Comparing Hospice and Palliative Care Pathways for New Hospice and Palliative Medicine Physicians

By

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Contents

Summary

Over the past several years, anecdotal reports from hospice medical directors and fellowship directors indicated that hospice and palliative medicine (HPM) physicians preferred palliative care positions compared with hospice positions. Data from surveys of HPM fellows completing training in 2015 and 2016 did not show a strong difference in salaries between hospice and nonhospice jobs, nor were there questions on earlier surveys to assess why fellows were not selecting hospice jobs. To learn more, AAHPM asked the George Washington University Health Workforce Institute (GWHWI) to explore factors leading to job choices for graduating fellows as part of their 2018 research on HPM physicians. This included conducting focus groups and qualitative interviews and the addition of several questions to the 2018 survey of graduating fellows. One goal was to identify factors influencing the interest or lack of interest in hospice practice.

The survey, focus groups, and interviews all confirm the preference of new HPM physicians for palliative care compared with hospice positions. Although the respondents' views of hospice practice generally were positive, their views of palliative care were even more positive. It is worth noting that physicians completing their HPM fellowship rate their training and the specialty very highly. In 2018, 135 of 136 fellows responding to the survey said they would recommend the specialty to others.

New HPM physicians in general perceive palliative care as offering a more interesting career that better fits with their interests. Further

- HPM fellows enter fellowship training with a predisposition for palliative care, including hospital palliative care, compared with hospice practice
- their fellowship experience reinforces the preference for palliative care
- this is further reinforced by the marketplace, which offers more and slightly better-paid positions in palliative care
- palliative care positions are viewed as more appropriate and a better fit for younger physicians early in their career, as opposed to hospice employment, which is viewed as a good fit for more experienced physicians.

Over the past decade, palliative care has grown rapidly, especially in hospitals. The greater interest in palliative care by new HPM physicians is consistent with this growth in opportunities. Furthermore, with the likely growth in community-based palliative care in the coming years, the greater interest in palliative care positions may be consistent with future needs.

Given the perception that hospice practice is a better fit for older physicians, hospices may want to consider recruitment strategies targeted to older HPM physicians. In addition, the delivery of hospice and palliative care services is evolving in ways that may make the distinction between hospice and palliative care providers less clear. Hospitals are providing hospice and palliative services; some hospices are providing palliative care services; and community-based palliative care may be provided by hospitals, hospices, nursing homes, and community-based providers.

Methods

GWHWI combined qualitative and quantitative approaches to explore the question of career choice for graduating fellows. There were three data sources. The first consisted of phone interviews with 10 HPM fellows to explore the factors that influenced their interest in hospice versus palliative care practice. The second consisted of focus groups with practicing professionals (both physicians and nurses). Based on the themes that emerged from these qualitative approaches, we developed questions on this topic to add to the online survey sent to HPM fellows graduating in 2018. The survey results provided the quantitative data that enabled us to assess how widespread each theme was. Comments on the

survey (usually elaborating on "other" [ie, free text] responses to a question) also provided some qualitative information that illuminated issues related to career choices.

Fellows were selected for the phone interviews by randomly pulling names from the list of fellows who had graduated in 2017 and from the list of fellows who were about to graduate in 2018. Phone interviews were conducted by one interviewer in May and June of 2018. Five 2017 graduates and five 2018 graduates were interviewed.

Three focus groups were conducted at the 2018 Annual Assembly of Hospice & Palliative Care in Boston to explore issues of concern to practitioners about the future of HPM practice—including changing roles/responsibilities, satisfaction, burnout, and retirement plans—and information related to the supply, demand, and distribution of HPM physicians. Two focus groups consisted of individuals invited from the list of physicians registered for the conference. One focus group consisted of advanced practice nurses invited from the list of all nurses registered for the conference. Two facilitators from GWHWI moderated each group using a question guide that had been approved by the AAHPM Workforce Advisory Group.

The online survey of fellows who had completed training in 2018 was conducted in September through October of 2018. Using email addresses provided by AAHPM for 256 of the 292 fellows in Accreditation Council for Graduate Medicine Education (ACGME) fellowship programs, the GWHWI surveyed physicians who had finished their fellowship earlier in the year. One hundred forty-seven of the 256 responded, for a 57.4% response rate representing 50.3% of all 292 HPM residents. This is comparable to the response rates for the 2015 and 2016 surveys, which had response rates of 58% and 59%, respectively, of the fellows invited and 46% and 49.6%, respectively, of all ACGME HPM fellows. The respondents were comparable to all HPM fellows as reported by ACGME, with no statistical differences in demographic and educational characteristics.

For some of the analyses, data from the three graduating fellow surveys conducted in 2015, 2016, and 2018 were combined to explore differences between those graduates who chose a hospice job after graduation from those who did not. There were 30 fellows across the 3 years who had chosen hospice as their primary practice setting after graduation. This sample was large enough to permit simple exploratory analysis.

Results

New HPM Physicians Prefer Palliative Care Compared with Hospice Positions

Surveys of graduating HPM fellows conducted in 2015, 2016, and 2018 confirmed that the vast majority of new HPM physicians were not going into hospice: only about 9% of fellows accepted jobs with hospices. This proportion was constant across the time period (**Exhibit 1**).

Exhibit 1: Proportion of Graduating Fellows Working in Hospice as Primary Practice Setting After Graduation

	2015 percent (N = 95)	2016 percent (N =115)	2018 percent (N = 128)	Total percent (N = 338)
Hospice	9	9	8.6	9
All other settings	91	91	91.4	91
Totals	**100**	**100**	**100**	**100**

For this analysis, we combined responses from all three years (2015, 2016, and 2018): 28 fellows out of 333 (8.4%) chose to work in hospice. **Exhibit 2** compares the demographic characteristics of those choosing hospice versus nonhospice positions. Age and number of years worked prior to fellowship showed the greatest association with hospice choice, with older, more experienced practitioners choosing hospice at significantly greater rates: 20.6% of graduates age 41 years or older chose hospice versus 5.8% of graduates age 41 years or younger. Gender and type of education (US medical graduate versus international medical graduate) did not impact selection of hospice. Doctors of osteopathic medicine (DOs) were a little more likely than doctors of medicine (MDs) to select hospice positions (not significant).

Exhibit 2: Demographic Characteristics by Hospice Choice

Demographic characteristics	Palliative care percent	Hospice percent	*P* value
Gender (N = 333)			*P* = 0.532
Male (113)	90.3	9.7	
Female (220)	92.3	7.7	
Type of education (N = 338)			*P* = 0.841
USMG (275)	91.3	8.7	
IMG (63)	90.5	9.5	
Medical education type			*P* = 0.523
Allopathic (MD, 285)	91.6	8.4	
Osteopathic (DO, 54)	88.9	11.1	
Age (N = 323)			*P* = 0.000
< 40 years (260)	94.2	5.8	
40+ years (63)	79.4	20.6	
Years practicing (N = 339)			*P* = 0.029
0 to 4 (275)	93.5	6.5	
5 to 10 (32)	84.4	15.6	
11 or more (32)	78.1	21.9	

IMG, international medical graduate; USMG, US medical graduate

Family physicians were more likely to go into hospice (17.4%) compared with physicians entering with a background in internal medicine (8.2%).

Predisposition Toward Palliative Care: Selection of Fellowship Program Focus

The 2018 survey asked whether fellows sought certain training program characteristics when selecting their fellowship training program. This would help determine whether an interest in hospice work had preceded their training program. About one-third of fellows sought out a fellowship program with training in hospice (**Exhibit 3**). This was far less than the 61% who sought academic teaching and 60% who sought hospital-based palliative care. However, of the 11 graduates who worked primarily in a hospice setting after graduation, eight (72.7%) actively sought a fellowship program with a focus on hospice, suggesting that their interest in hospice and intention to practice there may have preceded fellowship.

Exhibit 3: HPM Fellowship Program Focus Sought

Program focus	Percent	N*
Academic teaching	61.2	90
Hospital-based palliative care	60.5	89
Hospice	31.3	46
Pediatric palliative care	20.4	30
Research	19	28
Other	4.1	6
None of the above	15.6	23
Total responses to any part of this question	**100**	**147**

**Respondents could select more than one response.*

The Fellowship Experience

Respondents described their hospice rotation experience quite differently than their palliative care rotation experience (**Exhibit 4**). They rated their palliative care rotation experience better than their hospice rotation experience in the areas of having many intellectually interesting cases, having many emotionally satisfying cases, having satisfying doctor-patient relationships, team-based care, continuity of relationships with patient/family, program innovation and growth, faculty for whom the specialty was a calling, and faculty who encouraged a career in the setting. Conversely, they rated their hospice rotation experience better than their palliative care rotation in the area of good provider work-life balance. For many negative factors, hospice was rated better in that those negative factors were more prevalent for palliative care than for hospice. These negative factors were much time spent on administration, frequent overnight call, frequent weekend call, providers experiencing burnout, and fellows experiencing burnout.

