Teaching at the Bedside

An Educational Monograph

For Community-Based Teachers

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**Purpose:** The purpose of this Preceptor Development Program Monograph Series is to provide training in teaching and educational techniques to individuals who teach health professions students in the community setting.

**Target Audience:** This monograph is designed for physicians, physician assistants and nurse practitioners who teach medical students, residents, nurse practitioner students and physician assistant students in the office or hospital settings in North Carolina.

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INTRODUCTION

“Teaching at the bedside” is defined as teaching in the presence of the patient. Sometimes thought to be applicable only to the hospital setting, bedside teaching skills apply to any situation where the teaching occurs in the presence of the patient, including the long-term care facility and the office setting.

Teaching at the hospital presents additional challenges and opportunities for the preceptor. The hospital preceptor is often working with a team of learners and frequently has inadequate facilities for teaching. On the other hand, the hospital setting also provides opportunities to expose the learner to a body of knowledge and skills that cannot be taught the office.

This monograph has been developed to explore issues related to teaching at the bedside and review teaching techniques and tips for all who find themselves at the bedside with patients and learners.

The goals for this monograph are to:

1) Review past and recent history of bedside teaching.
2) Discuss the advantages and challenges of teaching at the bedside.
3) Explore strategies for improving teaching at the bedside.
4) Review techniques for bedside teaching in the office setting.
TEACHING AT THE BEDSIDE: Past and Present

The importance of bedside teaching has been discussed throughout the history of medicine.

Like the modern preceptor, Hippocrates (460-370 BC) was both a teacher and a practitioner. The first two principles of his Hippocratic method are: 1) observe all, and 2) study the patient rather than the disease. Although his exact methods of teaching are not known, it is difficult to imagine how the importance of these principles could be communicated unless patients were present during these teaching encounters. The importance of observation and considering the patient and not just the disease are as relevant today and are still best taught in the presence of the patient.

Sylvius (1614-1672), a French practitioner for whom the Sylvian Fissure was named, was one of the first to record his thoughts on teaching on rounds:

“My method (is to) lead my students by hand to the practice of medicine, taking them everyday to see patients in the public hospital, that they may hear the patients’ symptoms and see their physical findings. Then I question the students as to what they have noted in their patients and about their thoughts and perceptions regarding the causes of the illness and the principles of treatment.”
(as quoted in Whitman, 1990: 23)

More recently, Sir William Osler (1849-1920), a renowned clinician and teacher in Canada, England and the United States, became a strong proponent of teaching on rounds and stressed the importance of teaching at the bedside. In 1903 he stated, “How can we make the work of the student…practical…? The answer is, take him from the lecture room, take him from the amphitheater – put him in the outpatient department – put him in the wards” (as quoted in Whitman, 1990: 24-25). He also expounded that there should be “no teaching without a patient for a text, and the best is that taught by the patient himself” (as quoted in Whitman & Schwenk, 1997: 181).

With this historical support for bedside teaching, where are we now? A study in 1964 indicated that less than 20% of teaching on rounds was done in the presence of the patient. In 1978 a similar study demonstrated a decline to 16% of teaching done at the bedside. Given the challenges of modern medicine with shortened hospital stays, increased acuity of illness in the patients and new requirements for oversight and documentation, it is doubtful that the amount of teaching at the bedside has increased. The conference room, nurses’ station or corridor have become the de facto location for teacher/learner interactions at the hospital.

History makes it clear that teaching at the bedside has been a vital component of medical training. We should strive to make it as productive and valuable as possible and to convey the energy and excitement of these past shapers of the profession.
TEACHING AT THE BEDSIDE: Obstacles to Bedside Teaching

If bedside teaching is valuable and important, why does it appear to be declining? A study of potential obstacles revealed that time was considered to be the most significant factor interfering with bedside teaching (Nair, Coughlan, & Hensley, 1998). Pressures to see more patients, shortened hospital stays and competing demands for increased documentation are contributing to this decline.

