

Original Article

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European interprofessional postgraduate curriculum in palliative care: A narrative synthesis of field interviews in the region of Middle, Eastern, and Southeastern Europe and Central and West Asia

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Abstract

Objectives. In 2018, a study was conducted in the Eastern and South-eastern Europe and Central Asia. National leaders of palliative care were asked to describe developments in postgraduate education in their region. They were asked whether the introduction of a European curriculum would be useful in their country. The aim was to explore the structures of postgraduate education at country level in order to define the barriers and opportunities.

Methods. This is an ethnographic study based on semi-structured field interviews. A thematic analysis was chosen for data extraction and a narrative synthesis for the systematic presentation and critical discussion of the results.

Results. Thirty-two interviews were recorded in 23 countries. The analysis revealed 4 main themes: (1) general barriers to access, (2) necessary to improve palliative care education, (3) palliative care core curriculum – the theoretical framework, and (4) challenges in implementation. These main themes were complemented by 19 subthemes.

Significance of results. Palliative care is understood as a universal idea, which in practice means accepting social pluralism and learning to respect unique individual needs. This makes teaching palliative care a very special task because there are no golden standards for dealing with each individual as they are. In theory, a European curriculum recommendation is useful to convince governments and other key stakeholders of the importance of postgraduate education. In practice, such a curriculum needs to be adapted to the constraints of health services and human resources. Validated quality assessment criteria for palliative care education are crucial to advance postgraduate education.

Introduction

In 2003, the European Council stressed the need for structured palliative care education programs to be integrated into the training of all concerned health professionals in the member states. It emphasized the need for all health and social care professionals and workers involved in the provision of palliative care to be trained for their roles in concrete and culturally sensitive ways (Council of Europe 2003). A decade later, the global guideline of the 67th World Health Assembly stated that all health professionals must be trained in palliative care according to their roles and responsibilities (World Health Organization 2014). The World Health Organization (WHO) has identified lack of training as a major barrier to access to palliative care. Together with the United Nations, the WHO promotes and facilitates activities to improve palliative care around the world (World Health Organization 2019, 2021a, 2021b, 2021d). The United Nations (UN) Sustainable Development Goal 3 “Leave no one behind” of the United Nations Group on Sustainable Development calls on member states and national governments to “combat inequalities and discrimination” (UN, 2017, ix), which often underlie the barriers people face, for example, in accessing health care and other services. With regard to palliative care, the statement “leaving no one behind” means that palliative care strategies need to be developed, including enabling access to palliative care training for all health-care providers, in order to reach the 60 million people worldwide who need this particular support. In low- and middle-income countries (LMICs), less than 10% of patients receive palliative care

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(Cherny et al. 2013; Cleary et al. 2013a, 2013b; Hawley 2017; Knaul et al. 2018; Pallium India 2012; World Health Organization 2021c), resulting in pain and unnecessary health-related suffering.

Background

Developing and improving access to palliative care education and training is a global effort (Arias-Casais et al. 2019a; De Lima and Radbruch 2018; Knaul et al. 2018; Rosa 2018). However, country-level information is needed to “describe existing structures of palliative care education and develop specialization at each professional level, and to develop comparable and reproducible assessment systems leading to comparable certifications and qualifications” (EAPC 2019). The gathering and sharing of information has a major impact on these developments (Arias-Casais et al. 2019b; Baur et al. 2019). Accordingly, the ATLANTES Global Observatory of Palliative Care project regularly maps the benefits of palliative care in the European region. The 2019 Atlas 3.0 includes data reports from 321 international experts from 51 countries. The results show that 41 countries have a national palliative care association. Most countries have established a legal framework for the provision of palliative care, with 8 countries having specific laws and 63% having other laws or statutory instruments. In terms of education and training, palliative care is a compulsory subject for more than 50% of medical students in 13 countries and for more than 50% of nursing students in 9 countries. In the vast majority of Western European countries, palliative care is recognized as a specialty, subspecialty, or specific area of competence (Arias-Casais et al. 2019b). There are some indications from high-income countries, such as Israel (Elsner et al. 2022) and Austria (Toussaint et al. 2022), that the results of the European Association for Palliative Care (EAPC) Atlas may be too auspicious. In all countries, access to postgraduate education and training is evolving, and there is enormous potential to learn from each other’s experiences, which is why there is a need for continuous exchange on this issue.

