The Pedagogical role at the Meyer Children's Hospital: A case study of an integrated care model

El rol pedagògic a l'Hospital Infantil Meyer: un estudi de cas d'un model d'atenció integrada

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Abstract

This investigation examines the pedagogical role within pediatric contexts through a case study of the Meyer University Hospital. The study is informed by the transformation of contemporary healthcare systems toward a holistic, person-centered, and systemic approach. The objective is to move beyond a fragmented approach to care by fostering an integrated model. This involves promoting interventions that support the child and family throughout the entire clinical pathway and into subsequent phases, thereby ensuring educational and therapeutic continuity after discharge. The primary purpose of this study is to define the professional profile of the hospital pedagogist, a specialist capable of effectively mediating between the educational and healthcare domains so as to manage the complexity at the intersection of health, school, and community. The research employed a mixed-methods, exploratory single-case study design at the Meyer Children's Hospital in Florence. Methodologically, it involved a six-month internship utilizing participant observation, documentary analysis, 22 semi-structured interviews, and a thematic focus group with key stakeholders. The most outstanding results portray the hospital pedagogist's role as a dynamic and systemic construct operating at micro, meso, and macro levels. This professional is conceptualized as a director of complex processes, requiring a multifaceted competency profile in pedagogical design, coordination, communication and reflection.

Keywords

Hospital pedagogy, continuity of care,

interprofessional collaboration, educational care, competencies.

Resum

Aquesta investigació analitza el rol pedagògic en contextos pediàtrics mitjançant un estudi de cas de l'Hospital Universitari Meyer. L'estudi s'emmarca en la transformació dels sistemes sanitaris contemporanis cap a un enfocament holístic, sistèmic i centrat en la persona. L'objectiu és superar un enfocament fragmentat de l'atenció fomentant un model integrat. Això implica promoure intervencions que acompanyin l'infant i la família al llarg de tot l'itinerari clínic i en les fases posteriors, garantint així la continuïtat educativa i terapèutica després de l'alta hospitalària. La finalitat principal d'aquest estudi és definir el perfil professional del pedagog hospitalari, un especialista capaç de mediar eficaçment entre els àmbits educatiu i sanitari per gestionar la complexitat en la intersecció entre salut, escola i comunitat. La recerca ha utilitzat un disseny d'estudi de cas únic exploratori amb mètodes mixtos a l'Hospital Pediàtric Meyer de Florència. Metodològicament, ha comportat una estada de sis mesos utilitzant l'observació participant, l'anàlisi documental, 22 entrevistes semiestructurades i un grup de discussió temàtic amb informants clau. Els resultats més destacats descriuen el rol del pedagog hospitalari com un constructe dinàmic i sistèmic que opera als nivells micro-, meso- i macro-. Aquest professional es conceptualitza com un director de processos complexos, que requereix un perfil competencial polifacètic en disseny pedagògic, coordinació, comunicació i reflexió.

Paraules clau

Pedagogia hospitalària, continuïtat assistencial, col·laboració interprofessional, atenció educativa, competències.

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1. Introduction

Healthcare today is experiencing a fundamental shake-up. We're moving away from the old, reductionist biomedical model to a holistic, person-centered, systemic approach (WHO, 1948, 2016). When it comes to the well-being of children and teens, it is not possible to separate education and health – they are two sides of the same coin, both essential for nurturing their physical and psychological growth (UN, 1989). In line with foundational frameworks, such as the Salamanca Declaration (UNESCO, 1994), and the specific legal framework for hospital pedagogy in **I**taly (Ministero della Salute, 1998), the fundamental rights to health and education for hospitalized children must be upheld not as separate entitlements, but as a unified right to the safeguarding of the whole person.

Grounded in this principle, educational institutions are obligated to cultivate student well-being. This requires a pedagogical approach that merges the cognitive aspects of teaching and learning with the emotional domain, achieved through deliberate strategies of communication, empathy and protection. Such a specialized and situated educational environment is characterized by greater emotional and relational flexibility, focusing on the needs of hospitalized students and the emotional relational priorities over strictly therapeutic pedagogical content.

The idea of continuity of care is fundamental to the new paradigm. It is essential and innovative. This model is described as an uninterrupted continuum of pathways, services, and processes which include prevention, treatment, and rehabilitation (WHO, 2011). The central aim is to address the fragmentation of patient services through an integrated collective effort of various providers and professionals. The World Health Organization has labeled this approach as a measure of health system performance (WHO, 2018). It rests on the integrated seamless transition of care and services between hospitals and the community to create a personalized integrated care pathway. This approach must be planned because it starts with an active and thorough understanding of the patient's complex needs while they are still in a hospital and extends to the coordination of post-discharge community services (WHO, 2011).

The effective implementation of an integrated local care network is a strategic objective for national health systems, calling for a coordinated, twofold strategy (Ministero della Salute, 2024). First, the role of the hospital must be reoriented toward a highly specialized, technologically advanced model focused on managing acute pathologies, while decentralizing other aspects of care. Second, primary care must be remodeled to incorporate innovative approaches like proactive medicine, which promotes the active engagement of citizens in their own health and care pathways.

It is within this evolving framework that the hospital school functions as an intrinsic and vital component of the therapeutic process. It serves as an anchor for normalcy, future-planning, and educational continuity for the hospitalized child (Ferraro, 2013). However, its effectiveness depends on its ability to operate as a strategic nexus between the healthcare system, educational institutions, and community services. Because this network is crowded with so many different people, jargon, and procedures, we have a clear and urgent need for a specialized pedagogical

professional. This person would not be doing the work of a classroom teacher; instead, it should manage the whole thing at a systemic, organizational, and meta-reflective level.

