OPEN ACCESS

Received: 02/08/25
Accepted: 06/10/25
Online: 23/10/25

ORIGINAL ARTICLE

Pediatricians' perceptions of barriers to pediatric palliative care in two public hospitals in Lima, Peru

José Antonio Latorre-Merino[1,a]

[1] Universidad Nacional Mayor de San Marcos, Lima, Perú.
[a] MD, Pediatric Oncologist.

Keywords:
palliative care; pediatrics; medical education; palliative medicine; hospital (source: MeSH-NLM).

ABSTRACT

Objective. To determine pediatricians' perceptions of barriers to pediatric palliative care in two public hospitals in Lima, Peru. **Methods.** A quantitative, descriptive, cross-sectional study with non-probability convenience sampling was conducted. A total of 66 pediatricians from Hospital Dos de Mayo and Hospital Nacional Daniel Alcides Carrión were included. Data were collected through a previously validated, culturally adapted electronic survey translated into Spanish. **Results.** Of the total participants, 74.2% (n = 49) were general pediatricians and 25.8% (n = 17) were pediatric subspecialists. Only 28.8% (n = 19) reported having received training in pediatric palliative care, and 48.5% (n = 32) had referred patients to this type of care. A total of 68.2% (n = 45) acknowledged the lack of adequate pediatric palliative care teams to meet care demand, and 69.7% (n = 46) identified lack of funding as a barrier to patient referral. Likewise, 66.7% (n = 44) considered that discussions about palliative care may be perceived by families as an indicator of proximity to the end of life, and 62.1% (n = 41) indicated that quality of life is often relegated in favor of a curative approach. **Conclusions.** The main barriers identified for pediatric palliative care were lack of funding, insufficient specialized human resources, families' misconceptions about palliative care, and prioritization of curative treatments over quality of life. Limited training in pediatric palliative care among participating physicians was also identified.

Percepción de los médicos pediatras sobre las barreras para los cuidados paliativos pediátricos en dos hospitales públicos de Lima, Perú

Palabras clave:
cuidados paliativos; pediatría; educación médica; medicina paliativa; hospital (fuente: DeCS-BIREME).

RESUMEN

Objetivo. Determinar la percepción de los médicos pediatras sobre las barreras para los cuidados paliativos pediátricos en dos hospitales públicos de Lima, Perú. **Métodos.** Estudio cuantitativo, descriptivo y transversal, con muestreo no probabilístico por conveniencia. Fueron incluidos 66 médicos pediatras de los hospitales Dos de Mayo y Daniel Alcides Carrión del Callao. La información fue recolectada mediante una encuesta electrónica previamente validada, adaptada culturalmente y traducida al español. **Resultados.** Del total de participantes, el 74,2 % (n = 49) fueron médicos pediatras y el 25,8 % (n = 17) pediatras subespecialistas. Solo el 28,8 % (n = 19) refirió haber recibido formación en cuidados paliativos pediátricos, y el 48,5 % (n = 32) había derivado pacientes a este tipo de atención. El 68,2 % (n = 45) reconoció la inexistencia de equipos adecuados de cuidados paliativos pediátricos para cubrir la demanda asistencial, y el 69,7 % (n = 46) identificó un déficit de financiamiento como barrera para la referencia de pacientes. Así mismo, el 66,7 % (n = 44) consideró que la discusión sobre cuidados paliativos puede ser percibida por las familias como un indicador de proximidad del final de la vida, y el 62,1 % (n = 41) señaló que la calidad de vida suele relegarse frente al enfoque curativo. **Conclusiones.** Las principales barreras identificadas para los cuidados paliativos pediátricos fueron el déficit de financiamiento, la insuficiencia de recursos humanos especializados, la percepción errónea de las familias sobre estos cuidados y la priorización de tratamientos curativos por sobre la calidad de vida. Se evidenció además una limitada formación en cuidados paliativos pediátricos entre los médicos participantes.

Cite as: Latorre-Merino JA. Pediatricians' perceptions of barriers to pediatric palliative care in two public hospitals in Lima, Peru. Rev Peru Cienc Salud. 2025;7(4):321-9. doi: https://doi.org/10.37711/rpcs.2025.7.4.10

Correspondence:
José Antonio Latorre-Merino
jose_alm14@hotmail.com

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INTRODUCTION

The World Health Organization (WHO) [1,2] defines pediatric palliative care as an approach aimed at preventing and relieving suffering in patients (children and adolescents) with life-limiting or life-threatening diseases. In addition, it encompasses the patient's and family's physical, psychological, social, and spiritual domains. It is not limited solely to the end of life; however, it is at that stage that it becomes a fundamental pillar of quality care.