As part of this research, a quantitative survey was conducted by Stähli et al. (2020) in 21 LMIC countries in the WHO European region. This survey, conducted prior to fieldwork, revealed that postgraduate training in palliative care does not yet exist in one-third of the countries surveyed. The main obstacles to the development of educational work are limited political interest, limited educational structures, lack of curricula, lack of trainers, and limited access to health systems. Ninety-three percent of respondents ($N = 27$) agreed that an interprofessional postgraduate curriculum recommended by WHO would help promote palliative care. The survey by Stähli et al. (2020) showed a high level of agreement with the 10 palliative care competencies of the EAPC (Gamondi et al. 2013). The same result was confirmed in 2019 survey with predominantly Western European participation (Paal et al. 2019). Finally, about 60% of respondents indicated that cultural–religious aspects need to be taken into account when applying these competencies in their country (Stähli et al. 2020).

As a second part of this research, an ethnographic field study was conducted in 2018. This article on the European Interprofessional Postgraduate Curriculum in Palliative Care provides further professional insights into the development of generalist and specialist postgraduate education. According to the WHO Framework of Interprofessional Education, such education occurs when 2 or more professions learn with, from, and about each other to improve collaboration and quality of care (World Health Organization 2010). This paper focuses on

regional experiences to decipher and understand the challenges in promoting postgraduate education in palliative care in the WHO European region. The results of the semi-structured expert interviews will serve as an important complement to the quantitative findings (Stähli et al. 2020).

Aims

The WHO Regional Office in Europe and Paracelsus Medical University in Salzburg have agreed to strengthen education and training in palliative care throughout the region. During the first term as WHO Collaborating Centre (2016–2020), semi-structured field interviews with national leaders in palliative care in Central Asia, Eastern Europe and Southeastern Europe were conducted between April and September 2018 to explore the structures of postgraduate palliative care education at country level and the need for further development. As one of our reference objectives agreed with WHO, we wanted to find out whether the introduction of a European interprofessional palliative care curriculum would be useful and culturally acceptable in the different countries of the Region of Middle, Eastern, and Southeastern Europe and Central and West Asia. The findings of our study aim to support countries wishing to develop postgraduate education to strengthen the health-care workforce across Europe and thereby accelerate progress in implementing the WHO strategic directions to support the implementation of sustainable improvements in the quality of palliative care (World Health Organization 2021a).

Methods

This is ethnographic research based on semi-structured expert interviews. The field interview method was chosen to specify the results of the quantitative survey by Stähli et al. (2020) and to gain a better understanding of the local situation. The visits to the member states took place between April and October 2018. The term expert refers to the fact that all participants are involved in the development of palliative care education and training in their countries. Experts are assumed to have special knowledge and specific functions that are close to societal ascription (Bogner et al. 2009). The aim of this study was to explore the special knowledge and experiences of experts in postgraduate palliative care education that result from the actions, responsibilities, and obligations of their specific role. This knowledge is useful for future exchanges and targeting specific challenges.

Sampling strategy

Theoretical sampling in ethnographic studies is difficult, so we opted for purposive expert selection (Etikan and Bala 2017). The basic idea was to find people who could give a detailed description of palliative care education in their region and who were willing to take the time to talk about related issues. Before going into the field, various networks and individuals, such as members of the Worldwide Hospice Palliative Care Alliance and the European Palliative Care Academy, were contacted to create a sample of palliative care education experts and possible gatekeepers, such as leaders of national palliative care associations, staff of academic and educational institutions, and/or officials responsible for the development of palliative care in their country. The experts identified were invited to nominate other possible experts at country level to participate in the study. The experts recruited represented

a range of viewpoints depending on their role and daily challenges as those responsible for palliative care in their home countries. Considering that we covered a large geographical area, we estimated that our sample size reached the level of information power (Malterud et al. 2016) useful for understanding common needs, barriers, and solutions at regional level and across national borders.

Semi-structured interviews

An interview guide was developed for experts in palliative care in countries in the region of Eastern and Southern Europe and Central Asia to obtain their opinion on the first draft of a curriculum for palliative care (see Theoretical Framework below) and to learn more about training in palliative care in specific regions and countries. The semi-structured interviews focused on postgraduate palliative care education, the respective curricula and cultural issues, as well as a discussion on the draft core curriculum (*Supplementary Materials 1. Interview Guide*). The follow-up questions were formulated on the basis of the participants' answers and asked directly after the main statements.

