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Animal-Assisted Activities With Therapy Dogs in Pediatric Oncology: A Multicenter Survey of the Current Status, Implementation, and Challenges in Germany, Austria, and Switzerland

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ABSTRACT

Background: Animal-assisted activities (AAAs) with therapy dogs have shown positive effects on patient well-being and quality of life in various areas of medicine, including pediatric oncology. However, research on this topic is limited. The aim of this study is to present the current status of AAA in pediatric oncology in Germany, Austria, and Switzerland, to identify challenges, and to discuss potential implementation strategies.

Methods: A German-language questionnaire of 43 items was developed by an interdisciplinary team of experts in pediatric oncology, including physicians, nurses, psychosocial staff, physiotherapists, and sports therapists. The survey was made available online to members of 72 institutions in Germany, Austria, and the German-speaking regions of Switzerland. Responses from 60 institutions (Germany, 54; Austria, 3; and Switzerland, 3) were analyzed.

Results: Currently, 9/60 centers (15%) offer AAA with therapy dogs in pediatric oncology, 36/60 (60%) are interested in establishing such programs. All centers offering AAA have developed guidelines or regulations for its implementation and report positive feedback from patients. The following challenges were identified: hygiene and safety concepts, legal protection, staff shortage, funding, lack of standardized guidelines, and scientific evidence.

Conclusion: This study demonstrates strong interest in AAA in pediatric oncology with several institutions already implementing programs responsibly. Perceived benefits contrast with limited availability and structural barriers. Systematic evaluation in registries and appropriately designed studies, standardized guidelines, and collaborative networks are needed for broader, sustainable integration into acute pediatric oncology care. Pediatric oncology societies should play a key role in coordinating research efforts, study networks, and consensus-based standards.

Abbreviations: AAAs, animal-assisted activities; AAls, animal-assisted interventions; AAT, animal-assisted therapy.

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1 | Introduction

The diagnosis of cancer is a heavy burden for children and adolescents, as well as their families. It drastically changes their lives. Cancer treatment and frequent hospital stays may have a negative impact on the physical, psychological, and psychosocial well-being of children and adolescents. It impacts their quality of life through reduced physical activity, treatment, increased anxiety, and often negative emotions, as well as social isolation [1–5].

Therapeutic advances have significantly improved overall survival rates [6, 7]. Consequently, there has been a growing emphasis on long-term sequelae and quality of life among survivors in recent decades [8, 9]. Concurrently, there is increasing recognition of the potential benefits of complementary therapies to enhance the overall well-being of children undergoing cancer treatment [10, 11].

In this context, animal-assisted interventions (AAIs), often involving therapy dogs, are used in patients to positively affect physical and mental well-being and alleviate disease-related symptoms, such as pain, through interactions between patients and animals [12–14]. Both animal-assisted therapy (AAT) and animal-assisted activities (AAAs) are forms of AAI in which the animal may be part of a volunteer therapy animal team working under the guidance of a professional or belonging to a professional [15]. Although AAT is a structured and goal-directed intervention in which the animal is a defined part of the treatment process, AAA is not goal-directed but provides opportunities for motivation, recreation, and enhanced quality of life. In this manuscript, the term AAA will be used throughout unless AAT is explicitly specified.

Several studies suggest that AAA may improve patients' well-being and mood and may reduce stress, pain, and negative emotions, thereby enhancing overall quality of life [16–18]. AAA can also increase patients' activity levels [19].

In pediatric oncology, previous reports indicate that AAA with therapy dogs may be feasible and safe [20, 21]. However, introducing AAA in inpatient settings remains sensitive due to potential infection concerns for this vulnerable population [22–24]. AAA experience is steadily growing [25], with most top-ranked US pediatric oncology units offering AAA programs [26]. Hygiene standards vary considerably between hospitals [26].

Broader experience with AAA in pediatric oncology is missing in Germany, Austria, and Switzerland. The present study attempts to evaluate the current status of AAA in pediatric oncology in these countries to identify opportunities and barriers as well as basic requirements for broader implementation.

