young people and families with children (Saarto & Finne-Soveri, 2019). Moreover, the ethical and legal competence of palliative care received only a few mentions despite the increasing awareness and demands of patients and their significant others on treatment options, which eventually may delay the attainment of the state of consensus about advance care plan decision-making with the patient (Melender et al., 2020; Suikkala et al., 2021). Ethical issues compared to three main competencies found in this study might have received less attention within palliative care education, or ethical and legal competence might have been regarded as part of other competence areas. Therefore, competence in discussing and supporting patients and their ethical and juridical issues includes the ability to discuss and support patients in shared decision-making, based on the patients' and their significant others' preferences and values in the management of ethical dilemmas, in order to provide the optimal quality in palliative care. More attention needs to be paid to ethical and juridical competence development through training within palliative care, which, based on this and previous research, is still scarce. (De Panfilis et al., 2020; Hökkä et al., 2021; Melender et al., 2020).

Limitation of study

The strengths and limitations of the study were evaluated in terms of credibility, dependability, confirmability and transferability (Lincoln & Cuba, 1985). The viewpoints of participants from different professional groups with experience of palliative care, while working at the basic, specific or demanding levels of care, and representatives

of professional associations and patient organizations indicated the consistency of the data. However, the questionnaire reached only those stakeholder representatives having a Facebook account, which can be regarded as a limitation. Therefore, a Delphi-method might have been an alternative approach in this study. Moreover, as this was an independent study focusing on the main palliative care competencies of every healthcare professional in terms of physician, registered nurse and licensed practical nurse, the lack of other professionals within a multi-professional palliative care team can be seen as a limitation of the study. Since the data were collected using an electronic questionnaire, researchers did not have the opportunity to ask detailed questions at the analysis stage and thus gain in-depth information from whom the data were initially obtained.

The data were analyzed by two researchers, refined and confirmed with all the authors and only obvious content has been presented in the results. Original expressions and an example of the analysis process contribute toward illustrating the connection between the results and the data. The results indicate the participants' views on what are the main competencies within palliative care for every healthcare professional, as viewed by another professional group representative, which needs to be taken into account in the transferability of the results. The description of the study participants makes it possible to review the applicability of the findings in other similar contexts.

Conclusion

In general, the three most important competencies listed within the palliative care of every physician, registered nurse and licensed practical nurse had quite the same content, but their order varied. Each professional group representative has its own educational background and responsibilities within patients care, which should be utilized optimally in multi-professional work to ensure the best standard of care of palliative patients and their significant others. The results of the study can be utilized in designing and developing undergraduate and continuing education for healthcare professionals within palliative care. However, further research is needed with a focus on palliative care competencies and the educational needs of other members in palliative care teams, such as social workers, physiotherapists and professionals providing psychosocial support. The increasing diversity of palliative patients in different clinical settings affects the competence of palliative care professionals. Therefore, it is important to listen to the patients and their significant others concerning the palliative care competencies they regard as important.

Ethical aspects and conflict of interest

The Declaration of Helsinki and the General Data Protection Regulation (EU) 2016/679 were followed at all stages of the study. According to the decision of the Ethical Committee of North Ostrobothnia's Hospital District, i.e. North Ostrobothnia Medical District Ethics Commission, no prior ethical review was needed for the study. For data collection, the Finnish Medical Association gave permission to use the email addresses of physicians with special qualifications for palliative care. The cover letter attached to the front page of the survey included information about the study, voluntarily, anonymity and confidentiality of participation, and right to withdraw from the study at any time. Participants gave their informed consent by completing the survey. The participants' responses were coded, so it was not possible to identify individual participants from the data.

The authors declare that there is no conflict of interest.

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Author contributions

Conception and design (AS, SS, MH), data collection (MH), data analysis and interpretation (AS, SS), manuscript draft (AS, SS, ER, MH), critical revision of the manuscript (AS, SS, ER, MH), final approval of the manuscript (AS, SS, ER, MH).

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