Preceptors may avoid beside teaching because of concern for patient comfort, yet research has shown that a majority of patients enjoy and benefit from bedside teaching (Nair, Coughlan, & Hensley, 1997; Simons, Bailey, & Zwillich, 1989; Wang-Cheng, Barnas, Sigmann, Riendl, & Young, 1989). When conducted with sensitivity and respect, teaching in the presence of patients can add to rapport and communication. Learners feel that the bedside is an excellent place to learn a wide variety of skills and often value this teaching more highly than their teachers (Nair et al., 1998).

Many teachers may feel uncomfortable in the role of bedside teacher. Lack of experience, unrealistic expectations and discomfort with teaching in the presence of the patient can lead to a reluctance to teach at the bedside. As will be discussed later, there are techniques and approaches that help make bedside teaching more efficient, fun and effective.

THE MANY TASKS OF ROUNDEDING

The bedside is an important location for teaching, but it is not appropriate for all rounding functions. There are numerous functions that need to occur during rounds (see Table 1). Detailed discussion of differential diagnosis or care plan options is best done in a more confidential location. Administrative details and chart work will go more smoothly in a comfortable location away from interruptions.

Presenting patients is usually best performed away from the bedside. Presentations done in the presence of the patient need to be sensitive to the patient and understandable by the patient. The typical format of patient presentation with its medical jargon may intimidate or confuse a patient.

Mini-lectures or detailed discussions of differential diagnosis will almost always include terminology or information that may be confusing or difficult for the patient to understand.

As the attending physician, you will be visiting all patients and this is a prime opportunity for role-modeling and bedside teaching. Although there is an additional opportunity for teaching and role modeling in interactions with families, this can disrupt a more formal planned teaching experience. Judgement is needed on how to incorporate discussions with family members into teaching.
### TABLE 1

**Tasks on Rounds**

<table>
<thead>
<tr>
<th>Work rounds</th>
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<tbody>
<tr>
<td>Determine care plan</td>
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<tr>
<td>Administrative details/ Charges</td>
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<table>
<thead>
<tr>
<th>Chart rounds</th>
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<tbody>
<tr>
<td>Review and sign notes and orders</td>
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<td>Write notes</td>
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<table>
<thead>
<tr>
<th>Teaching rounds</th>
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<tbody>
<tr>
<td>Listening to presentations</td>
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<tr>
<td>Mini-lectures</td>
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<tr>
<td>Teaching interviewing and physical exam skills</td>
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<tr>
<th>Ward rounds</th>
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<tr>
<td>Seeing the patients</td>
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<td>Talking to families</td>
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**TEACHING ON ROUNDS: The Conference Room**

Since all rounding functions are not appropriate for the bedside, the conference room or nurses’ station is increasingly utilized. There are advantages and disadvantages to the use of this location (listed in Table 2). There are also specific strategies to get the most from this teaching.

As stated previously, time is the greatest obstacle to teaching, and if time spent in the conference room or nurses’ station is not budgeted well, there will be little time left for teaching in any other location. It is important for the teacher to direct the focus of the discussion and keep the flow of the many tasks going.

As teacher you must fulfill two roles simultaneously. While listening to a presentation or discussion, you are diagnosing the patient’s condition based on the data presented. At the same time also you need to diagnose the learner – his or her strengths, weakness, omissions and areas for improvement. Recognizing and remembering this dual role is half the battle. One technique is to take two columns of notes during a presentation. In one column list diagnoses and issues related to the patient, and in the second column list issues related to the learner, the presentation, differential diagnosis and care plan. This note-taking method will facilitate both of your roles as well as providing a record of learning and patient care issues to address.
Table 2

