A pioneering study uncovers mixed attitudes towards children's schooling while in hospital.

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Hospital education: effective or disruptive?

Under Section 298 of the 1993 Education Act, children who are out of school through illness become legally entitled to a suitable education. It states:

> *Each Local Authority shall make arrangements for the provision of suitable full-time or part-time education at school or otherwise than at school for those children of compulsory school age who, by reasons of illness, exclusion of school or otherwise, may not for any period receive suitable education unless such arrangements are made for them.*

According to the National Association for the Education of Sick Children (NAESC, 1996) approximately 3000 children and teenagers between the ages of 5 and 19 are taught daily in UK hospitals. Of these, 32% are short-stay (less than 5 days), while the remainder are long-stay or recurrent. Altogether, more than 105,000 children are taught in UK hospitals throughout each educational year.

Education within hospitals can be delivered in many different ways, at the bedside or in a special room set aside as a classroom, and it can be through a registered hospital school, the home tuition service, or a single hospital-based teacher.

Attitudes towards hospital education

As education within a hospital has been regarded as important since the 1944 Education Act, the question of what attitudes hospital professionals (e.g. doctors, nurses, hospital teachers) have towards hospital education plays an important role in its smooth operation. Although there have been a few reports recently on the significance of hospital education (e.g. Dunkley 1991, Glucksmann 1990, and Matthews & Lonsday 1992), there has been surprisingly little systematic research on the actual attitudes of hospital professionals towards hospital education.

In a survey, Fassam (1982) assessed the views of ward sisters and families of patients towards hospital education. She concluded that there are at least three main factors that both the groups being studied regarded as important benefits:

- to continue with the child's schooling;
- to relieve boredom or to occupy the child;
- to contribute to a more normal setting for the child when it is hospitalised.

1. EDUCATIONAL PROCESS

The role of schooling in the hospital is important to maintain some form of normality in the children's lives.

School helps to relieve boredom during a hospital stay.

Education helps to maximise quality of life, and so should be available whatever the medical circumstances of the child.

Attending the hospital school suggests permanence to the hospital stay.

The continuation of education through a hospital stay can help to ease integration back into the home school.

Participating in a schoolroom in hospital can help to develop healthy social relationships with peers.

Attending school in the hospital when the child is sick adds unnecessary extra stress to the child.

Hospital school can help to aid a quicker recovery.

2. CURRICULUM

Imaginative practical work that is interesting is more important than 'book work' in a hospital setting.

Learning new skills in hospital is more important than developing old skills, so giving the child a sense of achievement.

Routine procedures such as X-ray and physio should be arranged outside school hours, to allow children the maximum time in school.

3. INTERFERENCE

Schooling in the hospital often involves separation from parents, which could be negative to the whole family.

Schooling can lead to interference with medical procedures.

Meeting chronically sick or disfigured children in the schoolroom can have adverse effects on children.

The 14 questionnaire statements, grouped by factor. Responses were on a scale from 1 (strongly agree) to 7 (strongly disagree).

No systematic research has been conducted on the effectiveness of hospital education.

See also Cross (1983) and Wiles (1988).

An interesting point in Fassam's study was that significantly more ward sisters placed greater value on hospital education as a reliever of boredom (42%) than being important for the child's education (7%) or as being the child's right (6%). Moreover, it was noted that the teacher in a hospital was often referred to as a 'library lady', a nurse, or a helper. Indeed, if the teacher was wearing a white coat she was often mistaken for a doctor!

Fassam's study, however, was directed only at ward sisters and parents, and did not incorporate teachers and doctors. However, for hospital education to operate effectively it is imperative that all the professionals involved (both medical and educational) have an understanding and supportive view of its role and significance. Moreover, this study was based on survey-type research, with no inferential statistics being reported. Systematic research is therefore needed to give a more stringent answer regarding the attitudes of all the professionals involved. Finally, there have not yet been any published reports on possible differences in attitude towards short-stay as opposed to long-stay education. (In our study, we define short-stay as fewer than 20 days.)

The present study pursues two aims and purposes:

- to initiate a pilot investigation into medical professionals' views about hospital education, and to contrast them with those of educational professionals working in the same setting;
- to assess attitudes towards short-stay as opposed to long-stay education.

It is hoped that this pilot work will help generate questions and issues for follow-up investigations.

The study was carried out in two phases.

Phase 1: Developing a questionnaire

In the absence of any published questionnaires on this topic, the first phase of the study involved developing and standardising the survey instrument. This was done by developing a list of 14 statements based on previously-reported work related to general issues and concerns regarding hospital education. A copy of the questionnaire is available from the first author, but the box shows the statements grouped within the three main factors discussed below.

