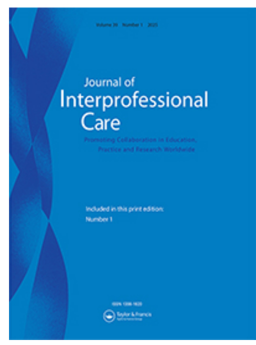

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Health and social care professionals' perspective on the interprofessional competencies required in palliative care

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ABSTRACT

Competent professionals are essential when delivering patient-centered and individual palliative care to patients and their families. However, interprofessional competencies for health and social care professionals in specialized palliative care have not been defined. The purpose of this study was to describe the competencies required for good interprofessional teamwork in specialized palliative care from the perspective of health and social care professionals. A qualitative descriptive study design was chosen to undertake the face-to-face individual and focus-group interviews. Fifty participants working in specialized palliative care units were recruited through a purposive sampling technique. The data were analyzed using abductive content analysis. The required interprofessional competencies in specialized palliative care were identified as values and ethics for interprofessional practice, roles and responsibilities, interprofessional communication, and teams and teamwork. Professionals should be interprofessionally competent to meet patients' care needs holistically and individually. Meeting patients and relatives with respect is vital, but respectful behavior and communication among professionals are also highlighted in palliative care. Certain professional qualities, such as patience, humility, and flexibility, were emphasized in interprofessional palliative care. It is important to note that the nature of palliative care affects even experienced professionals, who should be able to face death as a team in everyday work.

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Competence; interprofessional care; palliative care; professionals; qualitative research; teamwork

Introduction

In palliative care (PC), an interprofessional (IP) approach is highly recommended to meet the patients' and their families' care needs (Palliative and end-of-life care, 2019; Connolly et al., 2016; National Consensus Project for Quality Palliative Care, 2018). The goals of care differ in PC settings compared to other fields of care. When the disease cannot be cured or the patient's lifespan cannot be substantially influenced, the aim of PC is to alleviate suffering and maintain quality of life. As death approaches and occurs, the aim is to alleviate patients' symptoms and provide support patients' family members (2019; World Palliative Care Alliance & World Health Organization [WPCA & WHO], 2020). IP teamwork is one factor that promotes comprehensive and ethically approved care given to patients and their families in PC settings (Kesonen et al., 2024). Due to its holistic approach, PC is delivered by an IP team comprising physicians, advanced practice registered nurses, and other professionals depending on the patient's individual care needs. Each team member has a distinct role in planning and providing care for the benefit of both patients and families (National Consensus Project for Quality Palliative Care, 2018). This study focuses on specialized PC units where patients have complex care needs and different professionals' expertise is needed to meet patients holistically (Connolly et al., 2016; Hui et al., 2018). Complex care needs can be related to physical, social, psychological and spiritual issues, or a combination of these issues (Palliative and end-of-life care, 2019; National Consensus Project for Quality Palliative Care, 2018; Finucane et al., 2021).

Background

When providing quality PC for a patient in health and social care, professionals should be competent professionally and interprofessionally (Witt Sherman et al., 2017). IP competencies are needed when different professionals are working together but also when working with patients and their families. When a team is competent, it is possible to achieve both better individual care of singular patients (Interprofessional Education Collaborative IPEC, 2016; Palliative Care Competence Framework Steering Group, 2014) and of their families (Palliative Care Competence Framework Steering Group, 2014). The Interprofessional Education Collaborative IPEC, 2016) has identified four generic core competencies common for every professional participating in IP care; nevertheless, the IPEC does not define the care context or setting in which IP care is provided. First, values and ethics refer to the mutual working climate on an IP team. Second, the roles and responsibilities of collaborative practice are important when several professionals are meeting a patient's care by complementing each other's work. Third, IP

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communication practices refer both to the ways to communicate in a team but also with patients and their families. Fourth, IP teamwork and team-based practice and team dynamics are essential when planning, delivering, and evaluating care.

In this study, IP competence is defined as the integration of knowledge, skills, attitudes, and values in a specific context, allowing for the integration of the different educational and professional backgrounds of the team members (Fernandez et al., 2012; IPEC, 2016). IP teamwork refers to the process where different professionals interact with each other while having specialized roles in patient care (Klarare et al., 2013). When developing IP care in PC settings, the required competencies need to be defined because competent professionals have a vital role while solving problems in a specific care situation (Palliative Care Competence Framework Steering Group, 2014). In IP education, generic competencies like IPEC are frequently used when more universally accepted IP competencies are not available in PC context (Kirkpatrick et al., 2023). However, some competence frameworks have been developed for PC. Discipline-specific competencies have been created to identify the roles of each professional on an IP PC team (Connolly et al., 2016; Kang et al., 2013; McCallum et al., 2018). Also, shared competencies for different professionals on an IP team have been defined (Connolly et al., 2016; McCallum et al., 2018). Different levels of PC delivery have been noted in some studies (Connolly et al., 2016; McCallum et al., 2018); however, the contexts in which such care is provided have not always been defined (Buness et al., 2021).