<table>
<thead>
<tr>
<th>Teaching on Rounds</th>
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<tbody>
<tr>
<td><strong>Advantages:</strong></td>
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<tr>
<td>Comfortable/ Quiet</td>
</tr>
<tr>
<td>Confidential</td>
</tr>
<tr>
<td>Time efficient</td>
</tr>
<tr>
<td>Good for work rounds, presentation skills and mini-lectures</td>
</tr>
<tr>
<td>Team teaching – Pharmacy, Social Work, Etc</td>
</tr>
<tr>
<td><strong>Disadvantages:</strong></td>
</tr>
<tr>
<td>No patient contact</td>
</tr>
<tr>
<td>Relies on presentation/chart</td>
</tr>
<tr>
<td><strong>Strategies:</strong></td>
</tr>
<tr>
<td>Keep to task and time.</td>
</tr>
<tr>
<td>Diagnose the patient and the learner at the same time.</td>
</tr>
<tr>
<td>Look for (and capture) teachable moments.</td>
</tr>
<tr>
<td>Focus on clinical problem solving.</td>
</tr>
<tr>
<td>Keep topics related to current patient care.</td>
</tr>
<tr>
<td>Keep learning tools handy and use them.</td>
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</tbody>
</table>

Carefully noting patient care and learner issues as they arise will also help identify “teachable moments.” Although any piece of information can be presented to a learner at any time, the impact of this teaching is enhanced if it is relevant to the clinical situation at hand. For example, the role of magnesium deficiency as a cause for refractory hypokalemia can be discussed at any time, but when a patient with hypokalemia is identified, this clinical tidbit is much more meaningful and more likely to be remembered. A quick note on your paper can help you take advantage of this opportunity.

The conference room is perhaps the best place to focus on clinical problem solving. Discussion of an expanded differential is best done away from the patient, where it could be confusing or frightening to the patient. Even if a patient presents with a clear-cut diagnosis, the discussion can be enhanced by “What if?” By changing aspects of the case, you can exercise the clinical reasoning of the learners and help them to consider a larger differential. For example, if a patient with an asthma exacerbation is admitted, the discussion could be expanded to include pulmonary embolus by asking, “What if this patient’s left calf were swollen and tender? How would that change your differential diagnosis and evaluation?” This type of brief discussion can add interest to “routine” cases and foster improved clinical reasoning and allow discussion of additional clinical entities.
Use of the conference room or nurses’ station also allows the teacher to role model the use of additional sources of information. Pharmacy colleagues, social workers and nursing staff can be sources of valuable information and sometimes will attend rounds regularly. Asking appropriate questions of these care team members can foster an interdisciplinary approach for the learner. The preceptor can also role model the appropriate use of texts, journals and computerized sources of information. A frequent problem with learners is that they feel they must carry all medical knowledge in their heads, and this modeling can help foster adult learning and comprehensive care.

Teaching on rounds involves spontaneity. Often one does not know in advance what issues or diagnoses are likely to arise. No one can be expected to speak extemporaneously on all possible topics. When an important issue arises that may benefit from a mini-lecture, reserve some time the next day for a brief review. You may also assign a topic to a learner to present to the group at your next meeting.

TEACHING ON ROUNDS: The Corridor

It may seem that the corridor or hallway provides a location for rounding functions that are best not performed in the presence of the patient, while at the same time allowing ready access to the patient. Many teaching hospital hallways are clogged with clusters of learners craning to hear a case presentation while straining under a load of charts and dodging medicine carts and stretchers. At times these rounds can stretch on for hours and at their worst may be referred to by the learner as “shifting dullness” (after the physical finding related to ascites). At their best corridor rounds remain uncomfortable and at very high risk for violating the patients’ confidentiality.

<table>
<thead>
<tr>
<th>TABLE 3</th>
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<tbody>
<tr>
<td><strong>Teaching in the Corridor</strong></td>
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**Advantages**
- Allows ready access to the patient
- May be needed as a bridge to bedside teaching

**Disadvantages**
- Uncomfortable and tiring
- Many distractions
- Confidentiality very challenging
- Not a good location for chart rounds or work rounds

**Strategies**
- Limit corridor rounding
- Be vigilant of confidentiality
In general the use of the corridor should be limited. While trying to increase your bedside teaching you may find that brief hallway discussions are necessary, but an awareness of confidentiality should be maintained at all times.