Theoretical framework

A provisional palliative care curriculum compatible with and based on the EAPC Recommendations for the Development of Postgraduate Education in Palliative Care (*Supplementary Materials 2. Theoretical Framework*) served as the theoretical framework. Within this framework, Level A referred to basic training (duration of training: 40 hours; theoretical training, mono-professional) and Level B to the postgraduate diploma (duration of training: 160 hours; theoretical and practical training, inter-professional). The A (general)- and B (specialized)-level diploma was equivalent to 200 hours of work and was intended for professions such as doctors, nurses, psychologists, social workers, and chaplains. Upon completion of the course, participants would receive a certificate. The core curriculum was designed as a framework for postgraduate training as a recommendation, universally applicable to all countries.

Data collection and analysis

A.S. (PhD, nurse, educator, male) contacted experts and conducted ethnographic fieldwork. For most experts, the relationship was established by email prior to the field visit. Participants were informed about the personal interests of the interviewer as well as the general research objectives. The framework was sent to participants before a face-to-face meeting. The interview language was English; however, in one case, the interviews were conducted in German (the interviewer's mother tongue) or with the help of a translator in the local language. Interviews were usually conducted at universities, clinics, or hospices during working days. This and other information was recorded in field notes made after the interview. As these field notes contain many personal impressions, we have not included them in this report.

The semi-structured qualitative interviews were recorded with the consent of the interviewees and transcribed verbatim for the text analysis (P.P., C.B., and student assistants who are not listed as authors but are mentioned in the acknowledgments). Thematic analysis was used for data extraction. Thematic analysis helps to identify, analyze, and report themes within the data. A combined analysis approach was adopted, which included a data-driven inductive approach (Vaismoradi et al. 2013, 2016). First,

7 full-length transcripts were analyzed and coded by a group of researchers (P.P., C.B., and researchers from our institute who are not listed as authors but are mentioned in the acknowledgments). To develop themes, the following steps were taken: after careful study of the transcripts, units of meaning were identified and paraphrased into initial codes. These codes were written on index cards and iteratively summarized (Neale 2016). Subsequently, the identified themes and subthemes were applied to the rest of the data by 2 independent researchers, slowly skimming and reviewing the data. All original transcripts were repeatedly analyzed (Neale 2016), and code-level changes were made to the results of the group analysis until the final themes were identified to answer the research questions. Given the richness of the data, we cannot claim that these themes are based on consensus but only on a thorough analysis of each unit of meaning in a broader context of postgraduate palliative care education in the countries visited.

Narrative synthesis

Narrative synthesis was chosen as an appropriate method to systematically present and critically discuss the findings. Narrative synthesis allows for the description of patterns, further interrogation, and exploration of relationships (with) the data. It also enables the application of this theory to the findings. To increase credibility, direct, verbatim quotations are given when explaining the findings (Popay et al. 2006). It has been argued that narrative synthesis is less good at identifying commonality, but on the other hand, it is more likely to make transparent heterogeneity and the context and characteristics of identified barriers (Barnett-Page and Thomas 2009). Such synthesis informs important aspects, particularly within the practical decision-making contexts that professionals work in (Lockwood et al. 2015).

Rigor and trustworthiness

Two experts in qualitative thematic analysis (P.P. and C.B.) assessed the study's compliance with the guidelines for establishing trustworthiness (Lincoln 1995). To ensure credibility and reliability, a sample of transcripts was independently reviewed and coded by a group of researchers. A collegial team debriefing (A.S., P.P., S.L., and F.E.) was conducted to explore the relationships between the interview and the background context to increase reflexivity and validate findings. The findings were discussed with the researchers and distributed to selected participants to increase the confirmability of the research findings (A.S., P.P., and F.E.). The Consolidated Criteria for Reporting Qualitative Research checklist was used to report the findings (Tong et al. 2007).

