*Original Article*

# Comparative Analysis of Specialization in Palliative Medicine Processes Within the World Health Organization European Region

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## Abstract

**Context.** Palliative medicine (PM), still in the development phase, is a new, growing specialty aimed at caring for both oncology and non-oncology patients. There is still confusion about the training offered in the various European PM certification programs.

**Objectives.** To provide a detailed, comparative update and analysis of the PM certification process in Europe, including the different training approaches and their main features.

**Methods.** Experts from each country completed an online survey addressing historical background, program name, training requirements, length of time in training, characteristic and content, official certifying institution, effectiveness of accreditation, and 2013 workforce capacity. We prepared a comparative analysis of the data provided.

**Results.** In 2014, 18 of 53 European countries had official programs on specialization in PM (POSPM): Czech Republic, Denmark, Finland, France, Georgia, Germany, Hungary, Ireland, Israel, Italy, Latvia, Malta, Norway, Poland, Portugal, Romania, Slovakia, and the U.K. Ten of these programs were begun in the last five years. The PM is recognized as a "specialty," "subspecialty," or "special area of competence," with no substantial differences between the last two designations. The certification contains the term "palliative medicine" in most countries. Clinical training varies, with one to two years being the most frequent duration. There is a clear trend toward establishing the POSPM as a mandatory condition for obtaining a clinical PM position in countries' respective health systems.

**Conclusion.** PM is growing as a specialization field in Europe. Processes leading to certification are generally long and require substantial clinical training. The POSPM education plans are heterogeneous. The European Association for Palliative Care should commit to establishing common learning standards, leading to additional European-based recognition of expertise in PM. J Pain Symptom Manage 2015;49:861–870. © *2015 Published by Elsevier Inc. on behalf of American Academy of Hospice and Palliative Medicine.*

***Key Words***

*Palliative medicine, Europe, specialty, specialization, education, medical, graduate/organization and administration*

## Introduction

Palliative medicine (PM), a field currently in the development phase within mainstream medicine, is a new, growing specialty aimed at treating oncology and non-oncology patients.[1] Ten core interdisciplinary competencies for professionals in palliative care have been described.[2] PM is the physician component of the interdisciplinary practice of palliative care. Currently, there

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are some recommendations for developing postgraduate curricula for certification in PM.[3]

The PM specialists bring a holistic approach to medicine; in addition to having knowledge of many different diseases, they can evaluate and manage many symptoms in the physical, psychological, spiritual, and social spheres. The PM skills are mostly nonprocedural, requiring individual and family counseling and psychoeducational skills; indeed, ethical dilemmas, decision making, dying, and death are part of the PM framework. In addition to working in hospitals, the PM physicians work in home care, long-term care facilities, and day care centers.[4] These conditions have led the PM physicians to develop a distinct set of attitudes, with their own standards of practice, literature devoted to the field,[5] and a research foundation. The practice of PM is as challenging, demanding, and complex as that of any other medical field.[6]

Dame Cicely Saunders, who combined clinical care, teaching and research in the late 1950s,[7] set the stage for modern science and the art of caring for patients with advanced disease.[8] Since the development of hospice and palliative care in the U.K., there has been growing interest in establishing PM as a specialty. In 1987, PM became a subspecialty of general medicine, initially on a seven year "novitiate." Once the subspecialty successfully concluded, a specialty in its own right was created.[8] Considerable debate took place both in the U.K. and elsewhere as to whether PM should be considered a specialty or not.[9,10] Most PM professionals understand that considering PM as a speciality is a key condition for integrating palliative care into the health care system. Others think that the right method for integrating PM into the health care system is through generalist palliative care, obviating the need for specialist palliative care. This debate has recently become moot because a more sustainable model involving the combination of generalist palliative care with a palliative care specialist has prevailed.[11]

Doyle[1] enhanced the role of specialty programs in PM both in promoting the growth of palliative care services and in demonstrating that specialist palliative care is integral to good clinical care. The global categorization of palliative care is closely correlated with the country-level status of considering PM a specialty.[8,12] Accordingly, a European study[13] stressed that providing inadequate professional certification remains a barrier to the development of PM as a discipline. Universities also have an active, unavoidable role in the development and formal recognition of PM as a discipline.[14]