TEACHING AT THE BEDSIDE

Teaching in the presence of the patient has several advantages. The presence of the patient strengthens the learning possibilities. As opposed to listening to a presentation or reading off a blackboard, learners have the opportunity to use nearly all of their senses—hearing, vision, smell, touch—to learn more about the patient and their problems. The sterile facts and descriptions from a sterile presentation come alive and are tangible. These characteristics alone can help the learner remember the clinical situation. I suspect that you might be able to vividly recall certain patients that you saw early in your training: the first patient you admitted with diabetic ketoacidosis—the fruity smell of the breath, the air hunger of Kussmaul respirations, the decreased skin turgor. These experiences create hooks upon which a great deal of clinical learning can be hung for long-term storage and ready recall.

The presence of the patient allows for clarification of the history and physical. The case presentation is the result of a great deal of processing and interpretation by the learner. The bedside visit allows the teacher to clarify and confirm key aspects of the history and physical. Was the presentation of the characteristics of the patient’s pain accurate? Was an abdominal bruit present in this patient with a hypertensive emergency? Confirming this data is crucial to patient care and also provides an important chance to mold the learners’ clinical skills if performed in their presence.

Bedside teaching is very well suited for using role modeling as a teaching technique. Although it is possible to describe and discuss how to ask a question well or how to demonstrate sensitivity to a patient’s comfort and concerns, it can be far more effective to demonstrate those skills and techniques in front of the learner. The learner may be more apt to do as you do than as you say, and the positive results from good rapport and technique speak for themselves.

There are some perceived disadvantages of bedside teaching. There is no question that it takes more time. Given how effective it is as a teaching strategy, how can you find time to teach at the bedside? One strategy is to avoid duplication. If an issue related to the history or physical exam comes up in the conference room, save that time for a bedside visit. If you are going to see a new admission after the conference room session, bring at least one learner with you. We will discuss more strategies on how to incorporate bedside teaching into a busy day in a later section. The truth remains that if you want time to do bedside teaching, you will need to actively plan for it.
TABLE 4

Teaching at the Beside

Advantages

Strengthens learning
Allows clarification of history and physical in the presence of the learner
Allows teaching of history and physical skills
Allows role modeling

Disadvantages:
Takes time
Potential patient discomfort
Requires specific skills and techniques

Strategies

Go to the bedside with specific purpose.
Teach history and physical exam skills.
Teach observation.
Maintain a comfortable and positive environment for the patient and the learners.
Everyone should feel better after.

A concern for patient comfort is often expressed when discussing bedside teaching. Several studies have shown that a majority of patients enjoyed the experience and felt that they understood their problems (Nair et al., 1997). It seems certain though that patient comfort is dependent upon what is done at the bedside and how it is done. Table 5 lists several strategies to foster patient comfort during bedside teaching (Weinholtz & Edwards, 1992).

TABLE 5

Patient Comfort Issues

Provide advance notice of visit.
Limit length of time for patient comfort.
Explain all examinations and procedures to the patient.
All discussions and communications should be explained and understandable to the patient.
Avoid or modify presentations at the bedside.
Visit the patient after rounds to answer questions and thank him/her.
If possible, one should provide the patient with advance notice of a bedside visit with a brief discussion of its purpose and what to expect. The time spent at the bedside should be limited, probably to a maximum of 15 or 20 minutes. The teaching session can be very tiring for the patient, especially since hospitalized patients are more acutely ill now than they have been in the past.

All procedures that are to be performed should be explained to the patient, even something as simple as a heart exam. In addition any discussion or communication about the patient should be understandable by the patient and should be explained to the patient. For this reason, one should avoid presentations at the bedside. Presenting about the patient in the third person can be demeaning and confusing for the patient. Extensive theoretical discussions may be very difficult to explain to the patient.

