ACCESSING ABILITY: THE ACADEMIC AND SOCIO-EMOTIONAL VALUE OF IN-HOSPITAL EDUCATION

Accessing Ability: The Academic and Socio-Emotional Value of In-Hospital Education

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ACCESSING ABILITY: THE ACADEMIC AND SOCIO-EMOTIONAL VALUE OF IN-HOSPITAL EDUCATION

Abstract

Students with health conditions requiring medical intervention are at risk of developing severe academic and socio-emotional problems. Some pediatric hospital departments across Ontario employ in-hospital teachers to provide hospitalized students with access to education. The purpose of this Master of Teaching Research Project is to examine how a sample of in-hospital educators perceive the diverse academic and social needs of hospitalized students. Data was collected via a series of semi-structured interviews with three in-hospital teachers. Audio recordings of these interviews were transcribed, coded, and analyzed by the researcher via the theoretical lens of Critical Disability Theory. Results of this qualitative study indicate the specialized educational environment, resources, and personnel available in the hospital setting can be more academically beneficial to students with chronic health conditions than what is offered in a traditional classroom. Additionally, results suggest that placing students in a social environment where they are surrounded by peers who also have medical conditions can positively impact socio-emotional well-being, while providing students with socially normalized learning environments. Furthermore, results imply that in-hospital education has the potential to provide hospitalized students with optimism, hope, and motivation. This study also uncovered many roadblocks surrounding hospital logistics and confidentiality that restrict student access to education in the hospital setting. There is currently little academic research in this field, and this study has only begun to reveal the value of in-hospital education. Further recommendations suggest a deeper, more rigorous study in this field is required, as results imply in-hospital education has vast academic, social, and medical benefits.

Keywords: In-Hospital Education, Inclusive Education, Special Education, Hospital Schools
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# Table of Contents

Abstract .......................................................................................................................... 2  
Acknowledgements ........................................................................................................ 3  
Chapter I: Introduction ................................................................................................... 6  
  1.1 – Introduction to Research Study ........................................................................... 6  
  1.2 – Research Questions .............................................................................................. 7  
  1.3 – Background of Researcher .................................................................................. 7  
  1.4 – Overview of Research Paper .............................................................................. 8  
Chapter II: The Literature Review .................................................................................. 9  
  2.0 – Introduction ......................................................................................................... 9  
  2.1 – The Chronic Health Conditions .......................................................................... 9  
    2.1.1 – The Definition of a Chronic Condition and its Effect on Academics ............... 10  
    2.1.2 – In-Patient vs. Out Patient Care in Pediatrics ................................................. 10  
    2.1.3 – Academic and Social Concerns of Students with Chronic Health Conditions .... 11  
  2.2 – Chronic Conditions in the Classroom ................................................................. 13  
    2.2.1 – Bullying and the Influence of Peers .............................................................. 13  
    2.2.2 – The Role and Barriers Facing the Classroom Teacher ................................... 15  
  2.3 – In-Hospital Education ......................................................................................... 16  
    2.3.1 – The Nature of In-Hospital Education ............................................................ 17  
    2.3.2 The Role of the Classroom Teacher and Parent During Admission .................. 18  
  2.4 - Conclusion ......................................................................................................... 19  
Chapter III: Research Methodology and Theoretical Framework .................................. 20  
  3.0 – Introduction ....................................................................................................... 20  
  3.1 - Research Approach & Procedures of Data Collection ........................................ 20  
  3.2 - Instruments of Data Collection .......................................................................... 21  
  3.3 – Participants ........................................................................................................ 22  
    3.3.1 - Sampling Criteria ......................................................................................... 22  
    3.3.2 - Sampling Procedures/ Recruitment ............................................................... 23  
    3.3.3 - Participant Bios ............................................................................................ 23  
  3.4 - Data Analysis ..................................................................................................... 24  
  3.5 - Ethical Review Procedures .................................................................................. 25  
  3.6 - Methodological Limitations and Strengths ......................................................... 26  
  3.7 - Conclusion ....................................................................................................... 27
ACCESSING ABILITY: THE ACADEMIC AND SOCIO-EMOTIONAL VALUE OF IN-HOSPITAL EDUCATION

Chapter IV: Findings and Discussion

4.1 - Introduction

4.2 – Working in a Hyper-Specialized Educational Environment: Addressing Academic Concerns of Students with Chronic Conditions in a Hospital Environment

4.2.1 – Academic Advantages to Education in a Hospital Environment

4.2.2 – Academic Challenges in a Hospital Environment

4.3 – Education as a Socially Normalizing Factor: Addressing the Socio-Emotional Needs of Students with Chronic Conditions in a Hospital Environment

4.3.1 – Promoting Solidarity Within Peer Groups

4.3.2 – Education as a Source of Hope and Motivation

4.4 – Teacher Perceived Challenges Presented by In-Hospital Education

4.4.1 – Absence of Formalized Teacher Training

4.4.2 – Scheduling and Logistic Concerns

4.5 - Conclusion

Chapter V: Conclusion

5.0 - Introduction/Overview

5.1 – Overview of Key Findings and Significance

5.2 - Implications

5.2.1 - Broad Implications

5.2.2 - Narrow Implications

5.3 - Recommendations

5.4 - Concluding Comments

Works Cited

Appendix A: Letter of Consent

Appendix B: Interview Protocol
Chapter I: Introduction

“It is vital that […] young people who have fought valiantly to survive medical challenges have every opportunity to complete their education satisfactorily so that they can reap the full rewards of having overcome or lived with an illness or life threatening disease” (Shiu, 2001, p. 277).

1.1 – Introduction to Research Study

Students with health conditions requiring medical intervention are at risk of developing severe academic and social problems that can jeopardize their education and social development. Students with chronic conditions, shortened to CC students, may be subject to prolonged absence from class, a reduction of cognitive processing ability, intense bullying, increased stress, and a loss of academic and social motivation (Lightfoot, Wright & Solper, 1992; Shiu, 2004; West, Denzer, Wildman & Anhalt, 2013). This culminates in the statistic that children with chronic conditions are 3.5 times more likely to attempt suicide than their peers (Shaw & McCabe, 2008).

CC students are generally integrated into a traditional classroom (St. Leger 2012; Shaw & McCabe, 2008). There are instances, however, when a student must be admitted to a hospital for a prolonged period of time. Some pediatric medical institutions offer patients access to in-hospital teachers to help students engage in schoolwork outside of class. In this study, I examine how in-hospital educators help to support the diverse needs of these students.

This study also hopes to fill what I perceive as a gap in the academic literature surrounding in-hospital education, while painting a descriptive portrait of hospital schooling in Ontario. Initially, I endeavored to study how the arts, specifically drama, help to support the education of hospitalized students. After delving into the surrounding literature, however, I
found very little research discussing in-hospital education in general. Through this, I decided to broaden my research goals to help open a discussion on in-hospital schooling.

1.2 – Research Questions

The main question guiding this research study is: How do a sample of three in-hospital educators perceive and support the academic and social needs of hospitalized students?

Subsidiary questions include:

- What academic benefits can students experience while receiving education in a hospital environment?
- What range of challenges do these educators confront in this work, and how do they respond to these challenges?
- What is the social climate in a hospital school?
- What outcomes do these educators observe from students?

1.3 - Background of Researcher

This particular topic of study holds a great deal of personal importance to me. I was born with a congenital vascular malformation, and as a child I spent upwards of two months admitted to a pediatric hospital every school year. While in hospital I was assigned an in-hospital teacher to support my education while absent from class.

Additionally, I was fortunate to complete a practicum teaching placement at a pediatric hospital where I directly worked with hospitalized students. I have also volunteered at this particular hospital in a variety of capacities for the past sixteen years. My undergraduate education was in theatre and acting, and I have performed in a monthly musical-theatre presentation at a pediatric hospital since 2014. It is from this background that I desired to study
ACCESSING ABILITY: THE ACADEMIC AND SOCIO-EMOTIONAL VALUE OF IN-HOSPITAL EDUCATION

Arts integration in the hospital setting. I will note that the results reported in this study are solely derived from interviews with in-hospital teachers, and not from my personal experiences as a teacher-candidate, volunteer, or patient at a pediatric hospital.

1.4 – Overview of Research Paper

Chapter I of this project offers an introduction to the study, outlines the research questions, and provides a description of my personal positioning with the research.

Chapter II compiles and reviews the literature surrounding in-hospital education and the needs of CC students. This is intended to place the study within a broader context and identify the gaps this study aims to fill.

Chapter III describes the theoretical framework and methodology used in the research project. I outline the tools utilized for data collection, the ethical protocols observed, and introduce the backgrounds of the research participants.

Chapter IV presents the results of this study and unpacks significant findings.

Chapter V explores the implications of the findings, discusses their significance, and suggests recommendations.
Chapter II: The Literature Review

2.0 – Introduction

In this study, I endeavour to explore how in-hospital teachers provide social and academic support for hospitalized students. Through the following chapter I review the relevant literature surrounding chronic illnesses and the education of students with health conditions requiring medical intervention. This literature review is comprised of articles and book chapters from a variety of sources in the fields of education and pediatric medicine.

To begin, I examine the literature surrounding the academic and psychological impacts of chronic health conditions and hospitalization. Next, I explore the recent trend of integrating students with chronic illnesses into the traditional classrooms, and consider the barriers and concerns with this type of integration. Finally, I discuss the role in-hospital education has on students who are hospitalized and are unable to attend traditional classrooms. There is a significant body of research discussing the social and academic concerns of students with chronic health conditions. However, there is very little research on in-hospital education. I hope, in part, that my research helps to fill this gap.

2.1 – The Chronic Health Conditions

In the following section I review the medical and educational literature defining chronic conditions, focusing specifically on how a chronic illness cognitively and academically impacts a child’s growth and development. I also discuss the recent shift in pediatrics from an in-patient care model to an out-patient model. I conclude with an examination of the literature substantiating the right to education and equal opportunity for all students, including those with chronic conditions.
**2.1.1 – The Definition of a Chronic Condition and its Effect on Academics**

Phelps (2006) estimates that approximately 6.5% of all American children have a chronic medical condition or illness that interferes with their education. 1.5% of Canadian children have an illness which prevents attendance from traditional schooling (Shaw & McCabe, 2008).