The status of PM and its development are poorly documented in the published literature. The first mapping of PM in Europe was performed and reported in a European Association for Palliative Care (EAPC) survey[15] that mentions seven of the 53 countries that have PM as a specialty or subspecialty and another 10 countries where the development of PM is in progress. The recent EAPC Atlas of Palliative Care in Europe 2013[16] shows 15 countries that offer official PM certification programs: Czech Republic, Finland, France, Georgia, Germany, Ireland, Israel, Italy, Latvia, Malta, Norway, Poland, Romania, Slovakia, and the U.K. The authors of the Atlas noted that there is still confusion about the training offered in the various PM certification programs. We aim to provide a detailed, comparative update and analysis of the PM certification process in Europe, including the different training approaches and their main features.

## Methods

This was an online experts survey of the existing programs on specialization in PM (POSPM), followed by expert discussion and comparative analysis. For this research, the working definition of POSPM was understood as the set of conditions for obtaining the maximum level of professional training in PM and official certification that is valid within the entire country. Any specialty, subspecialty, or other terms indicative of an official certification for full-time palliative care physicians were included in this working definition.

### *Country Selection*

We assessed countries within the World Health Organization European Region (53 countries) that permitted POSPM according to the ATLAS of Palliative Care in Europe 2013, plus countries identified in the Atlas as still developing a POSPM. Five additional countries were included in the survey for comparison and as benchmarks: the U.S., Australia, Canada, Portugal, and Spain. The first three countries have recently approved and consolidated POSPM, whereas Portugal and Spain were European countries still defining their POSPM. The study and data collection were closed in January 2014; by then, Portugal had completed the process of defining POSPM. To extend the study at the global level to include all countries with existing POSPM, for example, some Latin American countries (Costa Rica, Venezuela, Colombia, and Brazil)[17] or others from Asia, was beyond the scope of the European Task Force.

### *EAPC Endorsement of the Project*

In October 2012, we outlined the project, main questions, and methods. A dedicated EAPC Task Force, funded by the Accademia delle Scienze di Medicina Palliativa, was formally approved.

*Selection of Experts*

The first step in the process included approaching a network of national experts for the Task Force, using the following criteria: the PM physicians currently working in the selected countries who demonstrate a deep understanding of POSPM, fluency in English, and the ability to work online and to attend a meeting. The candidates were primarily recruited from the network of collaborators of the EAPC Task Force on the Development of Palliative Care in Europe or the Board of National Associations. We then sent the selected candidates a letter with a brief explanation of the study and the participants provided written consent. The experts were required to identify and obtain a source of official documentation on POSPM in their country.

*Questionnaire*

At a research meeting in Pamplona, the authors designed a questionnaire. They first chose the topics for the study (historical background, program name, training requirements, length of time in training, characteristics and content, official certifying body, effectiveness of accreditation, and 2013 workforce capacity); they then developed specific questions with checklists when appropriate; respondents also were able to respond in free-text format about their training program. The tool was placed on an online platform and, to refine the questions, a pilot study was performed with two countries. Launching the survey, authors asked representatives of each country to respond to the online survey, with several reminders sent to nonresponders.

*Discussion Process*

Initial results were presented to the plenary group of experts at an in-person meeting at the 2013 EAPC Congress in Prague. There, experts received queries and discussed the results, making notes and providing clarifications. Subsequently, two additional rounds of online fine-tuning of the results were performed. Finally, the manuscripts were submitted to them for comment and final approval.

*Complementary Information*

More information from this study, for example, the survey procedure, the study questionnaire, and exhaustive data from each country, was presented at the recent World Palliative Care Congress in Lleida, June 2014, and is available as descriptive information in a report.[18]

## Results

We received answers from all country experts contacted (response rate 100%). At the in-person meeting at the 2013 EAPC Congress in Prague, 16 experts were able to attend. All experts contacted maintained ongoing communication, answering queries and sending clarifications during a very rich process that lasted until the review of the outcomes, which received approval from all of them.

