



# **A Career Guide for Pediatric Hospice and Palliative Medicine**

**Developed by the AAP Section on Hospice  
and Palliative Medicine**

# A Career Guide for Pediatric Hospice and Palliative Medicine: “Would this be the right job for me?”

## A LETTER FROM YOUR AUTHORS

Dear Colleagues,

Welcome! We developed this career guide to help you understand more about pediatric hospice and palliative medicine (PHPM) to answer questions such as— *What is the field of PHPM? What do PHPM doctors on a day-to-day basis? and How does one go about becoming a PHPM doctor?*—so that you can make a more informed choice about whether PHPM would be the “right job” for you.

We hope you find this guide beneficial and that it provides the guidance you are seeking as you learn more about a challenging yet rewarding field of pediatric medicine.

Sincerely,

Jennifer Linebarger, MD, MPH, FAAP

Elissa Miller, MD, FAAP

Rachel Thienprayoon, MD, MSCS, FAAP

## AUTHORS

**Jennifer Linebarger, MD, MPH,  
FAAP**

Associate Professor, UMKC School  
of Medicine  
Medical Director, Palliative Care  
Team (PaCT)  
Children’s Mercy Hospital

**Elissa Miller, MD, FAAP  
Clinical Assistant Professor of  
Pediatrics Sidney**

Kimmel Medical College at Thomas  
Jefferson University  
Division Chief, Division of Pediatric  
Palliative and Supportive Care  
Nemours/Alfred I. duPont Hospital  
for Children

**Rachel Thienprayoon, MD, MSCS,  
FAAP**

**Assistant Professor,  
Anesthesiology and Pediatrics**  
Medical Director, StarShine  
Hospice  
Pediatric Palliative and Comfort  
Care Team (PACT)  
Cancer and Blood Diseases  
Institute  
Cincinnati Children's Hospital  
Medical Center

# WHAT IS PEDIATRIC HOSPICE AND PALLIATIVE MEDICINE?

## What is palliative care?

According to the *National Consensus Project for Quality Palliative Care, Third Edition*,<sup>1</sup> “palliative care” is patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care may be offered throughout the continuum of illness and involves addressing patient and family physical, intellectual, emotional, social, and spiritual needs as well as facilitating autonomy, access to information, and medical decision making.

The following features characterize the philosophy and delivery of palliative care<sup>1</sup>:

- Care is provided and services are coordinated by an interdisciplinary team;
- Patients, families, and palliative and nonpalliative health care providers collaborate and communicate about care needs;
- Services are available concurrently with or independent of curative or life-prolonging care;
- Patient and family hopes for peace and dignity are supported throughout the course of illness, during the dying process, and after death.

## What is hospice care?

Hospice is both a philosophy of care and an insurance benefit covered under Medicare, Medicaid, most private insurance plans, HMOs, and other managed care organizations.<sup>2</sup> Hospice is considered the model for compassionate care for people facing a life-limiting illness, with a focus on caring, not curing. Hospice care is most commonly provided in the patient’s home but may also be provided in hospitals, nursing homes, and free-standing hospice units.

## What is pediatric hospice and palliative medicine?

Pediatric hospice and palliative medicine (PHPM) is both a philosophy and an organized method for delivering competent, compassionate, and consistent care to children with chronic, complex, and/or life-threatening conditions, as well as to their families.<sup>3</sup> PHPM is provided along with concurrent disease-modifying therapy when disease-modifying therapy is appropriate or as the main focus of care when disease-modifying therapy is no longer effective and comfort is of the utmost importance.

The American Academy of Pediatrics (AAP) released a policy statement on PHPM in 2013,<sup>4</sup> outlining core commitments to the discipline:

- Being patient centered and family engaged;
- Respecting and partnering with patients and families;
- Pursuing care that is high quality, readily accessible, and equitable;
- Providing care across the age spectrum and life span, integrated into the continuum of care;
- Ensuring that all clinicians can provide basic palliative care and consult pediatric palliative and hospice care specialists in a timely manner;
- Improving care through research and quality improvement efforts.

# WHAT IS A TYPICAL “DAY IN THE LIFE” OF A PHPM PHYSICIAN?

There are many paths to a career in pediatric hospice and palliative medicine, and one physician’s day may look very different from another’s day. To answer this question, we reached out to the group of our colleagues to comment and share their “typical” day.