The participants were required to respond twice to each statement, from the point of view of short-stay and long-stay patients. They used a Likert-type scale, ranging from *strongly agree* (1) to *strongly disagree* (7), and the results were subjected to a Principal Components Analysis.

It will be observed that agreement with some of the statements implied support for the particular aspect of hospital education, but in the case of other statements agreement implied disapproval.

Phase 2: The study

Of the 48 professionals who agreed to take part in the study, 18 came into the 'medical' category (doctors and nurses), and 30 were hospital teachers and play specialists — the 'educational' category.

Room was left on the questionnaire for the respondents to make any comments they wished about hospital education.

The study was carried out in Great Ormond

	Long stay	Short stay	
1. *Educational process*			*Overall mean**
Medical	3.00 (0.49)	3.17 (0.51)	3.08
Educational	2.60 (0.68)	2.87 (0.43)	2.73
*Overall mean**	2.80	3.02	
2. *Curriculum*			*Overall mean**
Medical	3.17 (1.20)	3.67 (1.37)	3.42
Educational	2.90 (1.19)	3.27 (0.94)	3.08
*Overall mean**	3.03	3.47	
3. *Interference*			*Overall mean*
Medical	5.06 (1.00)	4.72 (0.96)	4.89
Educational	4.43 (0.97)	4.40 (1.00)	4.41
Overall mean	4.74	4.56	

Educational process: Lower score = more favourable attitude.

Curriculum: Lower score = support suggested changes.

Interference: Lower score = fewer worries about interference.

The mean ratings for the three derived factors. Standard deviations are shown in parentheses, and an asterisk indicates statistical significance.

The research gives cause for optimism about the future educational provision for young people in hospital.

Street Hospital, London, a tertiary referral children's hospital, with a registered hospital school. The responses were returned through the internal post system. The confidential nature of the enquiry was emphasised at all times.

After analysing the responses to the 14 statements, we derived three main factors, which accounted for more than 43% of the variance. These we labelled:

Educational process

Curriculum

Interference

The mean ratings for each of the three factors, with their corresponding standard deviations (in parentheses) are shown in the box.

As can be seen, in most cases the respondents have more favourable views towards hospital education, and attach more significance to changes in its curriculum, in the case of long-stay patients.

Comparing the two groups of respondents, it is the educational professionals that have the more favourable views about hospital education, greater approval for curriculum change, and fewer worries about its disruptive aspects.

Separate analysis by age and gender of the respondents did not show any significant results regarding any of the above factors.

The implications

The main purpose of the present study was to examine the attitudes of medical and educational hospital staff to short-stay and long-stay hospital education. Generally, the results showed that:

Hospital professionals are more concerned about the educational needs of long-stay children.

Since long-stay children miss considerably more schooling, and normally have a longer recuperation period at home, this conclusion seems to be understandable.

The second finding did not cause surprise either:

Medical professionals have less favourable views than educational professionals about hospital education.

McLean (1990) accounts for this because of the different thought models of the two groups. Medics 'frequently adopt a disease model of illness, without relation to the whole child', while educationalists take a 'holistic view, where the child is seen as a member in a family or society and as a pupil'.

These differences in priorities may lead both to conflict and to lack of co-ordination within the hospital setting, and so, whatever the reasons for them, it is important that each group is sensitive to the other's views. For example, there should be consultation with respect to any changes in the curriculum. Such co-operation will help the child physically and psychologically as well as educationally.

The third finding was particularly encouraging:

Although the mean 'interference' ratings did show some differences between the two groups, these did not reach statistical significance.

Therefore it seems that doctors and nurses do not feel significantly more strongly than teachers that hospital education need interfere with medical treatment. This finding gives cause for optimism about the future educational provision for young people in hospital.

The next step . . .

This was a pilot study in an area with remarkably little published research, and it was conducted to uncover issues for follow-up research. In particular, it would be of interest to discover if similar views are held by medical professionals and teaching staff in other UK hospitals. The

population of patients in Great Ormond Street Hospital is widely diverse in culture and language, and in hospitals serving a more localised community it will be easier for the teachers to establish direct links with the children's schools. The medical staff may be more supportive if they see that the schools are involved in the educational process.

Finally, the questionnaire developed in the present study could also be administered to parents and pupils before and after the child has been admitted to the hospital. Analysis of the responses should provide valuable information regarding the significance of hospital education from the point of view of those directly benefiting from it.

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