*Which Countries Have Specialized PM Programs?*

Eighteen European countries have a POSPM program; the following 15 were identified by the EAPC Atlas 2013: Czech Republic, Finland, France, Georgia, Germany, Ireland, Israel, Italy, Latvia, Malta, Norway, Poland, Romania, Slovakia, and the U.K. Additionally, Portugal, Denmark, and Hungary were recently approved (Table 1). Thus, 34% (18 of 53) European countries have POSPM, including countries from the West and East, Nordic and Mediterranean, Anglo-Saxon, and Latin regions. Malta does not have its own training program, but recognizes doctors with a PM specialization who trained abroad.

National experts generally used official acts or ministerial decrees as the main source of information for this study; the experts from the U.K., Ireland, and Portugal used a document from the General Medical Council.

*A Process that, in Most Countries, Is Still in the Works*

With the exception of the U.K., which pioneered the institution of POSPM in 1987, and Ireland, which followed in 1995, the POSPM programs in all other countries were developed in the last 15 years, with eight countries having initiated the process in just the last five years (Fig. 1).

In some countries, the process has changed over the years. For example, Poland approved specialization in 1999 and subsequently revised the process in 2003 and 2013, transitioning to a more flexible system with different options for achieving certification. Georgia proposed changes to the specialist list. Outside of Europe, Canada and the U.S. started with fellowship training and have transitioned to a system of subspecialization. In Australia, PM was first instituted as a subspecialty of internal medicine, but it then became open to physicians in other fields in 2000, permitting access to a large number of professionals.

The Czech Republic first approved a Palliative Medicine and Pain speciality, but, as of 2011, it has been divided into two different subspecialties. The PM approval process is generally long: In France, the approval took eight years of work because the ministry wanted a joint program for Palliative Care and Pain Training. In Israel, it took 12 years of discussions before PM was approved as a subspecialty in 2012. Over the past 15 years, the Spanish legislature has intermittently discussed the POSPM; but, for various reasons, the discussions have been halted and, as of today, a decision is still pending.

*Table 1*
**Specialization Programs in Palliative Medicine in Europe**[a]