2 | Methods

2.1 | Survey Design

The survey was designed to assess the current status of AAA in pediatric oncology in Germany, Austria, and Switzerland. In

addition, it aimed to generate insights that could facilitate the development of standardized guidelines with general concepts and objectives as well as basic requirements for AAA in this setting.

To inform questionnaire development, a structured literature search was performed in PubMed/MEDLINE, EMBASE, Cochrane CENTRAL, and Web of Science. Search terms included combinations of “AAI,” “AAT,” “AAT,” “therapy dog,” “pediatric oncology,” “pediatric oncology,” “childhood cancer,” “hospitalized children,” “infection risk,” “zoonosis,” “implementation,” “hygiene,” and “feasibility.” The search was intended to identify relevant themes and domains for item generation and was complemented by screening the reference lists of key publications. It was not conducted as a formal systematic review. The questionnaire was developed by a multidisciplinary expert team consisting of three pediatric oncologists, a pediatric oncology nurse, a pediatric infectious disease specialist, two sports scientists, and a physical therapist.

The final German-language questionnaire consisted of 43 items for pediatric oncology care professionals. The questionnaire was divided into 10 sections with the following topic headings: (1) contact information, (2) overall status, (3) participants, (4) objectives, (5) organization and structure, (6) general guidelines and hygiene, (7) animal welfare, (8) evaluation, (9) experiences and future plans, and (10) free-text section (see Table S1 for complete questionnaire). The questionnaire was designed to take 15–20 min to complete. Medical terminology familiar to the target group was used. Most questions were close ended with predefined response options; multiple-choice and free-text answers were possible in several questions. Responses to the question “What support, structures, or processes would be helpful for your work in the project?” were evaluated using the thematic analysis method according to Braun and Clarke [27].

2.2 | Pilot Testing

The preliminary questionnaire was pilot-tested at the University Hospitals of Göttingen, Essen, and Münster, as well as at the Institute of Sports Science in Hildesheim. It was reviewed by 10 professionals with expertise in pediatric oncology and AAA. The pilot testing focused on clarity, relevance, comprehensibility, and feasibility of the survey items. On the basis of the feedback received, wording was refined, response options were adjusted, and the structure of individual items was revised prior to dissemination of the final questionnaire.

2.3 | Distribution

In October 2025, we contacted all pediatric oncology institutions in Germany ($n = 60$) and Austria ($n = 6$) and the predominantly German-speaking institutions in Switzerland ($n = 6$) regarding AAA with therapy dogs in pediatric oncology. The survey was sent by email via the network of the national societies (Germany: Gesellschaft für Pädiatrische Onkologie und Hämatologie [GPOH]; Switzerland: Swiss Pediatric Oncology Group [SPOG]; Austria: Österreichische Gesellschaft für Kinder- und Jugendheilkunde [ÖGKJ]) and the German ActiveOncoKids

network (NAOK), as well as directly to colleagues in pediatric oncology at various locations, and was open for responses until January 28, 2026.

2.4 | Participants

Participants were pediatric cancer care professionals, including nurses, physicians, psychosocial professionals, physiotherapists, sports therapists, dog handlers, and administrative staff from various centers. Participation in the survey was voluntary.

2.5 | Statistical Analysis

The survey was created using German-language online survey tool LimeSurvey [28]. Subsequently, descriptive analysis was performed using IBM SPSS Statistics Version 31.0.0.0. Graphics were generated with the R base stats package [29].

A total of 143 questionnaire responses were collected via LimeSurvey. Empty responses with no information were excluded ($n = 43$) as well as exact duplicates from the same institutions ($n = 3$). Furthermore, nine additional responses were excluded because fewer than three survey questions had been answered. From the resulting $n = 88$ responses, 45 originated from institutions with only one response each, whereas 43 represented multiple submissions from 15 additional institutions. The content of multiple answers from the same institution was merged following predefined rules. In three cases, the respective institutions were contacted for clarification of implausible responses. The final analytical sample comprised 60 datasets from 60 different institutions. Exact exclusion and merging procedures are described as a flowchart in Figure S1.