It is estimated that approximately 21 million children worldwide require this type of care, which begins at the time of diagnosis and continues throughout life, death, and bereavement. It does not involve only the pharmacological management of signs and symptoms, but also includes end-of-life care and family support during bereavement. Accordingly, it should be incorporated alongside disease-directed medical treatment. These efforts are provided by a multidisciplinary team whose care strategies are individualized for each patient [1,3,4].

Figures published by the Pan American Health Organization (PAHO) in 2022 reported that, within the context of Latin America, Argentina had 58 pediatric palliative care teams, while Brazil and Uruguay had 14 teams each, and Chile had 13 teams. All of these countries were among those with the highest number of such units. In Peru, there are few pediatric palliative care units, including those at the Instituto Nacional de Salud del Niño – Breña, the Instituto Nacional de Salud del Niño – San Borja, and the Instituto Nacional de Enfermedades Neoplásicas (INEN). Based on these data, the rate is estimated at 0.23 units per million inhabitants under 15 years of age [5,6].

On September 19, 2018, Law No. 30846 was enacted, creating the National Palliative Care Plan for oncologic and non-oncologic diseases. Likewise, on July 26, 2021, through Ministerial Resolution No. 939-2021 of the Ministry of Health, the technical document pertaining to this law was published. The objectives have been to include palliative care as part of the National Health System, in order to enable the population of Peru to access care aimed at achieving the highest possible quality of life [7,8].

Although there is information and awareness regarding the need for pediatric and adolescent patients with chronic diseases to receive palliative care, healthcare professionals may feel uncomfortable addressing symptoms in a timely manner, the proximity of death, and family bereavement. Evidence shows that resources for these age groups are limited and, furthermore, patients in middle-income countries are less likely to have access to pediatric palliative care services [9,10].

Some barriers that affect the timely recognition of and referral of patients to pediatric palliative care services include lack of awareness of the existence of this approach and its actual goals, shortage of human resources trained in this field, bureaucratic barriers, as well as the belief that implementing such care would require a high investment of time. However, collaborative work with the pediatric palliative care team helps provide higher-quality care for both the child and the family [11,12].

Other identified barriers include fear of the family's reaction, difficulties between attending physicians and the palliative care unit team, as well as the absence of a clear prognosis in certain pathologies. Shortcomings in the health system and the lack of adequate policies are also part of these barriers [13,14].

Healthcare personnel working in pediatric areas face complex diagnoses and diseases with fatal outcomes at varying time points on a daily basis. Therefore, the aim of this study was to determine pediatricians' perceptions of barriers to pediatric palliative care in two public hospitals in Lima, Peru.

METHODS

Study type and area

This was an observational study with a non-experimental, quantitative, cross-sectional design. It was conducted in the Department of Pediatrics of Hospital Nacional Dos de Mayo and Hospital Nacional Daniel Alcides Carrión in the Constitutional Province of Callao, Peru. The Department of Pediatrics at both hospitals is composed of the Pediatrics, Neonatology, and Pediatric Intensive Care Unit services. The data collection period spanned from January to June 2025.

Population and sample

The total population consisted of 87 pediatricians from both hospitals. A non-probability convenience sampling method was used for sample selection. Selection criteria were applied, including attending physicians belonging to the Department of Pediatrics of the Hospital Nacional Dos de Mayo and the

Hospital Nacional Daniel Alcides Carrión, as well as those who provided consent to participate in the study. On the other hand, resident physicians and attending physicians who were not part of the staff registered in the Department of Pediatrics of the Hospital Nacional Dos de Mayo or the Hospital Nacional Daniel Alcides Carrión during 2025, as well as those who did not provide consent to participate, were excluded.

Variables and data collection instruments

The data collection instrument used had been previously validated in the publication by Ceballos et al. [13], conducted in Chile in 2023, to assess the perception of facilitators of and barriers to referral to pediatric palliative care. This instrument was developed based on an adaptation of the electronic survey used by Dalberg et al. [15] in 2018.

The electronic survey used in Chile underwent cultural adaptation through a translation and back-translation method, both of which were carried out with the authorization and approval of the original author.

The survey consisted of three sections: sociodemographic data, training in pediatric palliative care, and barriers to referral to such care. The variable "perception of barriers" was one-dimensional, and 25 statements assessed through a Likert scale were used. A pilot test was conducted with 12 physicians from pediatric departments of other hospitals. Through Cronbach's alpha test, a final value of 0.76 was obtained; therefore, it was classified as acceptable.

Data collection techniques and procedures

The survey was used as the data collection technique, and the instrument applied was a fully anonymous digital questionnaire (developed on the Google Forms digital platform). With the approval of the ethics committees and the knowledge of the heads of the Pediatrics Department of both hospitals, the access link to the informed consent form and the data collection sheet was sent digitally. Data collection took place between January and June of the present year. Reminder messages were sent every two weeks and monthly.