## Dr. David Korones, MD, University of Rochester Medical Center, Rochester, NY

*I am a pediatric hematologist/oncologist and also practice pediatric and adult palliative care. I guess I would be considered senior in my career, although that is hard to believe because I feel like I just started and I continue to be humbled by things on a daily basis. My time is approximately 50% pediatric hem/onc and 50% palliative care. One of the things I like about my typical “day in the life” is that there is no such thing as a typical day, and no matter what hat I’m wearing, the other hat comes into play. So, as I see my pediatric oncology patients, I try to integrate palliative care, and plenty of my palliative care patients are struggling with cancer—it all speaks to how tightly integrated and intertwining it all is.*

*It is easier to describe a typical week than a typical day: Mondays – Fridays I spend a few hours with our inpatient pediatric palliative care consultations; Mondays I have an adult palliative care clinic, Tuesdays and Wednesdays I work with a community-based pediatric palliative care group and make lots of house calls, which is lots of fun (more overlap and integration, as many are my oncology patients), Thursdays are my pediatric hematology/oncology clinic days (more overlap because many have palliative care needs), and Fridays are my day of rest (sort of). This all changes when I attend on the pediatric heme/onc inpatient or adult palliative care inpatient rotation (about 12 weeks a year). It’s all fun and I wouldn’t have it any other way!*

## Dr. Sirisha Perugu, MD, Children’s Hospital of Orange County, Orange, CA

*I completed my neonatology fellowship 4 years ago and work with a group that covers a busy academic children’s hospital and other peripheral NICUs. I obtained palliative care certification and training just last year and currently limit myself to only the children’s hospital and another hospital with busy perinatology service. My day at work is rounding with pediatric residents and fellows on complex NICU patients. I initially started a palliative care program and Q/I development in my personal time but am now clarifying administrative or research time definitions.*

*I still believe that there is now more recognition for the value that a neonatologist/critical care doctor with advanced training in palliative care. I do round on medically and ethically complex patients and teach skills like family conferences and processing of care integration on the job. I did spend a lot of time and effort in team building and education so there is always someone in addition to my nurse practitioner to bridge my absence. Day-to-day patient and family care, team leadership, and my own job/personal satisfaction seems so much more enriching with the enhanced knowledge and skill sets from palliative care education and training. I think I am still “midlevel”/“young” on a career time span trajectory but believe that there will be more exciting and academically solid years ahead for future trainees also.*



# WHAT IS A TYPICAL “DAY IN THE LIFE” OF A PHPM PHYSICIAN?

## Dr. Kris Catrine, MD, Children’s Hospitals and Clinics of Minnesota, Minneapolis, MN

*I'm on a combined pain/palliative care service. We come in around 7:00, divide up the inpatient service between the available providers (MDs and APRNs) and pre-round by computer until 8:00. We meet as a team at 8:00 and review the patients on the list, then see our patients for the rest of the day. We see anywhere from 5 to 8 patients on a typical day, including consults, more on weekends.*

*I have a clinic day once per week, slots are also used for home visits (telemedicine starting shortly) and I may see 1 to 3 inpatients if the clinic isn't full. I am on call 1 night per week and 1 in 5 weekends. Weekends are busy, as most patients are rounded on and the others managed by phone if needed. An average Saturday is usually 6 to 15 patients seen.*

*For palliative care, we see anything from symptom management to medical decision-making conversations to running compassionate extubation or compassionate removal from ECMO. I work on a multidisciplinary team inpatient, outpatient, and in our home palliative and hospice programs. We meet weekly to review management of the patients in the home programs. I'm on service daily, with a half day off per week.*

## Dr. Elaine Morgan, MD, Ann and Robert H. Lurie Children’s Hospital of Chicago, Chicago, IL

*I attend on hem/onc and palliative care. I do not do simultaneous inpatient service on the 2 services and so I spend close to 40% of the year on an inpatient service somewhere. Our palliative care inpatient is currently a consult service, so when we are on, we are coordinating with residents and staff on multiple services. We are hospital based and provide oversight/consultation for 2 outpatient palliative care/hospice organizations that care for the majority of our patients.*

*For palliative care, I have morning meetings with the peds residents (not palliative care related) and clinic 2 days a week. On those 2 days, rounds and consults happen later in the day. On nonclinic days, I try to round in the mornings. Our inpatient census can vary from minimal to up to 10 to 12 in general. Likewise, inpatient consults are not predictable, and we have as few as none to as many as 4 to 5 on a given day. We try to see those patients same day or within 24 hours if there are no pressing needs.*