| Country | Year | Name (in English) | Type of Certificate | Main Source of Information Used in This Survey |
|---|---|---|---|---|
| Australia | 2004 | Palliative Medicine (medical specialty) | Specialty | www.amc.org.au/index/ar |
| Canada | 2013 | Subspecialty of Palliative Medicine | Subspecialty | Objectives of training of the subspecialty of palliative medicine version 1.0 (2011) |
| Czech Republic | 2004 | Palliative Medicine | Subspecialty | http://www.paliativnimedicina.cz/sites/www.paliativnimedicina.cz/files/users/spravce/paliativnc3ad_medicc3adna_vc49bstnc3adk_2011_c48dc3a1stka_5_kvc49bten_2011.pdf |
| Denmark | 2014 | Recognition of Palliative Medicine as Field of Competence | Special denomination | Fagområdebeskrivelse for Palliative Medicine, Dansk Selskab for Palliative Medicin. http://www.selskaberne.dk/portal/pls/portal/!PORTAL.wwpob_page.show?_docname=10406985.PDF |
| Finland | 2007 | Special competence for Palliative Medicine | Special denomination | http://www.laakariliitto.fi/koulutus/erityispatevyydet/index.html |
| France | 2008 | Diploma of complementary specialized studies Pain Medicine and Palliative Medicine | Special denomination | Ministere de la Sante www.sante.gouv.fr |
| Georgia | 2010 | Palliative Care and Pain Medicine | Subspecialty | www.moh.gov.ge; www.palliativecare.org.ge |
| Germany | 2004 | Palliative Medicine | Subspecialty | http://www.dgpalliativmedizin.de/images/stories/pdf/fachkompetenz/WB%20Kursbuch%20Palliativmedizin%20%28Stand%2041126%29.pdf |
| Hungary | 2013 | Subspecialty in Palliative Medicine | Subspecialty | 69/2013. (Xl. 19), EMMI-rendelet (Ministry of Health Decree on palliative sub-specialty) |
| Ireland | 1995 | Certificate of Completion of Training as Specialist in Palliative Medicine | Specialty | Medical Practitioners Act 2007. Acts of the Oireachtas No 25/2007. Irish Medical Council Guide to the Application Procedure and Rules for Registration in the Register of Medical Practitioners Version 11.0 (August 2012) |
| Israel | 2012 | Palliative Medicine Subspecialty | Subspecialty | The subspecialty notice of approval was published in the official Monitor by December 2012 |
| Italy | 2012 | Post-Specialty Master of Higher Education and Qualification in Palliative Care for Specialist Physicians | Special denomination | Ministry of Education, University and Research Decree April 4, 2012 (12ª04291) (G.U. Serie Generale, n.89 del 16 aprile 2012) |
| Latvia | 2009 | Special Competence in Palliative Care | Special denomination | PC approved in the State programme: 01/29/2009 Act of the Cabinet of Ministers No 48 "About the Control Programme of the Oncological Diseases from 2009 to 2015", PC Chapter. Protocol No 3, Paragraph 47. Published in "Latvijas Vestnesis" 29 (4015), 20/02/2009. Valid from 29/01/2009 |
| Malta | 2003 | Palliative Medicine | Specialty | Health Lane professions Act of 2003 |
| Norway | 2011 | The Formal Competence Field of Palliative Medicine | Special denomination | http://helsedirektoratet.no/helsepersonell/spesialistomradet/delprosjekter/palliativ-medisin/Sider/default.aspx; http://www.nscpm.org (theoretical training course) |
| Poland | 1999 | Program of Specialization in Palliative Medicine for Physicians | Specialty | Minister of Health Regulation of January 2, 2013 on the specialisations of physicians and dentists. See: http://www.cmkp.edu.pl |
| Portugal | 2013 | Palliative Medicine Competence | Special denomination | Official document presented by a group I coordinated to the College of Doctors (Ordem dos Médicos) |
| Romania | 2000 | Diploma of Complementary Studies in Palliative Care (Subspecialty) | Subspecialty | Order of the Minister of Health no 418 from 20.04.2005; the web site of the National School for Education for Physicians (http://webmail.smip.ro/mewebmail/Mondo/lang/sys/client.aspx?CDT=41729.5558516898 |
| Slovakia | 2012 | Specialization Study in the Field of Palliative Medicine | Special denomination | Vestník MZ SR z 31.08.2006, mimoriadne vydanie; Source 2 - Vestník MZ SR z 15.10.2010, ročník 58, s. 123 - 124; |
| Spain | In process | Area of Specific Training in Palliative Care | Special denomination | 11/11/12 Draft Royal Decree on the core curriculum and other aspects of the healthcare system specialized training in health sciences is regulated. |
| U.K. | 1987 | Certificate of Completion of Training as Specialist in Palliative Medicine | Specialty | Palliative Medicine Approved Specialty Curriculum and Associated Assessment System 2010 General Medical council |
| U.S. | 2006 | Hospice and Palliative Medicine Certification | Subspecialty | http://www.nhpco.org/palliative-care/physician-certification |

[a]Includes the U.S., Canada, Australia, and Spain for contrast.

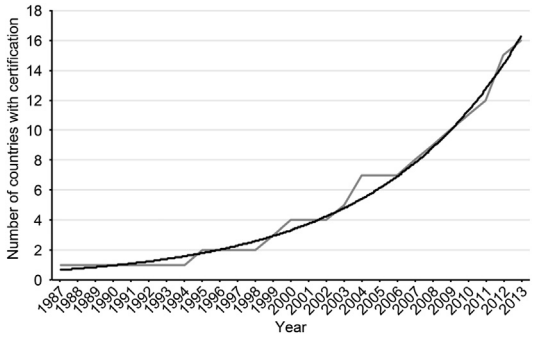


Fig. 1. Exponential development of specialization in palliative medicine in Europe (1987–2014).

### *What Names Are Being Used for Specialization in PM? Do Different Names Represent Different Tracks?*

The current names used for PM are generally "specialization" and "subspecialty;" but in recent years, other names have begun to be used (Table 1). Today, Europeans seem to prefer alternative names for new certification of a new competence field and avoid the terms "specialties" or "subspecialties." Accordingly, performing comparisons by name is impossible because the same name does not always refer to the same track.