A chronic condition or illness can be defined as “a condition which lasts for a considerable period of time, or has a sequelae which persists for a substantial period, and/or persists for more than 3 months in a year, or necessitates a period of continuous hospitalizations for more than a month” (Thompson & Gustafson, 1996, p. 4). Examples of chronic conditions include, but are not limited to, asthma, HIV/AIDS, cancer, epilepsy, cerebral palsy, multiple sclerosis, severe allergies or, in my personal case, cystic hygroma.

There exists an important distinction between chronic conditions and acute illness or temporary injury (Shiu, 2004). Chronic conditions, by definition, persist in patients for a prolonged period of time, requiring frequent and lengthy hospitalizations or absences from traditional schooling (Shaw & McCabe, 2008). Acute illness, such as the flu or measles, is characterized by short, intense bouts of sickness with the prospect of quick recovery (Shiu, 2004). Acute illness or temporary injury may result in brief absences from schooling, but those absences do not have as profound an impact on a child’s education as the absences caused by a chronic condition (Shaw & McCabe, 2008).

**2.1.2 – In-Patient vs. Out Patient Care in Pediatrics**

The recent trends in pediatric medicine indicate a shift from in-patient to out-patient care (St. Leger 2012; Shaw & McCabe, 2008). This leads to a patient care model characterized by shorter, less frequent hospital admittances. An increase in the quality of medical practices and a desire to reduce health-care costs has led to this shift in pediatrics (Shaw & McCabe, 2008; Thies...
ACCESSING ABILITY: THE ACADEMIC AND SOCIO-EMOTIONAL VALUE OF IN-HOSPITAL EDUCATION

& McAllister, 2001). Landrigan, Conway, Edwards & Srivastava (2006) exemplify this trend by indicating that the average admittance duration for children with severe asthmatic attacks has been reduced by 50%: from 4 days in 2000 to 2 days in 2006. It is not uncommon for patients receiving chemotherapy to attend treatment during clinical day-time hours and return home in the evenings, as opposed to being admitted for the duration of treatment (Shaw & McCabe, 2008).

This reduction of in-patient care means children with chronic health conditions are spending less time admitted to hospital and more time integrated into their traditional classrooms. In theory, this integration is a positive experience, as traditional schooling has been found to be the most ideal environment for education (St. Leger, 2014). The literature, however, indicates that there are many obstacles and potential issues that must be considered when integrating out-patient students in traditional classrooms. These concerns will be discussed in Section 2.2 of this literature review.

2.1.3 – Academic and Social Concerns of Students with Chronic Health Conditions

Research indicates that students with chronic conditions are at risk of developing severe academic or psychological problems over the course of their medical treatment (Lightfoot et al, 1999; Shiu, 2004; West et al, 2013). Shaw and McCabe (2008) state that “children recovering from chronic illness may experience lack of academic motivation, frustration, and external locus of control, and feelings of helplessness” (p. 83). This culminates in the statistic that students with chronic conditions are twice as likely to consider, and 3.5 times more likely to attempt suicide than their peers (Shaw & McCabe, 2008).
ACCESSING ABILITY: THE ACADEMIC AND SOCIO-EMOTIONAL VALUE OF IN-HOSPITAL EDUCATION

Side-effects of treatment and medication can make it difficult for CC students to concentrate on academics and schooling (West et al, 2013; Shaw & McCabe, 2008). Treatment may induce a reduction in a student’s attention span and memory, slow processing speeds and cognitive function, increase irritability, and induce pain, fatigue, and/or drowsiness (St. Leger, 2014; Shaw & McCabe, 2008; Lightfoot et al, 1999). It is important to note that each condition and its treatment offer a diverse range of side-effects. Because these effects are sometimes temporary, students undergoing treatment may not receive an Individual Education Plan (IEP), placing the onus on the students’ classroom teachers to offer accommodations for CC students (Shaw & McCabe, 2008).

A sense of hopelessness and loss of motivation can also negatively impact a CC student’s academic performance (Shiu, 2004). Shaw and McCabe (2008) describe a student with HIV/AIDS who views their prognosis as bleak and suffers a severe loss in motivation to succeed in academics. A focus on life and future goals beyond the context of illness can help to keep students engaged (St. Leger, 2014). A positive outlook can also promote stronger mental and physical health in CC patients (ibid.).

When considering the individuality of each case, it is important to remember that all students, regardless of condition, ability or capacity, share the commonality of the right to education. Students with chronic conditions are entitled to equal access to the academic and social education afforded to their peers (Shiu, 2004; Shaw & McCabe, 2008; Seymour, 2004).

Shiu (2001) concludes her research by writing that “it is vital that these young people who have fought valiantly to survive medical challenges have every opportunity to complete their education satisfactorily so that they can reap the full rewards of having overcome or lived with an illness or life threatening disease” (p. 277).
2.2 – Chronic Conditions in the Classroom

With the recent pediatric trend of shorter hospital admissions, many children with chronic conditions are being integrated into the traditional classroom (Sentenac, Gavin, Arnaud, Molcho, Godeau & Gabhainn, 2011; Shaw & McCabe, 2008). This may seem like an ideal solution for providing inclusive education for children with chronic conditions, but integration presents a myriad of problems for students and teachers alike. In this section I review the literature surrounding the social concerns for students with chronic conditions, and the additional workload these students place on teachers and schools.

2.2.1– Bullying and the Influence of Peers

Students with chronic conditions are significantly more likely to be victims of bullying than their peers (Sentenac et al, 2011). At its most innocent, this takes the form of frequent questions and curiosities from fellow students (Shaw & McCabe, 2008). At its most harmful, this can culminate in intense bullying, such as physical violence, relentless taunting, and complete exclusion from social groups (Shaw & McCabe, 2008; St. Leger, 2014; Lightfoot et al, 1999). Lightfoot et al (1999) indicate that only one third of children with chronic conditions do not experience negative interactions with peers as a direct result of their conditions.

Student can be self-conscious of their appearance while receiving medical treatment (St. Leger, 2014; Shiu, 2004). Bringing these anxieties into the classroom is not conducive to positive learning, and can result in a decrease of focus, participation, and motivation (Shiu, 2004). Patients receiving chemotherapy may feel self-conscious about hair loss, where other patients may be embarrassed by bandaging, IV/Port line tubing, scars, or other physical symbols of their condition or treatment (St. Leger, 2014; Shaw & McCabe, 2008; Thompson & Gustafson, 1996).
ACCESSING ABILITY: THE ACADEMIC AND SOCIO-EMOTIONAL VALUE OF IN-HOSPITAL EDUCATION

A number of youth with chronic conditions also indicated that their condition is occasionally ignored by peers (Lightfoot et al, 1999). This may be ideal for CC students who do not desire additional attention. However, ignoring the illness can easily morph into ignoring the person and lead to exclusion from social events (Lightfoot et al, 1999; Shaw & McCabe, 2008). This can manifest in the CC student withdrawing from their school, learning, and social communities (Shiu, 2004).

Finally, there exists a fear in younger students that chronic conditions are universally contagious (Shaw & McCabe, 2008). This can lead to active avoidance of the CC student. Lightfoot et al (1999) suggests that having medical specialists or nurses speak with fellow pupils can help mitigate these concerns. However, transparency about conditions and side effect can lead to patient confidentiality issues.

Bossert, Holaday, Harkins, & Turner-Henson (1990) write that many children with chronic conditions desire to lead a socially “normal” childhood, which is complicated by their condition. Normalization, however, is not a denial of one’s conditions, but rather an acceptance of the condition into normal life (ibid).

Physical and emotional abuse from peers are large contributors in the depression and suicide rates of children with chronic conditions (Shaw & McCabe, 2008). Transparency about conditions and medical explanations to CC students’ peers can help to reduce the risk of bullying, however students with chronic conditions may wish that their condition not be discussed publicly (St. Leger 2012; Lightfoot et al, 1999). The classroom teacher plays a major role in monitoring and mitigating the social concerns of students with chronic conditions, however the classroom teacher faces their own barriers when working with CC students. In the
following section I describe these challenges and roadblocks and expand on the role of the classroom teacher when working with CC students.

**2.2.2 – The Role and Barriers Facing the Classroom Teacher**

A supportive, inclusive, and transparent classroom teacher can be a significant help to CC students and their families (Shiu, 2004). Empathy, flexibility, and adaptability are of the utmost importance when planning around the needs of students with chronic conditions (Shaw & McCabe, 2008; West et al, 2013). While classroom teachers generally have positive experiences working with children with chronic conditions, a few key concerns have been raised in the literature surrounding the in-classroom teaching of CC students (West et al, 2013).

Firstly, some teachers feel unprepared to appropriately work with CC students (West et al 2013). Clay, Cortina, Harper, Cocco & Drotar (2004) claim that between 60-65% of teachers with CC students in their classroom received no additional training from their schools or boards. There is a general consensus in the literature that a lack of clarity exists in school and board procedures regarding CC students (Clay et al, 2004; Thies & McAllister, 2001). Policies are occasionally unclear when designating which people and departments are responsible for which services, and often students with chronic conditions are not provided adequate educational support (ibid.).

