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Integrating Palliative Care into Pediatric Oncology Education: A Critical Curriculum Gap and a Priority for Iran

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Abstract

Advances in diagnostic and therapeutic strategies have substantially improved survival among children with cancer. Nevertheless, children with advanced, relapsed, refractory, or life-limiting disease, along with their families, continue to experience a substantial burden of physical, psychological, social, and spiritual suffering. Pediatric palliative care should begin at the time of diagnosis of a life-threatening illness and be delivered concurrently with disease-directed therapy, rather than being confined to end-of-life care. However, palliative-care education remains limited, unstructured, and inadequately assessed in many pediatric oncology training programs. Drawing on international evidence and the Iranian context, this letter proposes incorporating competency-based education, guided clinical exposure, communication simulation, interprofessional learning, and structured assessment into pediatric oncology curricula.

Key Words: Curriculum, Iran, Medical education, Pediatric oncology, Pediatric palliative care.

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Dear Editor,

Advances in diagnosis, risk stratification, systemic therapy, hematopoietic stem-cell transplantation, targeted therapies, and supportive care have transformed pediatric oncology. Nevertheless, some children continue to experience high-risk, relapsed, refractory, or life-limiting cancer and may endure considerable pain, nausea, fatigue, sleep disturbance, dyspnea, anxiety, depression, family distress, and spiritual concerns. Pediatric palliative care is an active, comprehensive, and family-centered approach that should begin at the diagnosis of a life-threatening condition and be delivered concurrently with disease-directed treatment. It should therefore not be reduced to end-of-life care or interpreted as discontinuation of anticancer therapy (1–3).

Despite this principle, pediatric oncology education in many academic and clinical settings remains predominantly focused on diagnosis, chemotherapy protocols, treatment toxicity, laboratory monitoring, and disease-directed decision-making. By comparison, structured education in multidimensional symptom assessment, pain and symptom management, difficult communication with families, discussions of prognosis and goals of care, shared decision-making, psychosocial and spiritual support, and end-of-life care is frequently limited or fragmented (1, 2, 4). This educational gap may leave early-career clinicians insufficiently prepared when curative treatment is no longer feasible or when symptom burden is substantial. Inadequate preparation may also hinder timely palliative-care integration, effective communication with families, and care planning that reflects the preferences and values of the child and family (2, 4, 5).

Available evidence suggests that early and integrated palliative care in pediatric oncology can improve symptom management, support children and families, facilitate communication, and promote coordinated, goal-concordant care (1–3, 5, 6). Nevertheless, palliative-care education in pediatric hematology-oncology fellowship programs remains variable and is not uniformly structured within fellowship training (4). Thus, this deficiency is not merely a local problem; it is an important global priority in pediatric oncology education.

In Iran, published evidence on the preparedness of medical students, residents, fellows, and specialists to provide pediatric palliative care remains limited. This absence of data itself underscores the need for national educational needs assessments and systematic appraisal of existing curricula. Nevertheless, implementation of palliative-care education may be challenging because of broader constraints in clinical medical education, including high service demands, overcrowded or inadequately equipped training environments, limited educational infrastructure, weak alignment between curricula and practical clinical needs, and insufficient opportunities for active, supervised skills development (7). In addition, locally relevant barriers to pediatric palliative care—such as limited specialist services, time constraints for family meetings, and cultural considerations related to prognosis and end-of-life discussions—should be explored through national needs assessments.

Curriculum reform in Iran should move beyond the false dichotomy of curative care versus palliative care. Palliative care is not an alternative to anticancer treatment; rather, it is a complementary approach that should be integrated with disease-directed care from diagnosis onward and adapted to the changing needs of the child and family throughout the illness trajectory (2, 3, 6). Five components may be considered in developing or revising pediatric oncology training programs.

First, a competency-based framework for pediatric palliative care should be established. Such a framework should define observable and assessable learning outcomes related to pain and symptom assessment, pharmacological and non-pharmacological symptom management, communication with children and families, shared decision-making, ethical practice, care for children with advanced illness, and collaboration with multidisciplinary teams. Educational activities should extend beyond the transfer of theoretical knowledge and assess whether learners can apply these competencies in clinical settings (8, 9).

Second, pediatric oncology trainees should have opportunities for guided clinical exposure to palliative-care teams. This may include short rotations or observerships in pediatric palliative-care services, participation in joint consultations, attendance at multidisciplinary case conferences, and

case-based discussions with palliative-care clinicians. Such exposure can help trainees understand concurrent care, symptom management, family support, and complex decision-making beyond the final days of life (2, 5, 10).

Third, communication education should use active and experiential strategies, including standardized patients, role-play, simulation, and structured feedback. Skills such as delivering serious news, responding to family emotions, eliciting the child's and parents' values and priorities, discussing goals of care, and addressing treatment-related conflict are unlikely to be acquired through lectures alone. Educational initiatives such as Peds OncoTalk illustrate how structured, practice-based communication curricula can be incorporated into pediatric hematology-oncology fellowship training. Together with simulation-based educational approaches, these initiatives provide a practical model for teaching skills related to responding to emotion, delivering serious news, eliciting family values, and aligning care plans with those values (11, 12).

Fourth, training should be designed as an interprofessional educational experience. Pediatric palliative care is delivered through collaboration among physicians, nurses, psychologists, social workers, pharmacists, rehabilitation professionals, and, where appropriate, spiritual-care providers. Consequently, a physician-only curriculum does not reflect the nature of real-world palliative care. Because pediatric palliative care depends on coordinated work across professional roles, interprofessional learning should be considered a core feature of training. Such learning can help trainees understand the contributions of different team members and support collaborative, coordinated care (3).