Certain elements are repetitive across these frameworks, whether they cover PC competencies or IP competencies. Such skills as communication (Buness et al., 2021; McCallum et al., 2018), listening, and flexibility (Buness et al., 2021) are regarded as essential. Professionals should be able to plan and coordinate patients' PC (National Consensus Project for Quality Palliative Care, 2018, Buness et al., 2021; McCallum et al., 2018) and set care goals regarding patients' individual wishes (Buness et al., 2021; Connolly et al., 2016). Delivering person-centered care to meet particular patients' specific care needs (Buness et al., 2021; Connolly et al., 2016; McCallum et al., 2018) and improving quality of life until the patient dies – for example, by managing patients' symptoms – are essential (Buness et al., 2021; Connolly et al., 2016; McCallum et al., 2018). Professionals should master collaboration not only with their teams but also with patients and their families (Buness et al., 2021; Connolly et al., 2016; Kang et al., 2013). Frameworks have described the ethical aspects (Kang et al., 2013; McCallum et al., 2018) of PC as a team's professional relationship based on dignity and integrity (Buness et al., 2021). From patients' point of view, respecting values and wishes under life-limiting conditions is necessary (Connolly et al., 2016; McCallum et al., 2018). Additionally, professionals should be able to identify people who need bereavement counseling or might face issues with grieving (Connolly et al., 2016). Professionals' self-awareness abilities have been used to describe how their personal attitudes might affect the care provided (Buness et al., 2021; McCallum et al., 2018). Additionally, self-care and self-awareness have been described as part of professionals' competencies to, for example, prevent burnout while working in PC settings (McCallum et al., 2018). IP team processes should be tailored to promote self-care and mutual support among professionals to mitigate the emotional distress associated with PC. Emotional support is essential to reduce stress and maintain teams' well-being. Workload and workflow should also be optimized to improve patient and family outcomes while also enhancing professional engagement and promoting staff well-ness (National Consensus Project for Quality Palliative Care, 2018).

To the best of our knowledge, a gap in the literature persists concerning the required IP competencies needed for good teamwork in specialized PC. The previously mentioned frameworks have not purely described common IP competence requirements for health and social care professionals working in specialized PC settings to meet palliative patients' and their families' complex care needs. Therefore, the purpose of this study is to describe the competencies required for good IP teamwork in specialized PC from health and social care professionals' perspective. The ultimate goals are, first, to produce knowledge that can be used to evaluate not only how professionals perform as a team but also their IP competence and, second, to help develop education that increases the care quality of severely ill patients and their families. This study is a part of a larger research project considering evidence-based PC.

Method

Design

A qualitative, descriptive study design with semi-structured interviews was applied (Doyle et al., 2020). The Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines for qualitative research were followed (Tong et al., 2007) (Supplementary File 1).

Research setting

Interviews were conducted at five specialized PC units across three hospital districts in southern and southwestern Finland. Four specialized PC wards and one outpatient clinic were selected for the study due to their focus on complex and intensive PC, and the advanced skills of their healthcare professionals in PC (Gamondi et al., 2013). In Finland, PC is organized according to a three-tier model. At the basic level, there are reserved beds for PC, particularly in primary care hospitals. At the specialized level, PC units are present in all hospital districts, encompassing both inpatient and outpatient units. At the demanding specialized level, specialized PC centers are located in five university hospitals (Saarto et al., 2022). Approximately 43% (2.4 million) of all Finnish people live in this area (2021).

Participants and sampling

Purposive sampling was used (Elo et al., 2014) to identify health and social care professionals experienced with IP teamwork in a specialized PC context. The study's inclusion criteria

for participation were the following roles: registered nurses, practical nurses, medical professionals, and social workers working in specialized PC units.

Data collection

Before data collection, the researchers provided oral and written information about the whole research project, and only the broad theme was stated in advance. A semi-structured interview format was chosen as a data collection method in order to allow participants to describe IP competencies in their own words (Kallio et al., 2016). Before their interviews, participants submitted completed consent forms and background information forms, including their age, education, title, work experience (both total and in PC settings) and additional PC-related education.