In the U.K., Ireland, Poland, and Malta, "specialization" refers to a track that starts immediately after medical school and continues with specialized training in PM. But Slovakia uses "Specialization Study" and requires a previous specialty. Tracks from previous specialties are, in general, called "subspecialties" in some countries and the same is called "Field of Competence" (Denmark), "Diploma in Pain Medicine and Palliative Medicine" (France), "Formal Competence Field" (Norway), "Special Competence Field" (Finland), "Complementary Studies for Special Competence" (Latvia), "Complementary Studies" (Romania), and "Competence in Palliative Medicine" (Portugal). Italy designates its program as a "post-specialty Master in Higher Education and Qualification."

The term "palliative medicine" is used in 13 countries and "palliative care" is used in only five countries. Generally, countries outside of Europe refer to the field as "Palliative Medicine," but the U.S. also includes the term "hospice." The French and Georgian names indicate that the PM specialization is shared with pain specialists.

### *What Previous Specialization or Training Is Required?*

In Europe, 13 countries require the completion of a specialty as a prerequisite for POSPM (Table 2). Six countries accept any clinical specialty and seven countries accept related specialties; the list of alternatives is large, although most are related to oncology, internal medicine, and family medicine. In France, Finland, Denmark, and Slovakia, specialists in general medicine also are suitable for the POSPM. In a few cases, completing training in another specialty is not mandatory (Latvia accepts individuals with four years of residency training in any of several specialties; Poland accepts those with three years of training in internal medicine or pediatrics).

### *How Long Is the Certification Process for PM From the Time of Commencement of Medical Training?*

Including time spent in medical school, the average time required for obtaining a PM title is 12 years. The quickest certification can be obtained in Romania (eight years), and the longest periods reported are in Germany, Israel, Norway, and Poland (15 years maximum) and Spain. Spain is still developing its plan for PM specialization, but the proposal indicates a requirement of a prior specialty and two years of specialized practice.

### *Content and Length of Specialized Training*

Analyzing the POSPM composition, we found different emphases on palliative care clinical practice, theory, teaching, and research (Table 3). Most countries have developed a program that focuses more on clinical practice such that a rotation in different palliative care settings is officially accredited by the program. The minimum required training program in clinical practice in the U.K. and Ireland lasts seven years, including basic and higher specialist training. Finland, France, Israel, Norway, and Poland require two or two and a half years (after a prior specialization). The exceptions are Germany, Portugal, and Hungary (one year), Slovakia (10 months), Italy (three months), Romania (one month), Latvia (320 hours), and Georgia (100 hours). In Germany, there is an option where 12 months' training in palliative care services can be substituted by 120 hours of courses/seminars. In the U.S., training includes a one year clinical rotation. Canada will require two years in clinical practice when their subspecialty program is up and running, and Australia requires three years. Only three countries (Romania, Latvia, and the Czech Republic) have developed a program that is more theoretically focused.

Generally, theory, which is still a considerable part of all the programs, is organized into modules or courses. The themes included in the modules are typical of the discipline; in most of the program descriptions, we found the following topics: pain and symptom management, opioids and pharmacology, psychological and psychosocial issues, ethical issues, communication, team work, organization in palliative care, final hours, normative and legal issues, and oncology and nononcological diseases. Additional topics are included in some

*Table 2*
**Previous Training Required to Enter a PM Specialization Program in Some European Countries**

| Country | Condition for Entry | Details |
|---|---|---|
| Czech Republic | Specialty | Any clinical specialty |
| Denmark | Specialty determined | Medical oncology, anesthesiology, cardiology, and pneumology. General practitioners, after speciality training, have to work in palliative care units |
| Finland | Period of clinical practice | Two years of clinical practice as a licensed medical doctor |
| France | Specialty determined | Oncology, internal medicine, general medicine, and many other specialities |
| Georgia | Specialty determined | Oncology, family medicine, surgery, critical care, neurology and infectious diseases, internal medicine, and pediatrics |
| Germany | Specialty | Any clinical specialty. |
| Hungary | Specialty | Internal medicine, oncology, neurology, anesthesiology, pneumology, geriatrics, surgery, urology, pediatrics, psychiatry, and general medicine |
| Israel | Specialty determined | Oncology, internal medicine, family medicine, geriatrics, anesthesiology, rehabilitation, pediatrics, hematology, and neurology |
| Italy | Specialty plus clinical practice | Medical oncology, anesthesiology, rehabilitation, geriatrics, neurology, radiotherapy, and pediatrics. Family medicine with three years of experience in palliative care |
| Latvia | Clinical practice as specialist | Medical oncology, family medicine, geriatrics, internal medicine, neurology, rehabilitation, and pediatrics |
| Norway | Specialty | Any clinical specialty |
| Poland | Training in a specialty | Three years training in internal medicine or pediatrics |
| Portugal | Specialty | Any clinical specialty |
| Romania | Specialty | Any clinical specialty |
| Slovakia | Specialty determined | Oncology, internal medicine, pediatrics, geriatric, algesiology, and intensive and general medicine. |