Data analysis

The data obtained were tabulated in Excel. Subsequently, SPSS version 25 statistical software was used for descriptive analysis and information management.

Ethical considerations

The research project was approved by the ethics committees of the Hospital Nacional Dos de Mayo (Evaluation 003-2025-CEIB-HNDM), as well as the Hospital Nacional Daniel Alcides Carrión (Approval Certificate 004-2025-CEI-HNDAC). The digital questionnaire contained the informed consent form in its first section and was programmed so that, if the participant did not agree to participate, they would not be allowed to continue with the remaining questions. Throughout the data collection process, the bioethical principles of beneficence, non-maleficence, justice, and autonomy were respected.

RESULTS

Of the participants, 47.0% (31) were from Hospital Nacional Dos de Mayo, whereas 53.0% (35) belonged to Hospital Nacional Daniel Alcides Carrión. A total of 74.2% (49) were pediatricians and 25.8% (17) were pediatric subspecialists. Furthermore, 48.5% (32) of the physicians had referred patients at some point during their clinical practice to a pediatric palliative care unit, whereas 51.5% (34) had not. Overall, 71.2% (47) of the physicians had not received any type of training in pediatric palliative care, whereas 28.8% (19) had received such training. Of those who had received it, only 6.1% (4) considered it "sufficient." However, 18.2% (12) perceived the training as "insufficient," and 4.5% (3) as "very insufficient" (see Table 1).

Regarding the statements that explored participants' perceptions of barriers to timely referral to pediatric palliative care, 68.2% (45) of the physicians acknowledged that there are no specialized pediatric palliative care teams appropriately equipped to meet the demand of the patients under their care. A total of 69.7% (46) stated that there is a funding deficit for referring patients to pediatric palliative care units.

Likewise, 36.3% (24) acknowledged that, due to the demand from patients requiring evaluations, the time available to discuss end-of-life issues and related matters in greater depth is very limited.

A total of 69.7% (46) disagreed that speaking about pediatric palliative care early causes anxiety in the family environment, and 75.8% (50) thought that it would not generate any additional burden for families, nor would it damage the physician-patient relationship [86.4% (57)]. In addition, 66.7% (44) acknowledged that discussing it may be perceived

Table 1. Sociodemographic characteristics of participants

Characteristics	n = 66	
	fi	%
Age (years)		
25-30	3	4.5
31-35	15	22.7
36-40	13	19.7
41-45	9	13.6
46-50	3	4.5
Older than 50 years	23	34.8
Gender		
Female	41	62.1
Male	25	37.9
Hospital of origin		
Hospital Dos de Mayo	31	47.0
Hospital Daniel Alcides Carrión	35	53.0
Academic training		
Pediatrician	49	74.2
Pediatric subspecialist	17	25.8
Years of professional practice		
1 to 4 years	6	9.1
5 to 10 years	28	42.4
11 to 15 years	6	9.1
16 to 20 years	4	6.1
More than 20 years	22	33.3
Training in pediatric palliative care		
Yes	19	28.8
No	47	71.2
Perception of training in pediatric palliative care		
None	47	71.2
Very insufficient	3	4.5
Insufficient	12	18.2
Sufficient	4	6.1
Referral to pediatric palliative care		
Yes	32	48.5
No	34	51.5

by the family as meaning that the end of life is near. Furthermore, 51.5% (34) agreed that, if end-of-life issues are discussed with parents, they may fear that the healthcare team will not provide appropriate care.

In addition, 53.0% (35) agreed that symptoms associated with the treatments received should be managed by the attending team and not by the pediatric palliative care team, whereas 57.6% (38) acknowledged that symptoms associated with the disease should also be managed by the attending team and not by palliative care specialists. On the other hand, 40.9% (27) indicated that it is difficult for them to transfer the care of their patients to another healthcare team.

Similarly, 54.6% (36) agreed that consultations with the pediatric palliative care service should be determined by the attending team and not by the palliative care team. In contrast, 65.2% (43) disagreed that role overlap between attending physicians and the palliative care team could negatively affect patient care.

A total of 62.1% (41) acknowledged that quality of life tends to take second place to curative treatment. Meanwhile, 59.1% (39) disagreed that their specialty does not promote pediatric palliative care, whereas 72.7% (48) also disagreed that pediatric palliative care is synonymous with end-of-life care. A total of 48.4% (32) stated that they find it difficult to recognize the most appropriate moment in the course of the disease to refer their patients to this type of care, and 45.5% (30) reported that they find it difficult to talk about death with the family.

Furthermore, 72.8% (48) disagreed that the death of a patient leads them to feel guilt and that this influences decision-making. In addition, 75.8% (50) disagreed that pediatric palliative care is incompatible with the type of patients they treat (see Table 2).