2.6 | Ethics and Data Protection

The survey was conducted among healthcare professionals via relevant professional societies. It did not involve patients, patient-related data, or personal health data. Participation was voluntary, and respondents were informed about the purpose of the survey and the intended aggregated publication of the results. After completion of data cleaning and institutional verification, the analysis dataset was anonymized, and responses could no longer be attributed to individual persons or centers. The local ethics committee was consulted prior to the study and confirmed that formal ethical approval was not required.

3 | Results

3.1 | Locations and Facilities, Project Status of AAA

Fifty-four institutions from Germany, three from Switzerland, and three from Austria participated in the present survey. A total of 56 medical centers were acute care hospitals, three locations were rehabilitation facilities, and one center was an outpatient facility.

AAA with therapy dogs has been established in nine pediatric oncology institutions in Germany for a median duration of 1.5 years (mean: 3.2 years, range: 0.7–15.7 years). A total of 36 centers were generally interested in AAA, nine had conducted initial explorations, and two centers reported that they were setting up an AAA program at the time of the survey (Figure 1).

In addition to therapy dogs, other animals were used for AAA in 10 centers with 6 centers offering therapeutic horse riding in an inpatient ($n = 5$) or outpatient ($n = 1$) setting. Two hospitals used dogs in palliative care settings (for home care). One center worked with alpacas, llamas, and donkeys, and one center used rabbits and cats.

3.2 | Participants and AAA Settings

Seven hospitals offered AAA with therapy dogs to patients aged 0–3 years. Nine hospitals offered this to patients aged 4–18 years, and four hospitals also offered AAA with therapy dogs to patients over 18 years of age. AAA sessions were conducted as individual sessions by seven hospitals, five hospitals offered group sessions, three offered family-oriented services, and two hospitals also offered services for siblings.

3.3 | Objectives and Areas of Application

All nine AAA centers used therapy dogs in oncology; further applications included palliative care ($n = 8$), hematology ($n = 7$), rehabilitation ($n = 2$) in systemic family work ($n = 1$), and intensive care ($n = 1$). None of the centers used therapy dogs in psychosomatic medicine. AAA programs were established in an inpatient setting ($n = 5$) only or in both, inpatient and outpatient settings ($n = 4$).

Regarding the objectives of AAA for pediatric oncology patients, the nine centers answered as follows: increased well-being ($n = 8$), stress reduction ($n = 9$), increased self-determination ($n = 5$), increased self-confidence ($n = 7$), mobilization ($n = 6$), relief for parents ($n = 9$), social integration ($n = 4$), improved adherence ($n = 9$), involvement of siblings ($n = 2$), and animals as emotional companions ($n = 7$). Two centers were also aiming at reducing anxiety and building relationships.

Four centers set goals for each session with the therapy dog in advance. Five centers did not set goals before each AAA session. In all nine centers, the therapy dogs were handled by the following individuals/professionals: a team consisting of a nurse and a psychologist ($n = 1$), a doctor ($n = 1$), a nurse ($n = 1$), external dog specialists, including dog trainers ($n = 5$) and volunteers ($n = 1$).

3.4 | Organization and Implementation

The qualifications of dog handlers included certified AAA training alone ($n = 5$) or certified AA training plus additional qualifications in therapy or education ($n = 2$), only basic introductory training ($n = 1$) or still undergoing training ($n = 1$).

