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RESEARCH ARTICLE

THE CLINICAL TEACHER

Good bedside teaching on secondary care placement: The student perspective

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Abstract

Background: Students' experience of bedside teaching (BST) on clinical placement has significantly decreased, with a shift in teaching away from the bedside. The educational value of teaching on ward rounds (WRs) has also been debated.

Objective: This research considered what constitutes good BST from the student perspective; guidance to support clinician teachers was produced.

Methods: Semi-structured interviews were conducted with 10 second-year students and 10 fourth- and fifth-year students studying at Leeds Medical School. Data were analysed using thematic analysis.

Findings: We identified four themes: (1) benefits of early clinical experience, (2) qualities of good clinical teachers, (3) shift in preference from structured to opportunistic learning and (4) increased valuing of the WR as a site of learning.

Conclusion: The structure of BST should be adapted to the learners' stage of training with a graduated approach, from a structured preparation for observation to authentic, observed participation with feedback. Students' early lack of clinical knowledge makes it difficult to meaningfully observe and partake in ward activities. During early clinical experience, good teaching is perceived as structured and supported by the clinician. As learners progress, they are better able to engage in opportunistic learning, which actively involves them in patient care. They also valued structured teaching and feedback. While patient contact should be supervised, a more participatory, observed and feedback-driven approach should be adopted in the later years. Teaching must address both knowledge and skills required to be a doctor; this is facilitated by an active role in patient care.

1 | BACKGROUND

Bedside teaching (BST) on clinical placement is often considered the cornerstone of learning during the undergraduate medical degree, demonstrating holistic patient care.[1] It has been defined as a form of small group teaching that takes place in the presence of the patient,[2] allowing students to develop their history, examination, communication skills and professionalism.[1,3] Medical educators suggest that further benefits include the opportunity for role modelling skills and attitudes and that it is an active learning process.[4] In this paper, we consider BST to be any teaching that occurs in the clinical environment with a real patient.

However, despite its known benefits, the amount of BST students experience has significantly decreased,[1,5] and a recent study exploring medical students' perceptions of BST in the UK highlighted the need for more supervised BST.[6] From the teacher perspective, time

constraints, patient availability, noisy wards and students' lack of clinical skills and knowledge of basic science are some of the most commonly reported barriers.[7] Teachers have also reported a lack of confidence in their own ability to teach at the bedside, due to fear of facing the unknown in front of a patient,[4] a perception shared by students.[8]

While patient anxiety was a barrier perceived by teachers, 77% of respondents to an inpatient survey reported enjoying BST, and 83% responded that it did not make them anxious. However, only 37% felt they were properly forewarned and 12% thought BST breaches confidentiality.[9] From the learner perspective, concerns regarding a lack of respect for the patient were a perceived barrier,[8] as well as time constraints, faculty attitudes and overreliance on technology.

Since the first teaching WR in 1660, BST has traditionally taken place on WRs.[10] However, Blaschke et al.[11] argue that there has been recent 'didactic diversification' of this format, with various models of 'patient-based teaching', including direct observation, case conference, reporting back and videoing.[12] Previous authors have proposed that learning with patients is most valuable when experiences are structured to incorporate practical experience and feedback.[4,13] Moreover, organisational and interpersonal factors that maximise students' participation within the team on clinical placement affect how positively students perceive the quality of teaching.[14]

There also seems to be a shift in the preferred location of BST, with increased teacher preference for case presentation to be done away from the bedside.[7] Recent video analysis of BST found that less than a third of the time was spent at the patient's bedside, and clinical examination was taught more often in the conference room.[11] Based on review of the literature and workshops with medical educators, Janicik and Fletcher[4] proposed a structured approach to BST that began and ended away from the patient, with some discussions (such as '*what ifs*?') being best left to the conference room, before or after the patient is seen.

Recent video analysis of BST found that less than a third of the time was spent at the patient's bedside.

There is also a reported reduction in the amount of junior doctors' learning that takes place on WRs, and their educational value as a site of BST has been debated, with approximately only one third of FY1 doctors agreeing that WRs 'are a good learning experience'. While WRs were often perceived to be a good opportunity to learn investigations and management, they were not perceived to be a good opportunity to learn examination skills or the basic sciences. Barriers to learning included a lack of time and high patient numbers. However, the authors suggested that there may be an under-recognition of learning on WRs, with teachers perceiving to spend more time on their WRs teaching than learners. The reduction in perceived learning on WRs could also be explained by an increase in separate formalised educational opportunities provided by clinical skills labs, lectures and facilitated sessions.[10]

Recent research has explored the clinician perspective of excellent BST and analysed video recording of BST.[11] Features of excellent teaching included deliberate learning objectives, facilitation of learner-patient interaction and immediate feedback.[15] However, the student perspective was not explored. Therefore, we aimed to understand what constitutes good BST from the student' perspective. Greater understanding in this area will inform clinical teachers how best to conduct BST.

2 | METHODS

This research project aims to answer the question:

How does recognition and perceptions of good BST change as medical students progress through the undergraduate course?

