

BED SIDE TEACHING: PAST AND PRESENT

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Introduction

Sir William Osler (1849-1920), asserted that there should be “no teaching without a patient for a text, and the best is that taught by the patient himself [1].” The objective of the medical colleges is production of good doctors. Bedside clinical teaching in the presence of patients is the most relevant to this aim. Clinical teaching is concerned with the learning of several clinical skills such as history taking, physical examination, clinical reasoning, decision making, communication, and professionalism (such as learning how to work in teams, and how to interact with the public). More than half of the patients’ problems can be diagnosed after history taking, and up to 75% of these problems can be diagnosed by the end of physical examination [2]. The traditional clinical teacher will maintain that there is no substitute for clinical bedside teaching, while the modern educationalist will opt for multimedia applications, audio CDs and patient simulators [2,3]. Although bedside teaching has been a mainstay of medical education since Osler, it has declined substantially in recent years [4-8].

Where are we now?

There is some consensus among medical educators that bedside teaching in the past 30 years is suffering from significant deficiencies that lead to its decline and poor yield [2].

Very poor success in post graduation examination, and rural health care service rendering is the reflection of poor clinical skill. In the United States, less than 25% of clinical teaching occurs at the bedside and less than 5% of time is spent on observing learners’ clinical skills and correcting faulty exam techniques [9].

In contrast to the close teaching and mentoring relationship between faculty and students 50 years ago, today’s medical students may interact with hundreds of faculty members without the benefit of a focused program of teaching and evaluating clinical skills to form the core of their five-year curriculum [10].

Factors account for this extreme decline

Reasons of decline in clinical teaching might be: a) Patient and teaching-climate related, b) teachers related c) students related and d) teaching methods and curricular factors

a) Patient and teaching-climate related

The numbers of ‘cases’ available for teaching is decreasing as there are other avenues for care outside traditional teaching hospitals like primary care hospitals, private clinics, where there are no students’ teaching programs. Profound advances in imaging and laboratory facilities lead to a shorter length of stay of hospital patients. More patients nowadays refuse to be taught upon for several reasons. Some patients simply fear to be examined by several students as they believe that this may harm their diseases. Most patients are naturally apprehensive when they come to hospitals; this apprehension is more exaggerated when they are seen by a doctor with a large group of students [10]. Some patients simply dislike open discussions of their illnesses in open ward rounds in front of other patients. Teaching environment in Govt. hospitals is almost unsuitable because of crowd, noise, uncontrolled anxious attendants, and limited space to stay even.

The traditional teaching hospitals have become more specialized and less suitable for general medical education [11]. The usual situation, nowadays, is that clinical teachers select only patients with multiple physical signs, and omit patients who present without signs or with signs that do not attract teachers.

b) Teacher related

Senior doctors and teachers are overburden with clinical, administrative, and research duties apart from teaching. As a result the frequency of bedside rounds is decreasing, and the time spent at rounds has become much shorter than in the golden era of bedside teaching [12]. Recently, there is a trend among clinical teachers to specialize in small areas in medicine such as rheumatology, gastroenterology neurology etc. This has led to the emergence of ‘narrow generalists’ with a ‘tunnel vision’ to his own subspecialty. While undergraduate students need only the basic bedside techniques. Moreover there is no formal training for the teachers.

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c) Teaching methods and curriculum related

New educational trend values self-learning, diverting clinical teaching to some extent, away from bedside concentration on signs, and detection of omission of other skills, omission of teaching problem-solving strategies, teaching of communication skills [13].

Teaching of history-taking is a commonly neglected art in bed side teaching in medical colleges, although it is well-known that more than half of diagnoses can be reached by performing a good history alone.

More time at bedside is consumed in discussing abstract principles away from bedside skills. There is an increasing reliance on 'long cases' where students are not directly observed by teachers during history taking and examination. In a classical clinical round the teacher comes to the ward after one of students had taken the history, then he cannot directly observe the student while taking history and then loses the chance of immediately correcting any deficiency. The teacher usually comes in the 'last minutes' to listen to a presentation of the case. This means that a little or even no time is spent on direct observation of the students, while he was taking the history and doing the examination of the case. This results in failure to detect the defective clinical skills at the very early phase, and then their persistence in future professional life. Sometimes, the teaching round is conducted without the patient in question even been seen [14,15].