The bedside is an excellent place to teach history taking and physical exam skills. An additional skill that is often neglected is observation. Important clues to the patient’s illness, disease, or response to being hospitalized may often be found in the room or at the bedside. Snacks on the diabetic patient’s bedside table, blood streaked sputum in the emesis basin of a patient with cough and weight loss, or a Jehovah’s Witness pamphlet on the bedside table can shed important light. The bedside visit is the time to teach and practice careful observation.

Bedside teaching is more efficient and effective when done with a specific purpose in mind. Use the list you created in the conference room to identify the issues you wish to review with the patient or physical exam findings you wish to confirm. What teaching opportunities are presented? Limiting the focus of the bedside visit will help control the time spent and make the visit more efficient.

After the teaching session is concluded, a learner or the teacher should return briefly to see the patient to answer any questions that may have arisen as a result of the visit and to thank the patient for his or her time and assistance.

It is important to maintain a comfortable environment for all participants. As discussed, the patient’s comfort is a vital consideration. Learners’ comfort is important too. The bedside visit is not the place for pointed questioning or criticism of learners. This should be a place for positive learning. By the same token, the preceptor should feel as comfortable as possible in his or her role as bedside teacher. Avoid teaching topics that you are less comfortable with. Use the skills and attitudes that come naturally to you most often, and gradually hone and add new skills with repeated visits to the bedside. It is said that an episode of bedside teaching is successful only when everyone involved feels better afterward – patient, learners and teacher (LaCombe, 1997).
BEDSIDE TEACHING: Getting Started

At this point we hope that you see the unique value of the bedside as a site for teaching. If you are already doing some bedside teaching, we hope that you have inspiration and ideas on how to improve your teaching. If you do not already do some bedside teaching, the primary obstacle is getting started. Do not set unrealistic expectations. You may not have the luxury of a full half-day spent moving from one stimulating clinical case to another accompanied by a group of enthusiastic and appreciative learners. The key to doing more bedside teaching is to start small.

First, budget some time for going to the bedside. Find a time when you are going to see a patient anyway and make this a teaching visit by bringing one or more learners and entering the room with a purpose. Even if you can only do it once or twice a week, you have opened the door. This may add a little time to that normally spent with the patient, but could provide a significant learning experience.

You may look at your patient list and feel that there are no interesting teaching opportunities. Diagnoses that seem old hat to you may be new for your learner. All patients, whatever their diagnoses, have histories and physical findings. A review of a good normal exam can be valuable from time to time, and physical findings that are not related to the diagnosis could be exciting for a learner (such as a benign seborrheic keratosis, a torus palatini, or an accessory nipple). More routine cases are a good time to strengthen observation skills. There is teaching and learning in any encounter.

If you are working with a team of learners, you do not need to have the entire team with you to do bedside teaching. Take one learner with you to see a new patient whom he or she has admitted. Ask another learner to accompany you when you need to discuss a case with a family after rounds are completed. These less formal instances are still bedside teaching and can be very valuable.

All the responsibility need not fall to you alone. Get your learners involved in selecting and presenting patients. Inform learners that they will be asked to point out three physical findings on a patient on bedside rounds the following day. Inform a skilled learner in advance that you would like him or her to demonstrate a specific technique at bedside teaching rounds. Have learners select the focus for a bedside visit or conduct a bedside visit for their peers.

