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EDITORIAL

Beyond pain and death: incorporating humanization into pediatric care

Para além da dor e da morte: integrando a humanização no cuidado pediátrico

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Few experiences challenge pediatric professionals more deeply than witnessing a child's pain or death. Both moments reveal the limits of biomedical intervention and the true essence of care. They remind us that pediatrics is not only about curing disease, but essentially about relieving suffering and accompanying families through the most vulnerable period of life.

In this issue, two original studies bring these dimensions into focus. One explores the perceptions and experiences of healthcare providers facing pediatric death in a level II Portuguese hospital[1]. The other analyzes professionals' knowledge and practices regarding pain assessment in children[2]. Together, they complement the same perspective: the need for competence and compassion for those who deal with suffering in childhood.

The study by Costa et al. reveals the profound personal and professional impact of pediatric death on healthcare teams. Although death in childhood is rare, 82% of respondents had faced it, mostly in emergency contexts. Sadness and compassion were the most commonly reported emotions, transcending professional experience. Yet the study also uncovers important fragilities: younger professionals reported more anxiety and sleep disturbance; few had received specific training in palliative or bereavement care; and there were no structured debriefing protocols after a child's death. The findings echo what many pediatricians intuitively know, that behind the clinical assessment lies an emotional background that often remains unmentioned and unsupported[3].

Saraiva et al. address a different dimension of pediatric suffering: pain. Their survey, conducted in another Portuguese hospital, shows encouraging levels of theoretical knowledge and confidence among doctors and nurses. However, important gaps persist, particularly in the use of pain scales for younger children and in the safe use of opioids. The study also highlights a discrepancy between recognition and treatment: while most professionals felt pain was often identified, only two-thirds believed it was well treated, which is also confirmed by other international studies[4]. Nurses tended to use non-pharmacological strategies more consistently than physicians, and both groups expressed the need for continuous education. These findings mirror international data showing that, despite advances, one in three hospitalized children still experiences moderate or severe pain[5,6].

These two studies are not about exceptional moments – they are about everyday pediatric hospital care. Pain and death are part of the same continuum of human experience, and both require a multidimensional approach that conjugates clinical expertise with emotional intelligence, communication competence, and ethical reflection.

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Pediatric Palliative Care (PPC) embodies this integration. It is never too much to reinforce that PPC is not constrained to the final days of life, but that it begins at diagnosis and accompanies the child and family throughout the course of the illness, seeking to relieve suffering in all its forms[7].

In Portugal, the development of PPC has made significant progress in recent years, with growing awareness, training initiatives, and the creation of specialized and generalist teams within the National Palliative Care Network. Yet the findings of these two articles remind us that the principles of palliative care – effective pain control (as well as the control of other complex symptoms), emotional support, and reflection on loss – must extend beyond these teams to all pediatric care environments. Every pediatrician, nurse, and allied professional should feel prepared to recognize pain, to communicate difficult news, and to support both families and colleagues in times of loss.

Moving forward, three key priorities stand out. First, education: incorporating PPC, communication skills, and grief support into undergraduate and postgraduate pediatric training. These must be core, not optional competencies[8].

Second, institutions should provide spaces for structured debriefing and peer support, which is still far from reality in many hospitals. Acknowledging the emotional impact of pediatric work is an essential component of institutional humanization – caring for healthcare providers as an institutional responsibility[3].

Third, continuity of care: ensuring that pain management, symptom control, and psychosocial support are consistent across hospital, home, and community settings. In complex or prolonged conditions, early referral to specialized PPC teams should be standard practice – allowing shared care, coordinated support, and the prevention of avoidable suffering for children, families, and professionals[7,9].

Ultimately, both studies point to a common message: compassion must be intentional. It requires knowledge, teamwork, and reflection. It also requires caring for those who care – recognizing that the well-being of professionals is inseparable from the quality of care offered to children and families.

Humanization, in this sense, is not an abstract principle, but a daily practice, expressed in how we listen, comfort, and remain present. As pediatricians, we cannot always prevent pain or death, but we can ensure that neither occurs without presence and dedication. By acknowledging children's suffering, we honor the true essence of pediatrics: to always care, even when we cannot cure.

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