Fifth, assessment methods should be aligned with stated learning objectives. Objective Structured Clinical Examinations (OSCEs) for communication and decision-making scenarios, direct observation of clinical performance, multisource feedback, reflective writing, and case-based assessments may simultaneously evaluate knowledge, skills, attitudes, and professional behavior. Incorporating these competencies into trainee logbooks, periodic formative assessments, and program accreditation standards may help establish palliative care as a visible component of professional competence rather than an optional topic (8, 9).

Implementing these changes in Iran does not necessarily require expensive infrastructure. Persian-language e-learning modules, short communication workshops, multidisciplinary case conferences, standardized-patient encounters, faculty-development programs, and collaboration between academic centers and existing palliative-care services may offer feasible starting points. Educational interventions should then be piloted across several institutions and evaluated for feasibility, acceptability, effects on trainee competence, and patient- and family-relevant outcomes.

CONCLUSION

Palliative care should not be viewed as a secondary component of pediatric oncology education or as care reserved exclusively for the terminal phase of illness. Rather, it is an integral, complementary component of comprehensive cancer care that should be delivered concurrently with disease-directed treatment. Integrating palliative care into pediatric oncology education can help reduce suffering, support families, strengthen clinical communication, and improve the overall quality of care. A structured revision of pediatric oncology curricula in Iran—incorporating competency-based education, guided clinical exposure, communication simulation, interprofessional learning, and valid assessment—could better prepare future specialists to deliver both effective disease-directed treatment and compassionate, family-centered care.

CONFLICT OF INTEREST: None.

REFERENCES

1. Liben S, Papadatou D, Wolfe J. Paediatric palliative care: challenges and emerging ideas. Lancet. 2008 Mar 8;371(9615):852-64. doi: 10.1016/S0140-6736(07)61203-3. PMID: 17707080.

2. World Health Organization. Integrating palliative care and symptom relief into paediatrics: a WHO guide for health-care planners, implementers and managers.

Geneva: World Health Organization; 2018. Available from: https://www.who.int/publications/i/item/integrating-palliative-care-and-symptom-relief-into-paediatrics.

3. Benini F, Papadatou D, Bernadá M, Craig F, De Zen L, Downing J, et al. International Standards for Pediatric Palliative Care: From IMPaCCT to GO-PPaCS. J Pain Symptom Manage. 2022 May;63(5):e529-e543. doi: 10.1016/j.jpainsymman.2021.12.031. Epub 2022 Jan 11. PMID: 35031506.

4. Roth M, Wang D, Kim M, Moody K. An assessment of the current state of palliative care education in pediatric hematology/oncology fellowship training. Pediatr Blood Cancer. 2009 Oct;53(4):647-51. doi: 10.1002/pbc.22110. PMID: 19449397.

5. Kaye EC, Friebert S, Baker JN. Early Integration of Palliative Care for Children with High-Risk Cancer and Their Families. Pediatr Blood Cancer. 2016 Apr;63(4):593-7. doi: 10.1002/pbc.25848. Epub 2015 Nov 18. PMID: 26579997.

6. Benini F, Avagnina I, Giacomelli L, Papa S, Mercante A, Perilongo G. Pediatric Palliative Care in Oncology: Basic Principles. Cancers (Basel). 2022 Apr 13;14(8):1972. doi: 10.3390/cancers14081972. PMID: 35454879; PMCID: PMC9031296.

7. Bahreini A., Javan S., Araghi F., Shariati K., Ghazanfarpour M. Challenges and Obstacles of Clinical Medical Education in Iran: A Literature Review. MEB. 2025;6(2):1115-1126. doi: 10.22034/meb.2025.544604.1122.

8. Klick JC, Friebert S, Hutton N, Osenga K, Pituch KJ, Vesel T, Weidner N, Block SD, Morrison LJ; American Board of Hospice and Palliative Medicine Competencies Work Group. Developing competencies for pediatric hospice and palliative medicine. Pediatrics. 2014 Dec;134(6):e1670-7. doi: 10.1542/peds.2014-0748. Epub 2014 Nov 17. PMID: 25404726.

9. European Association for Palliative Care. Core competencies for education in paediatric palliative care. Brussels: EAPC; 2013. Available from: https://icpcn.org/wp-content/uploads/2022/11/WP-Education-in-paediatric-PC_2013.pdf.

10. Feudtner C, Womer J, Augustin R, Remke S, Wolfe J, Friebert S, Weissman D. Pediatric palliative care programs in children's hospitals: a cross-sectional national survey. Pediatrics. 2013 Dec;132(6):1063-70. doi: 10.1542/peds.2013-1286. Epub 2013 Nov 4. PMID: 24190689.

11. Mack MC, Claxton RN, Arnold RM, Maurer SH. Peds OncoTalk: A Curriculum to Teach Communication Skills to Pediatric Hematology/Oncology Fellows. Pediatr Blood Cancer. 2025 Nov;72(11):e31912. doi: 10.1002/pbc.31912. Epub 2025 Jul 21. PMID: 40692208; PMCID: PMC12331155.

12. Brock KE, Cohen HJ, Sourkes BM, Good JJ, Halamek LP. Training Pediatric Fellows in Palliative Care: A Pilot Comparison of Simulation Training and Didactic Education. J Palliat Med. 2017 Oct;20(10):1074-1084. doi: 10.1089/jpm.2016.0556. Epub 2017 Apr 24. PMID: 28436742; PMCID: PMC5647504.