*We confer with our outpatient colleagues about patients every 2 weeks. We also have palliative care educational and program meetings twice weekly and attempt to provide resident teaching several times a year. We are on call when we are on service plus 1 weekend every 3 to 3.5 weekends. We may have no night calls or, on bad nights, multiple calls and occasionally have to return to the hospital at night. We generally round once daily on the weekends.*

*Outpatient consults are not predictable as well and tend to happen in coordination with other general and specialty appointments, sometimes are scheduled in advance but in general, timing is not within our control.*

# WHAT IS A TYPICAL “DAY IN THE LIFE” OF A PHPM PHYSICIAN?

## Dr. Norbert Weidner, MD, Cincinnati Children’s Hospital Medical Center, Cincinnati, OH

*Arrive at work 6:30ish and finish any remaining notes from the prior day, and work through email. Morning rounds 7:00 to 8:00 am. Hospice interdisciplinary team rounds on Monday mornings every week until 9:30 am. Round on assigned patients through the morning to early afternoon. Spend time speaking with patients and their families and connecting with collaborating MD during joint rounds or following joint MD’s rounds. Afternoon may involve formal appointed meetings with collaborating MD or jointly with primary MD and patient/family in conferences to sort through goals for care, ethical issues, conflict, etc. Pending the situation, I will see outpatients in subspecialty or palliative clinic scattered in morning and afternoon. Depending on the day, there may be scheduled home visits either in afternoon or early evening. Teaching of med students, residents rotating on service, and fellows is at point of care.*

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The variety in these responses illustrates the breadth and depth of possibility in the field of palliative medicine. Many PHPM physicians divide their time between palliative care and other specialties: general pediatrics, complex chronic care pediatrics, hematology-oncology, intensive care, neonatology, anesthesia, and so on. Some physicians divide time based on weeks of one service line versus another, while others integrate palliative care consults into their days serving in other areas.

Many patients cared for in pediatric hospitals are eligible for palliative care, but not all programs care for the same populations of patients. Some teams focus a great deal on pain and symptom management, in addition to other responsibilities, while other teams are not invited to consult for this purpose. Some teams are consulted to assist in evaluating patients for solid organ transplant, others are consulted in all patients receiving bone marrow transplants, and yet others are not involved in caring for children in either population. Most palliative care teams have close relationships with hospice organizations nearby. Some PHPM physicians serve as the medical director of the pediatric arm of a hospice; some pediatric hospitals directly provide pediatric home-based hospice and palliative care through their affiliated homecare organizations. Palliative care teams in those institutions are typically intimately involved in caring for patients who are receiving home-based hospice and palliative care through the institutional program.

There are commonalities to differing palliative care programs; the following are activities a given team may encounter in a day:

- Complicated pain and/or symptom management
- Evaluating goals of care with a family
- Assisting families as they define quality of life
- Evaluating and recognizing the importance of spirituality
- Coordinating care among multiple hospital-based teams, primary care doctors, and home health care
- Improving communication between teams and families
- Leading or participating in care conferences
- End-of-life care, advance directives, DNR orders
- Hospice care

There is some truth to the quote, “If you have seen one pediatric palliative care team, you have seen one pediatric palliative care team.” But spending time with any PHPM team in an elective rotation can offer you critical insight into how all teams care for a variety of patients. For this reason, we recommend that any resident considering a career in PHPM seek to spend time with a palliative care team, either in his or her institution or on an away-rotation. If your institution does not offer a palliative care rotation, consider reaching out to adult palliative care teams in your area or to programs with palliative care fellowships. Most programs that offer fellowships also offer rotations for residents.

# HOW DO I GET TRAINING TO BECOME A PHPM PHYSICIAN?

The first step is to know that PHPM is the right field for you. This is why we recommend spending time with a PHPM team on an elective rotation, especially if you are considering a PHPM fellowship immediately after a general pediatrics residency.

You can also learn more by joining the AAP Section on Hospice and Palliative Medicine (SOHPM). The SOHPM hosts a Web site and a listserv that can connect you with others in the field of PHPM. You may also consider joining the American Academy of Hospice and Palliative Medicine (AAHPM) and attending its annual assembly, if you are able, to make contacts in PHPM and to appreciate the breadth and depth of the field.