Exhibit 4: Characteristics of Hospice and Palliative Care Rotation Experience

"Based on your experience during your HPM fellowship, were any of the following factors characteristic of your rotations? (Select all that apply)"	Hospice percent (N = 142)	Palliative care percent (N = 146)
POSITIVE FACTORS		
Team-based care	83.8	93.2
Many emotionally satisfying cases	76.1	91.1
Providers with good work-life balance	76.1	67.8
Satisfying doctor-patient relationships	74.6	89
Faculty who encouraged a career in the setting	66.9	80.1
Faculty for whom the specialty was a calling	65.5	76
Many intellectually interesting cases	59.2	97.3
Continuity of relationships with patient/family	54.2	70.5
Program innovation and growth	23.2	61.6
NEGATIVE FACTORS		
Providers experiencing burnout	16.2	34.2
Frequent weekend call	11.3	24.7
Much time spent on administration	11.3	21.2
Fellows experiencing burnout	5.6	23.3
Faculty who discouraged a career in the setting	3.5	4.8
Other	0.7	0.7

Although most fellows (70%) rated their hospice fellowship experience as excellent or very good, as indicated in **Exhibits 5** and **6**, they rated their palliative care experience more highly: 61.1% of fellows rated their palliative care fellowship experience as excellent compared with 41.8% for hospice. Almost one in 10 (9.5%) rated their hospice fellowship experience as fair or poor compared with only 3.5% rating their palliative care experience as fair. None rated their palliative care experience as poor.

Exhibit 5: Quality Rating of Fellowship

"How would you rate the quality of the experience you had during fellowship?"	Hospice percent (N = 146)	Palliative care percent (N = 144)
Excellent	41.8	61.1
Very good	28.1	26.4
Good	20.5	9
Fair	6.8	3.5
Poor	2.7	0.0
Totals	**100**	**100**

Respondents indicated that their exposure to palliative care during fellowship encouraged them to follow a career in palliative care more than their exposure to hospice encouraged them to follow a career in hospice: 82% felt strongly encouraged or encouraged to work in palliative care compared with only 44.8% for hospice (**Exhibit 7**).

Exhibit 6: Rating of Quality of Rotation Experience During Fellowship

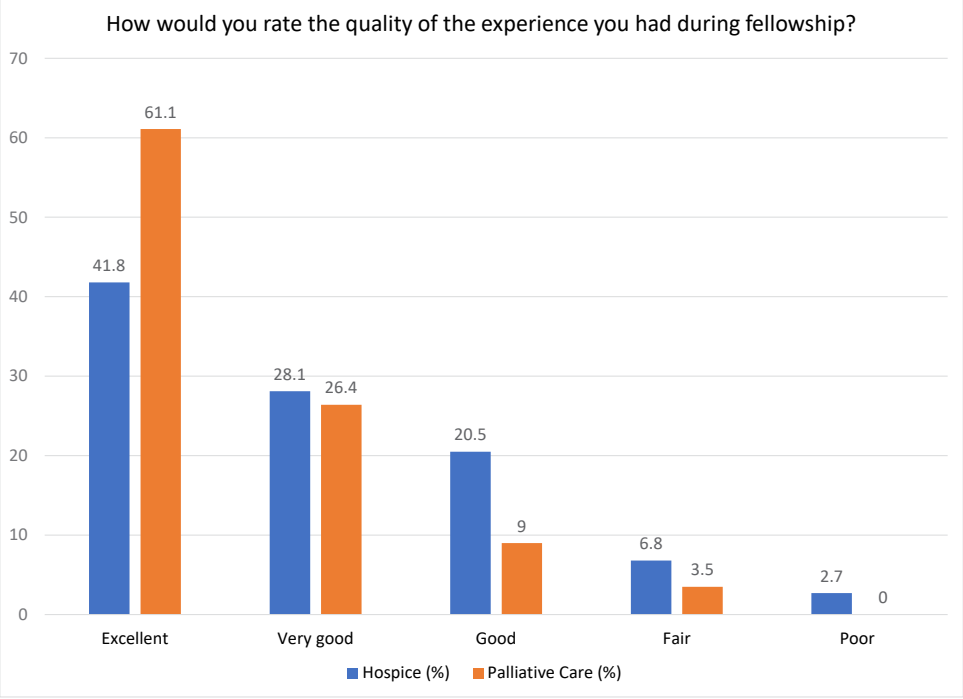
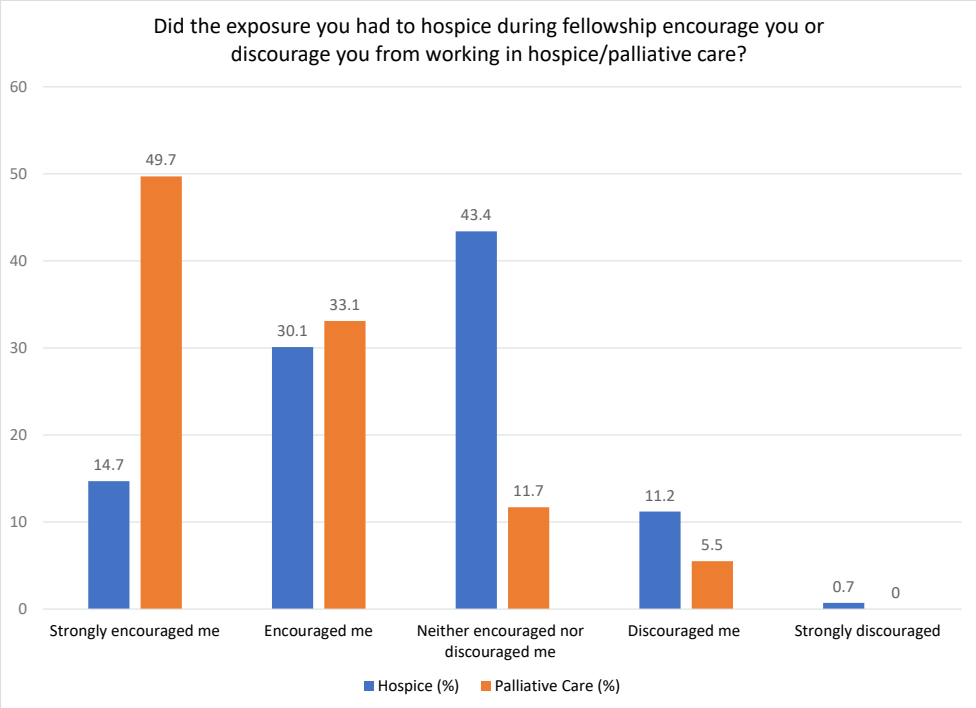


Exhibit 7: Impact of Exposure to Hospice and Palliative Care During Fellowship



Perspectives on Careers in Hospice Versus Palliative Care

Exhibits 8 and **9** show important differences in the perspective of 2018 HPM fellows regarding hospice compared with palliative care. When asked which statements they agreed with concerning careers in hospice or palliative care, respondents had many more responses—both positive and negative—about palliative care than about hospice. Fellows rated palliative care as being more in line with the postive statements "is intellectually stimulating," "is a prestigious career path," is a "good fit with my interests," and "has good income potential." The biggest gap between palliative care and hospice occurred for the statements "is intellectually stimulating" and is a "good fit with my interests." The only statement they tended to agree with more for hospice was "is suitable at an early career point." The greatest differences between hospice and palliative care were for the statements "is intellectually stimulating" and is a "good fit with my interests." Regarding negative statements, many more fellows agreed with statements about burnout (both for providers and fellows) for palliative care than for hospice.

Exhibit 8: Agreement with Positive Statements About Careers in HPM

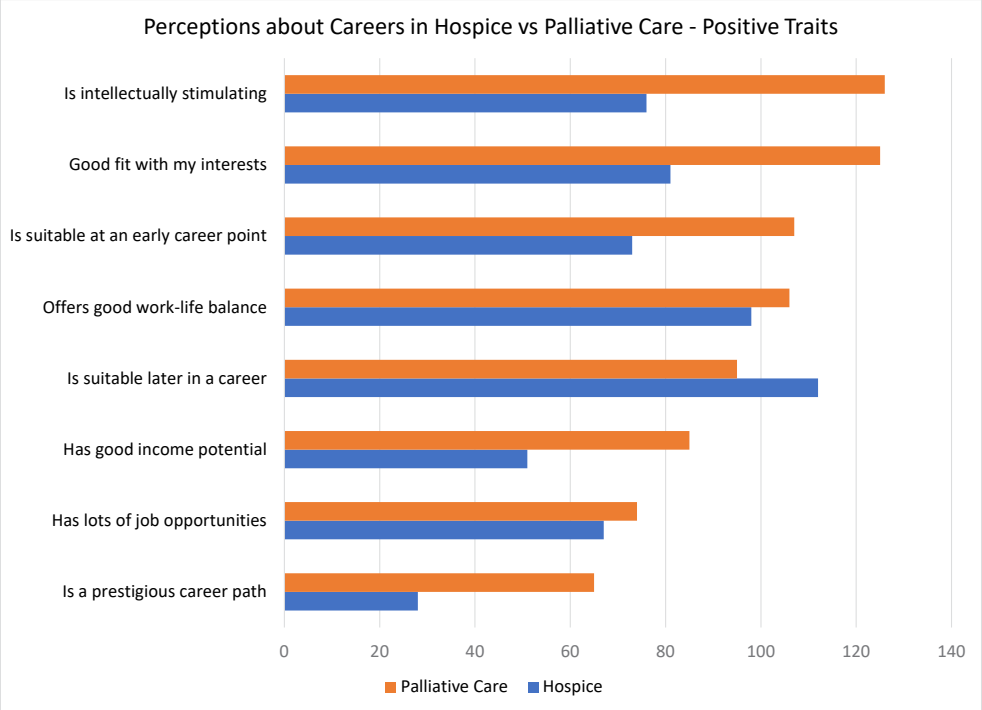
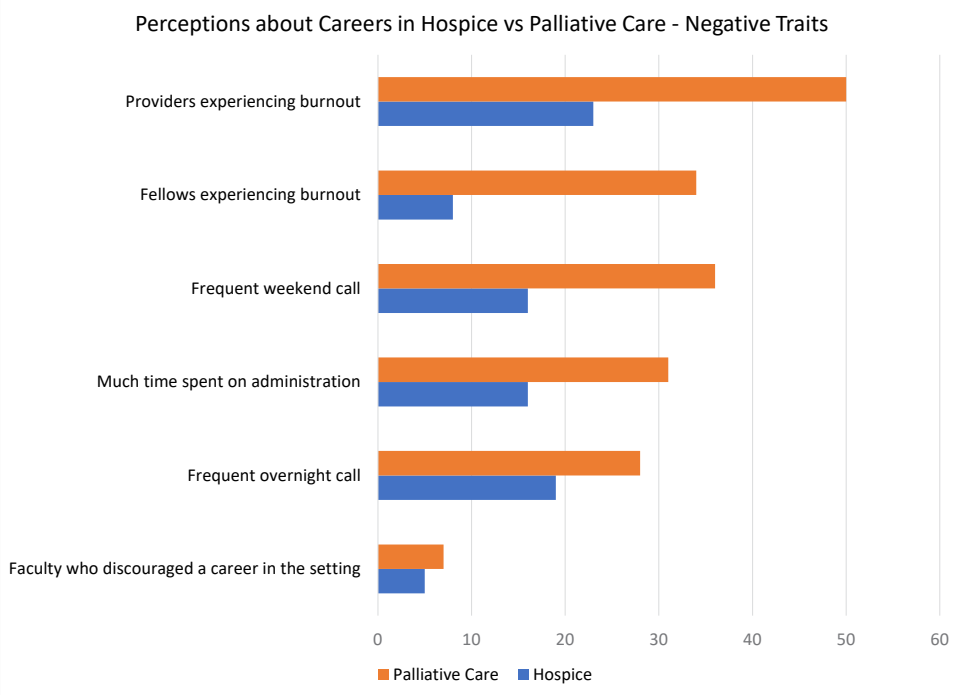