There are some curricular issues such as teaching format and assessment methods that might lead to decline in bed side teaching. Teaching programs and evaluation methods concentrate on the detection of physical signs, and giving little weight for other clinical faculties such as, history taking, presentation, and communication skills. Although useful evaluation method is logbooks, which is not appropriately evaluated,(usually left to individual decisions of teachers, only signing and countersigning hurriedly) [16].

BMDC curriculum follows carry on system. The students without passing 1st professional exam is allowed to attend clinical classes which they don't or cannot attend or follow the teaching attentively. As a result they fell in a vicious cycle.

2nd professional MBBS exam comprising 5 major subjects within two years time makes the clinical students more inclined to para clinical subjects abstaining from clinical subjects and hospital wards. As there are examinations in these subjects, the students opt to absent themselves from Bed side teaching sessions to save time for these subjects.

Some students tend to be frequently absent themselves from bedside rounds, especially in the early course of clinical study. This early period of the clinical phase of medical study is the most crucial period, where the students are introduced to the skills of history taking and examination. There is no doubt that absenteeism means only under achievement.

Other causes of absenteeism include illness, family commitments, feeling bore or even lack of interest, or motivation.

Students get minimum time at the morning due to busy schedule of theoretical classes, and supposed to practice on hands at the evening, but they pay less interest, attend minimum as they find less guided, less effective, unfavorable environment and dealt by junior teachers.

Examination system though appropriate theoretically, but practically less emphasis is given or practiced during bed side evaluation.

During in service training practically the trainees contact the patients very minimum as less interest and less time is paid to them as they are no more students, teacher's accountability is minimum.

Although log book, grading system is prevailing for in service and post graduate trainees practically evaluation carries less or minimum value, only signing and finishing liability.

d) Student related

The number of students at a bedside round have reached unprecedented figures (up to 40-80) at many occasions. The patients tend to refuse to be subjects for training as more than one student group may see them in the same day. The large number of students may make patients uncomfortable. Some students believe that bedside skills can be acquired during in service or postgraduate training and then no need to rush them with 'heavy' training during under graduate period.

Strategies to improve bed side teaching

This decline in clinical skill results in calls for reform, to modify and improve curricular and teaching approaches in medical education frequently and regularly since 1980.

Learners should be encouraged to read around cases which will help them integrate clinical and basic science learning. Small group bedside teaching involving only one patient and a small group of students, useful in learning specific clinical skills need to be practiced. Bedside teaching should be structured well before, during and after the encounter, thereby reducing the risk of possible

discomfort from the side of the patient, as well as learners and teachers, the large teaching hospitals are increasingly becoming more specialized, and then less friendly for general undergraduate training, attention needs to be paid at this aspect [17]. Bed side learning environment needs to be suitable by restraining visitors, undue noise and crowd.

Teaching in community settings has the advantage to learn similar to their future working environments. However, this setting as a site for training is not without drawbacks. There is a wide variation in quality of teaching due to variation in interest and motivation of staff involved in teaching at these sites.

Outpatient departments are a poorly utilized source of clinical teaching. Even the few numbers of students who go there are not actively involved. There is a need to provide adequate time, enough dedicated space.

Use of logbooks may help to limit absenteeism but we need to regularly assess the validity of filling up logbooks.

Teachers need to pay more attention in teaching and critical evaluation at the bed side program. Overall as in other disciplines, there is a need to improve the skills of clinical teachers themselves. As in other disciplines, training of trainers is of utmost necessity.

Conclusion

Clinical judgment is the key to patient management. Bedside teaching plays a vital role to achieve the skill. Despite this belief, the frequency of bedside rounds is decreasing and it is considered that this is a major factor causing a sharp decline in trainees' clinical skills. Several reasons like teaching methods and curricular factors, teachers' factors, students' factors, and patients' factors and other practical obstacles are frequently argued. Faculty must assume responsibility for the present decline in clinical skill and performance. If we are to reverse this trend, we will need to address the barriers and overcome them.

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