A total of 50 social and healthcare professionals from specialized PC units participated in this study (Table 1). Semi-structured interviews were conducted from May to November 2019. Data were collected through six focus groups and one couple interview with registered nurses ($n = 27$), three focus groups with practical nurses ($n = 13$), three individual and dyadic interviews with physicians ($n = 5$), and individual interviews with social workers ($n = 5$). Because of the large number of participating nurses, focus-group interviews were chosen to use resources efficiently (Parahoo, 2014). The registered nurses' couple interview was conducted due to an urgent-care-related situation in their unit. The number of participating physicians and social workers was relatively small, and because these participants worked in different units, assembling these groups for interviews was impossible. Instead of participating in individual interviews, two physicians working in the same unit requested to be interviewed together. All participants were interviewed face-to-face except for one physician, who was interviewed by telephone for logistical reasons.

The interviews were conducted by four interviewers in clinical settings to ensure confidentiality and avoid distractions. The interviewers were briefed before starting data collection so that the interviews would be conducted uniformly. Participants were asked to describe the IP competencies (knowledge, skills, and attitudes) required for good teamwork in PC. Supportive questions and concrete examples were asked alongside the probing questions. The questions had been pilot-tested, and the data from the pilot testing were included in the final data since no changes were needed. The individual interviews' average length was 48 min (ranging from 29 min to 1 h and 3 min), while the couple interview and focus-group discussions lasted an average of 1 h and 10 min (ranging from 37 min to 2 h and 53 min). These times represent the duration of the whole interviews as part of the larger research project, not only the sessions' focus on the IP competence theme. All interviews were digitally audio-recorded with interviewees' consent and transcribed verbatim. Data collection continued until saturation was achieved.

Analysis

Content analysis was chosen to describe participants' experiences, based on this study's research task. More precisely, an abductive approach was selected to provide a more complete understanding of the IP teamwork as phenomenon in a specific clinical context (Graneheim et al., 2017). This abductive content analysis was based on the four competency domains: *values and ethics for interprofessional practice*, *roles and responsibilities*, *interprofessional communication* and *teams and teamwork*. During the first phase, the interview material was read through several times to allow for familiarity with the content. Original expressions were identified deductively from the transcripts, based on the competency domains of the IPEC framework (IPEC, 2016), following the research purpose. During the second phase, the selected expressions were simplified by removing unnecessary words. The simplifications were inductively formed into sub-categories and subcategories, which were combined into main categories (Graneheim et al., 2017) (Table 2). The analyzed data comprised only the transcribed interview material (Kyngäs et al., 2020). Data analysis was conducted by an individual researcher (PK) and verified by the research group.

Ethical considerations

This study followed the principles of the *Declaration of Helsinki* (World Medical Association, 2013). Ethical approval was requested and received from the Ethics Committee for Human Sciences at the University of Turku (15/2019). Also, permissions were obtained from the organizations from which the data were collected. After receiving verbal and written information, all participants consented in writing to

Table 1. Description of data collection ($n = 50$).

Participating professionals	Method of data collection	Number of participants
Registered nurses ($n = 27$)	Focus group	6
	Focus group	5
	Focus group	4
	Focus group	4
	Focus group	3
	Focus group	3
	Couple interview	2
Practical nurses ($n = 13$)	Focus group	5
	Focus group	4
	Focus group	4
Physicians ($n = 5$)	Individual interview	3
	Couple interview	2
Social workers ($n = 5$)	Individual interview	5

Table 2. An example of the analysis process.