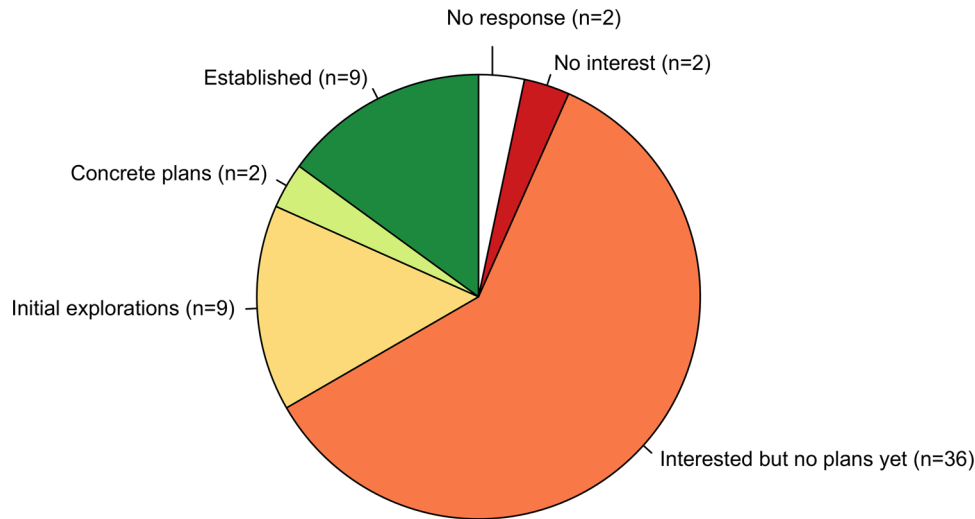


FIGURE 1 | Status of implementation: current status of AAA with therapy dogs in pediatric oncology in Germany, Austria, and Switzerland.

The number of participants in AAA also varied with most centers involving 1–4 patients per session, some centers did not specify limits.

All programs were financed by donations. No intramural or other funding programs were reported.

In most centers, participation in AAA was decided jointly by several professions: the medical team, dog handler, and psychosocial team ($n = 3$); by the medical team and psychosocial service ($n = 2$); by physicians and psychosocial service ($n = 1$); by psychosocial service and nursing staff ($n = 1$); by physicians and dog handlers ($n = 1$); and by the medical team alone ($n = 1$).

AAA programs involved either one dog ($n = 5$) or two dogs ($n = 4$) per center. Regarding session length, one center reported 30–60 min, one reported 45-min individual sessions or 60-min group sessions, one reported 45–90 min, and two reported 60 min. One center reported the frequency only as “once per month.” Three centers did not respond to this question.

3.5 | Framework Conditions and Hygiene

In five centers, written consent forms, and in three centers, verbal consents were obtained from parents or patients for AAA participation. One center did not ask for any consent.

Five locations did not provide any information about dog breeds. Reported breeds included Border Collies, Cocker Spaniels, Australian Shepherds, Dalmatian mixes, Labradors, and Bernese Mountain Dogs. The age of therapy dogs ranged from 4 to 11 years.

AAA sessions were conducted in patient rooms ($n = 3$ centers), meeting rooms ($n = 4$), patient common rooms ($n = 2$), an outdoor area on hospital grounds ($n = 5$), gym ($n = 1$), and in the outpatient area ($n = 4$). AAA-specified rooms and physiotherapy rooms were mentioned as additional locations.

The following exclusion criteria for AAA were reported: allergies ($n = 9$), severe neutropenia ($<500/\mu\text{L}$) ($n = 4$), moderate

neutropenia ($<1000/\mu\text{L}$) ($n = 1$), dog phobia ($n = 5$), open wounds ($n = 7$), and lack of compliance ($n = 6$). No further exclusion criteria for AAA sessions were specified.

Eight hospitals followed AAA-specific hygiene concepts, including one for the dogs ($n = 8$), for patients ($n = 7$), for the premises ($n = 7$), and for dog routes ($n = 6$). AAA-allocated rooms were found in five centers, and AAA-specific cleaning concept in six centers. One center did not use an AAA-specific hygiene concept but instead followed the general hospital hygiene concept.

3.6 | Animal Welfare

Maximum AAA hours per dog per week varied as follows: 0–2 h ($n = 4$), 2–4 h ($n = 1$), and 4–6 h ($n = 3$). Six centers reported regular session breaks. One center stated that it provides twice as much break time as activity time, and one center stated that it provides breaks for dogs according to the standards of the dog trainer.