2.1 | Study design

This research was conducted from an interpretivist standpoint, which values researcher subjectivity, and used a qualitative interpretive research design.

2.2 | Study Setting

This study was conducted at the University of Leeds, UK. The lead author is now a graduate of this institution and was a medical student at the time of data collection and initial data analysis. Students here experience BST from the first year of the course.

2.3 | Data collection

A convenience, self-selected sampling method was used; students were invited to voluntarily participate via email, which was sent to all students in years two, four and five of the MBChB. Ten-year two medical students and 10-year four or five students were recruited to explore and compare the perspective of students at different stages of the course. Semi-structured interviews were conducted. The interview topic guide was designed based on the aims of the study, allowing flexibility to explore students' experiences. During the interview, students were also provided with a definition of BST. The questions and definition included in the interview topic guide can be seen in Box 1.

BOX 1 Interview topic guide used in semi-structured interviews with participants.

1. How would you describe bedside teaching?
   - When do you think bedside teaching occurs?
   - Who do you think conducts bedside teaching?

Provide definition of bedside teaching: 'teaching that occurs in the clinical environment with a real patient and may be led by any member of the multidisciplinary team'.

2. Can you tell me about a good teaching experience that you had during your secondary care placement?
   - If this is a bedside teaching session, explore this further as with 3.
   - If this is not a bedside teaching session, consider:
     - What was good about this session?
     - Why was this important to your learning?

3. Tell me about a time when you had a good bedside teaching experience.
   - What was good about this session?
   - Why was this important to your learning?

4. Tell me about a time when you had a bedside teaching experience that could have been improved.
   - How could it be improved?
   - Why would this improve your learning?

5. Tell me about your experiences of ward rounds.
   - How often are you involved in the ward round?
   - What is your role?
   - How do doctors interact with you?
   - What and how do you learn during ward rounds?

6. Who have you sought assistance from when on the wards?
   - How do you choose whom to ask for help?
   - Does the support vary between professionals? How?

7. How do you think your experiences on placement during the first 2 years of the course have influenced how you approach learning during clinical placement now?
   - Do you think your learning preferences on placement have changed?

8. Have you been in a position to teach a peer or younger student on placement?
   - How do you teach them?

9. How do you think clinical placement in secondary care could be improved?

2.4 | Data analysis

Interviews were audio-recorded and transcribed verbatim. Data were analysed using Braun and Clarke's[16] approach to reflexive thematic analysis, whereby 'meaning and knowledge are understood as situated and contextual, and researcher subjectivity is conceptualised as a *resource* for knowledge production' [Correction added on 11 December 2023, after first online publication: The reference citation for Braun and Clarke has been corrected.].[13] The researchers' position as a peer was valuable during data analysis, as they could understand and interpret participants' experiences in a way that would not be possible for a researcher without these shared experiences. Analysis was data driven. Data were coded independently by two researchers. The coding was reviewed during supervision meetings (where the supervisor was not a medical doctor) to resolve any discrepancies and agree on the coding frame. This allowed both insider and outsider research positions to be examined, enabling a breadth of understanding to be developed. Semantic themes spanning the data set were then defined in relation to the aims of the research.

2.5 | Ethical approval

Ethical approval was granted by the University of Leeds School of Medicine Ethics Committee. Informed consent was gained, including consent for data collection and publication. Interviews were transcribed anonymously, and participants were anonymised as P1 to P10 (year 2 students) and P11 to P20 (year 4 and 5 students). Confidentiality was maintained throughout; all data was securely stored electronically.

3 | FINDINGS

From the dataset, we identified four key themes (see Figure 1).

Participants identified several benefits of participating in early clinical experience (ECE), as well as many qualities and skills of good clinical teachers. However, this paper will focus on themes three and four, as these are the key findings of this research. Participants preferred a more structured approach to clinical placement and BST during ECE, whereas a more participatory, yet supervised approach with feedback was valued in the later years.

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3.1 | Shift in preference from structured to opportunistic learning

Second-year participants reported a common structure when describing a teaching session they perceived as good (Figure 2).

Teaching perceived as good began away from the clinical environment, which may include the opportunity for students to practice on their peers. This provided a safe space to ask question and built feelings of confidence and professionalism. Teachers then took students to the bedside, sometimes demonstrating the skill, before allowing students the opportunity to practice under observation. This allowed teachers to provide immediate, constructive feedback, which participants highly valued (Box 2).

However, fourth- and fifth-year participants articulated a distinction between scheduled, formal BST and opportunistic, informal teaching with patients. Teaching during WRs and ad hoc teaching from junior doctors on the ward were given as examples of opportunistic teaching. Opportunistic teaching during authentic patient contact was positively perceived by fourth- and fifth-year participants as it helped to prepare them for the workplace.