Competency domain	Quotation examples	Simplification	Subcategory	Main category
Competency 2: Roles/ Responsibilities	*"Well, of course, it's essential to have a good understanding of your own core duties..."* *"You definitely need to know the requirements of your own profession."* *"One should continuously update your knowledge and skills related to their own job..."*	Must know of your core duties. Must know the requirements of your profession. Must continuously update your knowledge and skills.	One's own professional knowledge	*Professional knowledge*
	"...so in this matter, you need to speak with a doctor. I cannot take a stance on this." *"...but also to avoid meddling in someone else's area of responsibility."* *"...to recognize your own limitations and understand that you might need advice from another professional."*	Must know when to say that you cannot take a stance. Must not meddle in someone else's area of responsibility. Recognize your own limitations when you may need advice.	Limitations of one's own professional knowledge	
	"It's extremely important to understand the full range of skills that people have." *"Well, it's probably important to have some understanding of what each professional group's area of expertise is."* *"You need to know what the other person does..."*	Important to understand the full range of skills that others have. An understanding of the areas of expertise of each professional group. Need to know what other professional does.	Team members' professional knowledge	
	"But mostly, of course, it must be said that you need to take responsibility for work that corresponds to your professional group and training." *"Everyone takes care of their own responsibilities and does not delegate their tasks to others."*	Must take responsibility for work that aligns with your professional group/training. Each professional takes care of their own area. Professionals don´t delegate their tasks to others.	Knowledge of one's own professional responsibility	*Knowledge of roles and responsibilities on an interprofessional team*
	"Also, perhaps information about who is responsible for specific tasks and who should handle them – usually related to arranging life matters before death." *"In my opinion, it's also important to know what the other person's job entails, because you can't really collaborate effectively if you don't know e.g. what the physiotherapist does."*	Knowledge of who is responsible for different tasks. Knowledge of who is responsible for handling different matters. Can't collaborate if you don't know what the other person is doing.	Knowledge of team members' responsibilities	
	"You have to know to ask for help or inquire about the right things from the right person." *"...so you know who to contact to ensure the patient receives the help they need."* *"...and know how to consult a physician if appropriate medications are not prescribed."*	Know how to ask the right questions to the right person. Know who to contact to ensure the patient receives help. Can consult a physician if appropriate medications are not prescribed.	Knowledge of interprofessional roles	

participate in the study. Participation was voluntary, and participants retained the right to withdraw at any stage.

Results

Participant characteristics

In total, 50 professionals from five different PC units (four wards and one outpatient clinic) in Finland participated in this study (Table 3). Their age varied from 24 to 62 years (mean: 43.8 years). Participants' total work experience ranged from less than 1 year to 37 years (mean: 14.89 years), while their PC work experience ranged from less than 1 year to 19 years (mean: 4.52 years). Thirty professionals (60%) had received continuous education related to PC.

Interprofessional competencies in specialised palliative care

The IP competencies in specialized PC were described in four main categories as follows: *value and ethics for interprofessional practice in specialised PC, roles and responsibilities in specialised PC, interprofessional communication in specialised PC and teams and teamwork in specialised PC.*

The values and ethics for interprofessional practice in specialised PC

The main category *value and ethics for interprofessional practice in specialised PC* comprised three categories: *embracing individuality*, *mutual respect* and *a trusting relationship between professionals* (Figure 1). *Embracing individuality* comprised two subcategories: *acceptance of differences* and *individual ways of working. Acceptance of differences* was understood as accepting all team members as individual people and coworkers with different personal qualities. Regardless of variations in these personalities, everyone should be able to work with each other and accept other team members as they are. Meanwhile, *individual ways of working* referred to the diverse qualities and individual approaches to working for the good of the patient that different professionals brought to an IP team. Individuality describes professionals' different ways of

Table 3. Participant characteristics.

Professionals involved ($n = 50$)	Age, in years M (range)	Total working experience in years M (range)	Working experience in PC in years M (range)	Continuous education related to PC % (n)
Registered nurses ($n = 27$)	42,4 (24–60)	14,6 (<1–37)	4,6 (<1–19)	63 (17)
Practical nurses ($n = 13$)	40,6 (19–59)	13,0 (1,75–36)	4,4 (<1–13)	62 (8)
Physicians ($n = 5$)	51,2 (40–62)	23,4 (12–34)	6,3 (1,5–16)	100 (5)
Social workers ($n = 5$)	52,4 (47–56)	13,4 (2–22,4)	3,9 (<1–10)	0 (0)

Value/Ethics for Interprofessional Practice in specialised PC	Roles/Responsibilities in specialised PC	Interprofessional Communication in specialised PC	Teams and Teamwork in specialised PC
• Embracing individuality • Mutual respect • Trusting relationhip between professionals	• Professional knowledge • Knowledge of roles and responsibilities on an interprofessional team	• Communication skills • Interaction skills	• Collaboration skills • Professional qualities • Providing holistic palliative care

Figure 1. Interprofessional competencies in specialized palliative care.

addressing PC-related situations. One of the participating practical nurses said:

> Accepting the fact that we all are humans, different kind of personalities, so not everyone can like everybody, but every professional must be able to work together. (Practical nurse)