DISCUSSION

In the field of pediatrics, medical personnel face daily situations that require competencies such as breaking bad news, managing end-of-life symptoms, and providing emotional support to the patient and family. However, the training received, or previously received, is limited, which creates difficulties in the proper management of these patients. Moreover, over the years there has been an increase in patients eligible for this type of care, making the need for human resources trained in this area even more evident [16,17].

A total of 48.5% (32) of pediatric physicians stated that, at some point in their professional activities, they

 https://doi.org/10.37711/rpcs.2025.7.4.10

Table 2. Perception of barriers associated with early referral of patients to pediatric palliative care

Statements	n = 66				
	Do not know / No answer	Strongly disagree	Disagree	Agree	Strongly agree
	fi (%)	fi (%)	fi (%)	fi (%)	fi (%)
1) The attending team—and not the PPC team—should manage symptoms associated with treatments	6 (9.1)	5 (7.6)	20 (30.3)	29 (43.9)	6 (9.1)
2) The attending team—and not the PPC team—should manage symptoms associated with the disease	6 (9.1)	7 (10.6)	15 (22.7)	30 (45.5)	8 (12.1)
3) Early exposure to PPC will cause anxiety in parents and their families	3 (4.5)	19 (28.8)	27 (40.9)	14 (21.2)	3 (4.5)
4) PPC is perceived by patients and their families as a sign that the end of life is near	2 (3.0)	3 (4.5)	17 (25.8)	34 (51.5)	10 (15.2)
5) The frequency of follow-up by PPC teams, after the first consultation, should be according to need and determined by the attending team	3 (4.5)	7 (10.6)	20 (30.3)	31 (47.0)	5 (7.6)
6) Quality of life is often overlooked in favor of curative treatment	3 (4.5)	8 (12.1)	14 (21.2)	33 (50.0)	8 (12.1)
7) It is difficult to find PPC teams appropriate for my patients' needs	3 (4.5)	5 (7.6)	13 (19.7)	28 (42.4)	17 (25.8)
8) There is a funding deficit for referral to PPC programs	10 (15.2)	3 (4.5)	7 (10.6)	29 (43.9)	17 (25.8)
9) It is difficult for me, as a physician, to transfer responsibility for my patients' care to another healthcare team	3 (4.5)	6 (9.1)	30 (45.5)	23 (34.8)	4 (6.1)
10) Role overlap between the attending team and the PPC team may negatively affect patient care	5 (7.6)	11 (16.7)	32 (48.5)	16 (24.2)	2 (3.0)
11) Early referral of patients to PPC may damage the attending team's relationship with patients/family	2 (3.0)	18 (27.3)	39 (59.1)	6 (9.1)	1 (1.5)
12) Optimal patient care may be limited by the attending physician's need to control all aspects of care	5 (7.6)	7 (10.6)	20 (30.3)	28 (42.4)	6 (9.1)
13) My specialty does not promote PPC as much as other specialties	6 (9.1)	11 (16.7)	28 (42.4)	20 (30.3)	1 (1.5)
14) PPC is not compatible with the curative or active treatment of my patients	7 (10.6)	20 (30.3)	30 (45.5)	8 (12.1)	1 (1.5)
15) I perceive PPC as synonymous with end-of-life care or death	4 (6.1)	14 (21.2)	34 (51.5)	13 (19.7)	1 (1.5)
16) Early introduction of PPC teams generates an additional burden for parents	6 (9.1)	17 (25.8)	33 (50.0)	9 (13.6)	1 (1.5)
17) It is difficult for me to know at what point in the course of the disease patients will benefit from referral to PPC	6 (9.1)	7 (10.6)	21 (31.8)	29 (43.9)	3 (4.5)
18) My emotional relationship with patients and their families influences which treatment options I can offer during relapses or disease progression	2 (3.0)	13 (19.7)	30 (45.5)	20 (30.3)	1 (1.5)
19) My emotional relationship with patients and their families influences how treatment options are communicated during relapses or disease progression	2 (3.0)	9 (13.6)	29 (43.9)	25 (37.9)	1 (1.5)
20) As the attending physician, I tend to feel guilty about the death of my patients, which may influence my treatment decisions	4 (6.1)	11 (16.7)	37 (56.1)	14 (21.2)	0 (0.0)
21) As the attending physician, I tend to be overly optimistic in the information I provide regarding experimental or second-line therapies	8 (12.1)	4 (6.1)	32 (48.5)	22 (33.3)	0 (0.0)
22) As a pediatrician, I find it difficult to talk about death with my patients and their families	2 (3.0)	7 (10.6)	27 (40.9)	26 (39.4)	4 (6.1)
23) In my clinical practice, I do not have adequate time to discuss end-of-life issues with families and patients	4 (6.1)	13 (19.7)	25 (37.9)	21 (31.8)	3 (4.5)
24) Patients avoid reporting symptoms to their attending pediatricians for fear of disappointing them	11 (16.7)	9 (13.6)	24 (36.4)	22 (33.3)	0 (0.0)
25) I believe that parents fear that, if the possibility that their child may die is raised, the attending team will "give up" on their child	4 (6.1)	11 (16.7)	17 (25.8)	31 (47.0)	3 (4.5)

PPC: Pediatric Palliative Care.

had referred or participated in the referral process of patients to a pediatric palliative care unit. Cevallos et al. [13], in Chile, and Florez et al. [18], in Colombia, reported percentages close to ours.