In modern medicine we are less reliant on our physical exam skills, and as a result they are less finely honed. Bedside teaching is an opportunity for the preceptor to focus more energy on these clinical skills. It may require some brushing up, so start small. Select an area of interest and read a little. Dust off your medical school text on physical diagnosis and stash it at the nurses’ station or in the conference room for your and learners’ reference. Some additional focus and bit of practice will polish up those skills quickly.
Table 6

<table>
<thead>
<tr>
<th>BEDSIDE TEACHING: Getting Started</th>
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<tbody>
<tr>
<td>Budget time for bedside teaching.</td>
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<tr>
<td>Start small.</td>
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<tr>
<td>Use the material you have.</td>
</tr>
<tr>
<td>Involve learners in bedside teaching.</td>
</tr>
<tr>
<td>See one or two new admissions at bedside.</td>
</tr>
<tr>
<td>Review your own physical exam skills.</td>
</tr>
<tr>
<td>Have references on H&amp;P skills readily available.</td>
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TEACHING AT THE BEDSIDE: The Office Setting

There are significant opportunities for teaching in the presence of the patient in the office or ambulatory setting. In the typical interaction, the learner sees the patient first, presents the patient to the preceptor outside of the exam room and then both return to the room to complete the visit. One can vary this order and all of these components allow chances for bedside teaching.

Although typically the learner sees the patient first, seeing the occasional patient together can allow an opportunity for significant role modeling. Although shadowing is usually considered a technique for early learners, it may be judiciously employed with more higher-level learners to demonstrate advanced techniques of managing the visit, advanced questioning and dealing with multiple problems presented by the patient. The outpatient preceptor can often predict the challenges that certain patients will offer and can discuss in advance the goals and strategies planned for the encounter so that the learner can be actively analyzing the interaction.

As discussed in rounding techniques, it is possible to have the learner do his or her presentation in the presence of the patient. This technique requires some preparation. The learner should already be fairly adept at presentation and should be informed in advance that this technique will be used. He or she should be encouraged to use terms that are likely to be understood by the patient. The patient should be instructed to be an active part of the presentation, clarifying or correcting parts of the presentation as appropriate. Presenting at the bedside requires careful patient selection, but can be an efficient, useful and enjoyable technique.
**Table 7**

### OUT-PATIENT BEDSIDE TEACHING

#### HISTORY TAKING
- Advanced shadowing.
- Select patient in advance.
- Discuss anticipated issues and planned technique.
- Instruct learner to be active observer and to critique the visit.

#### PRESENTING IN THE PRESENCE OF THE PATIENT
- Learner should be skilled at basic presentation.
- Inform learner in advance.
- Learner should use language understandable to patient.
- Patient should be actively involved in clarifying or adding to presentation.

#### THE VISIT WRAP-UP
- Allow learner to ask additional questions or clarify points.
- Review physical exam and teach techniques.
- Learner provides medication instruction and patient education to patient.
- Role model the clinician/patient relationship.
- Thank the patient for his/her time and teaching.

Returning to the room to complete the visit invites the use of a variety of techniques. The learner may be given the opportunity to ask additional questions or clarify points that arose in the discussion of a presentation. This allows the preceptor to observe immediately how the learner responds to feedback and advice. Role modeling the doctor/patient relationship is a valuable component of the wrap-up portion of the visit. The learner can be given the opportunity to provide medication or patient education, allowing the preceptor to observe these skills. As at the bedside, it is important to thank patients for their help and their contribution to teaching.

### TEACHING AT THE BEDSIDE: Conclusion

Bedside teaching has a long and venerable history and with good reason. Teaching in the presence of patients provides unique and valuable opportunities to integrate the knowledge and skills of medicine for the direct benefit of the patient. The teacher is able to role model skills and attitudes which are vital, but hard to communicate with words. Modern medicine has placed additional demands on all parties involved, but
that is insufficient reason to abandon a teaching tradition that spans several millennia. We must renew and increase our efforts to pass on this tradition of medical education.

REFERENCES


OTHER RESOURCES


RELATED PRECEPTOR DEVELOPMENT PROGRAM TOPICS

The Effective Preceptor
Teaching Styles/ Learning Styles
POST-TEST QUESTIONS:

1.) Beside teaching has been promoted throughout the history of medicine. Which of the following statements in not correct?