Mutual respect consisted of three subcategories: *interprofessional equity*, *respectful behaviour* and *valuing other professionals' expertise*. Participants described *interprofessional equity* to mean that every team member had an equal status on a team and that each member's skills were equally important to patients' care. *Respectful behaviour* among IP team members concerned team members' treating each other with respect despite their profession. Loyalty toward other team members was one way to express respect for them. Respect was also an important part of communication. Professionals should focus on respectfully expressing their ideas or suggestions, not commanding, or undervaluing coworkers. Team members should never dismiss other professionals or their thoughts but, conversely, respect their divergent educational backgrounds. *Valuing other professionals' expertise* appeared when valuing not only team members' work but also their profession-specific knowledge and skills. One social worker explained:

> And then respect every colleague despite their profession … because, nevertheless, we all have the same goal, that the person who ended up in the unit would receive the best possible care for the rest of her/his life. (Social worker)

A trusting relationship between professionals comprised two subcategories: *trustworthiness for colleagues* and *trust in colleagues*. *Trustworthiness for colleagues* was described as every professional's obligation to earn other team members' trust. Earning trust was emphasized most concerning early stages, such as when an IP team has been newly built or a new member has joined, and less concerning situations in which the team's composition had remained the same for some time. Participants described *trust in colleagues* as a necessity within the team. Everyone should trust that other team members will attend to patients' care as well as they themselves would. Questioning other professionals' ability to perform well in PC-related issues because of differing educational backgrounds was seen as a disadvantage regarding IP teamwork.

> In palliative and end-of-life care, you can't work here if you don´t trust that the next person is doing everything as well as you are. (Practical nurse)

Roles and responsibilities in specialised PC

Roles and responsibilities in specialised PC comprised two categories: *professional knowledge* and *knowledge of roles and responsibilities on an interprofessional team* (Figure 1). Further, *professional knowledge* comprised three subcategories: *one's own professional knowledge, limitations of one's own professional knowledge* and *team members' professional knowledge*. Participants explained that every professional on an IP team should master their *own professional knowledge*. This knowledge is obtained from both professional education and experience working in the PC field. Updating one's own professional knowledge was regarded as vital when working interprofessionally, and participants emphasized that PC professionals should be constantly willing to learn. Understanding *the limitations of one's own professional knowledge* was seen as equally important to one's own professional knowledge. Participants described that professionals should know the limitations of their profession and know when undertaking tasks which are part of other professionals' expertise would be unacceptable, and professionals should also be able to communicate that limitation with patients. Professionals' noticing that another individual's expertise is needed, which leads to *team members' professional knowledge*. Participants explained that every professional who participates in IP care should understand their colleagues' knowledge base and expertise in palliative patients' care. Every participating professional is meaningful to their IP team and has something to offer patients with life-limiting health conditions. For instance, one participating physician said:

> So, it is vital to know the requirements of own profession, but also to acknowledge the expertise of other profession, too. (Physician)

Knowledge of roles and responsibilities on an interprofessional team consisted of three subcategories: *knowledge of one's own*

professional responsibility, *knowledge of team members' responsibilities* and *knowledge of interprofessional roles. Knowledge of one's own professional responsibility* meant that each professional must take responsibility for the work that corresponded with their professional training. To achieve functional collaboration, according to the participants every team member needs to complete their own tasks and not assign them to others. If one team member fails to do their task or does not take responsibility, they will inevitably have a negative impact on teamworking. *Knowledge of team members' responsibilities* referred to knowledge of which tasks belonged to other professionals. Without knowing in which aspects other professionals can help a patient, teamwork is impossible. *Knowledge of interprofessional roles* describes a professional's knowing to ask the right questions of the right colleague in order to provide the most applicable help for a patient regarding a particular issue. Other professionals should, therefore, be sufficiently open to providing the help patient needs. Nurses were described as greatly responsible in this kind of consultation because they are not only the professionals who are usually closest to patients and monitoring patients' needs but also the largest single professional group on an IP team. One of the registered nurses explained:

> It doesn't matter what is the profession or the education; it is important to know the meaning of each professional in patients' care. (Registered nurse)

Interprofessional communication in specialised PC

Interprofessional communication in specialised PC comprised two main categories: *communication skills* and *interaction skills* (Figure 1). *Communication skills*, in turn, comprised two subcategories: *discussing with colleagues, patients and family* and *ability to listen*. In IP teamwork, patients and their family members are considered part of the team, so *discussing with colleagues, patients and family members* is important. Professionals should be able to discuss and express new ideas politely and calmly. Commanding or dominating others was seen as a disadvantage for good behavior on a team. In IP teamworking, it is vital that information is transmitted and shared so that other team members would understand the current situation of patients' well-being and care. In addition to discussing with others, communication skills also include the *ability to listen*. Communication in an IP team should be a dialogue rather than monologue, where every team member has the opportunity to express their opinion on matters related to the patient's care.