Six centers offer places of retreat for dogs. Reported retreat areas include a botanical garden, a separate room, and specifically designated areas (e.g., a towel in the fitness room). Seven centers provide outdoor access for the dog during breaks. Nine centers had established criteria for terminating AAA sessions for animal welfare reasons.

3.7 | Evaluation

Only in one center, AAA is accompanied by a scientific study, and one center plans to initiate scientific evaluation at a later date.

3.8 | Experiences and Future Plans

Several positive experiences were reported. One center reported considerable interest in AAA involving a therapy dog. According to subjective perceptions and observational assessments, the intervention was associated with enhanced patient well-being

TABLE 1 | Barriers to the successful implementation of animal-assisted activity (AAA) in pediatric oncology.

Question: "What were/are the biggest obstacles to the successful implementation of the project?"	Yes n (%)	No n (%)	Missing n (%)
Hygiene requirements	41 (68.3)	11 (18.3)	8 (13.3)
Financing	25 (41.6)	27 (45)	8 (13.3)
Legal uncertainty	23 (38.3)	29 (48.3)	8 (13.3)
Lack of suitable dog	23 (38.3)	29 (48.3)	8 (13.3)
Lack of space	21 (35)	31 (51.6)	8 (13.3)
Bureaucracy	20 (33.3)	32 (53.3)	8 (13.3)
Organizational difficulties	19 (31.6)	33 (55)	8 (13.3)
Staff shortage	17 (28.3)	35 (58.3)	8 (13.3)
Lack of acceptance among medical staff	11 (18.3)	41 (68.3)	8 (13.3)
Other obstacles ^a	9 (15)	43 (71.6)	8 (13.3)
Lack of interest among patients	1 (1.6)	51 (85)	8 (13.3)

Note: Centers were asked a multiple-choice question regarding the main obstacles to the successful implementation of an AAA program. Total numbers and percentages of yes, no, and missing responses are shown.

^aIn the open-response category "Other obstacles", reported reasons included competing priorities, lack of implementation experience, limited interest, and lack of approval from the public health department.

and improved adherence following the sessions. Another location reported that children appeared notably happy and seemed to "flourish" during the intervention. One center stated that patients across all age groups showed interest in and enjoyment of physical activities involving the therapy dog. In particular, patients with brain tumors and neurological deficits were reported to demonstrate improved control of paretic limbs during dog-assisted activities. At one site, patients consistently expressed positive attitudes toward AAA and reported anticipating the sessions with enthusiasm. Another location observed that AAA promoted children's autonomy and adherence to therapy. Furthermore, positive effects were reported in children with verbal communication difficulties.

It should be noted that these responses reflect participants' subjective perceptions and reported experiences.

Only one center reported negative experiences related to ongoing hygiene discussions.

The most frequently reported barriers to implementing AAA across all 60 centers were hygiene requirements, followed by funding, legal uncertainty, and lack of a suitable dog. Less frequently mentioned were lack of suitable premises, bureaucracy, organizational difficulties, staff shortages, and overall limited acceptance (Table 1).

Using Braun and Clarke's [27] thematic analysis approach, seven themes were identified from the open-ended responses (for details on the selection process, see Supporting Information). The results are presented below, illustrated with illustrative quotations: First, a clear need for uniform hygiene, safety, and legal frameworks and safeguards was identified ("clear hygiene requirements that are binding across clinics are needed"). Second, standardized, preferably evidence-based guidelines applicable across pediatric oncology centers were considered necessary

to ensure legitimacy and process reliability for implementing AAA ("internationally recognized SOPs and binding guidelines would be helpful"). Third, structural resources, such as staffing and funding, were regarded as essential for AAA implementation ("sufficient personnel resources and financial support are required"). Fourth, institutional support for AAA—for example, from hospital leadership, medical chairs, and infection control officers—was seen as crucial ("support from clinic leadership and the medical director is crucial"). Fifth, respondents expressed a strong desire for exchange within an AAA network to continuously improve practice ("exchange with centers already implementing therapy dogs would be very valuable"). Sixth, a need for concrete implementation support was identified (e.g., step-by-step concepts and process guidance) ("a step-by-step implementation concept and hygiene framework from an experienced center would be helpful"). Finally, continuous advocacy for AAA promotion using evidence-based arguments and practical demonstrations was considered important ("scientific evidence and real-life demonstrations are needed to convince stakeholders").