Furthermore, many teachers harbour misconceptions about chronic conditions. West et al (2013) describes teachers who are unaware of the effects of their students’ medications, and the reduction in cognitive ability brought on by treatment. This can cause confusion or unnecessary exclusion from activities. Teachers who have knowledge of their students’ conditions, or first-hand experience with chronic illness, are more likely to be empathic towards the accommodations necessary for working with CC students (Shaw & McCabe, 2008).
West et al. (2013) have also determined that many teachers view the additional amount of preparation or modifications required to successfully accommodate CC students as burdensome. These additional accommodations include allowing the CC student to eat in class, offering them private space to take medication or change bandages, or preparing work packages while the student is absent. Frequently, CC students may be required to miss half-days of school due to treatment or fatigue, causing the teacher to have to juggle lessons to ensure the student is present for the most productive class time (Shaw & McCabe, 2008). The additional workload may also include having to explain difficult concepts without classroom instruction, or managing troublesome behaviors brought into the classroom via either treatment or bullying (Sentenac et al., 2011; St. Leger, 2014). The additional workload brought on by teaching CC students is estimated to equal approximately 26 minutes a day (West et al., 2013).

Some teachers struggle to teach CC students as their presence is a reminder of the teacher’s personal experiences with illness (St. Leger, 2014). St. Leger (2014) writes about a teacher who had cancer and found the presence of a cancer patient in her classroom to be “emotionally draining” (p. 263).

It is essential for teachers to be empathetic and supportive towards their CC students, despite the additional workloads they may place on the classroom. All of the reviewed academic and medical literature agree that strong social support from teachers is vital for students with chronic conditions (Lightfoort et al., 1999; Clay et al., 2004; Shaw & McCabe, 2008; St. Leger 2012; Seymour, 2004).

2.3 – In-Hospital Education

While the recent trend suggests that students with chronic conditions are spending less time hospitalized, CC students still miss an average of 16 school days per year as a direct result of
ACCESSING ABILITY: THE ACADEMIC AND SOCIO-EMOTIONAL VALUE OF IN-HOSPITAL EDUCATION

their condition (Shaw & McCabe, 2008). There exists a great deal of literature surrounding the social and academic needs of students with chronic conditions, however there are decidedly fewer voices discussing the in-hospital education of student-patients. In the following section I explore the nature of in-hospital education programs, and discuss roadblocks faced by in-hospital educators.

2.3.1 – The Nature of In-Hospital Education

Hospitalization is an immensely stressful experience for children and families (Rokarch & Rokarch, 2006). The stress of hospitalization can be magnified by a student’s academic concerns, as students often fall behind in their schooling due to absence (Shaw & McCabe, 2008). Some pediatric institutions offer in-hospital teachers to help their admitted students keep current with their classwork, and provide an appropriate education until the in-patient can return to their home classroom (Myers, 1997; Isiktekiner & Akbaba Altun, 2011).

Due to the individuality of each patient’s medical and cognitive needs, in-hospital teachers work in a variety of environments. Some patients receive daily visits from teachers, while others may be invited to an in-hospital classroom to learn with similarly aged in-patients.

As previously discussed, students receiving treatments may be subject to a decrease in cognitive ability and a loss of academic motivation (St. Leger, 2014; Shaw & McCabe, 2008; Lightfoot et al 1999; Shiu, 2004). These needs must be properly and appropriately addressed by in-hospital educators to ensure students do not become estranged from their education (Isiktekiner & Akbaba Altun, 2011).

The child’s medical concerns, and not their education, are the top priority of the hospital staff (Seymour, 2004). Medical teams tend to operate on strict timelines with inflexible
schedules. In-hospital teachers can struggle to find consistent time to work with their students (St. Leger, 2014). Furthermore, due to confidentiality concerns, some in-hospital educators complain of a problem with communication between teaching and health teams (Isiktekiner & Akbaba Altun, 2011; St. Leger, 2014). This breakdown, or lack, of communication can make scheduling lessons and tutoring difficult (St. Leger, 2014).

Despite the difficulties in communication, in-hospital schooling has can be therapeutic for patients (Isiktekiner & Akbaba Altun, 2011). Not only does in-hospital tuition reduce the stress of falling behind in school work, it also provides a reminder of life outside of the hospital (Shaw & McCabe, 2008; Seymour, 2004). Activities like drama and music are immensely powerful therapeutic devices (Rokarch & Rokarch, 2006). Empathy, as fostered by drama, and creation through music and art can help students to better understand their conditions and alleviate the stress of institutionalization (ibid). Unfortunately, there are very few arts, music or drama teachers available to patients in hospitals (Isiktekiner & Akbaba Altun, 2011).

2.3.2 The Role of the Classroom Teacher and Parent During Admission

The classroom teacher is often responsible for supplying in-hospital educators with the content their absent students will be missing (Isiktekiner & Akbaba Altun, 2011; Meyers, 1997). The responsibility of facilitating the exchange of information (i.e. picking up work packages from the school) can often fall onto the patients’ parents (Meyers, 1997). This can add unnecessary stress to parents, who are already concerned for their children’s wellbeing (Rokarch & Rokarch, 2006).

Technology also plays a major role in connecting the patient to their home classroom (St. Leger, 2014; Shaw & McCabe, 2008). E-mail, Skype and the internet all assist in the transfer of lessons and work between hospital and school (St. Leger, 2014).
ACCESSING ABILITY: THE ACADEMIC AND SOCIO-EMOTIONAL VALUE OF IN-HOSPITAL EDUCATION

It is important to have the absent student remain visible in their home classroom (St. Leger, 2014). An assistant principal interviewed by St. Leger (2014) claimed that “in the day to day classroom situation if you’re not in the class you just disappear” (p. 259). Teachers have overcome this in a multitude of ways. Some place a photograph of the student in the classroom, while others use Skype to telephone their absent student (St. Leger, 2014). In primary classrooms, some teachers have placed a Teddy-Bear in seat of the absent student (ibid). However, these reminders are merely passive and cannot replace face-to-face interaction (ibid).

Adequately supporting the educational needs of absent students requires the commitment and co-operation of many parties. Through all of the difficulties and accommodations, it is essential to remember that all children are entitled to an education (Shiu, 2004). Seymour (2004) writes that “there should be no justifiable reason why children with complex healthcare needs should not also have their education needs addressed efficiently and effectively” (p.254).

2.4 - Conclusion

Throughout this literature review I examined the social and academic concerns of students with chronic medical conditions. I first explored the psychological and cogitative implications of chronic conditions and their treatment. I next discussed the literature surrounding the integration of students with chronic conditions into the traditional classroom, identifying that supportive and flexible teachers are required to help mitigate bullying and academic concerns. Lastly, I examined the role of in-hospital education, and the support and communication required to ensure smooth transitions between school and hospital.
Chapter III: Research Methodology and Theoretical Framework

3.0 – Introduction

In the following chapter I describe the guiding methodology that was used in this qualitative research study. I begin this chapter by outlining the research approach, procedures and instrumentation used in data collection and interpretation. I discuss the criteria for participant selection and recruitment, before the describing participants’ backgrounds. I explain the procedure used to analyze the collected data, and review the ethical procedures observed and the theoretical framework employed. I identify the limitations and strengths of my methodology, before concluding this chapter with a brief overview of my methodological decisions as they pertain to my research purpose and questions.

3.1 - Research Approach & Procedures of Data Collection

In the following section I outline the approach and procedures used in this qualitative research study. I also discuss the intent behind the use of the qualitative research model as it relates to my project.

Prior to commencing my research I conducted an initial review of the literature discussing the social and academic needs of students with chronic conditions, and the nature of in-hospital education. The literature review provided a starting place for the development of the interview protocol.

The results of this study are based on a series of semi-structured interviews conducted with three in-hospital educators who have significant experience working with hospitalized students. The interviews were recorded on a digital audio recording device, transcribed, and coded. The coded data was analyzed and the results of the study represent the practices and perceptions of these three educators. Results will help to inform my practices as a new teacher,
while filling a self-perceived gap in the academic literature discussing the education of hospitalized students. The qualitative research design allows me to uncover concrete, lived data that can transition into my personal practices (Clark & Creswell, n.d.).

Creswell (2007) asserts that the practices of qualitative research have the ability to foster significant change. Given my current position as a teacher-candidate, I feel this definition accurately represents my relationship with my research: I hope that my work in this study, when coupled with my course-work at the Ontario Institute for Studies in Education at the University of Toronto, will provide me with a solid foundation from which to build my teaching career.

This project was conducted through the interpretive lens of Critical Disability Theory (CDT). CDT respects that chronic conditions are simply one facet of an individual’s identity (Creswell, 2007). Disability is viewed as a single dimension of human difference, and not seen as a deficiency or defect (ibid). CDT argues that the defect lies not within the individual with the disability, but the society which constructs the oppressive concept of disability. Pothier and Devlin (2006) explain that “the biggest challenge comes from mainstream society’s unwillingness to adapt, transform, and even abandon its ‘normal’ way of doing things” (p. 13). For the sake of this project, the ‘normal’ way of doing things is traditional classroom schooling in relationship to in-hospital education.

3.2 - Instruments of Data Collection

Data was collected via a series of semi-structured interviews. The interviews were conducted by myself, the researcher. All participants were asked the same set of predetermined questions, which are available for review in Appendix B. The nature of semi-structured interviews allows flexibility to request elaboration on topics, or ask contextual questions (Creswell, 2007). Cridland, Jones, Caputi & Magee (2015) state that the semi-structured
interview promotes familiarity between researcher and participant, while allowing the flexibility to focus on topics which are meaningful to participants.

The interviews were conducted at a location and time determined by the participants. The interviews were recorded with a digital audio recorder and transcribed shortly after their conclusion. The transcripts were reviewed and analysed before being coded according to identifiable themes. The themes were analyzed based on trends, patterns, and divergences uncovered across the interviews, through the interpretative framework of Critical Disability Theory.

3.3 – Participants

In the following paragraphs I explain the criteria and recruitment process used to locate suitable participants, before offering a brief introduction to the selected participants. To respect confidentiality, the participants are referred by pseudonym, and any information that may identify them, their workplace, or their students has been omitted.