This study is funded by the Next Generation EU program and is part of the "Tuscany Health Ecosystem" project—the only one of Italy's eleven innovation ecosystems dedicated entirely to the Life Sciences. The present research builds upon the teacher training model for hospital educators that was developed and piloted at the Meyer Hospital between 2015 and 2025 by the FORLILPSI Department of the University of Florence (Boffo, 2022). The project's objective is to move beyond a fragmented view of care by promoting interventions that support the child and their family throughout the entire hospital journey and into subsequent phases, thereby ensuring the educational and care continuity that is foundational for their holistic development.

The primary purpose of this study is to define and delineate the professional profile of the Hospital Pedagogist, a specialist capable of effectively mediating between the educational and healthcare domains to manage the complexity at the intersection of health, school, and community. This figure is conceptualized not as a mere support operator but as an education and training professional vested with complex functions, including inter-institutional coordination, intervention design, continuous training, and pedagogical supervision. While such a profile awaits full legal recognition in Italy, its necessity is an operational imperative already addressed in other European contexts. A key precedent is the Spanish system, which has long institutionalized the role of the Director de Aula Hospitalaria (Hospital School Director) (*Decreto 127/2017, de 24 de octubre, del Consejo de Gobierno, por el que se establece la estructura orgánica de la Consejería de Educación e Investigación*).

The research is guided by the following three questions:

- What is the role of the pedagogist within the hospital setting in promoting more effective care and facilitating children's reintegration into their home and community environment?
- What organizational factors within the hospital can foster and support a child's developmental path before, during, and after hospitalization?
- What are the core leadership competencies required for an education professional to operate effectively in multifaceted healthcare systems?

2. Material and methods

2.1. *Methodological design*

This research project is framed within the ecological paradigm (Bronfenbrenner, 1979), with a holistic, socio-constructivist, and critical-transformative approach (Del Gobbo, 2018). To ensure a rigorous investigation of the complex phenomena within the

pediatric hospital setting, the study employed an exploratory single-case study design (Yin, 2018) centered on the Meyer Children's Hospital (AOU Meyer) in Florence.

The research followed a Mixed Methods Research (MMR) approach, utilizing a convergent design where qualitative and quantitative data (via frequency analysis of observational grids) were collected to provide a comprehensive understanding of the research problem (Creswell & Clark, 2018). This design was chosen to facilitate methodological triangulation, allowing the researcher to cross-verify findings from different sources—observations, interviews, and documents—thereby enhancing the validity and depth of the scientific knowledge produced. By combining procedures and results from both approaches, it is possible to produce superior results in terms of scientific knowledge (Del Gobbo, 2018).

The empirical observational research, with varying degrees of structure, adopts a descriptive-interpretive approach. The main purpose is to explore and understand the phenomenon under examination, as well as to describe and explain the relationships between the variables studied, in order to develop an analytical model that can also inform macro-political strategies (Bateson, 1977; Bronfenbrenner, 1979). The primary research setting was the Children's Hospital Meyer in Florence (AOU Meyer), a nationally recognized center of excellence in pediatric care. The case study was our preferred research method during the doctoral internship because nothing else can provide such a deep, contextualized understanding of complex phenomena in a real setting.

The investigation was a six-month doctoral internship (from September 1, 2024, to February 28, 2025), focused primarily on two key areas within the hospital: the Family Center's Care Continuity Unit (UCOT, from the Italian) and the hospital school. This allowed for an invaluable vantage point, giving us a holistic, transversal look at all the various professions and services integral to the care pathways of hospitalized children and their families. The internship involved a total commitment of approximately 800 hours, divided into 600 hours of on-site activity within the units and 200 hours of back-office activity dedicated to data systematization and elaboration.

This research aims to stimulate the innovative dimension of work, both at a professional and a purely political level. Through the various research phases, it intends to outline the role of the pedagogist as well as the hospital system (macro level), specifically the hospital school, within the life planning process of the hospitalized minor, together with the organizational practices (meso level) required for its proper functioning. Finally, this study aims to define the framework of competencies that characterizes the role of pedagogical educational leadership (micro level) in highly complex contexts. It is also hoped that this research can give impetus to new national and international synergies, as well as facilitate collaboration between professionals from different scientific-disciplinary fields.

2.2. *Participants*

Across its various phases, the study engaged approximately 100 professionals from the care sector. Participant selection for the interviews and focus group was guided by a

non-probabilistic sampling strategy. An initial convenience sampling approach was adopted, which is well-suited for the exploratory nature of this research as it allows for the inclusion of accessible and information-rich participants (Etikan et al., 2016). This was subsequently refined with a quota sampling technique to ensure that key professional profiles were adequately represented in the final sample (Campbell et al., 2020).

The resulting sample was intentionally heterogeneous in order to capture a plurality of perspectives. It comprised healthcare personnel, such as hospital directors, department heads, and nursing coordinators; educational staff, including hospital school teachers, regional school principals, and a delegate from the Regional School Office (USR, from the Italian); and staff from families associations, foundations, and hospitality organizations, such as volunteers, social workers, and representatives from parents' associations active within the hospital.

Specifically, the study involved 22 in-depth semi-structured interviews and one focus group with 6 participants, totaling 28 key informants directly engaged in the qualitative phase. The sample distribution covered eight distinct thematic areas of intervention to ensure a 360-degree view of the pediatric care system:

- Continuity of care: including the director of the Global Health Center, medical heads of Maternity and Neonatal Intensive Care (TIN, from the Italian), nursing coordinators from the Hospital-Territory Continuity Office, and school-health facilitators.