   A) The patient has been considered an indispensable component of clinical teaching.
   B) Bedside teaching appears to be declining.
   C) Recent changes in medical care are promoting bedside teaching.
   D) The conference room and corridor are the chief sites of hospital teaching.

2) Which of the following is not an obstacle to bedside teaching?

   A) Perceived lack of time.
   B) Concern for patient comfort.
   C) Teacher discomfort.
   D) Learner disapproval.

3) Not all rounding functions are appropriate for the bedside. Which one of the following is most appropriate at the bedside?

   A) Mini-lectures.
   B) Discussion of differential diagnosis.
   C) Teaching history taking skills.
   D) Chart rounds.

4) The conference room can be a useful place to perform some of the functions of hospital rounds and provide teaching. Which of the following is not an advantage of the conference room?

   A) Time efficiency.
   B) Confidentiality.
   C) Comfort and lack of distractions.
   D) Good for teaching history taking and physical exam.

5) There are many advantages to the use of the bedside for clinical teaching. Which of the following is not an advantage of bedside teaching?

   A) The learner is able to practice using all his or her senses.
   B) The preceptor can clarify and confirm key portions of the history and physical.
   C) Teaching at the bedside is time efficient and easy to do.
   D) The preceptor can teach by role modeling positive behaviors.
6) Concern for patient comfort is considered an obstacle to bedside teaching. Research has shown that patients often enjoy and benefit from bedside teaching. Which of the following strategies would be unlikely to promote patient comfort?

A) Sessions should be long enough to cover all issues in depth.
B) Advance notice of visit should be provided to the patient.
C) The patient should be able to understand what is said and discussed.
D) A visit should be made at the end of rounds to answer questions and thank the patient.

7) The challenges to increasing the amount of bedside teaching done can seem overwhelming. Which of the following strategies for getting started with bedside teaching is incorrect?

A) Set aside time for going to the bedside.
B) Begin with small manageable goals.
C) Wait for exciting cases before you begin.
D) Involve the learners in selecting cases and coordinating visits.

8) Which of the following statements is correct?

A) Bedside teaching is restricted to the hospital setting only.
B) Presentations at the bedside need not be modified.
C) Shadowing should only be used for early students.
D) Patients can provide useful clarification and feedback for the learner.

9) True or False: The hospital corridor is an efficient and practical place for most rounding functions.

10) True or False: Bedside teaching is a useful teaching technique as well as a longstanding tradition of medical education.
POST-TEST ANSWERS AND DISCUSSION:

1) C.

Recent changes in medical care, including shorter hospital stays and changing requirement for supervision of learners have made it more difficult to find the time to do bedside teaching. As a result, bedside teaching has been on the decline and the conference room and corridor are the chief sites of hospital teaching. The patient remains an indispensable component of clinical teaching and modern preceptors need to be creative in continuing the tradition of bedside teaching.

2) D.

Research has shown that obstacles to bedside teaching include perceived lack of time, discomfort of the teacher with teaching at the bedside and concerns over patient discomfort and disapproval. It has been shown that learners and patients value and benefit from bedside teaching.

3) C.

There are many functions of hospital rounds and not all are appropriate for the bedside. Mini-lectures and discussions of differential diagnosis usually involve a significant amount of jargon and information that may not be relevant to the patient and should occur in the conference room. Chart rounds involve reviewing notes, writing notes and writing and signing orders – not a good use of valuable bedside teaching time. Teaching history taking and physical exam skills is very appropriate use of the bedside.

4) D.

The conference room has many advantages. It is a quiet, comfortable location where teaching, care planning, presentations and case discussion can take place confidentially. It is least desirable as a location for teaching history and physical skills – an area where the bedside is best.

5) C.

Bedside teaching can be time consuming and takes practice to do well. However, there are many advantages of doing some teaching at the bedside. Learners are able to use all their senses in learning about the patient and their condition. The preceptor is able to confirm information obtained in the presentation and can role model positive behaviors.
6) A.