3.3.1 - Sampling Criteria

The following criteria was considered when selecting appropriate participants for this study:

- Participants must currently, or have recently taught students who have been diagnosed with and/or are currently undergoing treatment for a chronic health condition.
- Participants must be members of the Ontario College of Teachers.
- Participants must have at least five years of teaching experience, with at least two years of experience teaching in a hospital environment.
- Participants must consent to partake in this research study, and be willing to share and reflect on their experiences and practices as educators.
ACCESSING ABILITY: THE ACADEMIC AND SOCIO-EMOTIONAL VALUE OF IN-HOSPITAL EDUCATION

I employed this criteria to ensure my participants were experienced educators with an understanding needs of hospitalized students. I required a minimum of five years’ experience as I was curious to see how the participants’ views and opinions have evolved over their careers.

3.3.2 - Sampling Procedures/ Recruitment

I located participants via convenience sampling. As a former patient and current volunteer a pediatric hospital, I distributed my criteria and research overview among in-hospital educators with whom I am acquainted. I requested that my overview, criteria, and contact information be shared among teachers they believe to be suitable for the purposes of this study. I invited the perspective participants to contact me directly if they feel they fit the criteria and would be willing to contribute. This was to ensue participants were volunteering on their own volition, without feeling pressured to partake.

As an active member of the hospital community, I am surrounded by educators who work directly with children with chronic conditions. It was necessary to rely on convenience sampling to locate participants due to the scope and sample size of this study.

3.3.3 - Participant Bios

Participants of this study include three in-hospital educators, all of whom come from diverse career backgrounds and teach in different in-hospital environments.

Joy has been teaching for fifteen years, and thirteen of those years has been in a hospital setting. Prior to her employment as a teacher, Joy worked, and still works part-time, as a nurse at the hospital where she currently teaches. It is important to note that Joy does not teach students whom she nurses. Joy also serves as the teacher-librarian at the hospital’s patient library. Joy generally works on a one-to-one basis with elementary aged hospitalized students from the
ACCESSING ABILITY: THE ACADEMIC AND SOCIO-EMOTIONAL VALUE OF IN-HOSPITAL EDUCATION

facility’s general population. She teaches upwards of six students daily, and each student is allotted approximately sixty minutes each. She only works with her students while they are admitted to the hospital and her goal is to keep her students current with their home-classrooms.

Sabrina works in the same hospital as Joy, and teaches in a classroom specifically designed for students with epilepsy. She has been teaching since 2001 and has been working in the hospital setting since 2003. Her classroom comprises of eight elementary students, all of whom have been diagnosed with epilepsy.

Jennifer works in a separate school authority in a children’s rehabilitation hospital. Her students are aged 4-21 and come from the hospital’s Complex Continuing Care, Specialized Orthopedics, Brain Injury Rehab, and Respite Care units. Jennifer completed a practicum placement at her hospital in advance of her employment, and had sixteen students in her classroom at the time of our interview.

3.4 - Data Analysis

In the following section I describe how the collected data was analyzed.

All interviews were recorded with a digital audio recording device and transcribed. I then read, scrutinized, and disassembled the transcripts, before individually coding them based on themes identified, and through the interpretive lens of Critical Disability Theory. I read the transcripts both independently and comparatively before identifying themes across the interviews.

The identified themes were then linked and combined in an effort to form a more comprehensive understanding of the practices of the participants. As Creswell (2013) suggests,
ACCESSING ABILITY: THE ACADEMIC AND SOCIO-EMOTIONAL VALUE OF IN-HOSPITAL EDUCATION

all of the steps of the data analysis process were interconnected, allowing the analysis to be “intuitive, soft and relativistic” (p. 182).

Across the analysis I looked to find meaning in the data as it relates to existing research. The identified themes include academic benefits to in-hospital education, social normalization in hospital environments, and teacher-perceived challenges in hospital schooling. These themes are discussed and expanded upon in Chapter IV, Findings and Discussion.

3.5 - Ethical Review Procedures

I took every precaution to ensure this study conformed to the ethical standards disseminated to me from the Master of Teaching Program at the Ontario Institute for Studies in Education. I outline these precautions below.

As previously discussed, all participants have been assigned a pseudonym and I have excluded any wording that may identify the participants’ workplaces or students. Furthermore, all participants have been made aware of their right to withdraw from the study at any point in the process.

There is the possibility of minimal risk in participation in this study. Given participants have been asked to speak about children with illnesses and chronic conditions, it is possible that a question may elicit an emotional response from participants which cause them to feel uncomfortable. To mitigate this risk I have provided all participants with a copy of the interview protocol prior to the interview, and have reminded them of their right to decline any question they do not wish to answer.
All data, including audio, transcripts, and coding will be stored on an encrypted and password protected external hard drive and will be destroyed five years after the conclusion of this study.

All participants have been made aware of the ethical considerations listed above, and have signed a letter of consent (Appendix A) affirming they understand their rights as a research participant.

3.6 - Methodological Limitations and Strengths

In the following section I describe the limitations inherent in this research project. I also discuss the strengths of this qualitative study.

The ethical guidelines of the Masters of Teaching Research Project limit the scope of this research. The project only allows teachers and educators to be interviewed, meaning that data has not been collected from students, parents, surveys and/or practical observations.

The sample size of this project is extremely small. This means the data collected will not represent trends that encompass the entire field of in-hospital education, but will rather pinpoint the current practices and lived experiences of three experienced in-hospital educators. These finding will help to inform my decisions as I begin my career as a teacher.

In terms of this study’s strengths, the semi-structured process creates meaningful data that comes directly from the words of the participant (Cridland et al, 2015). The data represents the personal experiences of the participants (Cridland et al, 2015; Clark & Creswell, n.d.). The small sample size means the data analysis will very specifically focus on the experiences of the three educators. Finally, the semi-structured process allows participants to reflect on their
ACCESSING ABILITY: THE ACADEMIC AND SOCIO-EMOTIONAL VALUE OF IN-HOSPITAL EDUCATION

experiences, providing more in depth responses than a survey could accommodate (Clark & Creswell, n.d.).

3.7 - Conclusion

In this chapter I have discussed my research approach and procedures, while outlining the instruments used in the collection of data. I have introduced the participants, and the selection criteria and process behind their recruitment. The methods of data analysis have been described, as have the ethical considerations pertinent to this study. Finally, the strengths and limitations of this study have been explained.

In this research project I endeavour to determine how educators address the diverse social and academic needs of students with chronic health conditions. The results of this study are based on a series of semi-structured interviews with three in-hospital educators. These interviews were recorded on a digital audio recording device, transcribed, coded, and analyzed. The participants were located through convenience sampling, and have signed a letter of consent confirming they understand the ethical considerations of this study. While the sample size and scope of this project is small, the results will help to inform my practices as a new teacher while beginning to fill the gap in the literature discussing the education of hospitalized students. Next, in Chapter IV, I report the research finding and begin to discuss their significance.
Chapter IV: Findings and Discussion

4.1 - Introduction

The following chapter is comprised of a discussion and analysis of the data obtained via three semi-structured interviews with three teachers who work in hospital environments. The names of the participants, as well as the hospitals where they work, have been altered to afford the participants complete confidentiality.

Sabrina and Joy both teach in a Ministry of Education Section 23 program at a pediatric hospital in a major Ontario city. Sabrina teaches in a day program designed for elementary aged students with epilepsy. Joy, who is both a certified teacher and registered nurse, works individually with elementary students whose conditions prevent them from attending traditional classrooms. She is also a librarian at the hospital’s patient library. Jennifer teaches in a separate-school-authority day program for in- and out-patients aged 4-21 from the Complex Continuing Care, Specialized Orthopedics, Brain Injury Rehab, and Respite Care units at a children’s rehabilitation centre in a major Ontario city. In-depth descriptions of participants can be found in Chapter III.

The analysis of the data is organized into three overarching themes which reflect commonalities that emerged in participants’ responses. Those themes are further broken down into various sub-topics to help structure analysis and discussion.

The key findings are addressed through the following three themes:

1) Working in a Hyper-Specialized Educational Environment: Addressing Academic Concerns of Students in a Hospital Environment, where the academic advantages and disadvantages of in-hospital education are described and deconstructed;
ACCESSING ABILITY: THE ACADEMIC AND SOCIO-EMOTIONAL VALUE OF IN-HOSPITAL EDUCATION

2) *Education as a Socially Normalizing Factor: Addressing the Socio-Emotional Needs of Students in a Hospital Environment*, where participants discuss the social value of the hospital setting, and suggest that in-hospital education can provide students with hope and optimism, and;

3) *Teacher Perceived Challenges Presented by In-Hospital Education*, as identified by participants.

I conclude this chapter by briefly reviewing the findings, before giving an overview of this paper’s significance and implications in advance of Chapter V.

4.2 – Working in a Hyper-Specialized Educational Environment: Addressing Academic Concerns of Students with Chronic Conditions in a Hospital Environment

Research indicates that students with chronic health conditions are at risk of developing severe academic problems (Lightfoot et al, 1992; Shiu 2004; West et al 2013). These academic concerns can be compounded by prolonged absences from school. Participants of this study identify numerous academic advantages and disadvantages for students working in the hospital environment. I have organized this theme as follows:

4.2.1 – *Academic Advantages to Education in a Hospital Environment*, and;

4.2.2 – *Academic Challenges in a Hospital Environment*.

4.2.1 – *Academic Advantages to Education in a Hospital Environment*

Participants all discuss major academic advantages for students receiving their education in a specialized hospital environment. All three participants acknowledge that health conditions requiring medical intervention present a diverse range of academic challenges, but all three
participants also agree that the specialized staff, technology and resources, and teaching environment offered in a hospital setting help to mitigate these challenges.

Joy’s students are members of the general hospital population. She typically works individually with her students. Joy gets to plan and conduct all lessons, units and assessments around the specific individual needs of her students and their IEPs. Joy primarily sits beside her students while teaching, as opposed to standing at the front of a classroom. Joy says this teaching environment helps her prepare students for assessment tasks, because she gets to watch her students work and immediately identify if they are grasping the concept of the lesson.

Joy’s programming strives to have her students remain current with the work of their home-classrooms. With parental consent, Joy communicates with her students’ home-teachers to determine what the class is working on and discuss the specific needs of the hospitalized student. This echoes the research of Isiktekiner & Akbaba Altun (2011), and Meyers (1997), who stress the important connection between hospital and classroom teachers.