- Hospital school and educational services: including the USR delegate, principals of hub schools, hospital teachers (primary and kindergarten), and educators from the Neuropsychiatry Department.

- Families and associations: including the director of the Family Center and representatives from four different parents' associations.

- Hospitality system: coordinators of external hospitality facilities (e.g., Ronald McDonald House, *Associazione italiana contro le leucemie-linfomi e myeloma* – AIL) and reception services.

- Cross-cutting areas: professionals involved in care of professions, interprofessional collaboration, organizational ecology, and research.

All participants were fully informed of the research objectives and provided informed consent prior to their involvement. Access to the field and participants was facilitated by the internship tutor, a nursing coordinator holding an organizational position within the hospital who acted as a gatekeeper and guarantor of the research activities.

2.3. *Instruments*

Our empirical foundation was 800 hours of participant observation. This prolonged immersion allowed for a live understanding of the interactions, practices, and organizational dynamics that define the pedagogical interventions at AOU Meyer. The

researcher wasn't just watching; he was actively involved in the daily life of the UCOT and Hospital school, constantly reflecting to capture the nuances of relationships and the meanings people attached to their work.

This hands-on work was documented in a field diary, which was our essential tool for processing observations and engaging in self-reflection. It captured the facts, the researcher's thinking, and emerging interpretations. The diary was not merely a chronological log but a reflective tool guided by specific prompts structured around the three analytical levels:

- Micro: focusing on professional needs, specific competencies, and individual interactions.
- Meso: focusing on organizational contexts, multidisciplinary coordination, and communication flows.
- Macro: focusing on institutional mission, policy alignment, and systemic advocacy.

We backed this up by collecting 154 critical incidents (anecdotal records) – specific events we flagged as particularly significant for understanding the case (Yin, 2018). These records focused on "target behaviors" and complex interactions, transcribed faithfully to avoid immediate judgment, providing concrete empirical material for analysis.

To corroborate these observational findings with formal evidence, a rigorous analysis was conducted on a vast corpus of institutional documents. This corpus included operational protocols (e.g., Procedure AZI144 on complex discharges), internal evaluation reports (e.g., Joint Commission International - JCI- mock survey summary of November 2024), activity data reports, and institutional statutes, providing insight into the official organizational framework.

Furthermore, the study utilized 92 monitoring grids, structured observation tools designed to track the frequency of specific indicators across the micro, meso, and macro levels. They allowed for the quantitative assessment of phenomena such as the frequency of interprofessional meetings, the presence of educational topics in discharge planning, and the activation of network protocols.

The 22 semi-structured interviews were conducted based on a flexible protocol defining "areas of interest" rather than rigid questions. The core areas explored included:

- Professional biography: Reconstructing training paths and career choices to understand the professional's background.
- Context reading: Analyzing the interviewee's perception of organizational goals, obstacles, and resources within their specific unit.

— Collaboration: Investigating the quality and structure of relationships with the hospital, schools, and territorial services.

A focus group was conducted to explore the specific theme of “facilitating complex discharges”. This session involved a multidisciplinary comparison between the AOU Meyer model and the AOU Careggi model, serving to highlight systemic discrepancies and generate collective proposals for organizational improvement.

2.4. *Data analysis strategies*

To ensure the reliability of the findings and address the complexity of the dataset, a rigorous analytical framework was applied, integrating inductive and deductive procedures.

1. Qualitative analysis: Thematic and deductive qualitative data derived from interview transcripts and field notes were subjected to thematic analysis, following the iterative phases outlined by Braun & Clarke (2006). This process began with a deep familiarization with the raw data through repeated reading, followed by the generation of initial codes to label relevant features. These codes were subsequently collated into potential themes, such as ”care of professions”, “ecological organization”, and “continuity of care”, which were then reviewed and refined against the entire dataset to ensure they accurately represented the participants’ narratives.

2. Complementing this inductive approach, deductive content analysis was employed to align the empirical findings with the study’s theoretical framework. A pre-defined coding matrix, established via a prior systematic literature review, mapped codes onto a multi-level structure:

- The micro level: focusing on “experiences and training”, “competencies”, and “professional needs”.

- The meso level: examining “function of service”, “organizational aspects and conditions”, “interprofessional collaboration”, and “networking”.

- The macro level: defining the overarching “role of the pedagogist”.

3. Quantitative integration to provide a quantitative dimension to this qualitative inquiry. The analysis included calculating the frequency of specific codes across the 92 monitoring grids and interview transcripts. This allowed the researcher to measure the prominence of specific themes; for instance, identifying that “organizational aspects” appeared with significantly higher frequency than “pedagogical supervision”, highlighting a systemic gap. Furthermore, a co-occurrence analysis was conducted to identify significant correlations between categories, such as the strong relationship observed between “organizational conditions” and “interprofessional collaboration”.

The validity of the results was ensured through a triangulation strategy that avoided analyzing data sources in isolation. The researcher cross-referenced “declared

practices" from interviews with "enacted practices" witnessed during observation and "formalized practices" found in institutional documents. For instance, the need for pedagogical coordination expressed in interviews was validated against the observation of fragmented communication in critical incidents and the absence of specific protocols in the documentary analysis. To mitigate researcher subjectivity, the analysis process included inter-coder comparison strategies, where interpretations of critical segments were reviewed against the defined operational categories to ensure consistency and rigor in the attribution of meaning.