The highest percentage of participants stated that they had not received any type of training in this model of care. These results are consistent with those of Moya in Spain [19], Cevallos et al. in Chile [13], McNeil et al. in Latin America [20], McNeil et al. in Brazil [21], and Argume in Peru [22], who found low levels of training in pediatric palliative care among medical personnel caring for children and adolescents.

Of the participants who stated that they had received training in this approach, most reported that they considered their knowledge insufficient. Our findings are consistent with those reported by Moya [19] and Ceballos et al. [13] in their publication.

In 2018, the International Association for Hospice and Palliative Care (IAHPC) issued recommendations to governments around the world, including that academic institutions and teaching sites should include research and training in this approach. Such training must be continuous and progressive for healthcare personnel, ranging from a basic to an advanced level [8].

Furthermore, one of the specific objectives of the National Palliative Care Plan for Oncologic and Non-Oncologic Diseases in Peru 2021-2023 is the need to strengthen training and the availability of human resources for the corresponding care. Therefore, the need for training human resources in palliative care is both an international and national priority [8].

To achieve this, academic training is an important, though not the only, pillar for improving quality of care. However, due to the complexity and scope of application, training levels differ and must be acquired progressively [23].

A large percentage of the medical personnel acknowledged that there are not enough pediatric palliative care teams to meet the demand of the patients under their care; likewise, the budget allocated to this area is limited. Only 36.3% (24) acknowledged that, because of the demand from patients requiring evaluations, the time available to discuss end-of-life issues, or related matters, in greater depth is very limited. In this regard, our findings are consistent with those reported by Florez et al. [18] and Cevallos et al. [13], who reported that there are not enough units and public funding for this type of care.

In 2021, Pastrana et al. [6] published the *Atlas of Palliative Care in Latin America 2020* (2nd edition), which describes that Peru has 0.6 care resources per million inhabitants and only 0.2 resources for children under 15 years of age per million inhabitants. However, comparatively, Uruguay is reported to have a rate of 19.3 resources for children under 15 years of age per million inhabitants, followed by Argentina with a rate of 5.3, Costa Rica with 2.8, and Chile with 2.2. The remaining countries are reported with rates below 1. Multiple factors influence these data, but it is also necessary to mention that per capita health expenditure is closely related to the economic level of each country.

A high percentage of participants disagreed that speaking about pediatric palliative care early causes anxiety in the family environment. Likewise, they acknowledged that it would not generate any additional burden for families, nor would it impair the physician-patient relationship. Khan et al. [24] and Cevallos et al. [13] reported similar findings.

In our results, nearly half of the participants (45.5%) reported that they find it difficult to talk about death with the family; a nearly similar percentage stated that they find it difficult to recognize at what point in the disease it would be most appropriate to refer their patients to this type of care. However, despite acknowledging this, more than half of the participants stated that the management of symptoms associated with the disease and treatment should be handled by the attending team and not by the palliative care team. A total of 40.9% (27) indicated that it is difficult for them to transfer the care of their patients to another healthcare team.

Parents facing their children's end-of-life process inherently need professional support. They consider natural communication necessary, but above all, honest and clear communication. Depending on how this is approached, positive or negative experiences will be generated. Some studies have demonstrated a positive impact on family members who were cared for by a pediatric palliative care team [25].

Likewise, it is an undeniable reality that, among members of the pediatrics team, conflicts may arise, both internal (among colleagues) and external (with the patient and family), in the face of complex

situations. However, the guiding principle for decision-making should always be the patient's best interest. In addition, a therapeutic goal must be established in order to define clear and concrete measures [26].

The four main barriers perceived by the participants were funding deficits in pediatric palliative care units, lack of available human resources, family misperceptions regarding this type of care, and the prioritization of "curative" treatments over quality of life. Late referral of patients to pediatric palliative care is not attributable solely to the lack of trained human resources, but also to public policies and to the sociocultural aspects of the patient and family [6].

Rost et al. [27] identified the main barriers in Switzerland as lack of personnel, cultural aspects, parents' hopes, and inadequate hospital infrastructure. Ehrlich et al. [28] identified, in countries of Europe and Asia (Eurasia), family resistance, lack of specialist training in this approach, as well as limited access to these services, as barriers.