Ethical considerations

Ethical approval (EK 398/19) was granted by the Ethics Committee of the Medical Faculty of RWTH Aachen University. In addition, all participants gave their verbal informed consent to participate in the study and, after being informed about the aims of the study and the data collection procedure, were tape-recorded. Participants were free to stop the interview at any time and for any reason. All participants gave their consent to the publication of the results. In line with the quality requirements for qualitative research (Tong et al. 2007), a draft of this article was sent to 12 participants to obtain their consent to use their names and quotes in the article. Quotes from people who did not respond have been removed from

Table 1. Characteristics of the participants

Region	Country	City	Participants per interview/ name	Profession
Central Asia	Kazakhstan	Almaty	Gulnara Kunirova	Psychologist
Central Asia	Kyrgyzstan	Bishkek	One/anonymous	Physician
Central Asia	Tajikistan	Dushanbe	One/anonymous	Physician
Central Asia	Turkmenistan	Ashgabat	Three/anonymous	Physician/translator/translator
Central Asia	Uzbekistan	Tashkent	One/anonymous	Physician
Central Europe	Czech Republic	Brno	One/anonymous	Physician
Central Europe	Latvia	Riga	One/anonymous	Physician
Central Europe	Lithuania	Siauliai	One/anonymous	Physician
Central Europe	Lithuania	Vilnius	Two/anonymous	Physician/psychologist
Central Europe	Lithuania	Vilnius	One/anonymous	Physician
Central Europe	Poland	Bydgoszcz	One/anonymous	Physician
Central Europe	Poland	Gdansk	Leszek Pawłowski	Lawyer
Eastern Europe	Belarus	Minsk	Three/anonymous	Physician/physician/physician
Eastern Europe	Russia	Moscow	One/anonymous	Physician
Eastern Europe	Ukraine	Ivano-Frankivsk	One/anonymous	Physician
Eastern Europe	Ukraine	Ivano-Frankivsk	One/anonymous	Physician
Eastern Europe	Ukraine	Kyiv	Three/anonymous	Physician/social worker/ adviser MOH
Southeastern Europe	Albania	Tirana	One/anonymous	Nurse
Southeastern Europe	Bosnia and Herzegovina	Tuzla	Two/anonymous	Physician/nurse
Southeastern Europe	Cyprus	Nikosia	Sophia Nestoros	Physician
Southeastern Europe	Greece	Athens	Elisabeth Patiraki	Nurse
Southeastern Europe	Greece	Spata	One/anonymous	Physician
Southeastern Europe	Hungary	Törökbálint	One/anonymous	Physician
Southeastern Europe	Republic of Moldova	Chisinau	One/anonymous	Nurse
Southeastern Europe	Romania	Brasov	One/Daniela Mosoiu	Physician
Southeastern Europe	Turkey	Istanbul	One/anonymous	Physician
Southeastern Europe	Turkey	Istanbul	One/anonymous	Physician
West Asia	Armenia	Yerevan	One/anonymous	Psychologist
West Asia	Armenia	Yerevan	Four/anonymous	Psychologist/psychologist/ psychologist/unknown
West Asia	Azerbaijan	Baku	One/anonymous	Physician
West Asia	Georgia	Tbilisi	One/anonymous	Physician
West Asia	Georgia	Tbilisi	One/anonymous	Physician

the main body of the article but can be found in the tables and supplementary documents.

Results

Characterization of participants

Ethnographic fieldwork was conducted in Eastern Europe: Belarus, Russia, and Ukraine; Southeastern Europe: Albania, Bosnia and Herzegovina, Greece, Moldova, Romania, (Turkey), Hungary,

and Cyprus; Central Europe: Czech Republic, Latvia, Lithuania, Poland; Central Asia: Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan; West Asia (Near East): Armenia, Azerbaijan, and Georgia. A total of 32 semi-structured interviews were conducted with one or more participants from 23 countries. None of the participants who committed dropped out of this study. However, we did not hear from all participants contacted, such as representatives from Croatia, Estonia, and Bulgaria. The characteristics of the participants and the countries are shown in [Table 1](#).