3. Results

Through a systematic triangulation strategy – comparing declared practices (interviews), enacted practices (observation), and formalized practices (documents) – this section aims to unveil the convergences, divergences, and tensions that define the pedagogical role.

The analysis will be structured according to the three conceptual levels that guided the research:

- The macro level, which examines the systemic, political, and institutional positioning of the pedagogical role, interrogating its strategic function within healthcare governance and its interaction with the community.
- The meso level, which analyzes the organizational ecology, the dynamics of interprofessional collaboration, and the structural conditions that facilitate or hinder the integration of pedagogy into care processes.
- The micro level, which outlines the competency profile of the individual professional, their training and support needs, and their identity as a reflective practitioner.

3.1. *The macro level: The pedagogical role as a systemic and political function*

The investigation at the macro level sought to answer the fundamental question not only of what the pedagogist does, but why their existence is strategically necessary for the health system as a whole. The data converge in defining this role not as an additional operational function, but as an agent of institutional coherence and an essential political mediator.

The documentary analysis at the macro level provides a clear vision of the institutional mission. The AOU Meyer corporate statute and the results of the JCI mock survey formalize an unequivocal commitment to a holistic, salutogenic, and "family-centered" care model. The very existence of structures like the Family Center is the architectural translation of this philosophy. This is the "macro-declared": an institution that places the patient and the family at the center of a continuum of care.

However, qualitative data from interviews and critical incidents reveal a “macro-perceived” reality that is significantly more fragmented. Interviews with parents’ associations and care continuity professionals highlight a critical gap, a true “void” (a term that emerged in the interviews), at the moment of the hospital-to-community transition. Families, accustomed to the intensity of hospital care, experience “disorientation” and “overload” upon returning home.

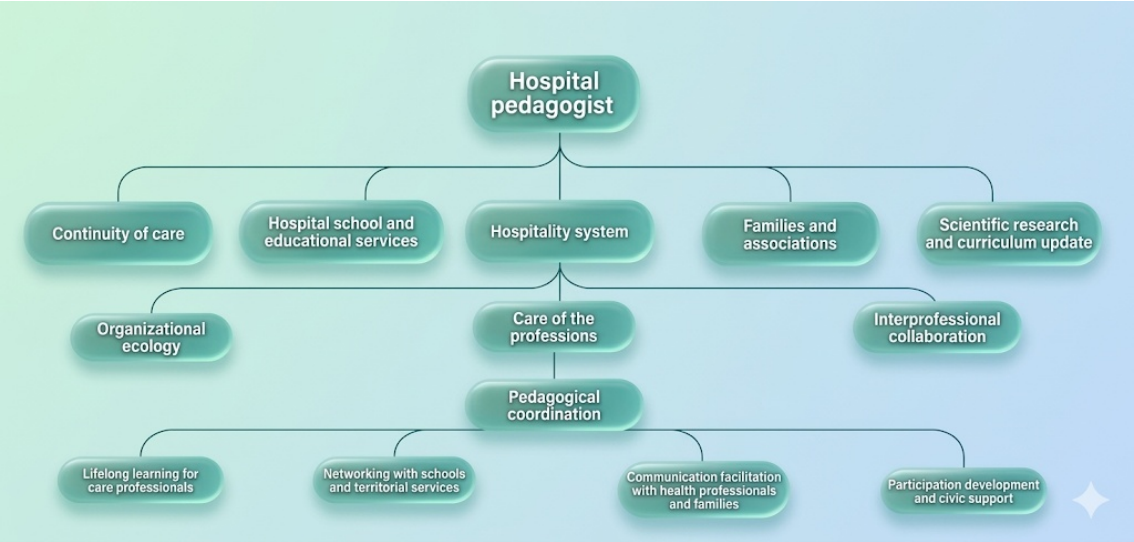
This divergence between the formalized holistic mission and the perceived external fragmentation defines the first space for the pedagogical role’s intervention at the macro level. The analysis of interviews with school principals and the USR delegate confirmed this disconnection, citing “bureaucratic complexities” and a chronic “difficulty in inter-agency dialogue” between the health and school systems. The healthcare system and the social/school system operate as two parallel worlds that struggle to communicate.

In this scenario, the macro role of the pedagogist emerges as that of an “agent of coherence” and advocacy. Parent associations, as emerged from the interviews, currently fulfill this function in a vicarious and voluntary manner. They act as "bridges" and advocacy actors, filling institutional gaps and bringing the “voice” of real needs into decision-making forums (as observed in the Participation Committee meeting)

The analysis of thematic categories reveals that “service function” and “interprofessional collaboration” are perceived as closely correlated with the “potential role of the pedagogist”. This suggests that the interviewed professionals intuitively identify the need for a figure who operates above the individual departmental functions (meso) to ensure the alignment of the entire system (macro). The pedagogist is seen as the potential “orchestrator of complex processes”, a figure not limited to executing care continuity, but one who contributes to designing it at the governance level.

One of the most significant findings of this research emerges from the triangulation between interview data and observational monitoring data. While the interviews and critical incidents are saturated with references to the need for better hospital-community linkage and systemic support for families, the analysis of the monitoring grids reveals an almost total absence of formal indicators for these macro functions.

FIGURE. 1
Areas of intervention of the hospital pedagogist



SOURCE: Prepared by the authors.

As indicated in Figure 1, the pedagogist acts as a guarantor of coherence between the institution's ethical mission and its practical application, constructing the necessary networks (hospital, schools, social services) to transform continuity of care from an exception into a structured practice.