PM = palliative medicine.

of the programs, including community palliative care; culture, language, and religion (Ireland); grief and bereavement; and more. In its theoretical program, Italy includes topics from other disciplines, including radiology, psychiatry, and public health. Most POSPM have a mandatory research component consisting of at least one research project or published projects or articles.

### *Fellow Requirements and Features*

Fee payments and fellows' salaries are not properly clarified in all countries. When applicable, fee

*Table 3*
**Comparison of Components of Specialized PM Training in European Countries**[a]

| Country | Length of PM Training Process | Clinical Practice in PM (y) | Theoretical Component | Research Component |
|---|---|---|---|---|
| Australia | 3 | 3 | NA | 3 Projects |
| Canada | 2 | 2 | 350 h | 1 Project |
| Czech Republic | 1 | 1 | 12 mo | NA |
| Denmark | 2 | 2 | 6 wk | 1 Project |
| Finland | 2 | 2 | 150–270 h | 1 Project |
| France | 2 | 2 | 170 h | 1 Project |
| Georgia | 0.5–1 | 0.5 | 75 h | NA |
| Germany | 1 | 1 | 40 units | NA |
| Hungary | 1 | 1 | 80 h | NA |
| Ireland | 4 | 4 | NA | NA |
| Israel | 2 | 2 | NA | NA |
| Italy[b] | 2 | 0.5 | 1550 h | 1 Project |
| Latvia | 2 | 2 | 400 h | 80 h |
| Norway | 2 | 2 | 180 h | 1 Project |
| Poland | 2 | 2 | NA | 1 Project |
| Portugal[c] | 1 | NA | 400 h | 3 Projects |
| Romania[d] | 1.5 | 0.25 | 8 wk | NA |
| Slovakia[e] | 3 | 0.5 | NA | NA |
| U.K. | 4 | 4 | NA | NA |
| U.S. | 1 | 1 | NA | NA |

PM = palliative medicine; NA = not available.
[a]Includes Australia, Canada, and the U.S. for contrast.
[b]Italy: The program consists of 3000 h involving lessons and internship during 24 mo, with 120 credits required divided in 55 Credits of Theoretical Training (1500 h), plus 50 Credits of Clinical Practice and the research project (practice + research: 1500 h).
[c]Portugal: 800 h of clinical practice in an accredited center are required as clinical practice in addition to the curriculum studies.
[d]Romania: Training takes 12 wk over a period of 18 mo. The 12 wk course is divided into 8 wk devoted to theoretical content (240 h) and 4 wk devoted to clinical practice.
[e]Slovakia: the fellows spend 3 y in their own clinical practice (usually in palliative care or related areas). During this period, they have to stay in a palliative care teaching department under supervision for periods of 1–2 mo per year.

payments comprise the following: 1) admission fee of 250–6000 Euros (average of 2313 Euros) in 10 of 19 countries, 2) annual fee required in three of 19 countries, and 3) fee per course, examination, or training period in three of 19 countries. The following nine (of 19) countries provide a salary: Australia, Canada, Finland, France, Ireland, Israel, Norway, the U.K., and the U.S. Some professional associations provide grants for theoretical courses (Finland and Norway).

With respect to other requirements, seven of 19 countries require candidates to attend to a minimum number of patients, and 16 of 19 countries require a final examination or evaluation.