Exhibit 9: Agreement with Negative Statements About Careers in HPM



The Job Search

Very few respondents (9.5%) searched for a hospice job. Almost twice as many (16%) searched for a job combining hospice and palliative care. There does not appear to be a shortage of hospice jobs, although particular markets may be crowded. Twenty-nine percent said there were many hospice positions other than medical director, compared with 14.5% who said there were few of these positions. However, hospital-based palliative care jobs were seen as even more plentiful, with 31.5% saying there were many of these jobs compared with 10.5% who said there were few (**Exhibit 10**).

Exhibit 10: Types of HPM Jobs Searched For

"You said earlier you searched for a job involving [HPM]. Were you primarily searching for a job that focused on:"	Frequency	Percent
Hospital palliative care	62	49.6
A combination of hospice and palliative care	20	16
A combination of palliative care with another specialty (such as oncology, pediatrics, nephrology, or emergency medicine)	18	14.4
Hospice home care	7	5.6
Other	7	5.6
Community (outpatient) palliative care	6	4.8
Hospice inpatient unit	3	2.4
Hospice in nursing home/long-term care	2	1.6
Totals	**125**	**100**

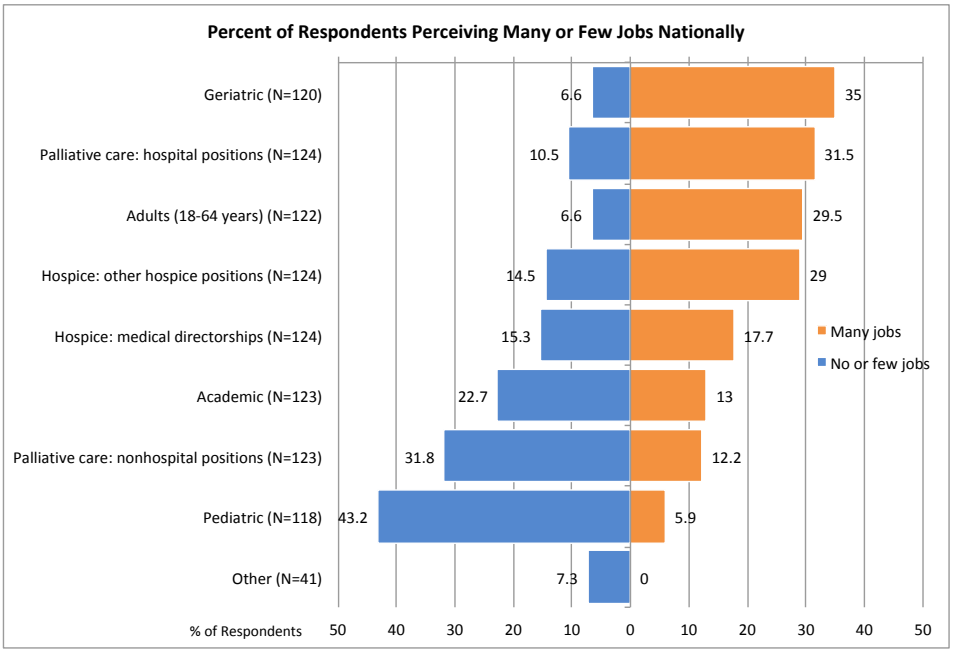
Graduates who took hospice positions had no more trouble finding positions than those who took palliative care positions (28.6% hospice versus 25.4% palliative care; not significant). Nor did they have to change their plans at a greater rate (21.4% hospice versus 19.0% palliative care; not significant). However, a greater proportion of those choosing hospice took part-time positions (25%) compared with those who did not choose hospice (9.9%). Although the numbers are far too small to draw a definitive conclusion, there is some indication that a greater proportion of those who took part-time jobs had to change their plans, suggesting that part-time work may not have been their first choice. Twenty-eight percent of those who took part-time jobs (either in hospice or palliative care) had changed their plans compared with 18.4% who took full-time jobs (**Exhibit 11**).

Exhibit 11: Job Search Experience by Hospice Choice

	N =	Palliative care	Hospice	Palliative care percent	Hospice percent	*P* value
Difficulty finding satisfactory position?	296					*P* = 0.712
No		200	20	74.6	71.4	
Yes		68	8	25.4	28.6	
Changed plans because of limited practice opportunities	297					*P* = 0.752
No		218	22	81	78.6	
Yes		51	6	19	21.4	
Full time						*P* = 0.39
No		22	5	9.9	25	
Yes		201	25	90.1	75	

The 2018 survey asked respondents about their perception of the types of positions that were more and less available based on their job search experience. Because the job market could be very different in different locations and for HPM physicians with different backgrounds and experiences, for most types of positions there were, not surprisingly, both positive and negative views of the job market. As indicated in **Exhibit 12**, far more respondents indicated that there were many hospital palliative care positions than responded that they thought there were no or few jobs (31.5% to 10.5%), indicating a strong job market for these positions. Nearly an equal percent indicated that hospice director positions were plentiful compared with those saying no or few jobs (17.7% to 15.3%). The job picture for other hospice positions was better, with 29% saying there were many jobs compared with 14.5% saying there were no or few jobs.

Exhibit 12: Positions More Available and Less Available Nationally



Income and Satisfaction

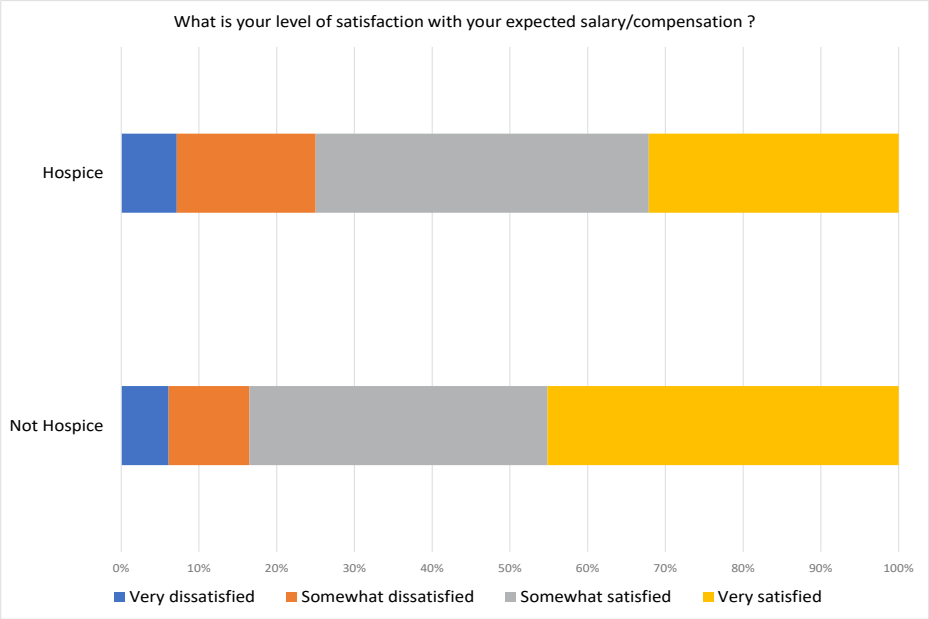
New HPM physicians joining hospital practices and nonhospital group practices had slightly higher average incomes than those going to work for hospices (**Exhibit 13**).