Often, hospitalized students academically fall behind the work of their peers (Shaw & McCabe, 2008). Joy acknowledges this, but states that under the direction of an individual in-hospital teacher, her students can catch-up quickly. Joy says that students are often proud of what they accomplish academically in the hospital, and note that students are happy to have access to schooling. This helps to mitigate Shaw & McCabe’s (2008) description of hospitalized students who experience anxiety from missed schooling. Joy believes schooling helps provide patients with a break from the rigours of hospitalization and offers patients a normal childhood experience (ibid).
Sabrina works in a different environment despite working at the same hospital. Her eight students all have epilepsy and are assigned to her classroom for the duration of the school year. The specialized environment and small population allows her to plan around the specific needs of her students, and directly address her students’ academic concerns. This leads to an environment where reciprocal teaching methods are employed to assist students with poor working memory, and epilepsy is an open topic for discussion and teaching in the classroom. Sabrina also has two specialized classroom assistants present at all times, as well as access to a special education co-ordinator, and medical practitioners from the social work, psychology, nursing, and neurology departments of her hospital. Sabrina has been given a classroom dedicated to addressing the needs of students with epilepsy, and Sabrina believes the environment in her classroom is the optimal space for supporting her students.

Jennifer also has access to a team of educational and medical assistants in her rehabilitation classroom. Unlike Sabrina, however, Jennifer’s students come from different departments across the rehabilitation centre and her teaching day is often interrupted while students leave the classroom for therapy. Another major difference is that Jennifer’s students do not generally remain in the classroom for an entire school year. At the time of our interview, Jennifer had sixteen students in her class, but she identifies that she can have upwards of sixty students move through her classroom over the course of a year. Regardless of these differences, Jennifer too believes that her classroom is an ideal setting for working with students who have brain injuries or who require complex critical care. This is because her students have access to a teacher who is exceptionally knowledgeable and experienced in addressing their academic needs, while learning in an environment populated by individuals with similar conditions. Therapy or
ACCESSING ABILITY: THE ACADEMIC AND SOCIO-EMOTIONAL VALUE OF IN-HOSPITAL EDUCATION

rest-breaks are consciously built into the daily schedule, and Jennifer herself understands the specific needs of her students’ conditions.

All three participants also acknowledge value of the vast range of teaching resources and adaptive technology available in their workspaces. Joy has access to the majority of resources used by Ontario school boards. This is so she can use the same textbooks and supplies her student’s home-classrooms use. The governing school board has also given large grants to Section 23, which allows the teachers in her hospital to have their own tablets and laptop computers, loaded with education applications and programs to support learning. Sabrina’s classroom uses a Promethean Board and has access to the same resources Joy uses. Jennifer’s students often have orthopedic restrictions which limit their ability to use technology. To support these students, Jennifer’s classroom is stocked with adaptive apparatuses like specialized keyboards, switches, and word prediction and diction software to ensure all students can appropriately use the technology available. This commitment to technology and resources allow hospitalized students to access education in a suitable and accessible capacity.

All other academic research consulted in education and medical journals neglect to comment on the positive academic aspects of in-hospital education. This may be because, as Myers (1997) describes, school boards tend use different strategies to address the education of students with chronic conditions, and there is no formal standard to hospital schooling beyond the hiring of certified teachers. Owing to this, it is important to consider that, while participants of this study generally paint a positive portrait of the academic advantages of in-hospital education, they are only discussing their personal experiences at their intuitions.
4.2.2 – Academic Challenges in a Hospital Environment

The participants in this study generally echoed the academic literature discussing the academic disadvantages to teaching in a hospital environment. All three participants indicate that medical conditions, symptoms, and side effects of treatment can have adverse effects on the academic capacity of students. This reflects the findings of West et al (2013), Shaw & McCabe (2008) and Lightfoot et al (1999). Joy accepts these challenges and always asks herself how she can best support the specific needs of her students on a daily basis. Since she works across the hospital, she sees many different students in many different medical states. Joy respects that conditions or treatments may have adverse effects on a student’s cognitive ability, and plans to be flexible. She may move assessment tasks to days when students are at their peak capacity and accepts that some sessions may be less productive than others. Shiu (2004) acknowledges that classroom teachers are often not afforded this level of flexibility, and suggests that ill students may need to perform academically in situations where they are not functioning at their full capacity.

Sabrina’s students, who are subject to ongoing seizure activity, may experience poor working memory or struggle to sleep at night. Beyond the effects of their conditions, Sabrina says it can be difficult to integrate physical activity in the hospital setting. Unlike Jennifer’s students and Joy’s in-patients, Sabrina’s students have full bodily mobility. Sabrina incorporates daily physical activity into her classroom, and will sometime encourage the students to use the stairs in the facility, but Sabrina believes these do not replace a gymnasium and school yard. Occasionally Sabrina will take her students to a near-by school and use their yard, but such excursions need to be arranged and can be problematic to execute.
The main reason students are in Jennifer’s classroom is because they have sustained an injury or developed a condition which adversely impacts the way in which they learn and think. Jennifer and her team are well equipped to support the needs of these students, but Jennifer admits that students can get frustrated by having to re-learn what they have already been taught, or by having to discover new ways to communicate.

For Joy, who works individually with her students, the biggest academic disadvantage to the hospital environment is her students not having a peer-learning group. While working one-on-one allows Joy to directly plan for and address the needs of her students, the socialization and practical benefits of working around other students are not present in the hospital setting. Her students cannot experience group projects and often miss their peers from their home-school. Jennifer summarizes this sentiment by suggesting that her students are merely trying to be as normal as possible, just as Bossert et al (1990) write.

While participants recognize academic disadvantages around teaching in a hospital setting, all three believe that these environments are the ideal spaces for addressing the academic needs of their students. A combination of personnel, resources, and specialized programming allow students to continue their education while hospitalized, despite the academic disadvantages outlined above.

4.3 – Education as a Socially Normalizing Factor: Addressing the Socio-Emotional Needs of Students with Chronic Conditions in a Hospital Environment

Along with the host of academic problems hospitalized students potentially face, research indicates that students with health concerns are also at risk of falling victim to intense bullying, developing social self-consciousness, and experiencing a lack of motivation (Shaw & McCabe, 2008; St. Leger, 2014; Lightfoot et al, 1999; Shiu, 2004). Participants in this study, however,
ACCESSING ABILITY: THE ACADEMIC AND SOCIO-EMOTIONAL VALUE OF IN-HOSPITAL EDUCATION

Praise the innate inclusivity of the hospital environment and suggest in-hospital education can give patients and parents a sense of hope. All three participants implied or outright stated that in-hospital education is a normalizing experience that helps students and families cope with the rigors and stresses of hospitalization.

In the following section I discuss participants’ conceptions of the socio-emotional effects of in-hospital education. Two major sub-themes emerged in the data:

4.3.1 – Promoting Solidarity Within Peer Groups, in which participants suggest students flourish socially in an environment where all children surrounding them have some form of illness or condition, and;

4.3.2 – Education as a Source of Hope and Motivation, in which participants explain the positive, normalizing experience of in-hospital education.

4.3.1 – Promoting Solidarity Within Peer Groups

Patients of a hospital or rehabilitation centre share the innate commonality of having a health condition serious enough to require admittance or medical intervention. In the traditional classroom, students with health conditions can experience self-conscience concerns about appearance and are often victims of bullying as a direct result of their conditions (Sentenac et al., 2011; St. Leger, 2014, Shiu, 2004, Lightfoot et al, 1999, Thompson & Gustafson, 1996). In a hospital setting, however, having a condition or illness are requisite for admittance. Joy identifies that conditions may or may not be outwardly visible, but suggest that appearance does not matter: if you are a patient of the hospital you share your patient-hood identity with all other patients.
ACCESSING ABILITY: THE ACADEMIC AND SOCIO-EMOTIONAL VALUE OF IN-HOSPITAL EDUCATION

For instance, all eight students in Sabrina’s classroom have epilepsy, making their condition a source of solidarity. In traditional classroom environments, many of Sabrina’s students were the only members of their class with epilepsy. Sabrina identifies this as a cause of immobilizing anxiety, echoing the research of Shiu (2001), as students can fear being teased or mistreated during or after an epileptic seizure. However, the students of Sabrina’s specialized classroom experience and witness numerous ecliptic episodes daily. The classroom has the support staff necessary to properly treat a student during a seizure, and class continues as usual during and after students seize. Epilepsy is the norm in Sabrina’s classroom, and her students experience the social benefits of learning in an environment where their conditions are a source of commonality, not difference.

Sabrina acknowledges that her students may lose contact with friends from their home-school, but she believes the friendships fostered in her classroom have immense value in strengthening social skills and confidence. St. Leger (2014) warns that students may experience stress over strained friendships from their home-school. However, Sabrina explains that her students return to their home-schools “empowered by their epilepsy”, which lessens social anxiety and increases her students’ ability to self-advocate for their educational needs. Sabrina believes these benefits are a direct result of her students’ exposure to peers with similar health conditions.

Jennifer’s rehabilitation hospital offers a specialized kindergarten classroom whose population consists of both students from the rehab centre with chronic conditions, and “healthy” private-school students from the community. Inclusion is a key tenant of this classroom, where the teachers and students alike strive to make every activity, lesson, project, and task inclusive. Students are encouraged to modify tasks to satisfy the physical abilities of all students in the
classroom. Beyond using a myriad of adaptive and assistive technologies, the teachers and students co-design devices which render activities accessible. For example, the class once affixed a paint-roller to a broomstick and attached the contraption to a student’s walking apparatus, allowing him to participate in an art project. This mandate helps teach both the patient-students and their “healthy” peers to advocate for inclusivity, while giving them practical experience in designing inclusive devices and programming. In this particular classroom the students with health conditions are not made to appear or feel different despite being juxtaposed with “healthy” peers, unlike instances of bullying and exclusion as described by Lightfoot et al, 1999. It would be beneficial to study the result this classroom has on the social development of the “healthy” students enrolled, but unfortunately such a task is beyond the scope of this research project. Participants of this study indicate there are social benefits to working in an environment where one’s condition is normalized, revealing that further research in this area is required.