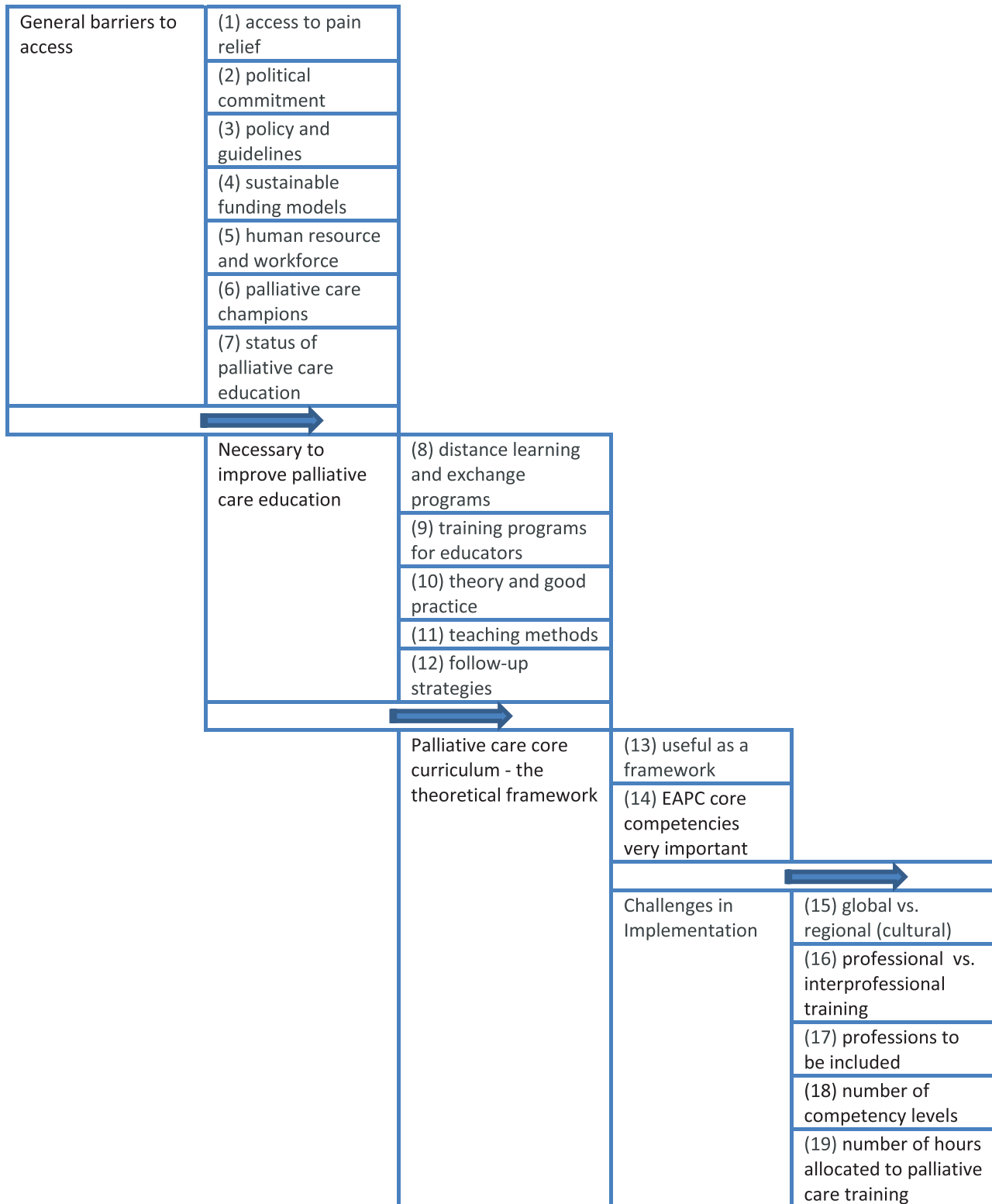


Fig. 1. The 3 main themes with their successive subthemes, ranging from more general to education-specific aspects.

Themes and subthemes

The 4 main themes with their successive subthemes, ranging from more general to education-specific aspects, are shown in Figure 1.

Of the 12 participants contacted with a request to use their direct quotes in this article, 5 responded gave consent for their names and quotes to be used in this article. Further direct quotes from participants can be found in Supplementary Materials 3.

Narrative synthesis of findings

The analysis revealed 4 main themes: (1) general barriers to access, (2) necessary to improve palliative care education, (3) palliative care core curriculum – the theoretical framework, and (4) challenges in implementation. These main themes were complemented by 19 subthemes. In the following, we present a narrative synthesis of the findings collected during the field interviews by placing these findings within a broader theoretical framework.

Barriers to access

The main subthemes of this theme were enabling access to pain relief, strengthening political commitment, the importance of policies and guidelines that support development, the problems with sustainable funding models, the lack of human resources and workforce, the role and importance of palliative care champions, and the importance of quality palliative care education (see Supplementary Materials 3 for references).

Some participants pointed out that it is considered normal by the general public to have pain in old age. In LMICs, law enforcement and government agencies need to be educated about pain relief and medication. All experts agreed that doctors, nurses, and health and social care workers need to be trained to access pain relief and overcome their misconceptions.

In many LMIC countries, health systems are underfunded and there are no accessible insurance policies. Countries where there is health insurance usually pay for palliative care services, even if the amounts allocated are minimal.