Exhibit 13: Expected Average Income by Practice Setting

Type of principal practice setting	Mean income	Percent of respondents (N = 114)
Nonhospital group practice	$214,000	7.1
Hospital-affiliated practice or employee	$212,000	65.5
Hospice	$208,500	8
Other	$209,000	19.5
Totals	**$209,000**	**100**

Those who went to work for hospices appeared somewhat less satisfied with their compensation than those who chose nonhospice jobs: 32% of hospice practitioners were very satisfied with their compensation compared with 45% of nonhospice practitioners (**Exhibit 14**).

Exhibit 14: Satisfaction with Compensation by Hospice/Palliative Care Position



Finally, we checked to see whether particular fellowship programs might be having greater success than others at moving fellows toward hospice jobs after graduation. Over the 3 years for which we had data, 25 training programs had at least one fellow choose hospice. Of these, only three training programs had two fellows choose hospice and no program produced more than two hospice choosers. Thus, there do not appear to be any training programs that are turning out large numbers of hospice choosers. It is possible that nonrespondents to the survey might show a different pattern, but this cannot be tested with current data.

Discussion

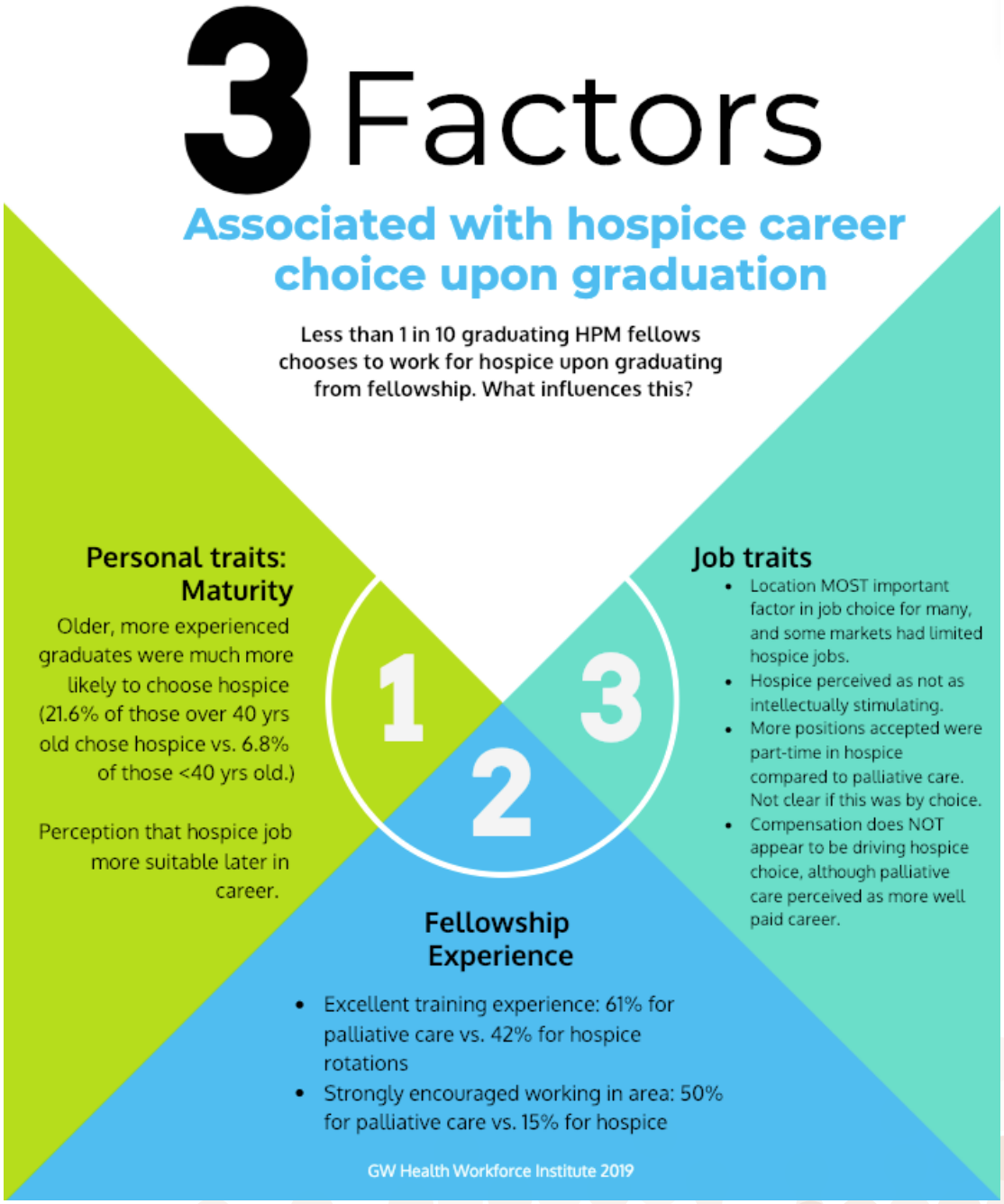
Three types of factors are associated with the choice of a hospice career immediately after graduating from an HPM fellowship program: personal traits of the fellow, experience during fellowship, and qualities of the job. The related traits of age and experience are strongly associated with the choice of hospice upon graduation. Older graduates choose hospice jobs at a much greater rate (21.6% for those older than 40 years versus 6.8% for those younger than 40 years), and the same trend was seen in the variable years of practice experience prior to fellowship. Hospice was seen as more suitable for a later stage in one's career, in part because of its flexibility, because it wasn't seen as pressured or fast paced, and because more independence—even loneliness—was part of the job. Even among those who liked the hospice setting, some expressed a preference for the inpatient hospice setting compared with home hospice care. What cannot be known from this data is whether graduates who did not choose a hospice job at the beginning of their career will move on to hospice jobs later in their careers. If they do, the small number of physicians entering hospice after graduation may not be a problem—hospices just would need to recruit these physicians a decade or two later in their careers. But if physicians do not turn to hospice later in their career, the pipeline of trained fellows entering hospice jobs appears to be diminishing as the number of more experienced fellows trends downward.

Experience during fellowship also seems to influence hospice choice. Although many fellows reported positive hospice experiences during fellowship, the overall rating of hospice training was lower than that for palliative care training. Trainees also reported feeling much more encouraged to go into palliative care (50% felt strongly encouraged) versus hospice care (15% felt strongly encouraged).

Whether this was direct encouragement by faculty or simply a reflection of what they observed during their rotations was not entirely clear.

Finally, a number of characteristics of hospice work itself were seen as unattractive compared with palliative care. Palliative care was perceived as more intellectually stimulating, a better fit with graduates' interests, and a more prestigious career path and as having better income potential. Furthermore, a greater proportion of fellows entering hospice took part-time jobs, and it was not possible to discern whether this was by choice or because they could not find a full-time hospice position. Location was the most important factor for many in their job search, with some reporting that they would sacrifice income or desired job characteristics to find a job in the desired location.

Within the larger context of graduates who are almost universally enthusiastic about their new specialty, there is a definite sense that hospice jobs are not widely attractive to new graduates, especially those at the start of their careers.



Appendix A: Themes from Qualitative Responses from Surveys, Interviews, and Focus Groups

This appendix provides rich qualitative texture to the survey data reported in the body of the report. Comments from the survey are organized by dominant themes comparing hospice with palliative care. Selected excerpts from the interviews and focus groups are given to convey the texture of respondents' reasoning and feelings about their selection of career pathway.

Survey Comments on Quality of Training Experience in Hospice or Palliative Care Rotations

The fellow survey gave respondents the opportunity to include a free text explanation of their numerical quality rating of their fellowship experience. Many respondents commented, some extensively. **Exhibit 15** compares comments about hospice and palliative care training experiences.

Exhibit 15: Free Text Explanations by Survey Respondents of Quality Rating Given to Educational Experience

	Hospice	Palliative care
Positive comments		
Good exposure to care model and role	• "I felt like at the end of fellowship, I would be able to step into the role of a hospice medical director, and felt comfortable running [an interdisciplinary team], understanding regulatory requirements, and assessing [patients] for eligibility/ineligibility, as well as understanding the cost structure of a nonprofit hospice organization." • "Amount of time in hospice just met ACGME minimum but was well structured, diverse (inpatient and outpatient, multiple hospice agencies, range of ages and diagnoses), well balanced between observation of other disciplines and direct participation as a physician, and with interested and supportive faculty and preceptors." • "Extremely robust hospice organization that completely embraced the multidisciplinary hospice model. Great team and support. Focus on providing the absolute best care for patients and families. Large inpatient hospice home now with 30 beds, own panel of home hospice patients for which we were the attending, and great experience taking call for the hospice home and the large home hospice population to get experience with this." • "Excellent exposure to both inpatient and outpatient hospice care for patients with a wide variety of diagnoses. Also gained a greater understanding of the administrative work involved." • "Good exposure to the administrative side of hospice as well as symptom management in a residential and inpatient hospice facility." • "Wonderful inpatient hospice rotation with a year-long home-based hospice longitudinal." • "Good education in regulations. Ability to do [quality improvement] project, which helped me understand aspects of hospice in more depth."	• "Worked in two different models of clinic, two(+) models of inpatient service; saw substantial advanced heart failure and [bone marrow transplant] in addition to the usual mix of patients. Rotations were split between a community hospital and an academic medical center. Breadth of training second to none." • "The fellows work in a variety of settings including a large cancer center, [Veterans Affairs] hospital, large trauma center, and long-term care setting."