Joy, who generally teaches on a one-on-one basis with her students, says that her students not having access to a peer group constitutes one of the greatest disadvantages to teaching in a hospital setting. While she appreciates that patients find solidarity in interacting with other patients, Joy says that grouping and cohorting similarly aged students present a number of scheduling and confidentiality problems. Joy attempts to connect her students with their home-classrooms via web-based tele-communication programs, such as Skype, which offers her students an opportunity to interact with peers from home. These web-based interactions humanize the hospital experience for the patients’ peers in their home-class, some of whom may have no conception of hospitalization. It also offers patients a window back to their home-school. Joy admits, however, that while this is a positive way to connect students, it is no substitute for having an active academic peer group in the hospital setting. St. Leger (2014) describes a variety
of techniques traditional classroom teachers use, including Skype, to connect absent students to their classroom. The intention is to keep the absent student present in the minds of the teacher and students because “in the day to day classroom situation if you’re not in the class you just disappear” (ibid, p. 259). Joy facilitates these connective practices from inside the hospital to ensure her students can maintain connection to their academic peer groups.

Developing and maintaining healthy relationships while admitted to a hospital helps to perpetuate courage and optimism in pediatric patients, and help decrease the risk of patients developing socio-emotional problems (West et al, 2013). In the following section I describe other ways in which in-hospital education provides hope and motivation for students.

4.3.2 – Education as a Source of Hope and Motivation

Students with chronic health conditions can experience a severe loss of academic motivation as a result of hospital admittances and poor medical prognosis (Shiu, 2004; Shaw & McCabe, 2008). Joy, however, praises in-hospital education as a source of courage and enthusiasm for students. During and after her hour-long sessions with students, Joy ensures she stresses the academic progress made that day to parents and students. Students and families appreciate hearing about positive progression because progress does not always happen medically. Joy’s hour with her students are positive moments in students’ days which are otherwise filled with the rigours and stresses of hospitalization.

Progress and academic advancement are more complicated in Sabrina’s epilepsy classroom and Jennifer’s population of students with brain injuries. Epilepsy causes some students to have poor working-memory and focus, while Jennifer’s students may need to re-learn curriculum they had already studied prior to their brain injuries. Brain injuries may also influence fatigue and focus levels. This echoes the writings Lightfoot, et al (1992) and Shiu
ACCESSING ABILITY: THE ACADEMIC AND SOCIO-EMOTIONAL VALUE OF IN-HOSPITAL EDUCATION

(2004), who recognize that side-effects of conditions can have adverse effects on students’ cognitive abilities. Sabrina and Jennifer employ reciprocal repetitive teaching methods to ensure lessons and topics are absorbed by their students. Jennifer suggests this repetition and reiteration of topics can be frustrating to her students.

Despite these challenges, Sabrina and Jennifer both identify in-hospital education as a normalizing experience. Jennifer states that her students are trying to be as normal as possible, which is complicated by their conditions and admittances to a rehabilitation facility. Joy outright states that students “feel normal because they are getting school” and “parents feel hope because they hope their kids are going back to [traditional] school”. In-hospital schooling perpetuates hope and motivation for parents and students alike. Joy, Sabrina and Jennifer affirm that “normal” students attend school, and having access to school in a hospital environment helps students to maintain a grasp on a normalized childhood experience, which Bossert et al (1990) recognize as extremely beneficial.

Academic motivation is a key factor in maintaining hope for students with chronic health conditions (Shiu, 2004). Unfortunately, medical concerns can make preserving optimism challenging as hospitalization is an immensely stressful experience for patients and families (Shaw & McCabe, 2008). This can be further problematized by the anxiety perpetuated by students knowing their condition is forcing them to miss school (ibid). However, participants in this research project unanimously agree that access to in-hospital education is an effective source of hope and motivation for students and families. St. Leger (2014) suggests that a positive outlook, such as one described by the participants of this study, can help strengthen mental and physical health in hospital patients. This implies that the value in-hospital tuition extends well beyond a student finding solidarity in a peer group and keeping current with the studies of their
ACCESSING ABILITY: THE ACADEMIC AND SOCIO-EMOTIONAL VALUE OF IN-HOSPITAL EDUCATION

home-classroom. The data, coupled with St. Leger’s (2012) research, suggests that in-hospital education has possible medical and therapeutic benefits. Joy and Seymour (2004) remind us that recovery and medical intervention, not education, are the priorities of hospital, however these results indicate that in-hospital education may also positively influence the healing process.

If this is the case, in-hospital tuition should be made available to as many pediatric patients as possible for its therapeutic and educational benefits, which will be expanded upon in Chapter V. Unfortunately, participants of this study identify a number of significant roadblocks that stand in the way of an ideal integration of in-hospital education with medical practice. I will discuss these challenges and roadblocks in the following section.

4.4 – Teacher Perceived Challenges Presented by In-Hospital Education

While participants praise the academic and socio-emotional benefits in-hospital education has on patients, they also identify a few challenges to working in a hospital environment. I will discuss those challenges below, including:

4.3.1 – Absence of Formalized Teacher Training, and;

4.3.2 – Scheduling and Logistic Concerns, where participants discuss navigating the confidentiality concerns of working in a hospital environment.

4.4.1 – Absence of Formalized Teacher Training

Sabrina, Joy and Jennifer all had remarkably different exposure to the hospital environment in advance of their employment as in-hospital educators. Joy worked, and continues to work, as a registered nurse at the hospital where she teaches, while Jennifer underwent a teaching placement at the rehab centre where she currently works. This stands in stark contrast to the experience of Sabrina, who humorously states that she is unsure if she ever stepped foot in a hospital prior to her employment, and had not heard of in-hospital education until a principal she
ACCESSING ABILITY: THE ACADEMIC AND SOCIO-EMOTIONAL VALUE OF IN-HOSPITAL EDUCATION

was working for suggested the program to her. This showcases the divergent experiences participants had prior to working as an in-hospital educator.

As a preface to this section, I will mention that Joy’s employment as a nurse and a teacher are completely separate. Joy does not teach children she nurses, and while Joy is teaching she is not working as a nurse.

The Ministry of Education Section 23 program where Joy and Sabrina work offers no specialized training to help new teachers acclimatize to the untraditional teaching environment. Joy says that she often unofficially and informally tours new teachers around the facility and demonstrates how equipment like IVs and adjustable hospital beds operate. Sabrina says the learning curve is very steep. Beyond learning how to navigate the hospital, Sabrina needed to learn about neurology and how her students’ conditions impact their academics. Sabrina admits that she came into the hospital environment extremely naïve, but was able to rely on a support network from her fellow teachers at the hospital.

Both Sabrina and Joy note that they are members of a strong, supportive teaching community at their hospital. Joy claims that teachers frequently collaborate when planning for challenging students and offer each other support whenever possible.

Joy states that the hospital has recently developed online standardized hospital training modules that all employees and volunteers of the facility must complete. It identifies the basic procedures and protocol of the facility, such as hand-washing and the use of personal-protective equipment. Joy asserts that these modules are “a step in the right direction”, but more work could be done to help teachers transition into the hospital environment.
Sabrina recommends that teachers who are interested in working in a hospital get practical experience acclimatizing to the hospital environment by either volunteering or undertaking a pre-service teaching practicum at a hospital, just as Jennifer had done. Exposure to the environment in advance of employment, Sabrina suggests, will help teachers exact realistic expectations and could help accommodate an absence of formalized training.

When considering this data, it is critical to remember that, of the thousands of teachers who work in Ontario, only a small fraction work in a hospital environment. Additional Qualification courses in Special Education can begin to prepare teachers for working non-traditional environments (Isiktekiner & Akbaba Altun, 2011), but these do not necessarily address the hospital environment. Through these interviews I believe it is clear that there is a significant amount of intuitional knowledge at the two hospital environments, but a lack of formalized training procedures mean this knowledge remains solely within these teaching communities. Developing specialized training programs for hospital environments could give experienced in-hospital educators an opportunity to share their practices, while providing new teachers an opportunity to more readily integrate into the hospital environment.

4.4.2 – Scheduling and Logistic Concerns

Beyond a lack of formalized training, Joy identified a host of logistic and scheduling concerns surrounding in-hospital education. Sabrina and Jennifer did not directly speak to these concerns, however Joy’s role as a one-on-one educator and nurse gives her unique insights into the metrics of hospital confidentiality and logistics.

Joy asserts that hospital employees appreciate the value of education in the hospital environment, but in-hospital teaching is not the priority for patients or health-care professionals. This reflects the research of Seymour (2004), who also states that rigid hospital schedules can
interfere with in-hospital teachers. Joy says she must be flexible in her teaching, because it is not uncommon to have hospital schedules precede teaching schedules, or to be interrupted in the middle of a lesson by a health care professional. Additionally, Joy tells stories of arriving to work with a student she had planned a lesson for, only to determine the student was too ill to conduct the planned lesson that day, or was rescheduled for a test or procedure during teaching time. Jennifer indicates that her students’ days are built around therapy schedules and the potential need for rest time, and that surprises can occasionally happen. These deviations from planned lessons and schedules exemplify an in-hospital educator’s need to be flexible and adaptable.

Additionally, teachers at the facility where Joy and Sabrina work are not considered members of a patient’s circle-of-care. Teachers are employees of the local school-board, not the hospital, which result in a number of confidentiality concerns. Joy cannot be told why an individual is admitted to the hospital by any member of a student’s health team. She can only learn about a patient’s medical situation from the patient or family themselves. This can be problematic for Joy, because a working understanding of a patient’s condition can help her to better address the specific academic needs of her students. Isiktekiner & Akbaba Altun (2011) and St. Leger (2014) both recognize that scheduling and confidentiality can limit an in-hospital educator’s ability to accommodate their students, but these statements are only casually mentioned. Joy directly validates these statements.