Levine et al. [29] found, in the United States, that barriers included the family's lack of understanding of the irreversibility of the disease, the family's pursuit of life-support therapies, uncertain prognosis, and parents' discomfort with the perception that death is being hastened. Grüneberg et al. [30], in 2024, identified as barriers the limitation of teams or support networks outside the hospital, the lack of training centers and human resources trained in this area, as well as legal and labor gaps affecting parents.

De Noriega et al. (2025) [31], in Spain, identified as barriers late referral, parents' negative views toward this approach, and the fact that other professionals do not perceive the need for this care in patients. Healthcare personnel in different parts of the world recognize the multiple difficulties involved in the recognition of and timely referral to pediatric palliative care. Many of them are consistent with our findings: limitations in human resources, perceptions held by healthcare personnel themselves, infrastructure, and family resistance.

All of this may lead to futile measures being placed at the forefront while quality of life is relegated to the background. Furthermore, patients and families are exposed to large amounts of information and advertising for products and procedures that offer "cures" for diseases, which leads to decisions that are not favorable for patients [23].

In June 2025, the "Report on the Situation of Palliative Care in Peru According to WHO Indicators" (World Health Organization) was published. This document describes 6 dimensions and 18 indicators to measure the development of palliative care in Peru. There are already established indicators, others in progress, and others that are emerging. The indicators that still require improvement are research in palliative care, use of essential medicines, and integrated palliative care services (29 specialized teams and a rate of 0.0084 specialized services per 100,000 inhabitants) [32].

Of the 29 available units, only four provide care to pediatric patients. Three of them are hospital-based: the National Institute of Child Health – Breña, the National Institute of Child Health – San Borja, and the National Institute of Neoplastic Diseases (INEN). Likewise, there is a pediatric hospice in Cusco (Casa Khuyana). In recent years, as a result of the enactment of the law and the National Palliative Care Plan in Peru, progressive improvements have been made, but there is still a long way to go [32].

The main limitations of the study were self-report bias, as well as a small sample size. In addition, although pediatricians do make decisions, other healthcare professionals involved in clinical care were not included, even though they often have greater contact and communication with the patient and the accompanying family member.

Conclusions

The main barriers identified were the funding deficit in pediatric palliative care units, the lack of available human resources, family misperceptions regarding this type of care, and the prioritization of "curative" treatments over quality of life. Furthermore, it was found that only 28.8% (19) of pediatric physicians had training in pediatric palliative care. Adequate academic training will help improve the quality of care. There are still many variables to improve, but a path has already been laid out.

Acknowledgments

Special thanks to Dr. Luis Podestá Gavilano for his suggestions and recommendations for the proper development of the topic, as well as to all the physicians of the Hospital Nacional Dos de Mayo and Hospital Nacional Daniel Alcides Carrión in Callao, who kindly participated in the study.

