For the Office-based Teacher of Family Medicine

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Editor's Note: In this month's column, John Langlois, MD, and Sarah Thach, MPH, of the Mountain Area Health Education Center (MAHEC) in Asheville, NC, provide a review of bedside teaching. The content of the article is based on materials developed as a part of the Preceptor Development Program (PDP), a comprehensive program of preceptor development materials supported by Health Resources and Services Administration Grant (1D15PE50119-01). Detailed information on this project can be obtained from the PDP Web site at www.mtn.ncahec.org/pdp.

I welcome your comments about this feature, which is also published on the STFM Web site at www.stfm.org. I also encourage all predoctoral directors to make copies of this feature and distribute it to their preceptors (with the appropriate *Family Medicine* citation). Send your submissions to Paul Paulman, MD, University of Nebraska Medical Center, Department of Family Medicine, 983075 Nebraska Medical Center, Omaha, NE 68198-3075. 402-559-6818. Fax: 402-559-6501. E-mail: ppaulman@unmc.edu. Submissions should be no longer than 3–4 double-spaced pages. References can be used but are not required. Count each table or figure as one page of text.

Teaching at the Bedside

John P. Langlois, MD; Sarah Thach, MPH

"Teaching at the bedside" may be defined as teaching in the presence of the patient. Sir William Osler advocated teaching in front of patients, stating that there should be " . . . no teaching without a patient for a text, and the best is that taught by the patient himself."[1] Bedside teaching skills apply not only to the hospital setting but also to teaching in the long-term care facility and the office setting.

Advantages

Teaching in the presence of the patient has several advantages (Table 1). The presence of the patient strengthens the learning possibilities. Unlike listening to a presentation or reading off a blackboard, learners can use nearly all of their senses—hearing, vision, smell, touch—to learn more about patients and their problems. Sterile facts and descriptions come alive and are tangible. These characteristics alone can help the learner remember the clinical situation.

You may recall certain patients 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 on 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. Did the learner accurately present characteristics of the patient's pain? Was an abdominal bruit present in this patient with a very high blood pressure? Confirming this data is crucial to patient care and also provides an important chance to mold learners' clinical skills if performed in their presence.

Bedside teaching helps preceptors model effective ways of asking questions and demonstrating sensitivity to patients' comfort and concerns. Learners are more apt to do as you do rather than as you say, and the positive results from good rapport and technique speak for themselves.

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From the Mountain Area Health Education Center Family Practice Residency, Asheville, NC.

Disadvantages

There are some perceived disadvantages to bedside teaching. It is possible that it will take additional time. Starting small and using some of the strategies discussed below can minimize this impact.

Preceptors often express concern about patient comfort when considering bedside teaching. Several studies have shown that a majority of patients enjoyed the experience of bedside teaching and felt that they understood their problems better afterward.[2] Patient comfort is dependent on what is done at the bedside and how it is done. Table 2 lists several strategies to foster patient comfort during bedside teaching.

Strategies

Bedside teaching is more efficient and effective when done with a specific purpose in mind. As you discuss cases with learners in the hospital conference room, list issues you want to review with patients or physical exam findings you want to confirm. Identify the specific teaching opportunities presented by each patient. Limiting the focus of the bedside visit will help make the visit more efficient and minimize the length of the visit.

The bedside is the premier location for teaching and reinforcing history and physical exam skills. Bedside teaching also provides an excellent opportunity to enhance the learner's observational skills. Encourage your learners to look for important clues to the patient's illness, disease, or response to being hospitalized. Snacks on the bedside table of the diabetic, blood-streaked sputum in the emesis basin of a patient with cough and weight loss, or a Jehovah's Witness pamphlet on the night stand can shed important light. A bedside visit is the time to teach and practice careful observation.

It is important to maintain a comfortable environment for all participants: patient, learner, and preceptor. The bedside visit is not the place for pointed questioning or criticism of learners. It should provide a positive learning experience. If you want the learner to present in the presence of the patient, tell both learner and patient in advance. Make sure the learner is already fairly adept at presentations and encourage him or her to use terms that the patient will understand. Tell the patient to actively participate in 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.

By the same token, you should feel as comfortable as possible in your role as bedside teacher. Avoid uncomfortable teaching topics. Start out with the skills and attitudes that come naturally to you 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, learner, and teacher.[3]

Getting Started

If you don't already do some bedside teaching, the primary obstacle is getting started. Don't set unrealistic expectations. The key to doing more bedside teaching is to start small. 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 it could provide a significant and enjoyable learning experience.