Once you are more certain that PHPM is the career for you, the next step to becoming board-eligible is to complete a fellowship in hospice and palliative medicine. Prior to 2012, practicing physicians who met certain patient care criteria could be “grandfathered” into sitting for the hospice and palliative medicine board exam. Since then, only those physicians who have completed a fellowship are considered board-eligible.

## How are typical hospice and palliative medicine fellowships structured?

Hospice and palliative medicine fellowships (HPM) are 12-month, clinical fellowships. The ACGME Program Requirements include:

- Patient care in the following locations:
  - Inpatient acute care site
    - Inpatient palliative care consultation service
    - Inpatient palliative care or hospice unit
- Home visits with hospice
  - Long-term care experience at a skilled nursing home facility, chronic care hospital, or children’s rehabilitation center
  - Ambulatory setting
- Scholarly activity or quality improvement project
- Electives

Fellowships may also offer some combination of the following:

- Acute and chronic pain management rotations
- Perinatal palliative care exposure

## How do I find out about fellowships?

The official list of all HPM fellowship programs can be found on the ACGME Web site, and the AAHPM supports a list of pediatric palliative care fellowships and available pediatric tracks at the following link: <http://aahpm.org/career/clinical-training>.

For those who are interested in pediatric-adult combined fellowships or pediatric-specific fellowships, it is important to note that HPM fellowships come in a number of different forms:

- Predominately adult HPM fellowships
- Adult HPM fellowships with additional pediatric time possible
- Pediatric fellowships
  - Free-standing pediatric fellowship programs; or
  - Embedded within an adult HPM fellowship program

# HOW DO I GET TRAINING TO BECOME A PHPM PHYSICIAN?

Stand-alone pediatric HPM training programs – These programs are at Children’s Hospitals and are run entirely by pediatric HPM faculty and staff. Some may include adult hospice rotations for 4-10 weeks or more during the academic year, the experience is otherwise wholly pediatric.

Pediatric tracks in conjunction with adult HPM training programs – These programs **vary significantly** in the amount of pediatric training offered, from as little as 4-15 weeks of pediatric time to as much as 9-10 months or more of time pediatric – equivalent to what is offered in the stand-alone pediatric HPM training programs. Some pediatric tracks have positions **reserved for pediatricians** and a rank list that is separate from the adult programs. Other pediatric tracks have a single rank list for all candidates and the pediatric track is utilized if a pediatrician matches in to that program. **Be sure to look up details of the pediatric experience for each program individually.**

Pediatricians welcome in adult training programs – ACGME Hospice Palliative Medicine program requirements includes two weeks of pediatrics minimum for all trainees. Some adult HPM training programs are willing to train pediatricians and may be willing to develop or have developed additional pediatric training experience (beyond the required 2 weeks). Each program will be different and should be contacted directly for details.

The difference between these three types of programs (stand-alone pediatric programs, pediatric tracks and pediatricians welcome in adult programs) is **not easily identified** within ERAS. **Be sure to view the program website or reach out to program directors if you have specific questions.** Questions to ask may include:

*“How much time do your pediatric fellows spend in pediatrics vs. adult medicine?”*

*“Do you rank your pediatric applicants separately or are they part of your general rank list?”*

*“What is your experience in training pediatricians? Have you had other pediatric fellows?”*

*“How many of your faculty are pediatric-trained?”*

## **How do I apply for fellowship?**

Applications are submitted via ERAS, which opens July 15 for fellowships starting July 1 of the following year. Typically fellowship interviews run August – October, with rank lists due in November for the December match. Applicants must register with both ERAS and NRMP/MSMP for the fellowship match.

## **Combined Fellowship Options:**

Experts have recently suggested an alternative pathway for combined HPM training with fields such as Hematology/Oncology, Critical Care and Neonatology.<sup>5</sup> However, at this time, the majority of programs require the completion of one fellowship training program before beginning another. If you are interested in a combined fellowship option, we recommend you contact program directors directly to see what options may be available at specific sites.

## **Mid-Career Pathways:**

At this time, no fellowships offer specific mid-career pathways. However programs may be willing to work with candidates to design a program that allows mid-career physicians to spread their fellowship training over two years in order to allow continued clinical practice during training. We recommend that you contact program directors directly to see what options may be available at specific sites.

## REFERENCES

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