Key findings include:

— Continuity of care: A significant gap persists between hospital and territorial services. While AOU Meyer's UCOT effectively coordinates logistical and sanitary discharge aspects, data indicates a lack of systematic integration of educational needs and school dialogue into the discharge planning process.

— The hospital school: Although universally recognized as a vital asset for normalization and patient well-being, the hospital school faces structural hurdles. These include bureaucratic delays, a lack of psycho-pedagogical supervision, and interprofessional tensions where medical staff may undervalue the therapeutic dimension of education.

— Families and associations: Patient associations play a critical role in mitigating the "care vacuum" experienced by families post-discharge. However, despite offering essential experiential knowledge and advocacy, their efficacy is often undermined by resource scarcity and institutional cultural resistance.

— Extended hospitality and research: The pedagogical remit extends to managing the hospitality system, converting residential networks into communities of practice and offering parental guidance. Scientific research is identified as the prerequisite for professional legitimation. Rigorous documentation and action research are essential to provide the empirical evidence needed to validate the

profession within a biomedical context and to advocate effectively for children's rights.

3.2. *The meso level: Organizational ecology and interprofessional collaboration*

The quantitative analysis of thematic categories is unequivocal: "interprofessional collaboration" and "organizational aspects and conditions" are among the most frequently cited categories across all interview groups. From healthcare staff to hospital school teachers, from welcome service coordinators to associations, a universal consensus emerges on the need to work in an integrated manner.

However, triangulation with observational and documentary data reveals a much more problematic reality.

- Documentary data: The JCI mock survey identified specific criticalities in the "Effective communication (IPSG.02)" standard, particularly in the handover. This indicates a systemic failure in information transmission even among healthcare professionals.

- Observational data: Participant observation revealed a "discontinuous participation" of physicians and psychologists in the hospital school operational committees. This is not a detail, but a symptom of a cultural hierarchy. Even more potent is the critical incident from September 16, which describes the verbal interaction between an educator and a nurse. The nurse's comment ("increased workload" due to the kindergarten) reveals a misunderstanding of the pedagogical role, seen not as an integral part of care, but as an ancillary activity and an obstacle to the healthcare workflow.

- Interview data: Interviews with hospital school teachers confirm this perception, lamenting the need to be "proactive" in seeking information from the wards and a sense of their educational role being "underestimated" by other professional figures.

The cause of this fragmentation lies not in the ill will of individuals, but in the organizational ecology itself. The analysis of the 92 UCOT monitoring grids offers overwhelming quantitative proof of this cultural asymmetry.

The indicator "Operates within and in conjunction with a multidisciplinary team" has a frequency of 78%, suggesting a high rate of interaction. However, if we disaggregate this data, we see that the indicator "Dialogues with the child's educational reference figures" drops to 23%, and "Contacts the hub schools and/or the patient's school of origin" drops even further to 16%. This triangulation is important: the UCOT (the quintessential meso structure for continuity) is highly effective at coordinating the healthcare team (78%), but its interaction with the educational system (23% and 16%) is significantly less frequent. The organizational ecology, through its own monitoring tools, defines continuity primarily as a healthcare-logistical process, not a pedagogical one. This reinforces the tension observed in the September 16 incident: the nurse acts in coherence with a system that, in its monitoring, marginalizes the educational dimension.

AOU Meyer has invested in creating dedicated meso structures: the UCOT and the Family Center. The analysis of these structures reveals a paradox.

The Family Center is conceived as the “nerve center” for holistic reception. However, interviews with the “hospitality system” staff show an extremely high frequency for “organizational aspects and conditions" (freq. > 230) and “interprofessional Collaboration” (freq. > 180) but a very low frequency for the “role of the pedagogist”. This suggests that, in daily practice, the primary challenge for these structures is logistical and organizational management (managing turnover, conflicts, bureaucracy), which consumes energy at the expense of pedagogical design.

The meso role of the pedagogist thus emerges not as a simple team participant, but as an “organizational architect” and a “cultural mediator”. Their function is not just to participate in multidisciplinary teams, but to design them. They must facilitate the creation of those “dedicated spaces and times for structured discussion” (a need that emerged in the interviews to hospital teachers) that are currently lacking. They must act as a “translator” between the language of healthcare (efficiency, protocol, logistics) and the language of educational care (development, life project, relationship), making pedagogical value visible within organizational processes (meso) and aligning them with the institutional mission (macro).

3.3. *The micro level: Competency profile and sustainability of the “reflective practitioner”*

The interview results, particularly with Hospital School teachers and educators, demolish the idea of the hospital pedagogist as a mere "teacher." The thematic analysis shows that "Competencies" is one of the highest-frequency categories, but these are not primarily didactic (figure 2). The competency profile that emerges is that of a designer of interventions and a facilitator of processes.

FIGURE 2
Hospital pedagogist competencies

SOURCE: Prepared by the authors.

The first, pedagogical-educational design, constitutes the epistemological core of the profession. Its specificity resides in the capacity for educational design at a systemic level, rather than in the mere delivery of instruction. Such competencies presuppose an acute observational ability to discern latent educational needs and contextual resources, coupled with a profound knowledge of developmental psychology and the psycho-pedagogical implications of pathologies. On this basis, the pedagogist designs personalized interventions aimed at supporting the resilience and the continuity of the minor's life trajectory. This is complemented by competencies in coordination, organization, and networking, which represent the strategic foundation of the pedagogist's action at the meso and macro levels. This area includes a capacity for analyzing complex organizational contexts – that is, the ability to decode institutional cultures and communication flows – and a solid competency in project management. The pedagogist acts as a proactive architect of networks, cultivating an effective collaborative network both intra-institutionally, through team building, and inter-institutionally, with schools, local health authorities, social services, and the third sector. The integration of these efforts is made possible by communicative-relational competencies, which serve as the connective tissue of the professional's practice. This competency goes beyond empathy; it's the skill to forge effective working relationships and act as a translator between different professional languages, like the clinical and the pedagogical. Its true test is in the generative management of conflict, turning disagreements into chances to build stronger, shared solutions.