	Hospice	Palliative care
Positive comments		
Stimulating cases	• "I appreciated having an early access hospice that allowed people to enroll while still getting radiation treatment, dobutamine, or [total parenteral nutrition] (with the plan to complete a short course, re-evaluate, or a set end date)." • "I had a wide range of patients that allowed me to learn different modalities of treatment as well as to understand relationships with families and nonhospice physicians. I was able to expand my understanding of hospice in the inpatient and outpatient settings, which opened my eyes as to what patients and their families experience outside of the hospital." • "Ability to encounter hospice home visits, hospice in the nursing home, and inpatient hospice units. Several different [hospice medical directors] with varying approaches and a broad patient population." • "Patient diversity."	• "It allows for exposure to variety of diverse patients and cases. Exposure to a lot of underserved communities." • "I was involved in many different cases, which were clinically and emotionally challenging and provided a route to further my knowledge and my expertise." • "Intense and variety of exposure in terms of multiple domains of palliative care issues." • "We have palliative care consultative services at three very different inpatient settings (academic center, smaller more community-based hospital, and Veterans Affairs hospital) so get a wide variety of patients and primary diagnoses." • "Variety of cases, patient populations, great teaching, different settings. Community academic hybrid, [Veterans Affairs], county, tertiary care center. Great training." • "Saw large variety of cases in inpatient, office based and nursing home palliative care." • "Robust inpatient and community-based palliative care experience—probably the most robust community-based palliative care program I had seen. Spent time at two different hospitals, one academic and one community, so got to see both of those environments. Also got to spend time in clinic to see the challenges facing clinic-based palliative care firsthand (eg. large no-show rate, large proportion of patients struggling with chronic pain and misuse of opioids, etc.)." • "I saw many, many diverse patients and families with regard to diagnosis, culture, emotional and psychological response, [and] socioeconomic situation!" • "Saw substantial advanced heart failure and [bone marrow transplant] in addition to the usual mix of patients." • "A dizzying array of cases and situations." • "Our case load, although very high, was very diverse." • "Excellent exposure to both common and challenging palliative care cases."
Team-based care	• "A wonderful [interdisciplinary team] that allowed for cohesive patient care." • "We also worked closely with nurses, social workers, and chaplains as well." • "Very passionate and friendly team members."	• "Was able to see how palliative teams in an academic center and a community hospital worked." • "Really good teams with lots of variety of patients. Fantastic outpatient palliative care clinic experience with very experienced preceptor." • "Amazing support, robust [interdisciplinary team], well regarded in our hospital." • "Great support from team members." • "Fully staffed [interdisciplinary team]." • "Supportive team."

	Hospice	Palliative care
Positive comments		
Faculty	• "I felt supported, that I had an excellent exposure and acceptance into the [interdisciplinary team] at all sites, and that I had a wide breadth of experiences that helped me feel prepared after fellowship was completed." • "All physicians I worked with in both the hospice and palliative care settings were incredible. They were dedicated to teaching fellows." • "I worked closely with a very intelligent and inspiring hospice medical director." • "We had excellent guidance from very experienced faculty—one who literally wrote the book on palliative care. She was an excellent teacher who actively challenged us and encouraged us to implement very thoughtful care." • "Emotionally connected faculty who had a tremendous love of hospice medicine." • "The hospice attending physicians for both inpatient and home settings were excellent and committed to teaching fellows." • "Preceptors very open to teaching, and patients loved to be seen by fellows."	• "The faculty were diverse, experienced, and caring. They demonstrated expertise in caring for patients and being involved in the palliative care community. They helped me find a job." • "This was the bulk of my day-to-day life. Our attendings had a wealth of knowledge and experience in palliative care!" • "The teaching came from four very different and excellent attendings so that diversity of style and approach was also mentored." • "Passionate and intelligent faculty" • "All physicians I worked with in both the hospice and palliative care settings were incredible. They were dedicated to teaching fellows." • "Brilliant physicians training me." • "Amazing teachers, inspiring attitudes and skills, and lots of meaningful interactions" • "Excellent teaching from expert faculty." • "Faculty in all locations is very committed to educating fellows."
Continuity of relationships	• "We had a continuity hospice experience where we went on home visits and attended [interdisciplinary team meetings] each week. We were able to follow patients from inpatient to hospice for continuity."	• "I could not have asked for a better experience. I was able to see community and academic programs. The cases were interesting and complex. I was able to have continuity with many patients." • "Both inpatient and outpatient settings. Was able to establish relationships with my patients from hospital to my own clinic." • "The palliative care service had a strong presence in the facilities where I rotated, as such we were involved early on in many cases and were able to establish good rapport with patients and/or families to carry on more difficult conversations later on."
Good work-life balance	• "Excellent work-life balance."	
Autonomy	• "Graded autonomy through the year." • "Not quite enough volume but excellent autonomy and richness." • "The experience was very rewarding, and I was afforded a lot of autonomy in the care for my patients."	• "Graded autonomy." • "All overseeing physicians provided us the utmost autonomy in our practice to feel strong and confident practicing independently upon graduation."

	Hospice	Palliative care
Negative comments		
Problems with care model and/or role	• "The [nonprofit] hospice was understaffed [and] management driven; [the] window into administrative and financial aspects of hospice definitely turned me off to it." • "The hospice we train with had recently been restructured. The hospice residence was operating at half capacity and there were new non-HPM trained medical directors that had to be trained prior to the fellows getting much involvement with directing patient care." • "I got a lot of experience spending time with the hospice nurses but wasn't able to spend a lot of time with the hospice [physician] doing patient visits."	• "The faculty were mostly amazing: brilliant, supportive, engaged. That being said, the service was not truly multidisciplinary; there were no palliative social workers … no dedicated chaplain … and limited palliative pharmacy support. We worked with unit social workers and collaborated with hospital chaplains. Helped me learn a lot about these aspects of palliative and made me realize how important it was for me to have these specialties dedicated on palliative team I would ultimately join." • "[Site] treated palliative care, during my fellowship, like more of a pain service than a palliative care service. Goals of care discussions, for example, were rare." • "The adult palliative care side did not have a full team, they were lacking a dedicated chaplain and the only nurse worked by herself in the [emergency department]. Also, there was no outpatient palliative care option for adults. This lead to trouble with follow-up options outpatient and thus what we could offer on the inpatient side." • "We are not strong in outpatient [palliative] care. Only had small number of patients and many of them died quickly so there were few longitudinal experiences." • "A little chaotic on the floors, not much appreciation of how the palliative team can be useful amongst specialty services and thus consults were often baffling or inappropriately timed/ordered (but it seems this is not an internal problem and certainly more widespread … but improving slowly)." • "Poor understanding of expectation in interactions with mid-levels."
Poor educational support	• "No structured education for fellows." • This is specifically for outpatient hospice—subpar attendings, little to no teaching, I rarely observed joy in the attendings, and I was bored in the outpatient setting." • "At the beginning of my fellowship year, the hospice with which we were associated closed and we ended up working with another hospice. This second hospice had not had fellows and included only one attending that was someone with whom we wanted to work." • "I got an overall exposure to hospice care, but it lacked depth and I did not come away feeling I could be a hospice medical director." • "Additionally, there were challenges in physician staffing that occurred during my fellowship that lead to some gaps in teaching."	• "This part of the education was understaffed by faculty and very overworked in volume of consults. A change in hospital site improved the rotation in the later part of the year."
Provider burnout/overwhelm	• "Providers/team were exhausted by daily requirements and expectations." • "The attendings seemed to be overwhelmed … with home call." • "I rarely observed joy in the attendings."	

	Hospice	Palliative care
Negative comments		
Fellow duties	• "At first, the burden of filling out [Certifications of Terminal Illness (CTIs)] was overwhelming and discouraging. It was difficult to give an overall picture of the patient, without ever having met them. Moreover, using the DAVE system for death certificates was extremely discouraging." • "Minimal contact with [physician] who seemed more focused on team management. Role ambiguity and possibly inappropriate reliance on me as a fellow in certifying patients and meeting regulatory requirements."	• "Fellow workload and burnout during the palliative care rotations was a problem." • "The hours were long and often times, the emotional stress of the day would fall by the wayside because of the documentation that needed to be fulfilled." • "Heavy workload and emotional burden."
Too few cases or too little variety	• "Home hospice—saw limited numbers of patients, most patients were dementia patients for recerts. Inpatient hospice—very good."	• "… [P]atient population lacked diversity including some groups very common in most palliative care settings (eg, geriatrics)."
Little autonomy	• "There was little autonomy during the hospice rotations; it was mainly shadowing. Thus, I did not get a good feel for the charting/regulatory requirements that a hospice physician and a hospice medical director deal with."	
Lack of continuity	• "Would have liked more continuity."	
Other		• "Poor pediatric rotation. The team stopped taking new consults and shortchanged my experience because they could not manage workflow—despite four attendings and three [nurse practitioners]. Arbitrary way of evaluating fellows. No substance except symptom management. The [pediatrics] track at my institution had so many problems over the past 5 years that [ACGME] shut it down for 2019 recruitment."

Positive Views of Hospice Education Experience—Interviews

Although criticisms of the hospice experience were more frequent than criticisms of the palliative care rotations, respondents still had many positive things to say about their hospice training experience in the interviews. These positive views often were rooted in the inpatient hospice experience.