In some countries, unpaid care by family members is still the norm, but a shift is taking place that means family care needs to be replaced by paid care, which means a need for more trained generalists and specialists. In many regions, people live alone and suffer without any support. In countries with few palliative care services, governments are accused of not caring for the people who need the most care. There are many changes of government, and each new health minister or reform brings turbulence and difficulties. Government interest and investment in palliative care is necessary to enact policies and guidelines that also provide opportunities for better palliative care education.

Respondents were very concerned about societal change and the shortage of workforce. Countries suffer from a lack of resources, including manpower, which directly affects the leadership and teaching of palliative care:

Palliative care is somehow exponentially developing and human resources are a kind of bottleneck, because you can have the structures, but if you do not have the people.... (Daniela Mosoiu, Brasov par. 73)

Necessary to improve palliative care education

All participants agreed that education and training in palliative care urgently need to be improved. Distance learning opportunities and exchange programs are perceived as beneficial. Investment is needed to provide training programs for educators. More thought should be given to how to balance theory and good practice and how to use better teaching methods and implement follow-up strategies.

Experts argued that poorly organized and uncoordinated educational activities are one of the main barriers that hinder the provision of palliative care to all who might benefit from it. All palliative care-related topics, including death and dying, require specific and well-planned teaching strategies, including sufficient

bedside training and practical, self-reflective, and communication tasks.

Educators, above all, need continuous training and exchange with other educators to develop and implement better teaching and assessment strategies. Furthermore, they face the problem of organizing a balanced education that includes both practical and theoretical aspects, while health-care providers prefer practical hands on education:

And from 2010 we are doing only interprofessional, also, organizing a Palliative Care Master program with the medical school. This is an interdisciplinary approach. It was again 2-year-program. It has 150 hours of practice. We now use the services that we have. As the program began, the services opened. (Elisabeth Patiraki, Athens, par. 36)

Teaching materials produced abroad may be desirable, but they are not perceived compatible with local health systems, which means that adaptations of curricula and available materials are needed.

Palliative care core curriculum: The theoretical framework

The experts argued that a European curriculum for palliative care would be useful as a framework. All of them agreed that the 10 EAPC core competencies are an excellent basis for developing palliative care curricula to improve the competencies of staff.

In theory, a curriculum recommendation for the WHO European region is seen as useful in convincing governments and other key stakeholders of the importance of postgraduate palliative care education. In practice, any curriculum recommendation needs to be adapted to local opportunities and health systems to meet learner's values and needs.

In developing or adapting a curriculum for postgraduate palliative care, a balance must be struck between the global and the regional. The development of a curriculum is less influenced by cultural and religious norms than by traditions of health professional training, which may not recognize interprofessional training. Nevertheless, the experts felt that more professions should benefit from palliative care training, but this places demands on the content and organization of such courses. There are serious concerns about the number of competence levels and hours allocated to palliative care training because palliative care training is not recognized as subspecialty of speciality.

Challenges in implementation

While national health systems need to become more aware of pluralism within society and populations, palliative care is person-centered. Although there are obvious differences between religious and ethnic groups, between secular and religious people, and between people from rural and urban areas, feelings such as fear of death and dying are universal. The experts in the current study say that in pluralist societies, professionalism, respect, emotional support, and compassion are universal human truths and should be accessible and available to all:

Besides, we are, you know, a multicultural country. Kazakhstan is home to representatives of around 125 ethnic groups: Kazakhs, Russians, Uzbeks, Ukrainians, Uyghurs, Tatars, Germans, Belarusians, and other nationalities. The Asian people who live here may or may not be Muslim. They may be Muslim by tradition, but not by ritual. However, many people are increasingly turning to Islam, not necessarily Asian people. Kazakhstan remains bilingual: the majority of people understands and speaks Kazakh and Russian equally

well. Cultural peculiarities of this or that region – such as predominant language, local traditions, customs, religious beliefs – should be and are taken into account when planning educational activities and palliative care interventions. But, from our experience, when it comes to medical care, and, especially, palliative care, cultural differences hardly ever lead to miscommunication, giving way to universal human truths: professionalism, respect, emotional support, compassion. (Gulnara Kunirova, Almaty, par. 89-90)

The historical lags in medical and nursing ethics, such as concealing the diagnosis from the patient and talking exclusively to the family, need to be changed, and palliative care education is necessary to change this:

I believe that all these principles are universally valid because the most important in palliative care, which I believe [is], allows respecting the every individual as a unique person. So, (.) Having in mind this, allowing every patient, to every person infected by one of these chronic diseases, to allow giving us (.) to tell us what (the patients) want and what they do not. If they did not want to know, we did not give them more information. We allow every patient to receive all palliative care services according to their needs. That is why palliative care is unique and is universally valid for everyone because it gives this opportunity to respect everybody, either in (the) jungle or in Western society, to respect all these humans about what they want and what they do not. (Sophia Nestoros, Nicosia, par. 67)

The experts agreed that in the heart of the palliative care lies a multiprofessional approach. The latter must be endorsed via interprofessional education programs:

Palliative care involves teamwork. If we do not understand that all have to offer something different that is very valuable, and we have to have it and you feel that it's just prescription of drugs from the one part and taking care from the other, as it is usually what nursing is and what medical is, (laughs) it will take time. Additionally, it works in practice. We have seen this that it works. (Elisabeth Patiraki, Athens, par. 91)

Organizing interprofessional training programs can be difficult because medicine, nursing, psychology, theology (pastoral care), and social work are located in different schools administered by different government agencies. Similarly, it can be challenging to provide training to nurses or social workers with vocational training and psychologists, chaplains, and doctors with more academic backgrounds. The social status of nurses and doctors is not compatible, and nurses have very few opportunities for professional development. Interprofessional education in palliative care thus contradicts long traditions that may be difficult but necessary to break:

I need to learn more about the symptoms and opioid management. However, everybody needs to know about meds because the family might ask the priest what am I doing, you know? I am getting morphine; they are going to kill me. And, the priest needs to answer correctly “morphine is for your pain not to shorten your life” and be convinced of the answer. (Daniela Mosoiu, Brasov, par. 339)

While countries with less advanced palliative care education are enthusiastic about the idea of interprofessional education in palliative care, countries with established programs face challenges in terms of accreditation. The academic degree obtained in another country may not be recognized in one's own working environment. The body responsible for medical education may not be willing to accredit interprofessional education or it may be the only existing body for continuing medical education. Admitting the difficulties related to organizing interprofessional education programs discussed above, the experts added pharmacists and therapists to the

multiprofessional group of palliative care professionals because of their essential role in palliative care:

Interprofessional training is not a common practice. Psychologists and social workers join the courses for physicians or nurses, and there is no program dedicated to them; this is also a barrier. Kind of course, which could limit their engagement in palliative care, the curriculum is not specific to the problems appropriated them they cannot learn things that will help to work in practice to provide palliative care in their specialty. (Leszek Pawłowski, Gdansk, par.150)

The current three-level approach (A, B, and C) was perceived as confusing. In practice, there are either generalists or people with additional training. In particular, generalists do not need lengthy mono-professional training, as suggested by the theoretical framework used as a basis for discussion in this study. Experts recommended that the introductory 40 hours be converted into interprofessional education.

Discussion of the main findings

The qualitative results of this study show how interwoven education is across the wide range of topics. To ensure access to pain relief and overcome public and professional misconceptions (Bashayreh 2011; Shunkina and Chukhray 2022), doctors, nurses, chaplains, therapists but also psychologists and pharmacists need to be trained in palliative care. Palliative care is seen as a universal idea, applicable at any stage of health-related suffering, which in practice means that pluralism needs to be accepted to guarantee equity in access and meet patients and caregivers individual needs. This makes the teaching and provision of palliative care a unique task that requires professional and personal qualities. To nurture professional and personal growth, all countries need to build and maintain a culture of learning in palliative care (Wee and Hughes 2012). It has been demonstrated that the Nordic Specialist Course in palliative care had a profound impact on the participants' post-course careers, influencing the development of palliative care in the region (Sigurdardottir et al. 2021). In member states where palliative care is not recognized as a subspecialty or specialization, any training is a major individual effort and financial burden, as the funds available to organize postgraduate training are paltry. Without recognition and professional and monetary benefits, the acquisition of palliative care competencies remains unappealing.

It became clear that the level of palliative care and related education varies greatly between countries. The main messages regarding a WHO curriculum recommendation for the European region were the following:

- (1) The principles of palliative care are universal and allow each person to be treated with compassion and respect as a unique person.
- (2) Fear of death and dying in the context of serious illness transcend cultural and religious differences and should not be neglected but treated as a universal phenomenon. Palliative care education is necessary to overcome this fear.
- (3) Curricula from other countries are a useful support, but they need to be adapted to local possibilities, values, and needs.