You may look at your patient list and feel that there are no interesting teaching opportunities. Remember that diagnoses that seem old hat to you may be new for your learner. Common physical findings—a benign seborrheic keratosis, a torus palantini, or an accessory nipple—are exciting for a learner who has never seen these things. Further, review of a good normal exam can be valuable from time to time. More routine cases provide a good opportunity to strengthen observation skills. Teaching and learning can occur in any encounter.

Table 1

Teaching at the Bedside

Advantages
- Strengthens learning
- Allows clarification of history and physical in presence of learner
- Allows role modeling

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

Strategies
- Go to the bedside with a specific purpose
- Teach history and physical exam skills
- Teach observation
- Maintain a comfortable and positive environment for the patient, learners, and you

Table 2

Patient Comfort Issues

- Ask for permission from the patient.
- Limit length of teaching session in front of the patient.
- Explain all examinations and procedures to the patient.
- Make sure the patient understands all discussions.
- Take time at the end to answer patient questions and thank the patient.

With modern medicine, we have become 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 use it as a ready reference for you and your learners. With some additional focus and a little practice, you can polish up these skills quickly and increase your comfort level as a bedside teacher.

Conclusions

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 model vital skills and attitudes and hone learners' history-taking, exam, and observational skills. This valuable tool can be employed in many teaching settings.

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References

1. Whitman N. Creative medical teaching. Salt Lake City: University of Utah School of Medicine, 1990.
2. Nair BR, Coughlan JL, Hensley MJ. Student and patient perspectives on bedside teaching. Med Educ 1997;31:341-6.
3. LaCombe MA. On bedside teaching. Ann Intern Med 1997;126(3):217-20.

Appendix

Resources to Use for Teaching at the Bedside

- Weinholtz D, Edwards JC, Mumford LM. Teaching during rounds: a handbook for attending physicians and residents. Baltimore: Johns Hopkins University Press, 1992 (a useful book that covers the details of rounding and teaching in the hospital setting, 124 pages).
- Sapira JD. The art and science of bedside diagnosis. Baltimore: Urban & Schwartzenberg, Williams & Wilkins, 1990 (a large and detailed work designed to advance bedside skills, no matter what the starting level, 557 pages).
- Degowin EL, Degowin RL. Diagnostic examination, sixth edition. New York: McGraw Hill, 1994 (classic handbook on physical examination skills, 1033 pages).
- Bates B. A guide to physical examination, sixth edition. Philadelphia: Lippincott, 1995 (classic text oriented toward earlier learners. Excellent descriptions of physical exam skills and findings, 711 pages).

Bedside teaching has been defined as, â€œa part of clinical rounds where both student and instructor attends the patientâ€™s bedside to discuss the case and/ or demonstrate a clinical procedure.â€ (Wojtczak, 2003). It provides students with the opportunity to see first-hand how a doctor relates to a patient and to receive supervised instruction and experience of interviewing a patient, physical examination, communication and counselling skills.Â Edinburgh: Churchill Livingstone Elsevier. The MedEdWorld Glossary can be accessed at www.mededworld.org/Glossary.aspx. REFLECTIONS. A space to share your thoughts and experiences of medical education. When we teach at the bedside we can show learners how we approach patients, how we deal with clinical or ethical problems, and how we interact with the patients and the material or findings generated. Our actual performance in outpatients, surgery or on the wards is a very powerful influence. We will look at this role modelling in more detail later in the paper. What are the goals for bedside teaching?Â 50% of clinical teaching time is spent in seminar rooms, 25% at the bedside. Students get to demonstrate their clinical skills for less than 5% of the time. Clinical teachers often have little idea about their studentsâ€™ learning needs, and tend to focus on knowledge objectives which could be met by other means. The patient is at the center of clinical medicine. In order to effectively teach clinical skills a teacher must learn to involve patients in the educational process. It is through this process that learners acquire the skills of observation, communication, examination and professionalism. Despite the importance of teaching with the patient present, many clinical teachers are hesitant to teach at the bedside. This paper describes a workshop on bedside teaching.Â The model includes suggested skills for effective bedside teaching that are arranged into three domains: attending to patient comfort, focused teaching and group dynamics.