BIBLIOGRAPHIC REFERENCES

1. Benini F, Avagnina I, Giacomelli L, Papa S, Mercante A, Perilongo G. Pediatric Palliative Care in Oncology: Basic Principles. Cancers (Basel) [Internet]. 2022 [cited 2025 Jul 24];14(8):1972. https://doi.org/10.3390/cancers14081972
2. Peláez M, Morales J, Navarro L, Velázquez M, Sánchez J, Rubio L, et al. El final de vida en pacientes atendidos por equipos de cuidados paliativos pediátricos. Estudio observacional multicéntrico. Anales de Pediatría [Internet]. 2022 [cited 2025 Jul 24];96(5):394-401. https://doi.org/10.1016/j.anpedi.2021.06.012
3. Salins N, Hughes S, Preston N. Palliative Care in Paediatric Oncology: an Update. Curr Oncol Rep [Internet].2022 [cited 2025 Jul 25];24(2):175-186. https://doi.org/10.1007/s11912-021-01170-3
4. Kenneson SA, Hughes-Visentin A, Wrigley J, Gujral P, Lodhi S, et al. Pediatric Palliative Care Program Implementation in LMICs: A Systematic Review using SWOT Analysis. J Pain Symptom Manage [Internet]. 2023 [cited 2025 Jul 25];66(4):338-350. https://doi.org/10.1016/j.jpainsymman.2023.06.032
5. Pan American Health Organization. *Palliative Care in Pediatric Oncology: Situation in Latin America and the Caribbean* [Internet]. Washington, D.C.: PAHO; 2022 [cited 2025 Jul 27]. Available from: https://iris.paho.org/server/api/core/bitstreams/11a1d9e4-ede4-4e49-abc0-93edac15e562/content
6. Pastrana T, De Lima L, Sánchez-Cárdenas M, Van Steijn D, Garralda E, Pons JJ, et al. Atlas de Cuidados Paliativos en Latinoamérica 2020. 2ª ed [Internet]. Houston: Errea Comunicación; 2021 [cited 2025 Jul 27]. Available from: https://cuidadospaliativos.org/uploads/2021/8/Atlas%20de%20Cuidados%20Paliativos%20en%20Latinoamerica%202020.pdf
7. Ley que crea el plan nacional de Cuidados Paliativos para enfermedades oncológicas y no oncológicas. Diario oficial El Peruano, Ley N° 30846 (19 de setiembre de 2018)
8. Documento Técnico: Plan Nacional de Cuidados Paliativos para enfermedades oncológicas y no oncológicas en el Perú 2021-2023. Resolución Ministerial, N°939-2021-MINSA (2021 Jul 26).
9. Cuervo-Suarez M, Cleves D, Duque-Nieto N, Claros-Hulbert A, Molina-Gómez K, Bolaños-López J, et al. Children with cancer at the end of life in a middle-income country: integrated pediatric palliative care improves outcomes. BMC Palliat Care [Internet]. 2024 [cited 2025 Aug 5];23(1):31-39. https://doi.org/10.1186/s12904-024-01354-1
10. Kang KA, Yu S, Kim CH, Lee M, Kim S, Kwon S, et al. Nurses' Perceived Needs and Barriers Regarding Pediatric Palliative Care: A Mixed-Methods Study. J Hosp Palliat Care [Internet]. 2022 [cited 2025 Aug 5];25(2):85-97. https://doi.org/10.14475/jhpc.2022.25.2.85
11. Garaycochea-Cannon V. Cuidados Paliativos Pediátricos como modelo de atención para niños con necesidades especiales de atención. Rev Peru Pediatr [Internet]. 2022 Dec 31 [cited 2025 Aug 5];74(2):29-33. Available from: https://pediatria.pe/index.php/pedperu/article/view/347
12. Brouwer M, Maeckelberghe ELM, Van der Heide A, Hein I, Vergahen E. Barriers in care for children with life-threatening conditions: a qualitative interview study in the Netherlands. BMJ Open [Internet]. 2020 [cited 2025 Aug 12];10:e035863. https://doi.org/10.1136/bmjopen-2019-035863
13. Ceballos-Yáñez D, Astudillo P, Eugenin-Soto MI. Percepción de facilitadores y barreras para la derivación a cuidados paliativos pediátricos. Andes Pediatr. [Internet]. 2023 [cited 2025 Aug 12];94(3):307-15. http://dx.doi.org/10.32641/andespediatr.v94i3.4382.
14. Haines ER, Frost AC, Kane HL, Rokoske FS. Barriers to accessing palliative care for pediatric patients with cancer: A review of the literature. Cancer [Internet]. 2018 [cited 2025 Aug 19];124(11):2278-2288. https://doi.org/10.1002/cncr.31265
15. Dalberg T, McNinch NL, Friebert S. Perceptions of barriers and facilitators to early integration of pediatric palliative care: A national survey of pediatric oncology providers. Pediatr Blood Cancer [Internet]. 2018 [cited 2025 Aug 19] ;65(6):e26996. https://doi.org/10.1002/pbc.26996
16. Gula AL, Merkel E, Bouchelle Z, Nelin T, Rojas C, Hwang J, et al. Primary Palliative Care for Pediatric Residents: A Curricular Framework and Pilot. Acad Pediatr. [Internet].2023 [cited 2025 Aug 20] ;23(6):1133-1137. https://doi.org/10.1016/j.acap.2023.03.006
17. Ochoa J, Del Villar P, De Llano J, Marugán J. Tendencia creciente de pacientes con condiciones limitantes para la vida y crónicos complejos. Anales de Pediatría [Internet]. 2024 [cited 2025 Oct 11];101:95-103. https://doi.org/10.1016/j.anpedi.2024.05.009
18. Florez S, Tovar M, León M, Villegas K, Villamizar D, Granados C. Caracterización del conocimiento en cuidado paliativo pediátrico y percepción de barreras por parte de los pediatras y residentes de pediatría. Med Paliativa [Internet]. 2015 [cited 2025 Oct 11];22(4):127-135. http://dx.doi.org/10.1016/j.medipa.2014.02.001
19. Moya-Dionisio V. Conocimiento sobre cuidados paliativos pediátricos de los pediatras de atención primaria del Principado de Asturias, España. Bol Med Hosp Infant Mex. [Internet]. 2020 [cited 2025 Oct 11];77(4):195-201. https://doi.org/10.24875/bmhim.20000046
20. McNeil MJ, Ehrlich B, Wang H, Bustamante M, Dussel V, Friedrich P, et al. Ideal vs Actual Timing of Palliative Care Integration for Children With Cancer in Latin America. JAMA Netw Open [Internet]. 2023 [cited 2025 Oct 18];6(1):e2251496. https://doi.org/10.1001/jamanetworkopen.2022.51496
21. McNeil MJ, Godfrey A, Loggetto P, de Oliveira-Junior A, Godwin J,Boldrini E, et al. Physician Perceptions of and Barriers to Pediatric Palliative Care for Children With Cancer in Brazil. JCO Glob Oncol. [Internet]. 2023 [cited 2025 Oct 18];9:e2300057. https://doi.org/10.1200/GO.23.00057
22. Argume Huaylinos AD. Conocimiento e identificación de necesidades en cuidados paliativos pediátricos en un instituto especializado de Perú. Horiz Med. [Internet]. 2024 [cited 2025 Oct 18];24(3):e2587. https://doi.org/10.24265/horizmed.2024.v24n3.05
23. Runzer F, Parodi J, Pérez C, Echegaray K, Samamé J. Las personas con enfermedad terminal y la necesidad de cuidados paliativos: una deuda pendiente de los servicios de salud. Acta Med Peru [Internet]. 2019 [cited 2025 Oct 18];36(2):134-44. Available from: http://www.scielo.org.pe/pdf/amp/v36n2/a10v36n2.pdf
24. Khan S, Sadler K, Sidiqui K, Aiyami H, AlGarni M, Al-Kofide A, et al. Physicians' Knowledge, Attitudes, and Perception Toward Pediatric Palliative Care in Saudi Arabia: A National Exploratory Survey. Palliat Med Rep. [Internet]. 2023 [cited 2025 Oct 25];4(1):185-192 https://doi.org/10.1089/pmr.2023.0010
25. Plaza-Fornieles M,García-Marcos P, Galera-Miñarro A, Barbieri G, Bellavia N, Bermúdez-Cortés M, et al. Eficacia del Equipo de Cuidados Paliativos Pediátricos de Murcia según la experiencia de los padres. An Pediatr (Barc) [Internet]. 2020 [cited 2025 Dec 27];93(1):4-15. https://doi.org/10.1016/j.anpedi.2019.07.001
26. Pérez-Martín MA, De Noriega-Echevarría I. Todo lo que el pediatra de AP puede aprender de los cuidados paliativos; Madrid 2023 mar 03 [Internet]. Madrid: Lúa Ediciones; 2023:437-448 [cited 2025 Dec 27]. Available from:https://www.aepap.org/sites/default/files/pag_437_448_cuidados_paliativos.pdf