The foundation for all this is reflective and meta-reflective competency, which we call the "competency of competencies". To handle the uncertainty and emotional strain of healthcare, continuous critical self-analysis and learning is essential. This allows the professional to not just cope with complexity, but to transform problems into learning moments for themselves and the organization as a whole.

The analysis identified the opportunity to "invest in a more favorable organizational climate" and to "strengthen corporate communication processes". The pedagogist, with their reflective and group-management competencies, is the ideal figure to guide these processes. Their role becomes meta-professional: it is the professional who "takes care" of the caring team, facilitating "reflection", "shared design", and the "constructive reprocessing of the work experience".

In conclusion, the synthesis of this research's main findings delineates a profile of educational-pedagogical professionalism within pediatric contexts that is characterized by high complexity, marked dynamism, and systemic interconnection. What emerges is the image of a professional called upon to constantly navigate between the individual needs of children and families, the specificities of the operational context, the demands of the healthcare organization, and the challenges of multidisciplinary collaboration (figure 3).

FIGURE 3
Pedagogical leadership, role and organizational factors in healthcare

SOURCE: Prepared by the authors.

4. Discussion and conclusions

The comprehensive analysis conducted within this case study at the AOU Meyer provides an empirical foundation for redefining the educational role within pediatric healthcare. The findings corroborate the initial hypothesis that the pedagogical function in advanced healthcare systems cannot remain ancillary or merely "recreational"; rather, it must evolve into a structural component of the care model.

The transition from a biomedical paradigm to a holistic, person-centered approach (WHO, 2016) has created a new operational complexity. As evidenced by the data collected through participant observation and interviews, the modern pediatric hospital is no longer just a place of clinical treatment but a "convergence zone" where health needs, developmental trajectories, educational rights, and family dynamics intersect. In this dense ecosystem, the fragmentation of interventions remains the primary risk. The hospital pedagogist emerges from this research not simply as a teacher in a ward, but as a strategic asset capable of governing this complexity.

The results of this study suggest that the effectiveness of the pedagogical role is not defined solely by the individual professional's skills (micro level) but by the dynamic interaction between the organizational ecology (meso level) and the institutional mandate (macro level). The discussion that follows analyzes these dimensions, highlighting the tensions, paradoxes, and immense potential of integrating a pedagogical "regie" (direction) into the healthcare system.

One of the most significant findings of this research is the critical disjunction between the strategic potential of the pedagogical function and its current institutional status in Italy. The analysis reveals a "paradox of legitimation": while the holistic mission is formally declared in documents like the AOU Meyer Statute and supported by global guidelines (WHO, 2018), the operational reality is characterized by a lack of a formalized normative framework for the hospital pedagogist.

Consequently, the role of the pedagogist at the macro level is inherently political. The research data indicates that in the absence of a formalized figure, parents' associations often fill the void, acting as advocacy agents. A structured hospital pedagogist would not replace these associations but would serve as their institutional counterpart, translating their specific needs into organizational policies. The pedagogist becomes an "agent of coherence", ensuring that the hospital's declared values (centrality of the child) are respected even under the pressure of efficiency protocols. This involves a continuous process of advocacy, promoting the understanding that time spent on education and play is not "lost time" regarding clinical schedules, but "gained time" for the patient's psychophysical recovery.

In the Italian context, as observed at AOU Meyer, the pedagogical role often relies on the "goodwill" of visionary leadership and the proactivity of individual professionals rather than on a structural mandate. While the AOU Meyer is a center of excellence that invests resources in the Family Center and continuity of care, the pedagogical coordination function remains largely implicit. The research shows that while there is a strong medical and nursing hierarchy, the educational component lacks a parallel chain of command and representation in decision-making boards. This leads to a fragility where the continuity of educational projects is susceptible to budget cuts or leadership changes. The "vacuum" identified by families during the discharge process is a direct symptom of this: without a recognized professional responsible for systemic integration, the burden of connecting hospital, school, and territory falls disproportionately on the parents.

A recurring theme in the interview data and critical incidents is the persistence of a "cultural hierarchy". Despite the emphasis on multidisciplinary teams, the observational data (specifically the 92 monitoring grids) revealed a significant imbalance: while UCOT effectively coordinates nursing and medical staff (78% frequency), the systematic coordination with educational figures drops precipitously (16-23%).

This data point is crucial. It suggests that "continuity of care" is still predominantly interpreted as "sanitary continuity" (drugs, devices, medical appointments) rather than "existential continuity" (school, social life, psychological well-being). The incident recorded on September 16th, where a nurse perceived the kindergarten activity as an "increased workload", perfectly encapsulates this tension. Without a meso-level figure – an organizational architect – capable of mediating between the nomothetic language of medicine (protocols, speed, standardization) and the idiographic language of pedagogy (personalization, time, relationship), these two worlds operate in parallel rather than in synergy.