> *Our [hospice] inpatient educational experience was really educationally dense. I truly consider that that's some of the best learning I've had. I was really challenged every day. I was challenged to, if I didn't know something, to look it up, to figure out resources, to figure out what I needed to do, but still supported. … I learned a lot about communication, and I learned a lot about symptom management. It was probably really densely packed education. I really actually enjoyed practicing, I would say a little bit more inpatient hospice. But I think that's also a pretty difficult full-[time] position to find. [RESPONDENT 1]*

> *We have [a] 32-bed inpatient unit called XX House. It was probably the most rich educational experience that I've had throughout residency and fellowship. Really great attendings who want to teach, allow the fellows to have autonomy, and also lead discussions. Challenge us to come up with multiple plans. If this doesn't work, then what? Let us lead when we go in for family meetings without interruptions, generally. Pathology was really good. Saw a variety of different things. [RESPONDENT 2]*

I would say the XX Hospice unit was a wonderful experience because the hospice director there is very oriented to learners. He has internal medicine and family medicine residents always coming through, so he's very focused on maximizing the benefit for them. Always thinking of ways to have them experience things that they don't experience at their home hospital. … Continual learning and providing resources for it. [RESPONDENT 3]

[Hospice inpatient unit is] something of a unicorn with regard to hospices. It is situated on the ocean, we literally roll the patients on to the dock and get some sun in their bed. I rounded on our patients on the dock because that's where the patient was when we were rounding. It's a hospice environment but to my estimation it's even better. Plus the medical director doesn't really play by all the rules in that he's willing to do what's right for the patient. I mean, he'll do antibiotics sometimes, if he thinks that it's going to make the patient more comfortable. And he will, you know, he's the only one who takes patients who are both bed and bath dependent. Things that other hospice directors I've worked with have said, this is ridiculous, no we don't have the capacity … he's got that very flexible attitude about you do what's right for the patient. So I loved it. I absolutely loved it. [RESPONDENT 4]

Fellows also appreciated learning about the regulatory aspects of the medical director role:

We have 1 month at XX hospice inpatient, and then we have 2 weeks of outpatient home hospice/home palliative care that is managed by XX Hospice. And then in addition to that we have 2 weeks of hospice through YY (large national company), but it's basically a medical directorship. We're working with the regional medical director, who is phenomenal, taught me a ton about how the Medicare guidelines govern things, how you know, it's supposed to be done. How compliance works, you know, verifications and recertifications for our hospice benefits, stuff like that. [RESPONDENT 4]

One fellow noted the unique value of participating in home visits:

Home visits, especially with a palliative care/hospice home care team are such a unique opportunity that you don't get elsewhere in your medical training usually. [RESPONDENT 3]

Shortcomings of Hospice Educational Experience—Interviews

Respondents noted lack of educational rigor, inattentiveness by the supervising physicians, a feeling of being used to just do the work rather than learn, dissatisfaction with the home visit structure, and simply not a lot of time in hospice as sources of dissatisfaction during hospice rotations.

Interviewer: Can you tell me a little bit about in fellowship, your hospice training experiences? Respondent: First month in orientation, we spend a good amount of time doing home hospice visits with various staff members for both the pediatric and adult hospices. And then we do a month at an adult hospice residence, where we really are just responsible for all the daily patient duties. And then we had another month where we dedicated to going to home hospices, with the adult hospice, with every member of the team. And then we had a weekly participation in an [interdisciplinary team] meeting… we go back and forth between adult and pediatric hospital [interdisciplinary teams]. Interviewer: And in terms of the educational aspects of the hospice rotations, how did you find them? Respondent: Not very educational. [RESPONDENT 5]

I would say on the outpatient side, the physician was very kind. He was a great guy. But he was a former physician from a different specialty who had always wanted to practice hospice medicine in his life, and so this was his retirement job. I think while he appreciated what he did and loved what he did and was great to work with, he wasn't the best at teaching. [RESPONDENT 1]

It certainly felt like the hospice was very under emphasized in the training program. It was really a more minor part. … One of the hospice experiences was not a very good one. The teacher didn't really … the guy, my preceptor … I felt like he didn't really care that much about what he was doing. … It wasn't a very good training experience for us. [RESPONDENT 6]

Interviewer: How did you feel like the educational aspect of the hospice experience was compared to the educational aspect of other rotations? Respondent: It was almost nonexistent. These attendings are not very good teaching attendings. They weren't really committed to the fellowship. Most of my learning was on my own, and then asking some of the inpatient attendings to review my CTIs or make sure that I understood the different rules when it came to hospice. … I was out there on my own; the attendings weren't with me. I presented the case to them usually over the phone and told them what my plan was, and generally it was fine. … There's a million ways to do the same thing. … My idea or my way of learning is to see a situation and then hear how people would treat it differently from how I would treat it. I really didn't get any of that. [RESPONDENT 2]

The home visits is something that I'm going to work on as a faculty member, I think, just maybe putting a little bit more structure. There are obviously learning goals and expectations, but it can be challenging for a fellow to know what the appropriate role is when in a home with a visiting nurse because there are these unique circumstances where you are a physician. You're with a nurse, but you're not really writing any orders or … you really don't have any say. You can make recommendations, but it's such a unique role for a medicine trainee unlike a medical student who isn't yet a physician. [RESPONDENT 3]

Exhibit 16 compares comments survey respondents made about why they were encouraged or discouraged to take up a career in hospice versus palliative care.

Exhibit 16: Free Text Survey Responses on Why Exposure During Fellowship Encouraged or Discouraged Career in Hospice Versus Palliative Care

	Hospice	Palliative Care
Positive comments		
Good exposure to care model and role	• "Hospice [physician] showed that you could be … involved directly in patient care and not just supervise nurses." • "The program well prepared me to be able to work in a hospice setting. I subsequently took a job where I work in both a palliative care and hospice setting." • "I did not see myself working in hospice prior to starting fellowship, though my experience during my fellowship made me consider it much more strongly. I have even started moonlighting for a hospice agency as I missed this aspect of our field."	• "Palliative care allowed for a more controlled setting as it was often in the hospital. I was able to have access to different consultants and get their immediate opinion of a case/patient. It was easier to orchestrate family meetings as most consultants are in the hospital and despite the long hours, I felt I had more control as to how my time was split up."
Opportunity for innovation and program growth		• "I was able to see that with a properly organized system and team, the palliative care team can become very important in the hospital setting and certainly a great service for the patients. Seeing such big impact did encourage me to work in this field and grow a service and change the culture of hospitals where palliative care is not viewed as an asset." • "I saw clearly how my surgical expertise could inform palliative care practice and how my newfound expertise in palliative care could help transform the surgical care of patients (both mine and my colleagues')."

	Hospice	Palliative Care
Positive comments		
Stimulating cases	• "Helped me see how fulfilling working in hospice can be. I saw that cases can often be every bit as intellectually and professionally challenging as cases in any other form of [internal medicine] or HPM practice. I also saw the incredible need for this service."	• "The variety and more hands-on direct patient care involved in palliative care reinforced my desire to pursue this primarily." • "Outstanding exposure to variety of complex cases." • "Intellectually stimulating cases." • "Palliative care in general was higher quantity of training and also a busier service so say large breadth of diagnoses."
Team-based care	• "I felt that the hospice way of caring for patients was wonderful especially the home hospice. The ability to work as a team to take care of the patients was novel and refreshing. I felt really supported by the team members while doing this important work. It was also emotionally fulfilling work." • "I have a primary care background and did not like being a consultant as much as I liked hospice care. I love the collaborative team working experience. I also find the work less emotionally draining than palliative care consults."	• "Although my fellowship did not model the truly interdisciplinary palliative team that is the ideal we all learn about, the [physicians] and [nurse practitioners] I learned from taught me an enormous amount about effective collaboration with other disciplines as well as about the medicine of palliative [care], creative thinking in patient care. I also learned quite a bit about how to think about quality improvement." • "I really enjoyed the interdisciplinary team–based approach and the majority of palliative care team members have a wonderful attitude towards work and life in general which I enjoy being around." • "Valuable work on an interdisciplinary team."
Gratifying experience	• "I had the opportunity to see the impact of hospice at the end of people's lives. I am grateful we are able to keep people at home and comfortable. Having studied in an underdeveloped country—where these resources are not available—I appreciate the opportunity to do this." • "Unique experience more gratifying than any other medical work I have done." • "Both adult and pediatric experiences instilled a deep respect for patients, families, and providers dealing with end-of-life experience." • "Really great to see how we can make a difference by getting involved in hospice."	• "We were able to give people their dignity and their functionality back in some cases … [l]et them feel like humans again instead of patients. • "To me, there is no better field of medicine. The opportunity to help guide patients through difficult decisions or follow them on their path through illness without a focus on labs/boring objective data makes it a unique and special part of medicine." • "I found the families quite inspirational on many days, and definitely filled my work with meaning and a sense of purpose."
Positive provider/ patient relationships	• "The hospice team was able to have a strong bond with patients and their families and often became a trusted part of their lives." • "Loved the home-based care, loved having the time to spend with patients and families, without someone hammering down my throat about 'the next patient waiting to be seen and you have to wrap up in 3 [minutes] or less.'" • "Good long-term relationships with patients/family."	• "Fulfilling patient relationships." • "Was thinking of going on to oncology but decided to stick with [palliative medicine] because of the quality of relationship we have with the patients and the supportive, mission-driven colleagues." • "Meaningful interactions at critical times during patient/family's life." • "Some days were very hectic but interactions with patients and families were satisfying." • "Enjoyed the relationships developed with families and the opportunity to walk with them through terrible situations."
Faculty	• "Active encouragement and positive feedback from the hospice clinicians I worked with."	• "I also feel the training of those training me was more heavily weighted towards palliative care as opposed to hospice and so there was more enthusiastic teaching on palliative care topics." • "Attendings demonstrated the art of palliative care."