27. Rost M, De Clercq E, Rakic M, Wangmo T, Elger B. Barriers to Palliative Care in Pediatric Oncology in Switzerland: A Focus Group Study. Journal of Pediatric Oncology Nursing [Internet]. 2019 [cited 2025 Oct 25];37(1):35-45. https://doi.org/10.1177/1043454219871082

28. Ehrlich, BS, Movsisyan, N, Batmunkh, T, Kumirova E, Borisevich M, Kirgizov K, et al. Barriers to the early integration of palliative care in pediatric oncology in 11 Eurasian countries. Cancer [Internet]. 2020 [cited 2025 Oct 26];126:4984-4993. https://doi.org/10.1002/cncr.33151

29. Levine A, Winn PA, Fogel AH, Lelkes E, Mc Poland P, Agrawal A, et al. Barriers to Pediatric Palliative Care: Trainee and Faculty Perspectives Across Two Academic Centers. J Palliat Med [Internet]. 2023 [cited 2025 Oct 26];26(10):1348-1356. https://doi.org/10.1089/jpm.2022.0580

30. Grüneberg ES, Ramos-Guerrero J, Pastrana T. Challenges in the Provision of Pediatric Palliative Care in Mexico: A Cross-Sectional Web-Based Survey. J Palliat Care [Internet]. 2024 [cited 2025 Oct 27];39(1):58-67. https://doi.org/10.1177/08258597211062767

31. De Noriega I, Plantagenet-Whyte FP, Antonio Salinas J, Michel G, Pedraza EC. Palliative care for pediatric cancer patients in Spain: analysis of described resources and barriers. An Pediatr (Engl Ed) [Internet]. 2025 [cited 2025 Oct 27];102(4):503767. https://doi.org/10.1016/j.anpede.2025.503767

32. Tripodoro V, Zapata-Del Mar C, Bejar-Alban A, Estrada C, Suárez D, Montero-Calero A, et al. Informe sobre la situación de los cuidados paliativos en Perú según los indicadores de la OMS. June 2025 [Internet]. España: ATLANTES Global Observatory of Palliative Care; 2025 [cited 2025 Dec 27]. Available from: https://dadun.unav.edu/entities/publication/79dc6980-2928-430a-951f-f8d1cce87cf8

Funding sources

Self-funded.

Conflict of interest statement

The author declares that he has no conflicts of interest.