When bedside teaching is conducted with respect, patients can be comfortable and benefit from the interaction. Advance notice should be provided as well as a follow-up visit by a team member at the end of the session. Information exchanged should be explained to the patient in a manner that he or she can understand. The preceptor should be sensitive to time, since patients are generally acutely ill and may fatigue easily.

7) C.

To get started in bedside teaching, it is most important to get started! Begin with small manageable goals – brief focused episodes. Schedule in some time to go to the bedside. The responsibility for arranging and selecting cases can be shared with the learners. It is not necessary to wait for some dramatic case or finding. There is something of value to learn at each bedside – it just takes practice to see it.

8) D.

Bedside teaching includes any teaching done in the presence of the patient: both in the hospital and outpatient settings. Presentations at the bedside should be modified from the usual form to make them more understandable by the patient, and the patient should be encouraged to clarify points and provide feedback to the presenter. Shadowing can be used with learners of all levels, especially if it is targeted to demonstrate certain aspects of the clinician/patient relationship.

9) False.

The corridor or hallway is noisy, uncomfortable and is not conducive to confidentiality. The use of the corridor should be avoided as much as possible.

10) True.

Bedside teaching has a long and distinguished history. Through your efforts, the tradition and benefits can continue.
CME POST-TEST and EVALUATION

Teaching at the Bedside Monograph

This Monograph is eligible for one (1) hour of AMA Category 1.

To receive credit: Please complete this Post-Test and Evaluation form and submit it to:

MAHEC Department of Continuing Medical Education
501 Biltmore Avenue
Asheville, NC 28801

NOTE: A processing fee of $10.00 is required from participants located outside MAHEC’s Western North Carolina region.

Name: ______________________________________________  Date ___________
Address: ____________________________________________
_______________________________________________
_______________________________________________
Social Security Number: ___ ___ ___--___ ___--___ ___ ___ ___
Profession:   MD/DO ___ NP___ PA ___  Other: __________________
Specialty: _________________

Type of Learners Taught: (Circle all that Apply)
Medical Students   Residents   NP Students   PA Students Other: ________

POST TEST ANSWERS:
Circle letter that corresponds to your answer for each question

1)   A   B   C   D   6)   A   B   C   D
2)   A   B   C   D   7)   A   B   C   D
3)   A   B   C   D   8)   A   B   C   D
4)   A   B   C   D   9)   T   F
5)   A   B   C   D   10) T   F

Please complete the evaluation form on the next page
PROGRAM EVALUATION: Teaching at the Bedside

Rating Scale Range is 5-1

5=Excellent  4=Good     3=Fair  2=Somewhat Disappointing  1=Poor

Please rate:
1. The monograph overall 5 4 3 2 1
2. The extent to which the learning objectives were met, that you are now able to:
   - Review past and recent history of bedside teaching. 5 4 3 2 1
   - Discuss advantages and challenges to teaching at the bedside. 5 4 3 2 1
   - Explore strategies to improve teaching on rounds & at bedside. 5 4 3 2 1
   - Review techniques for bedside teaching in the office setting. 5 4 3 2 1
3. The relevance of the content to your precepting 5 4 3 2 1
4. The extent to which this format makes it easier for you to participate in preceptor development activities 5 4 3 2 1
5. What did you like about this monograph (in terms of content or format)?

6. What would make it better?

7. List one idea or recommendation gained from this activity that you will use in your future clinical teaching.

Check off additional PDP topics that you are interested in learning more about:

_____ Setting Expectations       _____ Teaching Styles/ Learning Styles
_____ Effective Feedback         _____ Teaching in the Busy Practice
_____ Evaluation: Making it Work _____ Characteristics of the Effective Preceptor
_____ Dealing with the Difficult Learning Situation

Preferred Format(s):
_____ Monograph       _____ World-Wide Web
                     _____ Lecture/Seminar