	Hospice	Palliative Care
Positive comments		
Good work-life balance	• "Good work-life balance." • "I had a better experience in fellowship during my hospice rotations since I felt like I had more of an impact. The quality of the lifestyle that I witnessed my hospice medical director having was also appealing." • "Saw that there is excellent work-life balance, flexibility, and I love home visits, and the challenges of cases and doing work with what is in effect a limited tool set in the home."	• "Work seemed fulfilling to providers. There seemed to be a good work life balance." • "Encouraged me given the positive work-life balance of this career. Felt amazing to work with patients and families in this field of medicine. Very underserved and neglected field of medicine."
Good fit with my interests	• "I knew that I wanted to do hospice when I finished fellowship for excellent experiences in medical school and residency, so a fair experience in fellowship did not change my mind." • "Hospice is now part of my regular mix, and this was important when seeking a new job based on my work experience as a fellow." • "Surprisingly loved home visits and no home-based palliative in my area, so hospice is now 50% of my current job and hoping it increases in the future." • "The people and mission of the nonprofit hospice affiliated with my fellowship was very appealing."	• "Realized I didn't 'love' the work in hospital-based palliative care to do it full time. I did really enjoy the clinic time, so do part-time outpatient [palliative care]." • "Was excited to try a new challenge, and palliative care opportunities in clinic, inpatient, and home-based arenas were appealing to me." • "This was my calling." • "The team, case load, patient relationships all made me want to do palliative [care] long term." • "My fellowship cultivated a passion and joy for providing palliative care, as well as made me feel like I could bring my own unique perspective to help shape the field." • "I get to do what I love to do every single day and teach others about palliative care along the way." • "I went from not knowing if I wanted to do full-time palliative to signing on to faculty at an academic institution to teach others about palliative. I'm sold!"
Is suitable later in a career	• "My other medical specialty (surgery) is not especially compatible with working in a hospice program, and since I am fairly early in my career as a surgeon I would like to continue active hospital-based surgical practice for a time. However my hospice and visiting doctors' experiences in fellowship opened my eyes to future career possibilities including applying my surgical expertise in the outpatient hospice setting (for example in wound care)." • "I think I will enter the hospice field when my kids are a little older." • "I enjoyed it, and wondered if hospice was too narrow a spectrum at this point in my career."	
Good for career start		• "I enjoyed my inpatient consultations and it helped solidify that I wanted to start my career with inpatient consults in hospice [and] palliative medicine. More of what I envisioned my career to be and also felt it allowed faculty to best be involved in clinical and academic endeavors."
Other		• "Realized I didn't 'love' the work in hospital-based palliative care to do it full time. I did really enjoy the clinic time, so do part-time outpatient [palliative care]."

	Hospice	Palliative Care
Negative comments		
Problems with care model and/or role	• "I hate the three things home hospice involves: driving, phones, and lots of supervision/indirect patient care." • "I feel hospice unfortunately does not deliver on the end-of-life care we as palliative care teams promise to them. Perhaps this is due to under-staffing, cost-cutting, lack of support, systems reasons. Does not seem to be related at all to the desire of hospice providers to do good work." • "The hospice was very management-driven, financially minded. There was grievous, chronic under-staffing, staff satisfaction was not a priority, staff was paid poorly and changes during my rotation led to even lower pay for the home aides. And the oversedation and discontinuation of patients' non-'comfort' medications that I had heard patients/families complain about and thought was just a myth turned out to be all too common. The medical director was in charge of overseeing hundreds of patients and as a result had not time to do any of it well or thoughtfully. And the staff satisfaction initiatives like GEMBA were all a waste of time and served mostly just to make management feel self-satisfied and give consultants a job. Argh. Instead, they should have hired an extra nurse and aide or two, and an extra physician so the one they had could have enough time to keep up with the literature enough to know that Suboxone is not just for substance dependence. I know, ask me how I really feel. This was a widely respected, well-regarded hospice organization, too."	• "On one hand, I was turned off by certain rotations during fellowship in which I felt like a pain management physician only, where goals of care discussions etc. were uncommon. But on the other hand, during rotation in a community hospital, it felt like only reason we would get consulted was to change someone's code status. This type of inpatient consultant work was unappealing, and I had little exposure to outpatient palliative care." • "Palliative care is daunting—the perception of it as a [do-not-resuscitate] service is annoying. I personally am in no way interested in a career that is typified by doing palliative care consults."
Administrative burden	• "The only reason why it was not 'strongly encouraged' was because of all the administrative duties of a hospice physician. I love practicing hospice medicine and caring for patients in the inpatient hospice home, but carrying a home hospice team is more administrative than clinical." • "I only saw a pediatric physician role as one who was doing certifications and managing medications with minimal patient contact." • "The systems set up at our hospital for documentation made it discouraging to write notes/read nursing notes. Nurses were expected to document any and all notes on one EMR, while our notes would have to be written on a different system. Instead of moving communication, it would often feel as if you had to repeat the amount of work, to make sure nurses and physicians were on the same page. The DAVE system was discouraging to use. Neither [working on] CTIs or [with the interdisciplinary team] are credited, though they are unbelievably time consuming and burdensome."	

	Hospice	Palliative Care
Negative comments		
Provider burnout/ overwhelm	• "Attendings seemed overwhelmed by home call, although inpatient hospice was great."	• "Attendings seemed burnt out at university site, but my rotation at the [Veterans Affairs] specifically encouraged me to seek a specialty in [palliative] care." • "I found the inpatient palliative care consults very draining after some time. Hence in my career, I did not want to choose a place which only had inpatient consult teams. I liked working in the outpatient palliative clinic and the mix of these would be a better career choice."
Faculty discouraged	• "Palliative care was encouraged over hospice."	
Poor relations with team or other providers		• "I was frustrated by some bad interactions with the internists and gynecology-oncology doctors who consulted us, often felt my hands were tied in trying to care for patients by their primary teams, and found the work very emotionally taxing." • "Microaggression of mid-levels and nonphysicians against physicians. Constant litany of how physicians are poor communicators [and] have poor educational preparation in relation to this field by certain physicians and how nurses, PAs, chaplains, and social workers are so much more intrinsically suited." • "I came in more confident than I left due to team dynamics, which is very unfortunate." • "Hospital-based palliative care in my fellowship institution is fledgling but developing, but the team itself was occasionally poorly functional and at times not as supportive as I would expect of a palliative team inherently."
Too few cases or too little variety	• "While many of the [hospice medical directors] I worked with encouraged me to pursue hospice, I ultimately did not find it very interesting." • "Too narrow of a field for me personally. I like interacting with many different healthcare teams and on hospice everyone else mostly leaves."	
Other	• "Very rare to have pediatric hospice job opportunities but I loved the experience in fellowship." • "I would have loved to work in hospice; however, my hospital (the one I left for fellowship) does not have its own hospice." • "I would consider 'filling out' my schedule with hospice if I didn't have full time at an academic facility."	

Perception of Palliative Care as More Interesting Career

Examples of statements that showed the perception of palliative care as a more interesting career included the following.

> *While I enjoy the hospice component, toward the more end of the patients' lives, I do like [inaudible 00:23:22] little longer and more intense symptom management. Not that you don't get it with hospice, but I think … I just treat a broader variety of things, with the palliative [care]. … [N]ot that it's not challenging, I don't want it to sound like that, but I do find some of the palliative [care] to be a little more stimulating to me. A little more, just, diverse. [RESPONDENT 7]*

I don't mean any disrespect to hospice docs at all. It just seems like it's a much slower pace. That's awesome for people that like that. I get pretty antsy if I'm not busy doing something. I want to be running around and talking to consultants and trying to figure things out in a hurry. That's not the palliative care hurry, which is a week or something. But that's what to me feels like a challenge, and I always want to feel challenged. [RESPONDENT 2]

I knew this sort of going into the fellowship that I was more interested in palliative care consultation than working strictly with hospice patients all the time. I don't know, I guess on the nonacademic level, I just didn't want to have every one of my patients that close to death, whereas I really enjoy sort of being part of that longer journey as a palliative care provider. [RESPONDENT 3]

In the focus groups, respondents emphasized that the administrative aspects of a hospice medical director position were unattractive to many because they were seen as just paperwork.

My program is Joint Commission accredited, and the metrics, for example, that they keep adding to us every year … we have a very long template already. And when the new metrics came, it got longer. Because, even though we have probably the best [electronic medical record] out there, we as physicians, for example, have to actually physically type in, cut, and paste our advance care planning box to meet this new metric. Now, how much time does that take, in, I don't know, in this already very long [electronic medical record] … template? Sometimes you're just like 'Am I really doing this?' [focus group]

I retired a year earlier than I had planned on because I was just totally fed up with the paperwork, rat race, and fighting to get my kids the stuff they needed. You know I started getting prior authorization requests for lidocaine ointment. [Nurse practitioner respondent]

The call load at hospice was also seen as an unattractive feature of the job.