Joy also states that working in a teaching capacity gives her valuable insights into a child’s condition. Joy can notice signs and symptoms of medical value, such as a student’s capacity to focus or ability to use a pencil, but she can only informally share these beneficial observations and insights with a child’s medical team. Joy spends upwards of sixty minutes with
ACCESSING ABILITY: THE ACADEMIC AND SOCIO-EMOTIONAL VALUE OF IN-HOSPITAL EDUCATION

her students, and she works in a capacity where she can observe her students in ways a physician cannot.

Joy also identifies that students can only be given access to education in the hospital with parental consent. Students must be admitted, or projected to be admitted, for a minimum of fifteen school-days to be eligible. An internal automated system at the hospital has to identify and register eligible students before teachers can have access. This can lead to hiccups where students and parents are unaware of the existence of in-hospital education despite being meeting the fifteen school-day criteria, and do not get access. There is presently no accountable person at the hospital responsible for registering students. Joy identifies this as the “biggest glitch in the system”, because she believes there to be additional students who could use schooling that are not afforded access. This is problematic as this study has identified major benefits to in-hospital education.

Joy and Sabrina also identify the inconveniences of working in a satellite teaching environment as opposed to a traditional school, namely in access to school administration. Both Joy and Sabrina said that arranging face-to-face meetings with their principal or vice-principal, who work off-site and are in charge of all Section 23 programs across the school board, is more difficult than simply walking down the hallway and knocking on a door. This slows down interactions and problematizes communication.

It is important to note that these concerns were not supported by Jennifer’s experiences, who works in a separate school authority governed by the rehab hospital where she teaches. I speculate this is because the school authority is more closely tied to the rehab centre than the Section 23 program is to Joy and Sabrina’s hospital and there is a greater level of
ACCESSING ABILITY: THE ACADEMIC AND SOCIO-EMOTIONAL VALUE OF IN-HOSPITAL EDUCATION

communication, interaction, and scheduling. These assumptions, however, are merely speculative are not directly supported by the data.

The results of this study assert that in-hospital education is a positive experience for students, however the roadblocks identified prevent Joy and her fellow teachers from effectively servicing the educational and medical needs of all hospitalized patients.

4.5 - Conclusion

In this chapter I have identified and discussed the findings of this research study. Participants indicated that the specialized educational environment offered in the hospital setting can be academically beneficial to hospitalized students. Additionally, access to education can serve as a source of optimism, hope, and motivation for hospitalized patients and their families. Participants further indicated that CC students can gain social confidence from interacting with children who also have chronic conditions. This study also uncovered challenges in-hospital educators face, including a lack of formalized teacher training and logistical concerns stemming from scheduling and confidentiality. There is currently little academic research in this field, and this study has only begun to reveal the value of in-hospital education. A deeper, more rigorous study in this field is required, as results imply in-hospital education has vast academic, social, and medical benefits, which will be expanded upon in Chapter V.
Chapter V: Conclusion

5.0 - Introduction/Overview

In the following, and final, chapter of this research project I overview this study’s key findings, discuss broad and narrow implications, overview my recommendations as a researcher, and suggest areas for further study. I also review my personal positioning with the research and look toward future research on in-hospital education.

In this research project I have examined a sample of in-hospital educators’ perceptions on the diverse academic and social needs of hospitalized elementary students. Data was collected via a series of semi-structured interviews with three in-hospital teachers from two Ontario pediatric medical institutions. The recordings of these interviews were transcribed, coded and analyzed. Through the examination of these interviews and their transcripts I have determined that the sample of teachers who participated generally deem access to in-hospital schooling as a positive academic and social experience for students, however all three participants also indicated roadblocks and challenges which prevent hospitalized students from obtaining an ideal supplement for traditional classroom schooling. These findings are located in Chapter IV and are reviewed in section 5.1 of this chapter.

I arrived at the research topic of in-hospital schooling via a series of personal experiences and a self-perceived gap in the surrounding academic literature. As an elementary-aged student I was subject to prolonged hospitalizations as a direct result of a chronic congenital health condition. While admitted, I significantly benefited from access to teachers, and I volunteered at a pediatric hospital for over sixteen years. My original intention for this qualitative project was to specifically study the integration of the dramatic arts in hospital schools, as my undergraduate
education was in Theatre and Drama Studies and part of my hospital volunteer experience was performing in a weekly musical-theatre performance for patients. However, upon conducting an initial review of surrounding literature, I was surprised to find very little academic research on general, let alone arts-based, education in the hospital environment. I thus decided to broaden my research questions to explore how in-hospital teachers help to address the unique needs of hospitalized students. The literature identifies these challenges, such as reduced cognitive abilities, loss of focus, and lack of motivation (Shaw & McCabe, 2008; Shiu, 2004), however research does not discuss how they are tackled in the hospital setting. My research project aimed to fill this perceived gap. The findings of this study and a discussion of their significance are examined in the following section.

5.1 – Overview of Key Findings and Significance

Results of this qualitative study indicate the specialized educational environment, resources, and personnel available in the hospital setting can significantly help support the academic needs of students with health conditions requiring medical intervention. Additionally, results suggest that placing students in a social setting where they are surrounded by peers who also have medical conditions can positively impact socio-emotional well-being, while providing students with socially normalized learning environments. Finally, results imply that in-hospital education has the potential to provide ill students with optimism, hope, and motivation. This study also uncovered many roadblocks surrounding hospital logistics and confidentiality that restrict student access to education in the hospital setting. This section will review these findings and offer my analysis on their significance.

Shaw and McCabe (2008) identify that hospitalized students are at risk of developing a host of academic problems. These concerns include, but are not limited to, a lack of motivation,
feeling overwhelmed from missed schoolwork, and complete estrangement from education (Shaw & McCabe, 2008; Shiu, 2004; St. Leger 2012). The participants of this study acknowledged these concerns, but suggested that the specialized teaching staff and resources offered in the hospital environment can have an exceptionally beneficial educational impact on students. Joy, a hospital teacher who works one-to-one with her students, indicated that the individual attention she affords her students allows her to immediately and directly confront academic problems, which helps her students remain current with their home-class. Sabrina and Jennifer have a team of educational and support workers in their hospital classrooms and have access specialized adaptive technology to assist their students. All three participants imply that their specialized teaching environments better address the academic needs of their students than what they would receive in a traditional classroom setting.

Unfortunately, the participants indicated that not all hospitalized students receive access to educational support. At Joy and Sabrina’s hospital students must be admitted to the facility for a minimum of fifteen school-days to be eligible for in-hospital tuition. However, an automated system designed to identify eligible students occasionally misses potential students, and students who are hospitalized for less than fifteen school days do not receive any in-hospital support.

Patient mental and physical wellbeing is supported by, what participants glean to be, a positive social environment for students. Students with chronic health conditions may be the only individual in their traditional classrooms with major health concern, however in a hospital environment student-patients can find solidarity in peers who also conditions requiring medical intervention. Participants generally deemed being surrounded by fellow students with health conditions was a normalizing social experience. Sabrina claimed that the students in her classroom left “empowered by their epilepsy”.

ACCESSING ABILITY: THE ACADEMIC AND SOCIO-EMOTIONAL VALUE OF IN-HOSPITAL EDUCATION
ACCESSING ABILITY: THE ACADEMIC AND SOCIO-EMOTIONAL VALUE OF IN-HOSPITAL EDUCATION

After completing this research project I believe there exists a significant amount of institutional knowledge within the teaching communities at the two medical facilities where participants work. However, Joy and Sabrina indicated that they received little formal training for teaching in a hospital environment. Both Joy and Sabrina stated that a strong, supportive teaching community helps introduce and acclimatize new teachers to the unique hospital environment. Even with this support, however, Sabrina suggested there is a “steep learning curve” to working in a hospital. Jennifer underwent a practicum placement at the rehab facility where she works, so the transition was not as difficult for her. However, the participants and the research consulted did not indicate any level of communication between hospital teaching intuitions.

Furthermore, hospital teachers can gain insight into patients’ conditions and recovery which could support medical treatment. By working and observing students-patients in an academic capacity, teachers witness patients’ cognitive, occupational, and concentrative development over time. Joy believes this information can help support a patient’s medical team, however hospital teachers are not members of a patient’s circle-of-care and cannot share this information.

Because the scope of my literature review uncovered little discourse and discussion surrounding in-hospital education, this particular research study uncovered many implications I believe to be important to both the medical and educational communities. I discuss these implications, both broad and narrow, in the following section.

5.2 - Implications

The research goals of this study were extensive by asking how in-hospital educators support the academic and social needs of hospitalized students. Beyond the findings reviewed in
ACCESSING ABILITY: THE ACADEMIC AND SOCIO-EMOTIONAL VALUE OF IN-HOSPITAL EDUCATION

the preceding section, my research exposed what I consider to be significant implications which demand further study. I discuss the broad implications addressed to the educational and medical research communities in the following sub-section, before discussing my personal growth and learning in the sub-section entitled 5.2.2 Narrow Implications.

5.2.1 - Broad Implications

This sub-section looks to unpack the broad implications of my findings as they relate to medical and educational communities. First and foremost, the findings of this study indicate that in-hospital education is an immensely positive experience for hospitalized students, both academically and socially. Results of this study imply that patients who receive in-hospital schooling may also experience medical benefits. All three participants indicated that hospital schooling can serve as a source of academic motivation, hope, and optimism for students and their families. Shaw & McCabe (2008) write that hospitalization can be an immensely stressful experience for children, especially when students are cognizant of missing schooling. Academic motivation, however, can help to counteract this stress, and a positive outlook can promote mental and physical wellbeing in patients (St. Leger, 2014; Shiu, 2004). If this is the case, access to hospital schooling could encourage patient recovery and may result in reduced admission times, which Thies & McAllister (2001) claim to be a major goal of North America’s pediatric hospitals. The study of these benefits fall outside of the scope of this research study indicating that more research from medical communities is required.