### *POSPM Requirements for Training Institutions*

The institutional requirements for establishing a POSPM program are defined in 13 European countries. To launch a POSPM, the main requirements include:

- Institutions must have accredited clinical practice units and services for training physicians in palliative care.
- Directors must have specialized experience, including trained according to specific, acknowledged guidelines (U.K.), appointed by a specific Steering Committee (Finland, Ireland, Israel, Norway, Romania, the U.K., and the U.S.), university professor in a specific discipline (Canada: PM; Italy: medical oncology, internal medicine, anesthesiology, and others), and involvement in academic training (Germany and the U.S.).
- Faculty members must be both certified and acknowledged as multi-team specialists and experienced palliative care practitioners.

### *Certifying Bodies of PM Programs*

The POSPM are predominantly certified by the Ministry of Health (France), but can be associated with the Ministry of Universities (Italy) or College of Physicians (Israel, Denmark, and Portugal). In Ireland, the U.K., and Portugal, POSPM were originally certified by the Irish Medical Council (Ireland), General Medical Council (U.K.), and Conselho Nacional Executivo (Portugal).

### *Practical Consequences for Work Positions or Effectiveness of Certification*

In some countries (Table 4), obtaining a certificate is mandatory for acquiring a clinical position in the public sector, but not necessary for private institutions. Canada, Denmark, France, Portugal, and Slovakia declare that they are in the process of considering whether POSPM should be mandatory for university appointments beginning in 2014. Certification permits physicians in some countries to more easily acquire academic positions (Canada, Hungary, and Portugal), Ministerial Work Group access (Portugal), or work with units that require physicians to have five years of palliative care experience (Slovakia and the U.S.).

### *Workforce Capacity of PM Physicians*

Germany has the highest number of fellows/students trained in PM; from a population of 82 million, from 2004 to 2012, 6400 doctors received

*Table 4*
**Workforce Capacity of PM Physicians With the Highest Certification Possible by Country[a]**

| Country | Year of Institution | Total No. of Fellows Trained (up to 2012) | Trainees per 1 Million of Population | Approximate No. Trainees per Year | Use of a Palliative Care Certificate in Health Services |
|---|---|---|---|---|---|
| Australia | 2004 | 150 | 6.4 | 40 | Mandatory |
| Czech Republic | 2004 | 134 | 12.7 | 10 | Optional |
| Finland | 2007 | 84 | 15.5 | 40 | Optional |
| France | 2008 | 100 | 1.6 | 35 | Optional |
| Georgia | 2010 | 20 | 4.6 | 10 | Mandatory |
| Germany | 2004 | 6400 | 78.1 | 600 | Mandatory |
| Ireland | 1995 | 31 | 6.8 | 2–3 | Mandatory |
| Israel | 2012 | 0 | — | — | Mandatory |
| Italy | 2012 | 100 | 1.6 | 200 | Optional |
| Latvia | 2009 | 100 | 44.8 | 20 | Optional |
| Malta | 2003 | 0 | NA | NA | Mandatory |
| Norway | 2011 | 43 | 8.7 | 5–6 | Mandatory |
| Poland | 1999 | 340 | 9.7 | 40 | Mandatory |
| Portugal | 2013 | 0 | — | — | Optional |
| Romania | 2000 | 305 | 14.3 | 25 | Optional |
| Slovakia | 2012 | 6 | 1.1 | 1–3 | Optional |
| U.K. | 1987 | 334 | 5.3 | 50 | Mandatory |
| U.S. | 2006 | NA | NA | 300 | Optional |
| Denmark | 2013 | 0 | — | — | Optional |
| Hungary | 2013 | 0 | — | — | Mandatory |

PM = palliative medicine; NA = not available.
[a]Includes Australia and the U.S. for contrast.

POSPM certification, resulting in 78.1 specialists per million inhabitants (Table 4). For comparison, Poland has 9.7, the U.K. has 5.3, and France has 1.6.

## *Discussion*

The certification of PM specialization is a relatively new concept and still evolving in many countries. Its initial slow growth indicates the difficulties in certifying PM, but the number of countries that have launched postgraduate education programs has quickly increased in recent years, indicating the vitality of palliative care in Europe and the need for qualified doctors in the field.

The spread of POSPM is happening throughout Europe regardless of sociocultural or geographical markers, with several individual variations and program quirks in each country. Most countries include the term "palliative medicine" in the official title instead of "palliative care;" this common language could reinforce the understanding of PM as an official discipline in health care.