Of the 60 surveyed centers, 32 (53%) reported being interested in a joint AAA network or working group. Fifteen (25%) may be interested, five (8%) were not interested, and eight did not reply. A total of 27 centers (45%) were interested in participating in a multicenter study, 21 (35%) indicated that they might be interested, four (7%) were not interested, and eight did not answer.

In the final free-text section, participants asked questions and shared feedback. Many reported that they had previously been unaware of therapy dog projects but expressed strong interest. They noted that psychosocial care is often insufficiently supported in pediatric oncology and that AAA could be a valuable addition. Several sites rated the survey project positively and stated that the survey itself had prompted team discussions.

4 | Discussion

AAA is being used increasingly as a complementary intervention in pediatric oncology. The strong relevance of the subject is mirrored by a high participation rate in the present AAA-related survey among pediatric oncology centers in Germany, Austria, and Switzerland.

Although this observation shows great interest in AAA, only 15% of survey centers currently offer AAA. This proportion appears markedly lower than in the United States, for example, where 50% of large pediatric oncology centers have AAA programs in place [26]. Nevertheless, the majority of centers without established AAA programs expressed clear interest in starting a program or are already in the process of planning implementation.

The observed discrepancy between interest and implementation may indeed indicate structural barriers to starting AAA programs in pediatric oncology in Germany, Austria, and Switzerland rather than a lack of acceptance. Potential barriers identified in the present survey included strict regulatory and hygiene requirements, limited structural and financial support, lack of standardized guidelines, or limited general acceptance due to a lack of objective scientific evidence of AAA-related benefits for children with cancer.

Although AAA is intuitively appealing and widely perceived as beneficial, the current evidence base in oncology remains limited. Standardized protocols or consensus-based guidelines are scarce. Implementation of AAA in this study varied substantially across centers with respect to AAA formats, settings, and dog characteristics. In line with other reports [30], comparability of the different programs is limited, and robust data supporting AAA in the pediatric oncology setting can only be generated very restrictively. However, reported goals of AAA were highly consistent among centers, focusing mostly on well-being, stress reduction, self-efficacy, and mobilization. In this regard, our survey findings align with the predominantly positive self-reports of pediatric oncology patients undergoing AAA [18, 31] and are also consistent with the positive tone of previous trials, projects, and surveys regarding AAA in children with cancer [16, 32, 33]. At the same time, the present survey was descriptive in nature and does not allow conclusions regarding efficacy or patient-level benefit. Rather, it highlights current practice patterns, perceived aims of AAA programs, and the strong interest of centers in further development and evaluation of such approaches.

A major barrier is the lack of standardized hygiene concepts for AAA. This, in turn, increases procedural and personal uncertainty, legal liability, and overall safety concerns. In Germany, for instance, hygiene and infection control are regulated at state level and additionally at local level (e.g., municipalities and local health authorities), reflecting the country's decentralized approach to healthcare oversight [34]. In the absence of dedicated guidelines for AAA in pediatric oncology, institutions often adapt hygiene protocols from recommendations developed for rehabilitation facilities (KRINKO Guidelines [35]). However, these guidelines, for instance, specifically exclude patients with central lines, making direct application in acute-setting pediatric oncology impossible. Consequently, AAA programs must

adopt a carefully tailored approach that maintains exceptionally high hygiene standards to minimize risk while still enabling the potential benefits of AAA. This highlights the need for standardized, evidence-based AAA guidelines, comparable to the infection-control recommendations for AAIs in healthcare facilities proposed by a multidisciplinary expert panel for the US [36].