To date, according to WHO, the only quality indicator for postgraduate training in palliative care is “specialization in palliative medicine for physicians” (World Health Organization 2021a, 15), which seriously undermines the role of nurses and other professionals in the provision of palliative care services. Well-trained

psychologists, chaplains, social workers, and other professionals improve the quality of care, and a lack of training could limit their involvement in palliative care. The multiprofessional approach is a core element of palliative care that needs to be supported by interprofessional education models, even if this contradicts traditional profession-specific approaches. Interprofessional education helps to explore similarities and differences in roles, skills, knowledge, and ideology and to recognize the complementary skills and resources of the different professions (Pereira et al. 2022); it is in line with the WHO Framework of Interprofessional Education to improve collaboration and quality of care (World Health Organization 2010).

The landscape of palliative care education and training is changing rapidly, but it can be perceived as a mirror of a country's palliative care status (Elsner et al. 2022). Online teaching, webinars, massive open online courses, escape rooms, and serious games have become available since the first Covid-19-wave (Gatsios et al. 2021; Wilcha 2020). Well-planned teaching strategies, including sufficient bedside training and practical, self-reflective, and communication tasks are of essence (Mason et al. 2020b; Noguera et al. 2022; Paal et al. 2019). In previous studies, educators have expressed the need for new interactive teaching methods and assessment and evaluation strategies (Mason et al. 2020a, 2020b; Paal et al. 2019). Learning from learners' experiences is a key to better transfer from the classroom to the practice (Paal et al. 2020; Pereira et al. 2022).

To become a good educator requires great effort, and at the same time, the achievements of outstanding clinical teachers are undervalued and overlooked (Noguera et al. 2022; Paal et al. 2019; Wondwossen Fantaye et al. 2022). Because the time available for teaching is limited, educators and clinicians focus on the areas in which they feel most competent (Noguera et al.). Exchange and trainer programs are perceived as enriching (Noguera et al. 2022; Paal et al. 2022) but involve high expenditure, which is a major problem.

The need for care is also expected to increase in LMIC countries, and the shortage of skilled workers is a serious problem. Educational recommendations and quality assessment criteria validated by high-level nongovernmental organizations, governments, or professional bodies are crucial to advance postgraduate education nationally and internationally. Additional financial support from nongovernmental organizations and regulatory bodies to promote the development of palliative care education is paramount (Paal et al. 2020). As palliative care education development is critically underfunded, a number of human rights, including the right to autonomy, bodily integrity, equality, and protection from inhuman or degrading treatment, cannot be fulfilled in WHO European region. The development of palliative care in LMIC countries rests on the shoulders of palliative care champions. Without significant investment in the training of palliative care practitioners and future leaders, the expected growth of palliative care could come to a stop.

Limitations and strengths

Obtaining information from experts, as the primary source, is problematic. The results are related to the information provided by one or a few key people per country. The search for national experts led to a high percentage of respondents being physicians; the ratio of physicians to nurses was 18:3. Not all participants in a multidisciplinary palliative care team are represented in the study, particularly missing social work and chaplaincy. It is possible that topics relevant to these professional groups were not addressed for this reason. One participant did not stick to the interview guide but

provided good insight into country-level challenges. As some interviews took place in experts' workplaces, it was necessary to stop the interviews because of interruptions. For this reason, important information could have been lost. One interview was conducted over the phone. There were linguistic challenges, but participants were eager and willing to participate, and one participant changed from English to German during the interview. It is possible that the interviews would have been more detailed if they had been conducted in the mother tongue of the participants. Two research team members (A.S. and P.P.) operate in German, English, and Russian, making the data analysis effortless.

Conclusions

The findings of this study provide a number of themes and sub-themes on palliative care education and training that were shared by palliative care experts from different LMIC countries in the WHO European region. The research showed that there are large regional differences within and between countries. Nevertheless, improving access to palliative care education emerged as a crucial factor in addressing the multiple problems. Educational recommendations and quality assessment criteria validated by high-level governments or professional bodies are crucial to advance postgraduate education both nationally and globally. We believe that these ideas and experiences from the Eastern and Southern Europe and Central Asia region can stimulate and inform discussions in member states and internationally.

Supplementary material. The supplementary material for this article can be found at <https://doi.org/10.1017/S1478951522001651>.

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