> And of course, you need to know how to listen to others to avoid talking over one another. For example, in a meeting, there should be an effort to have a dialogue rather than having just one person speaking all the time. (Physician)

Interaction skills comprised two subcategories: *an open atmosphere* and *the courage to act. An open atmosphere* was related to a general understanding that every professional should be able to speak freely and express their feeling and desires. Also, per the previous subcategory, the members of an IP team should have enough *courage to act* in PC settings. Participants described that professionals meet different kinds of people with varying feelings because of PC's sensitivity. On an IP team, professionals should be courageous enough to express themselves; participants described feeling like advocates for their patients and, for example, courageously expressing opinions. On the other hand, professionals should have sufficient courage to trust in their own performance and not too easily rely on other professionals. IP team members' opinions might vary, so professionals should express themselves even if they do not agree, and they should bravely justify their points of view to others. As one of the registered nurses described:

> Courage to express one's own opinion and courage to ask, for example, more medication from the doctor. And you need to be able to instantly call the doctor if you observe something. Then you just react and call. (Registered nurse)

Teams and teamwork in specialised PC

Teams and teamwork in specialised PC consisted of three main categories: *collaboration skills*, *professional qualities* and *providing holistic palliative care* (Figure 1). Meanwhile, *collaboration skills* comprised four subcategories: *the ability to work on a team*, *mutual support*, *common time management* and *networking skills. The ability to work on a team* described professionals' collegial behavior on an IP team and their ability to keep up the team feeling. Working collaboratively and showing interest in teamworking by speculating about and reflecting on care-related issues are the ways to provide good PC. *Mutual support* described both being supportive and the sufficient humility to rely on other professionals. According to the participants, team support is important when making care-related decisions together, and colleagues can provide new information. Being supportive involved being open to discussions and expressing a desire to help others. Participants explained that IP teamwork also requires team members to rely on other professionals, asking for help and showing their weaknesses instead of solving everything on their own. On a well-functioning team, insecurity and team reliance are acceptable; the limits of seeking help within a team should be low, and the atmosphere should facilitate asking for support. As a practical nurse explained:

> *And to have enough courage to ask and admit that you don't have to know everything alone.* (Practical nurse)

Common time management, in IP teamworking, describes professionals' obligation to honor planned schedules, such as by arriving on time to IP meetings. According to the participants, professionals' good organization skills are essential, and they effectively support IP teamwork. In PC, *networking skills* are needed to connect different operators from various organizations to patients' care (e.g. other care units outside the particular institution, a third sector). The ability to create networks facilitates the opportunity to meet different care needs more holistically. Working respectfully to keep collaborators satisfied is also important.

> It is important to keep the collaborators satisfied and never break the bridges anywhere, to be as collaborative as possible and all the time so everything will work well next time also. (Registered nurse)

Professional qualities consisted of five subcategories: *working flexibly, being active, being friendly, acting patiently* and

being humble. Participants described different preferred personal qualities when working interprofessionally in PC settings. *Working flexibly* described the ability to establish not only a joint understanding of care-related issues but also the adaptability needed when working with several different professionals. Participants explained that jealousy about one's own expertise or area of responsibility was disadvantageous to teamworking. As one registered nurse stated:

> Either it does not help if you are really jealous of your area or expertise, nor it is not okay to be too sure in a wrong way. That sometimes we will step to each other's properties if you could say so. Doctors can sometimes intervene some nursing-related issues, and we can easily express our opinions about medical concerns. (Registered nurse)

According to the participants observations in IP teamworking, *being active* is essential for a well-functioning team. Team members should want to get to know fellow professionals on a team. Participants referred to their work as serving as detectives to achieve palliative patients' desired care results. *Being friendly* referred to polite and understanding behavior. Participants explained that, in PC settings, thankfulness and accepting thankful comments were vital. Not only care but also teamworking should be gentle, and a chaotic attitude does not befit the PC context. When working with EOL-related issues and confronting death often, professionals should *act patiently*. Participants explained that, with patience, good care, and teamwork are possible. Participants felt that discussions of PC are not a suitable time for haste. *Being humble* refers both to IP teamworking and PC-related situations, when the limits of life are clear. Humility is also required in situations where professionals realize that their own skills are inadequate. According to the participants, it is necessary to have the humility to acknowledge the limitations of one's own involvement and to ask for help from other professionals. When asking for help, participants explained, humility is preferable to excessive pride:

> But patience is required in the ward, and certain type of tenderness to provide good care. So it covers all professionals, that sizzling persons does not fit there, because I think that in that kind of environment everything should happen really peacefully. (Social worker)

Providing holistic PC comprised three subcategories: *assessing patients' care needs, understanding interprofessional resources* and *the ability to confront death and dying. Assessing patients' care needs* referred to holistic and individual care needs, considering overall support that professionals should be able to recognize. Such needs might be related to physical, mental, spiritual, and social issues. Additionally, such needs might change over time. *Understanding interprofessional resources* referred to knowledge about what professional expertise could be used as a part of palliative patient care and where to find help to address a particular issue. Such an understanding was also related to the ability to provide different professionals' expertise and ask whether a patient was willing to meet these professionals – for example, a chaplain in spiritual issues. Participants described *the ability to confront death and dying* as an important skill because, in PC settings, death and suffering can be confronted daily. Participants felt that certain types of professionals applied for jobs like PC, and professionals should experience PC "as their own field." For instance, one social worker explained:

> I think certain types of nurses apply to work in palliative ward because you work very close with death. It probably won't fit for everyone. (Social worker)

Discussion

The purpose of this study was to describe the competencies required for good IP teamwork in specialized PC from health and social care professionals' perspective. An abductive approach and the use of an existing competence framework (Interprofessional Education Collaborative IPEC, 2016; Kirkpatrick et al., 2023) enabled a holistic explanation of IP competencies common to all professionals in specialized PC (Graneheim et al., 2017). Nevertheless, the absence of IP competencies in specialized PC context generic IPEC competencies were used in the analysis (Kirkpatrick et al., 2023), the results of this study provide new insights into the specific features of IP competencies in specialized PC. To become interprofessionally competent, professionals should not only master their own profession but also understand other professionals' knowledge and expertise to meet patients' PC needs individually and holistically (Witt Sherman et al., 2017).

The importance of ethical competence emerged in the results of this study. Values and ethics were described through individuality, respect, and trust. Interestingly, participating professionals focused only on ethics between professionals and did not describe the ethical aspects typical of patient care, such as dignity or privacy (Interprofessional Education Collaborative IPEC, 2016). The results of this study are essential in explaining that ethical aspects in specialized PC are not limited to patients but also cover professionals and IP teamworking. While this study's results do not provide a direct answer as to why ethics was not also addressed from patient and relatives' perspective. This limitation may have been due to the IP competence as a topic and the fact that IP was not defined before starting the interviews so that team would also include patients and relatives. In IP teamworking, professionals' acceptance of different people and their individual approaches to work is important. The results were also interesting because, although participants described respect between different professionals, more work was needed to earn trust within their teams. Of course, this need was understandable, and it may reflect professionals' high work ethic.

In this study, knowledge of one's own, other team members' and a wider IP team's roles and responsibilities were recognized as one of the competence demands. Moreover, in specialized PC, where patients' care needs can be complex and related to physical, social, psychological, and spiritual issues or a combination thereof (National Consensus Project for Quality Palliative Care, 2018, Finucane et al., 2021), competency to assess patients' individual care needs (Buness et al., 2021; Connolly et al., 2016; McCallum et al., 2018) to provide holistic PC is essential for all professionals who join an IP team. Professionals should be able to identify care needs related to different aspects of care, such as who requires bereavement counseling or is facing possible issues with grieving (Connolly et al., 2016). This study

highlighted the importance of not only recognizing the need for care but also effectively utilizing the competence of all professionals when one cannot provide help and referring to professional expertise such as chaplains.

Supporting previous findings, this study found that IP teamwork is among the factors that promote comprehensive, ethically approved care for patients and their families in PC settings (Kesonen et al., 2024), and professionals communication skills are essential in an IP team but also with patients and their families (Buness et al., 2021; Interprofessional Education Collaborative IPEC, 2016; McCallum et al., 2018). An interesting detail in the results of the current study was that patients' and their families' involvement was mentioned only concerning the communication category, even though the research context was specialized PC, in which care needs are usually complex and include patients' family members too. This detail might have resulted from the term "interprofessional" referring to professionals and, for example, the "team" concept possibly being used widely to include patients and families. During the interviews, as mentioned previously, the interviewers did not define the term "interprofessional" in order to allow participants to provide their own descriptions of competence demands.