I think that's one of the differences between palliative [care] and hospice is hospice has a really heavy call load, and it's really heavy on Thursdays, Fridays, and Saturdays. [participant 2]: Especially Friday afternoons. [participant 3]: Yeah because of the hospital discharge. So one day out of every weekend is as busy as a weekday but you can't take time off, you know, unless you have a very large organization because then on Monday you're dealing with all the symptoms of all the people who came on the weekend that didn't get resolved with your first intervention. So I think it's harder to recruit for hospice at a high level than it is for palliative care where you're—I mean, I know it's really stressful but you also have the satisfaction of doing intensely good work and not, you know having to work weekends and nights. [focus group]

Perception of Hospice as More Interesting Career

Hospice is seen as an attractive work setting by some respondents, although within hospice, many preferred the inpatient hospice setting over home hospice.

To my surprise, hospice was the thing that I loved. And I think that being a hospice medical director, working part-time in patient hospice, I would love to do. [RESPONDENT 4]

Hospice Appropriate at Later Career Point

The perception that hospice was more appropriate at a later point in one's career was mentioned in several interviews and found some support in the survey.

I went straight from residency to fellowship. I feel like I'm still a new doctor. … I love seeing different pathology, I want to be challenged with different pathology. I want to run my butt off on the floors

and be constantly moving and active. But that's also a stage of my career. In 20 years, would I rather see four or five patients a day? Probably. But right now I want to feel pressure to see these patients and get things done. [RESPONDENT 2]

I was just talking about this with someone in our community who is a year out of fellowship. We were talking about job opportunities, and she said, 'Yeah, I think maybe hospice and medical directorship when I'm older and ready to kind of slow down a little bit.' And I think that's the way I felt about it also, is that it's something for a transition later in the career. [RESPONDENT 6]

Some felt that hospice work lent itself to part-time work.

I think doing hospice work in smaller bits maybe here and there is a little bit more digestible for some people. [RESPONDENT 3]

However, the lack of availability of full-time hospice positions was discussed in focus groups as a major limitation for new fellows seeking jobs in hospice (see below).

Personal Priorities Impacting Job Selection

Location Highest Priority for Many

For almost all of the respondents, location was an extremely important consideration, if not the most important factor. Many spoke about family considerations, such as having been away from a spouse during residency and now wanting to be in the same city with their spouse, or having family roots in a particular city. Many respondents were willing to bend on other criteria about a job as long as it was in the target geographic area.

I'm sure everyone has a location that they're interested in, but my fiancé is just about to start residency. I was a bit limited because I was waiting for the match, so I did start looking at jobs in the top three cities where he's from, where I'm from, and where his top choice was. That sort of narrowed down my search because I was only looking around three cities. I mean I was doing within an hour radius of the cities, but it was still around those areas. [RESPONDENT 7]

The number one point of where I wanted to move was wherever my husband wanted to be. I have always told him … his career is very specific. There's only about, I don't know what he exactly said, between 10 to 12 institutions and places across the country at least that actually kind of specialize in what he does. [RESPONDENT 1]

Interviewer: And you were sticking to the XX city geographic area? Respondent: Yes, because I own my apartment here and this is where my roots are. That's where I wanted to stay. [RESPONDENT 6]

To be perfectly honest, when I was on the job market during my fellowship year, I pretty much knew from family decisions that had been made prior to even beginning fellowship that we would be coming back to the city of XX, in XX. [RESPONDENT 8]

For those that wanted to stay in a city that was already saturated with HPM physicians, job choices were more limited.

The other thing is that we narrowed our job search to the XX area, which is in high demand, it's very saturated with regard to physicians in all specialties. And so I kind of had two strikes against me, because I wanted a [inaudible 00:05:09] job and I was not able to expand my job search beyond the XX academic system. [RESPONDENT 4]

Salary and Benefits Not the Top Priority for Most

Most respondents did not put salary and benefits at the top of the list of requirements. They saw the compensation as part of the entire situation.

> *For the right position, I would've taken a poorly paid job. Well, ideally not, but I probably would have. [RESPONDENT 8]*

> *Opportunities for growth and advancement [are] probably more important to me. I don't know if this is correct, but it seems more important to me to have that rather than list a great starting salary, like an amazing starting salary. Because then you really can't go up from there. [RESPONDENT 7]*

> *I'm right out of training. I went right through residency, right into fellowship, so I don't think that the finances, not that they don't matter to me, but to someone who'd already been practicing by themselves, they might get very nit-picky about, oh like, how much over 200 is this or that? But for me, who's only maximum made 65 in my life, I mean, anything around 200 is like, four times what I made before. [RESPONDENT 11]*

But at least one respondent chose some work time outside of the HPM field specifically because of compensation.

> *[Compensation] currently plays into my thinking in a big way because I could volunteer to do a lot more hospice shifts, and because I'm working just per diem and not full time and I'm the only bread-winner in my family, the [emergency room] pays twice as much per shift. So that has a big influence on my decision to do more [emergency room] shifts. … So I like that aspect of being in the hospice more, but financially if I don't want to work so much, that's why I [would] choose to do [emergency room] more." [RESPONDENT 10]*

Other Factors

Other factors mentioned were specific populations that respondents wanted to work with (one wanted to work exclusively with a pediatric population) and lifestyle issues such as amount of driving, and call schedule.

> *I think a lot of it is related to lifestyle. And that could go either way. Some people feel very strongly that they think hospice has a better lifestyle being all outpatient, whereas I don't love the idea of driving all day, especially somewhere where it snows. To me, I would almost call the lifestyle a little better for inpatient palliative [care]. I think lifestyle and then families. I mean, it depends on the call … I think, if you had a heavy call schedule or inpatient component, I think that deters some people. Anyways, I think lifestyle has a big thing to do with it. [RESPONDENT 7]*

> *I actually really enjoyed hospice. I loved hospice. But I also, I'm going to be really honest, I hate driving around everywhere. I like having that team; I like interacting and seeing a lot of my team members and having that support. So I guess my other uncertainty was [that] … I was coming into a new area and I didn't know the metro area. I've never lived there before … so I was hesitant to start outright working in the community in hospice. [RESPONDENT 1]*

Characteristics of the Jobs in Hospice Versus in Palliative Care Settings

One Undesirable Aspect of Hospice Jobs Mentioned in Focus Groups Was that Full-Time Hospice Positions Were Not Widely Available.

Speaker: The mom and pop hospice is generally just an hourly rate medical directorship. You have to have a job somewhere on the sidelines. Speaker: That's true, like the smaller hospices. I think the larger hospices … it depends. If they're very large, they could be competitive. [focus group]

Speaker: We're not a certificate of need state. Which means … like, in [city], we have 150 hospice agencies— Speaker: Jeez. Speaker: I mean, some crazy thing like that. So no one can have a full-time job in hospice… XX Hospice is one of the bigger ones … I think they have two or three doctors, but most agencies can't hire anybody full time. And so, it ends up being the thing you do on the side from your internal medicine practice or your family medicine practice. The jobs just aren't there to be 100% hospice doctor. And so, people when they're graduating and they're looking at what choices they have. … You can go hang up a shingle and be hospice medical director for five or six different hospices, but there's a lot of insecurity in that. Or you can say, 'Oh, the academic center is offering me a job and I'll be faculty and I have steady salary and benefits.' And it's really hard to hang out your shingle. [focus group]

However, one respondent valued and sought out the flexibility of per diem hospice work.

I started looking around and went on some interviews, and then I realized part of it is maybe my age and my life circumstances, but I didn't want a full-time job. I had just come out of working really hard and doing family medicine and the last few years I was also working at an [emergency room] and doing women's health work. I was kind of working too many jobs, which kind of I think led to my burnout. I think after the hospice year—the fellowship—that I wanted … a different life pace. I realized I didn't really want a full-time job. I started looking at either per diem or part time, and most of the hospitals that I had visited were really either looking to start or expand their programs. And I just thought this is getting myself into something that … I was really interested in it and I loved the idea, but I realized I didn't want to work that hard. I wanted more flexibility in when I could take time off and stuff, so that's what made me go towards hospice more and thinking of doing maybe some home hospice either per diem or part time. [RESPONDENT 9]

The Administrative Aspects of Hospice Medical Director Job, Including Face-to-Face Visits, Were Seen as Undesirable by Both Graduating Fellows and by Focus Group Participants.

Speaker: When I go to work, I start my day with signing seven death certificates, … answering 50 emails, doing a dozen prescriptions, and etc., etc., etc. Speaker: That becomes okay if you have an inpatient unit. Because then you still have those patients you're seeing [crosstalk 00:30:02], still have the family conferences, right. Speaker: But just doing the medical directorship, where you don't go see the home visits, and you don't have an inpatient unit. … It's all administrative. Speaker: You try to go see patients, but then you do a face to face, which is like, 'Hi, I'm [crosstalk 00:30:16].'— Speaker: Worthless. Speaker: It's a perfunctory— Speaker: It is. Speaker: It's a perfunctory act versus it's clinically meaningful. [focus group]

Speaker: I came out of palliative fellowship, I didn't want to go do administrative [work] … take nurse calls and write CTIs and sign prescriptions, right? I wanted to go see patients and do cool stuff in the hospital. That's my sense of why palliative is the sexier part of our— Speaker: Because less administrative burden, and— Speaker: No, you're seeing patients. Speaker: I was trained to manage symptoms, do family conferences, interact with my colleagues …. [focus group]

Several commented that the hospice physician job was lonely, despite the presence of the interdisciplinary team in hospice.

Speaker: You're alone. There's a lot of loneliness that comes from being the only hospice medical director. [focus group]