Specialization in PM has been mapped in previous studies. This survey, for its part, has addressed specialization in a more comprehensive and comparative manner, allowing deeper analysis and better understanding of the data and each country's current situation. The information provided herein aims to be useful to professionals (to make decisions about their training), professional institutions (palliative care promotion), and policymakers (comparative analysis of specialization in neighboring countries).

As a limitation of the study, a possible bias could be present because we used responses from only one representative from each country. We tried to avoid this possible bias by asking respondents to indicate the main official document source they used to answer the questionnaire; however; some kind of peer review process could improve results in similar studies. The method of comparison could be another limitation, highlighting what is common but giving less relevance to that which is specific to the process of specialization in each country.

In medicine, specialization in general represents the most advanced level of training in the field; specialists are called on to assist with the most complex patients and to set the academic level. How many doctors specialized in PM are needed in a country is an unresolved issue, as is the level of specialization. The number of doctors trained per population varies greatly between countries and it is not clear if a doctor certified in one country has the same level of education as a doctor certified in another. Germany has 80 subspecialists per million inhabitants. A neighboring country, France, starting four years later, has only 1.6. In Germany, the option to substitute 12 months' training in palliative care services with 120 hours of courses/seminars could have been used by many subspecialists in this country.

Some have suggested that the training process for PM should be more uniform throughout Europe. However, this kind of standardization may present a number of challenges, as evidenced by the diversity of approaches we found in countries offering PM programs. Based on this Task Force's analysis, an entirely uniform solution is not possible. Europe is strongly characterized by diversity in its organization, history, traditions, and cultures. Moreover, health system differences and the specialized training programs in each country require different approaches, reducing the usefulness of a more uniform program. However, it is important for each country to have official and effective certification at the highest level possible to recognize the highest training that a full-time physician in palliative care should obtain.

Having a specialist degree should result in greater value in the market for professional work. Nine countries require physicians to be certified before they practice in the field of palliative care/medicine, and the same condition is being evaluated for approval in another six countries. It is also important to note that most of the training courses provide a large amount of professional activity.

We have identified an issue in relation to the use of language/terminology. Terms such as "special field of capacitation or training" seem to be replacing the more traditional terms "specialty" or "subspecialty." This trend may not be exclusive to PM and may apply to other newly recognized areas of medicine across Europe. Whatever language is used, it will be essential to ensure that the same rigor is applied to the process of specialization in PM as that applied to other areas of medicine. This new terminology and the PM track are consistent with the field as a means to benefit from other disciplines and is necessary for many specialists in other fields. All clinical PM specialists are presented the opportunity to dedicate themselves to palliative care patients with extra training that must be adapted to their previous backgrounds during the training process. In addition, regarding the work capacity needed in palliative care, it has been suggested that a long training period with narrow requirements for achieving the title of specialist if one does not have previous clinical experience can make it difficult to attract young doctors. Indeed, countries with PM specialization have experienced some difficulties in recruiting a substantial number of PM specialists. Palliative care teams might be enhanced with new clinical doctors by offering recognized additional training in PM that lasts

two years and that is aimed at experienced physicians without limitations on the specialty background.

This analysis highlights the fact that the consolidation and/or regulation of the palliative care field can accelerate the process of POSPM recognition in some countries (such as Israel or Italy); for other countries, POSPM constitutes a preliminary condition for developing the field (Poland). Thus, acknowledged POSPM is a good indicator of vitality, but is not always indicative of advanced palliative care development.

Finally, although we wanted to focus this work on the importance of recognizing PM as a medical discipline, it also must be emphasized that it is essential that advanced training for all palliative care professionals be available.

## Conclusion

PM certification has grown in Europe, meaning that PM is more accepted than commonly perceived. Educational processes leading to certification are generally long and include substantial clinical training. The heterogeneity of the educational plans that lead to the various certifications (e.g., specialization, subspecialization, and field of competence) is unlikely to change soon. More likely, basic homogeneous elements for testing the skills acquired during the course of study will be developed. In this process, the EAPC also should commit to establishing common learning standards, thus leading to additional European-based recognition of expertise in PM.

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