The present survey also identified the predominant reliance of AAA programs on charitable funding combined with limited institutional support as a further major obstacle for broader dissemination of AAA programs. This phenomenon is well known from other highly regarded complementary measures, such as hospital clowns or art therapy, even in well-funded national health systems [37, 38]. However, funding structures differ between regions, and systems, such as that of the United States, may benefit from more widespread and accessible philanthropy-based funding [39].

Stronger scientific evidence would likely facilitate the development of formal recommendations and thereby support more sustainable financing of AAA programs. The present survey also revealed the lack of systematic scientific evaluation accompanying the existing AAA programs. Although most AAA centers are academic institutions and naturally acknowledge the need for scientific evaluation, only one site was conducting formal research in this area. Although AAA is being explored in a small but growing body of literature, only few prospective studies exist, mostly limited by small sample sizes and limited statistical power, such as the study recently published by Chubak et al., which faced recruitment challenges due to the COVID-19 pandemic [33]. Additional methodological limitations hindering the wider implementation of AAA programs also include insufficient standardization of interventions and outcome measures, as well as a lack of follow-up, as recently reviewed by Holder et al. and Duque et al. [40, 41]. The lack of scientific evaluation may perpetuate a cycle in which insufficient evidence prevents the development of formal guidelines and consequently limits widespread implementation and funding.

Findings from the present study suggest that many centers perceive AAA as a promising supportive care adjunct in pediatric oncology, yet its potential remains constrained by fragmentation and limited evidence. To promote the transition from isolated initiatives to routine care, coordinated efforts in standardization of interventions, research, and funding are essential [40]. At the same time, the broad willingness of centers in this study—and potentially beyond—to engage in AAA networks and larger scale AAA studies offers a unique opportunity to address these gaps collaboratively.

Future research should use study designs aligned with the respective research question. At a minimum, centers should collaborate within multicenter registries to generate standardized real-world data. Depending on the research aim, additional suitable approaches may include pragmatic multicenter studies, randomized adequately powered multicenter trials, mixed-methods designs, and stepped-wedge designs. Across these approaches, standardization of intervention protocols and outcome assessment would be desirable. To promote broader acceptance of AAA, adverse events and microbial transmission should be monitored

systematically in all studies. Our survey and other studies [40, 41] suggest that other priority outcomes should also include patient-reported well-being, stress, activity level, parental burden, and implementation fidelity.

Overall, the results of the present study suggest a high level of reported professionalism with regard to dog handling and safety awareness among centers offering AAA. The findings indicate that AAA may be integrated into clinical care in a responsible and controlled manner, while underscoring that questions of safety and efficacy have not yet been systematically resolved.

The study has several limitations. The questionnaire was specifically developed for this study using a structured literature search and was not based on a formal systematic review. The data are based on self-reported information and may be subject to reporting bias. Moreover, responses may reflect the perspective of individual respondents rather than the institution as a whole. Despite the provided definitions, variation in the interpretation of AAA and AAT across centers cannot be excluded. Additionally, the survey did not include objective outcome measures or patient-level data. Lastly, the findings are limited to the German-speaking countries and may not be fully generalizable to other healthcare systems.

5 | Conclusion

This study demonstrates a high level of interest in AAA within pediatric oncology, with several institutions already implementing such programs in a responsible manner. However, the perceived benefits stand in contrast to their limited availability and the presence of structural barriers. These findings underscore the need for more robust scientific evidence through the systematic evaluation of AAA in registries and other appropriately designed studies.

Furthermore, the results highlight the importance of developing standardized guidelines and strengthening collaborative networks to support broader and more sustainable integration of AAA into acute pediatric oncology care. Pediatric oncology societies can play a key role by providing a mandate for coordinated research efforts, study networks, and the development of consensus-based standards. Ultimately, such efforts may enhance well-being and improve the quality of life of children with cancer.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.

Table S1: Survey on therapy dogs in pediatric oncology. **Figure S1:**

Screening algorithm for questionnaire responses. Duplicate and invalid responses were excluded, resulting in 60 valid datasets from 60 distinct institutions. **Supporting Information:** Qualitative analysis of open-ended survey responses.