The research highlights a risk for structures like the Family Center: becoming purely logistical hubs. Managing bed turnover, room assignments for parents, and bureaucratic clearances are necessary tasks, but they consume the vast majority of the staff's time. The "pedagogist as director of care" (*regista della cura*) serves to re-inject meaning into these procedures. At the meso level, the pedagogist's role is to design the organizational environment so that it is "pedagogically enabled". This means:

- Creating spaces for reflection: Implementing the "structured moments of discussion" requested by hospital teachers in the interviews. These are not just administrative meetings but spaces for pedagogical supervision to process the emotional impact of the work.

- Designing protocols: Creating formal protocols for the "educational handover" just as there are protocols for the clinical handover. This ensures that when a child is discharged, the school information travels with the clinical letter.

- Team building: Facilitating the integration of diverse professionals (educators, psychologists, nurses) to move from a multidisciplinary approach (working side-by-side) to an interdisciplinary one (working with shared goals).

The study confirms that the hospital school is the operational heart of the pedagogical intervention, but it is currently under-utilized as a systemic resource. It often functions as a "service" provided to the child rather than a "partner" in the cure. The discussion points toward a shift where the pedagogist coordinates the Hospital School not just as a teaching staff, but as a strategic hub. This involves overcoming the "isolation" of the classroom by integrating teachers into the ward rounds and discharge planning meetings, a practice observed in some international contexts but inconsistent in the case study. The research identified the discharge process as the most critical vulnerability in the current system. It is the moment where the "bubble" of hospital protection bursts. The pedagogist's role here is operationalized through the educational discharge plan. This proposed instrument would complement the medical discharge letter, detailing not the drugs to be taken, but the strategies for school reintegration, the peer-group dynamics to watch for, and the family support resources available in the territory.

The study characterizes this role through the concept of *diffused and reflective leadership*, a dual approach necessitated by the unique dynamics of the hospital environment. First, leadership is "diffused" because the pedagogist typically operates without formal hierarchical power over medical staff; consequently, their influence relies on "authoritativeness" derived from competency rather than command-based "authority", requiring them to lead through process facilitation, conflict mediation, and the practical demonstration of educational utility. Second, the role is inherently "reflective" due to the emotionally saturated nature of healthcare, where professionals face constant suffering and high-stress decision-making. In this context, the pedagogist employs meta-reflective competencies to act as a team stabilizer, promoting resilience and motivation among staff.

4.1. *The Spanish model: A comparative benchmark*

To fully understand the potential of the pedagogical role, it is essential to look beyond national borders. The comparison with the Spanish system, specifically the model observed in Madrid hospitals during the broader research project, offers a stark and illuminating contrast.

Spain has moved beyond the phase of "experimentation" to achieve "institutionalization". The figure of the *director de aula hospitalaria* (hospital school director), formalized by decrees such as *Decreto 127/2017*, represents a professional profile of the second level with a clear pedagogical matrix. Unlike the Italian context, where educational coordination is often fragmented among various cooperative, state, and volunteer entities, the Spanish director holds a specific mandate for:

- Administrative and financial management: Having a dedicated budget and autonomy allows for long-term planning rather than short-term project-based survival.
- Staff leadership: The director coordinates the teaching staff, ensuring a unified pedagogical approach across different wards and pathologies.
- Inter-institutional networking: Crucially, this figure is legally empowered to coordinate with external schools and social services, acting as a recognized authority in the transition process.

This international comparison highlights the specific gap in the Italian system. In Italy, the "school in hospital" teachers are often detached from the hospital's organizational chart, reporting to external school administrators who may not understand the clinical context. The Spanish model demonstrates that when the pedagogical role is elevated to a managerial/directorial level (macro), it acts as a stabilizer for the entire care system, ensuring that the right to education is not just a declaration but an operational reality.

4.2. *Limitations and perspectives of the study*

While the findings provide a compelling argument for the institutionalization of the pedagogical role, several limitations must be acknowledged to contextualize the results properly.

- Single Case Study Bias: The AOU Meyer is a "best-case scenario" in the Italian landscape, boasting resources and a history of humanization that are not average. Consequently, the findings regarding the potential of the role are robust, but the transferability to smaller, under-resourced general hospitals requires careful adaptation. The model described relies on a "critical mass" of patients and professionals that exists in a University Research Hospital (*Istituto di ricovero e cura a carattere scientifico* – IRCCS) but may be absent elsewhere.
- Sample limitations: While the study engaged a diverse range of professionals, the direct voice of the patients (children and adolescents) is present only

indirectly through the mediation of adults (parents, teachers, nurses). A direct investigation into the children's perception of the pedagogical figure would have added a crucial phenomenological layer. Furthermore, the selection of interviewees, primarily those already involved in the care network, might have introduced a positive bias regarding the perceived utility of the role.

— Methodological constraints: The use of monitoring grids provided quantitative data, but the six-month duration of the internship was insufficient to measure long-term outcomes. Longitudinal data would be necessary to empirically prove that the presence of a pedagogist leads to quantifiable improvements in clinical outcomes (e.g., reduced length of stay) or educational retention.

The discussion of results opens up several trajectories for future development, moving from the "what is" to the "what should be". The primary challenge is political. The current reliance on precarious contracts, project-based funding, or volunteerism for educational coordination is unsustainable. The future perspective requires a top-down shift: the Ministry of Health and the Ministry of Education must collaborate to define a national profile for the hospital pedagogist/director, drawing inspiration from the Spanish legislation (*Decreto 127/2017*). Without this, the continuity of care will remain a lottery based on geography.