A remarkable result of this analysis was that participants described certain professional qualities as required competencies when working interprofessionally in specialized PC contexts. In addition to flexibility, which has been previously recognized (McCallum et al., 2018), participants emphasized activity, friendliness, patience, and humility. Interestingly generic frameworks, such as IPEC, do not highlight professional qualities this widely (Interprofessional Education Collaborative IPEC, 2016). This finding might have resulted from the sensitive nature of care provided. Additionally, professionals' self-awareness abilities were used to describe how their personal attitudes might affect the care that is given to the patients and family members (Buness et al., 2021; McCallum et al., 2018). This study provided other results which partly support that finding. Because of PC's demanding atmosphere – especially at a specialized level, where care needs can be very complex and intense – professionals who participate in teamwork should be able to confront death and dying. Understanding whether PC work suits them is important for professionals. However, supporting the well-being of an IP team is essential to maintaining the capacity of competent professionals to perform effectively in a highly demanding work environment (National Consensus Project for Quality Palliative Care, 2018). Overall, professionals must master a wide range of competencies to work interprofessionally in specialized PC. The results of this research emphasize that interprofessionally competent professionals can provide higher-quality care for palliative patients and their families (Palliative Care Competence Framework Steering Group, 2014), because a competent IP team is able to respond to the needs of the patient and their family in a more holistic way.

Limitations

The Guba and Lincoln criteria were utilized to ensure the quality of this study (Schwandt et al., 2007). Regarding credibility, the interviews' being conducted with four interviewers may have adversely influenced this study's data collection, but this choice enabled data collection from different PC units at geographical distances. Orientation sessions were held before data collection to minimize the possibility of differences. Also, an interview guide was used to direct the interview sessions (Kallio et al., 2016). The interviewers had no other connections to the PC wards, which suggests that they did not influence the descriptions participants provided.

The credibility of this research was increased by using direct quotations when reporting the study's findings. The fact that nurses represented the largest professional group who shared their perceptions may have affected the study's results. The numbers of physicians and social workers were relatively small, and these participants worked in different units. However, in working life, these professionals are similarly distributed (Henderson et al., 2019). Also other professionals, such as chaplains or health and social care professionals like nutritionists and physiotherapists, can contribute their expertise to meet the care needs of patients receiving PC and their family members (National Consensus Project for Quality Palliative Care, 2018). Due to the small number of specialists working at the specialized level PC and the subsequent risk of identification, they were not included into this study.

The transferability of the study's findings was enabled by conducting interviews in geographic areas which covered nearly half of Finland's population. The study's inclusion criteria and context were described as precisely as possible. Moreover, a conscious decision was taken to examine the competence of health and social care professionals and not to include volunteers. Additionally, the care delivery varies by country (Saarto et al., 2022), and as a result, the findings of this study are somewhat influenced by cultural factors. Describing these factors allows readers to assess the transferability of the study's results to other contexts after careful consideration. The data for this study was collected in 2019. Although changes may have occurred in PC since then, the study's results still provide insights into the type of IP competence required in specialized PC.

By providing detailed information about the study's aim, data collection, and process of analysis, dependability was increased. Clarifications and additional questions were asked during the interviews to increase the study's confirmability. Some elements started recurring during data collection, which was considered to indicate data saturation (Elo et al., 2014). Analysis was conducted individually by one researcher. However, when analyzing the data, the expertise of the wider research group ($n = 4$) was used to minimize individual interpretation (Schwandt et al., 2007). Yet, to some extent, the content analysis process involves interpretation (Elo et al., 2014).

Conclusion

This work contributes to understanding of how meeting patients' care needs holistically and individually requires different professionals' expertise. Without the ability to work on a team, communicate, or interact between team members, the advantages of IP teamwork cannot be achieved. This study's empirical findings provide a new

perspective on how PC's nature affects teamworking and required competencies, as well as the necessity of abilities to confront death in everyday work. Certain professional qualities were valued in IP PC, and respectful encounters between patients and their relatives were also acknowledged. Hence, this study's results also highlight the importance of quality encounters among professionals. Remembering that the presence of death also affects trained professionals is valuable, and it should not be assumed that professionals are fully accustomed to the presence of death. In the PC field, as with all teamwork, team members should work seamlessly and incorporate existing IP competencies. In future research, measuring the IP competence of professionals working in PC settings would be essential. Additionally, a greater focus on interventions to fluidly utilize various professionals' competencies to benefit palliative patients and their families would be important.

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Data availability statement

The study's data are not available due to ethical and legal restrictions.

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