Additionally, findings of this study imply that patients’ parents and guardians also benefit from their children receiving access to in-hospital schooling. This is best stated by Joy, who debriefs with her students’ parents as frequently as possible. Joy believes parents like to hear about their children’s academic progress because positive progress does not always occur
ACCESSING ABILITY: THE ACADEMIC AND SOCIO-EMOTIONAL VALUE OF IN-HOSPITAL EDUCATION

medically. Joy believes that schooling is an encouraging and optimistic symbol of normal childhood experiences for families of hospitalized students.

5.2.2 - Narrow Implications

This research study was completed as a graduation requirement for my initial teacher education program. As I evolve on my journey to become an educator, I have considered how this project will contribute to and inform my practices as a new teacher. This initially presented as a difficult problem because, as Joy expresses, applying to teach in a hospital environment often requires a few years of teaching experience. After conducting this study I still, if not more so, wish to eventually teach in a hospital setting. As I begin my career I feel I will take the following major learnings away from this project:

Firstly, this document has been the largest academic undertaking I have ever completed. Wrestling with a single research topic for two years has both coloured my experience in initial teacher education, and has extracted from me a sense of rigor and academic passion I did not know I possess. This project was also my first foray into qualitative research, and has excited me for future research opportunities.

Extracting and distilling my findings and their significance has led me to realize how vitally important it is to specialize a classroom to the specific needs of ones’ students. All three participants indicated that the specialized environment and support they offer their students directly leads to student success. This perhaps seems obvious, and this idea has been communicated to me countless times over the course of my initial teacher education, but my participants exemplified this support in their responses to my questions. The smaller, or individual, class sizes allow my participants to directly plan and conduct units, lessons, and assessments while considering the specific needs of each student. As a new teacher, I will aim to
personality my lessons to the needs of my students no matter the environment or class size where I find myself.

Finally, this research project has reinforced my passion for education and my belief that educators are immensely creative and empowering individuals. After completing this study I have developed some recommendations to help medical and educational communities better support the phenomenal work done by in-hospital educators. These recommendations are outlined in the following section.

5.3 - Recommendations

Throughout my analysis of the data collected in this research study I have generated a short list of recommendations to help further support in-hospital educators. In the scope of my literature review, and from what I have determined through my interviews, what I am recommending is not currently being exercised by in-hospital educators, Faculties of Education, or medical communities. However, it is possible that things I am recommending are currently being developed or implemented, though I am not aware of it.

From the interviews conducted and the literature consulted, I have determined there is a limited amount of communication between hospital schools in Ontario, and any communication that does exist is informal. Research participants of this study come from two different medical facilities, both of which employ different strategies and protocols, and both of which are successfully supporting the needs of their students. It is clear there is a great amount of knowledge and passion in these two facilities, however this experience and expertise currently remains locked within these teaching communities. The lack of academic research on hospital schooling implies that this is indicative of a trend across hospital schools. I recommend that hospital schools and in-hospital teachers form a support network across facilities to share
ACCESSING ABILITY: THE ACADEMIC AND SOCIO-EMOTIONAL VALUE OF IN-HOSPITAL EDUCATION

resources, strategies, experiences, and ideas. Were this to happen, each hospital teacher would have access to a wealth of knowledge to better support their students, and the transition between traditional teaching and in-hospital teaching would be simplified.

The findings of this study also indicate some teachers receive little formal training aimed to introduce the complexities of teaching a hospitalized population. Faculties of Education could better support teachers aiming to work in hospital environments via specialized workshops or courses. This is understandably difficult to implement, as there are only a small fraction of Ontario teachers working in hospital environments. However, access to these training systems could help flatten the steep learning curve participants described. Jennifer, who experienced a practicum placement at her rehab facility before her employment reported a significantly easier transition than Sabrina who had no hospital experience before her employment. Perhaps these training programs could be implemented in the recommended hospital teacher network proposed earlier. In-hospital education is a difficult and unique teaching challenge, and supporting in-hospital teachers will only help them to support the needs of their students.

Additionally, teachers have the ability to gain unique insights into their patients’ medical conditions, however in the hospital where Sabrina and Joy work, teachers are not a member of a patients’ circle-of-care. This means that medical teams cannot communicate with the teachers about student-patients’ conditions. Conversely, Jennifer’s students have therapy sessions intentionally built into their school days, and care givers are sometimes present in the classroom. The educational environment can provide medically-valuable insight into patient conditions. Confidentially is a major concern in this particular recommendation, but I suggest in-hospital teachers be welcomed into medical conversations, so both caregivers and educators can benefit from each other’s knowledge of their student-patients’ conditions.
Finally, and most importantly, I recommend that more research be done in this field. This study has barely begun to tackle the immense, nuanced, and complex topic of in-hospital education. I believe that both the educational and medical research communities could benefit from further study of hospital schools. For educators, this could take the form of qualitative studies on teachers’ practices and class observations to create universal resources to support in-hospital teachers and better understand the needs of hospitalized students. For physicians, this could include quantitative research on access to education’s impact on recovery and admission length. Additionally, more research could be conducted on the strategies in-hospital employ when working with students who are terminally ill. My study has uncovered a valuable and understudied seed of research, but the scope of this project prevents me from being the seed’s gardener for any longer. I encourage research communities to continue from where I am concluding, and to nurture this seed to grow and blossom, culminating in research and programs to further support the needs of hospitalized students and their teachers.

5.4 - Concluding Comments

This research study represents one of the first inquiries into the practices of in-hospital educators in Ontario. Through a series of three semi-structured interviews with teachers currently working a hospital environment, I have determined that the specialized staff and resources, coupled with the benefit of student-patients being surrounded by peer groups with medical conditions, may make the hospital a positive setting for students with chronic health conditions to receive their education. Unfortunately, issues surrounding confidentiality and logistics may prevent hospitalized students from accessing education. These claims, however, indefinitely require further study to be corroborated. This further research could result in the educational and
ACCESSING ABILITY: THE ACADEMIC AND SOCIO-EMOTIONAL VALUE OF IN-HOSPITAL EDUCATION

medical research communities better supporting the students and teachers who learn and work in hospitals.

Finally, results of this study may imply that the academic progress and socio-emotional wellbeing hospital teachers promote in their students can foster hope, courage, and optimism. If this is the case, access to hospital schooling has the potential to shorten admission lengths and have other medical and health benefits. While there is still a significant amount of research to be done in this area, I believe that hospital schooling should be made available to all the hospitalized students in Ontario and beyond to ensure that medical necessity does not overshadow a students’ right to a quality education.
ACCESSING ABILITY: THE ACADEMIC AND SOCIO-EMOTIONAL VALUE OF IN-HOSPITAL EDUCATION

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Appendix A: Letter of Consent

Dear Participant,

My name is Wesley Payne and I am a student in the Master of Teaching program at the Ontario Institute for Studies in Education at the University of Toronto (OISE/UT). A component of this degree program involves conducting a small-scale qualitative research study. My research will focus on the strategies in-hospital educators employ to help address the academic and social needs of hospitalized children. I am interested in interviewing teachers who have at least five years of teaching experience, and at least 2 years’ experience teaching in hospitals. I think that your knowledge and experience will provide insights into this topic.

Your participation in this research will involve one 45-60 minute interview, which will be transcribed and audio-recorded. I would be grateful if you would allow me to interview you at a place and time convenient for you, outside of school time. The contents of this interview will be used for my research project, which will include a final paper, as well as informal presentations to my classmates and/or potentially at research conferences and publication. You will be assigned a pseudonym to maintain your anonymity and I will not use your name or any other content that might identify you in my written work, oral presentations, or publications. This information will remain confidential. This data will be stored on my password-protected and encrypted hard drive and the only people who will have access to the research data will be myself and my course instructor, Dr. Eloise Tan. You are free to change your mind about your participation at any time, and to withdraw even after you have consented to participate. I will destroy the audio recording
ACCESSING ABILITY: THE ACADEMIC AND SOCIO-EMOTIONAL VALUE OF IN-HOSPITAL EDUCATION

after the paper has been presented and/or published, which may take up to a maximum of five years after the data has been collected. The only known risk in this study is that the questions may elicit an emotional response. To help mitigate this risk you may elect to pass on any question you do not wish to answer. There are no known benefits to participation.

Please sign this consent form, if you agree to be interviewed. The second copy is for your records. I am very grateful for your participation.

Sincerely,

Wesley Payne
Appendix B: Interview Protocol

1. First, I’d like to get to know a little bit more about you.
   a. Where are you teaching this school year?
   b. What grade/age group are you teaching this year?
   c. How long have you been teaching for?
   d. How long have you been teaching in hospitals?
   e. What drew you to teaching in a hospital?

2. The following questions look to create a description of a standard day of your experiences as an in-hospital educator.
   a. How many students do you work with in a single day? How many at a time?
   b. In what environment do you work with your students?
   c. Approximately how long do you spend with each student/group of students in a day?
   d. How much planning time are you allotted in a week?

3. What resources/technology do you frequently use in your teaching?
   a. Are these resources available at the hospital?
   b. How do you access resources?

4. In what ways, if at all, do students’ symptoms and/or side effects of their treatment influence a students’ ability to focus on education?
   a. If so, how do you address this?

5. What level of communication is present between a student’s health team and yourself?

6. Could you please outline any additional training you received for working in a hospital environment?
ACCESSING ABILITY: THE ACADEMIC AND SOCIO-EMOTIONAL VALUE OF IN-HOSPITAL EDUCATION

7. In your opinion, what are the most significant academic challenges a hospitalized student faces?
   a. How do you address these challenges?
   b. What would help you address these challenges?

8. In your opinion, what are the most significant social challenges a hospitalized student faces?
   a. How do you address these challenges?
   b. What would help you address these challenges?

11. What are some of the benefits and challenges that you experience as an in-hospital teacher?

12. What advice, if any, do you have for beginning teachers who are interested in supporting the in-hospital education of children?