A significant development in the Unit’s progress occurred on the 3rd of August 1997, when we ceased to be included in the financial structure of the University of Exeter and became a limited company. As far as our colleagues and customers are concerned, the only practical difference has been that payment for goods and services is now made to SHEU Ltd rather than the University of Exeter. We are still located in the School of Education at Exeter, our offices and telephone numbers remain unchanged, and the staff who attend to your needs. The inevitable effects of coming out of the University’s “umbrella” are, however, important.

1. We are now totally in charge of our own finances.
2. Staff members are more directly aware of the cost-effectiveness of their part of the operation.
3. Although John still takes overall responsibility for planning, costing, and completing contracts, some of these tasks will gradually be taken over by other members of the team.

All this talk of money will make readers assume that charges are going to increase! This should not be the case. One very positive benefit of going independent is that our overheads should be smaller than they were before.

At the present time we have so much work to do by the end of the year that Beryl has been training extra data processors and if this level of demand keeps up, SHEU Ltd will have to expand to a magnificent start. Surveys are already being pencilled in for the first half of 1998, so if you are thinking about surveying schools in your area, you should let us hear about it soon!

We did a tally the other day and discovered that by the end of this year the Unit will have issued and processed HALF A MILLION QUESTIONNAIRES relating to young people of between 7 and university age. This includes all surveys, principally Health Related Behaviour, but also just a few and special surveys on alcohol, smoking, travel to school, and many other aspects of the lives of young people in the 7-10s age range.

**Some Unit publications**

**Young People and Illegal Drugs**
In 1996 .................................. £14.00
A report based on data collected between 1987 and 1996 using the Health Related Behaviour Questionnaire.

**Cash and Carry?** ........................... £12.00
A report based on data collected between 1987 and 1996 using the Health Related Behaviour Questionnaire.

**Young People and Alcohol** ........................... £17.00
A study of the “alcohol environment” of 8,315 Year 8 and 10 pupils. In addition, baseline information about amounts, frequency, and types of drink consumed, the report examines alcohol-related domestic aggression and its relation to family structure.

**Young People in 1995-5** ........................... £20.00
Results from 18,929 young people between the ages of 9 and 12, who completed Version 5 of our Primary Health Related Behaviour Questionnaire.

**Young People in 1996** ........................... £33.00
The latest of our annual reports, with results from 22,607 young people between the ages of 12 and 15, who completed Version 17 of the Health Related Behaviour Questionnaire.

**Last Orders** ........................... £28.00

**Lifestyles 1-9** ........................... £18.00 each
A set of datafiles containing health-related behaviour data for 200 Year 10 pupils obtained from Unit surveys. Using these packages in the NC raises many health education topic. Please contact us for details of the set (reduced rates for sets of more). The price includes VAT.

**Prices include postage and packing**

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**Hospital education: effective or disruptive?**

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

Joanna Clark & Bahman Baluch

Education and Health is produced by the Schools Health Education Unit, St Luke’s, School of Education, Heawtree Road, Exeter, EX2 6EU 01392 264722, fax 264761.

**Hospital medics and educators have their say**

**Mark Griffiths:**

Virtual pets can lead to real grief

**Lesley Kendall:**

Telling asthma sufferers about the air they breathe

**Whelan & Culver:**

DARE needs to do more work on drug refusal skills

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**Attitudes towards hospital education**

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

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

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

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

School helps to relieve boredom during a hospital stay. Education helps to maximise quality of life, and so should be available whatever the medical circumstances of the child.

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

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

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

Hospital school can help to aid a quicker recovery.

## 2. CURRICULUM

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

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

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

## 3. INTERFERENCE

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

Schooling can lead to interference with medical procedures.

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

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

<table>
<thead>
<tr>
<th>Factor</th>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>The hospital school provides a good education</td>
<td>6.00</td>
</tr>
<tr>
<td>Social</td>
<td>The child is happy in the hospital setting</td>
<td>5.75</td>
</tr>
<tr>
<td>Medical</td>
<td>The hospital staff are helpful</td>
<td>5.50</td>
</tr>
<tr>
<td>Overall</td>
<td></td>
<td>5.35</td>
</tr>
</tbody>
</table>

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

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## The Implications

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

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

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

The second finding did not cause surprise either.

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

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

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

The third finding was particularly encouraging:

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

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

The next step . . .

This was a pilot study in an area with remarkably little published research, and it was conducted to uncover issues for follow-up research. In particular, it would be of interest to discover if similar views are held by medical professionals and teaching staff in other UK hospitals.
population of patients in Great Ormond Street Hospital is widely diverse in culture and language, and in hospitals serving a more localised community it will be easier for the teachers to establish direct links with the children’s schools. The medical staff may be more supportive if they see that the schools are involved in the educational process.

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

References

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...able to help children come to terms

gets more
than the real
games and toys. However, unlike most toys, which people eventually get bored with, it is alleged that Tamagotchis require their owners to be the slave rather than the master. This Christmas there is likely to be a Tamagothi bonus, which will be fuelled by more sophisticated versions and six more colours. Many schools, both here and in South East Asia, have already banned them in an attempt to stop them interfering with children’s educational development.

For those reading this who still have no idea what a Tamagothi is or does, then let me explain. Tamagotchi means ‘egg watch’ or ‘lovable egg’, and the device looks like an egg-shaped key ring. It is about 60mm in diameter and has a small liquid crystal display screen. By pulling a small tab on the side, an ‘egg’ hatches to reveal a small chick, and the owner has to attend to its every need by pressing the appropriate buttons.

Constant attention

These virtual pets demand all the things you would expect of a real pet (being fed, going to the toilet, going for walks, being disciplined when it is naughty, being given injections if it is sick, etc.). They require constant attention to survive. Unhappy animals that are not fed or nurtured make noises (squalls, smarts) at their owners and will die if they are ignored. The aim of the game — if indeed it is a game — is to keep the Tamagotchi alive for as long as possible. The