To survive in the evidence-based medicine (EBM) environment, hospital pedagogy must evolve into evidence-based pedagogy. The research highlights a desperate need for standardized indicators. Future studies should focus on validating metrics that can capture the intangible benefits of education: How do we measure the impact of a school lesson on a child's pain perception? How do we quantify the reduction of parental anxiety due to pedagogical counseling? Developing these metrics is the prerequisite for obtaining structural funding.

The complexity of the competency profile described (micro level) has direct implications for university training. A general degree in Pedagogy or Primary Education is insufficient.

Finally, the "integrated care model" fails if the territory is not receptive. The pedagogist must not only work within the hospital but project outwards. Future perspectives involve the hospital pedagogist acting as a trainer for mainstream school teachers, preparing them to welcome back the sick child. This "exporting of competency" is vital to creating an inclusive society that accommodates fragility.

4.3. *Conclusions*

This study set out to explore the pedagogical role within the high-complexity setting of the Meyer Children's Hospital. The investigation has spanned the institutional frameworks (macro), the organizational dynamics (meso), and the individual competencies (micro) that define this professional figure.

The overarching conclusion is that the hospital pedagogist is not a luxury for elite hospitals, but a structural necessity for the sustainability and humanity of modern

pediatric healthcare. As medical technology advances, allowing children with complex, chronic, and life-limiting conditions to survive and live longer, the "medical cure" becomes insufficient. These children require a "life care" that supports their development, identity, and education through and beyond the illness.

The case study illustrates that where this role is partially enacted (through the UCOT or Family Center), it generates resilience, coherence, and support. However, it also exposes the fragility of a system where this coordination is not formally recognized. The comparison with the Spanish model offers a clear roadmap: the formalization of a "director" of educational and pedagogical activities is the keystone that stabilizes the entire arch of integrated care.

Ultimately, the hospital pedagogist acts as the guardian of the child's future. By weaving together the threads of clinical protocols, school curricula, and family needs, they ensure that the hospital experience is not a suspension of life, but a chapter of it – managed with dignity, continuity, and hope. The path forward demands that institutions recognize this value, transforming the pedagogist from an invisible glue into a visible pillar of the healthcare system.

6. References

Bateson, G. (1977). *Verso un'ecologia della mente*. Adelphi.

Boffo, V. (2022). La cura della formazione e la relazione educativa. In Boffo, V. (ed.), *La scuola in ospedale: Tirocinio e formazione degli insegnanti* (pp. 19-36). Editpress. https://flore.unifi.it/handle/2158/1271389

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Bronfenbrenner, U. (1979). *The Ecology of Human Development: Experiments by Nature and Design*. Harvard University Press.

Campbell, S., Greenwood, M., Prior, S., Shearer, T., Walkem, K., Young, S., Bywaters, D., & Walker, K. (2020). Purposive sampling: Complex or simple? Research case examples. *Journal of Research in Nursing*, *25*(8), 652-661. https://doi.org/10.1177/1744987120927206

Creswell, J. W., & Clark, V. L. P. (2018). *Designing and Conducting Mixed Methods research*. Sage Publications.

Decreto 127/2017, de 24 de octubre, del Consejo de Gobierno, por el que se establece la estructura orgánica de la Consejería de Educación e Investigación, BOCM, No. 255, 26 October 2017.

Del Gobbo, G. (2018). Approccio olistico tra ricerca e azione educativa. Riflessioni

introduttive [A Holistic Approach Between Research and Educational Action: Introductory Reflections]. In P. Federighi (ed.), *Educazione in età adulta. Ricerche, politiche, luoghi e professioni* (pp. 112-122). FUP.

Emerson, R. M., Fretz, R. I., & Shaw, L. L. (2011). *Writing Ethnographic Fieldnotes* (2nd ed.). University of Chicago Press.

Etikan, I., Musa, S. A., & Alkassim, R. S. (2016). Comparison of convenience sampling and purposive sampling. *American Journal of Theoretical and Applied Statistics*, *5*(1), 1-4.

Ferraro, S. (2013). Dalla scuola in ospedale alla scuola a domicilio… e oltre: una sfida possibile [From hospital school to homebound education… and beyond: A possible challenge]. *Italian Journal of Educational Technology*, *21*(2), 110-113. https://doi.org/10.17471/2499-4324/104

Ministero della Salute (1998). Circolare Ministeriale 353/1998. https://www.edscuola.it/archivio/norme/circolari/cm353_98.html

Ministero della Salute (2024). *DIRETTIVA GENERALE PER L'ATTIVITA' AMMINISTRATIVA E LA GESTIONE.* https://www.salute.gov.it/new/sites/default/files/imported/C_17_pubblicazioni_3417_allegato.pdf

UN = United Nations (1989). *Convention on the Rights of the Child*. https://www.ohchr.org/en/professionalinterest/pages/crc.aspx

UNESCO (1994). *The Salamanca Statement and Framework for Action on Special Needs Education*. https://unesdoc.unesco.org/ark:/48223/pf0000098427

WHO = World Health Organization (1948). *Constitution of the World Health Organization*. https://www.who.int/about/governance/constitution

WHO = World Health Organization (2011).*WHO Patient Safety Curriculum Guide: Multi-professional Edition*. https://www.who.int/publications/i/item/9789241501958

WHO = World Health Organization (2016). *Integrated Care Models: An overview*. https://iris.who.int/server/api/core/bitstreams/6eb1da76-189c-4bbd-ac79-62523037ffae/content

WHO = World Health Organization 2018). *Declaración de Astaná (WHO/HIS/SDS/2018.61).* https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration-sp.pdf

Yin, R. K. (2018). *Case Study Research and Applications: Design and Methods* (6th ed.). Sage Publications.