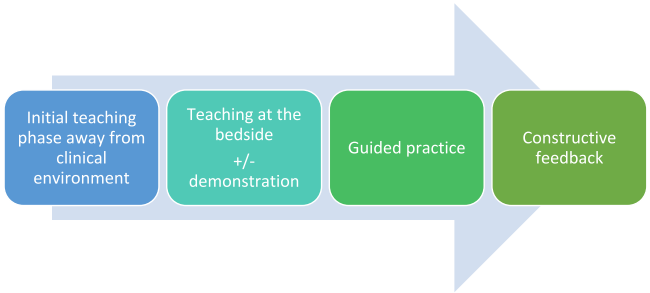

FIGURE 2 Common structure of a 'good' bedside teaching (BST) session described by second-year participants.

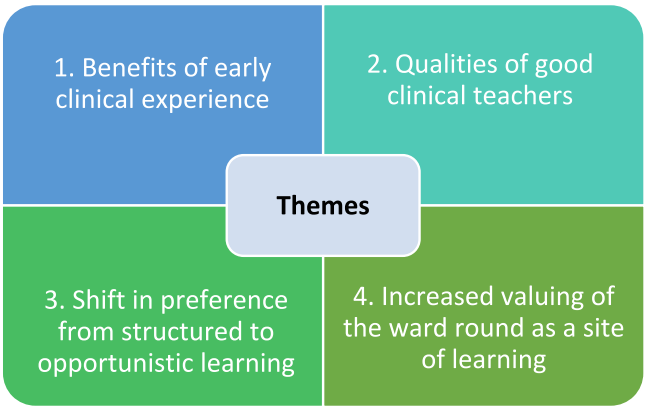

FIGURE 1 Key themes generated by reflexive thematic analysis.

BOX 2 **Second-year participants' description of a bedside teaching (BST) session perceived as good.**

Structure	Description	Quotes
Initial teaching phase away from clinical environment +/− opportunity to practice on peers	• This phase provided the opportunity to clarify knowledge in a safe environment. • Good teachers built on previous knowledge, pitched teaching at the right level, and asked questions, which was more engaging. • The opportunity to practice on peers allowed students to learn 'what normal is' (P2) and built feelings of confidence and professionalism before seeing patients.	*'[It] provides a safe space. Like, us as students won't feel stupid…to ask things that we think we should know…' (P1)* *'He put us on the spot and asked us a lot of questions so it made us think a lot more rather than someone just telling us so we were more engaged…' (P3)* *'…if I hadn't had that opportunity, I imagine I'd have been fumbling, I'd have forgotten quite a lot…the general impression the patient would have got is that medical students are quite incompetent. So…you feel more professional…' (P2)*
Teaching at the bedside +/− demonstration	• Participants valued the opportunity to observe the teacher demonstrating on a patient, with the opportunity for questions. • Teachers acted as role models, demonstrating professionalism and communication skills.	*'…when you see somebody doing it, you see it all put together, with the patient interaction as well, so you get an experience of that before you try and do it on a patient.' (P7)*
Guided practice	• Students valued being observed by the teacher, who guided them by asking questions and prompting when needed. • Students also valued the opportunity to practice independently of their peers. • Participants highlighted the importance of patient suitability for BST. • Patient contact made learning of the basic sciences more relevant and allowed students to develop skills which cannot be learnt in the classroom, such as communication.	*'I think it was good to be pointed in the right direction if we got stuck…because I think otherwise, we might have missed out parts or not done it to the best of our ability.' (P7)* *'Confidence, and I guess it proved to myself that I did actually know what was happening…it relied on my knowledge base, rather than a collective knowledge of like six medical students.' (P8)* *'…it just felt very mechanical to sit there with this person who was actually starting to get emotional and upset. We're really sorry to hear about your cancer, but do you mind just telling us about your symptoms before it happened…' (P1)*
Constructive feedback	• Observation allowed teachers to provide immediate feedback. • Good feedback was honest and constructive. • Good teachers also facilitated feedback from peers and patients.	*'What was important for me was the critical feedback and analysis at the end, where he pointed out what he thought we had done right and done wrong so you could actually learn from it rather than just, good job.' (P1)*

Opportunistic teaching during authentic patient contact was positively perceived by fourth- and fifth-year participants as it helped to prepare them for the workplace.

'…it wasn't formal bedside teaching, it's following the juniors on the ward round…things we needed to know because they're obviously doing what we'll be doing next year…But it wasn't structured at all, it's taking things as and when they happen.'

(P14)

In the later years of the course, with better knowledge, participants reported that learning opportunistically on the ward is a more beneficial experience. Despite the shift towards opportunistic learning, students valued structured teaching and reflected on positive experiences during earlier years of the course. When describing these, the initial stage away from the clinical environment was generally omitted, focusing on the importance of observation and feedback. Some participants felt they did not receive enough structured teaching; perceived barriers included a lack of time and feeling like a burden.

'It's not as if it's formal, it's as we're going on the ward round…this is what to prescribe, they've got some

good signs…it's not as structured maybe as you'd want…'

(P14)

'…we'd go to the patient and he'd ask us in turn to do histories, examinations and he'd give us feedback on those…then we'd speak about that specific abdominal disease…he gave really good structure to the session…'

(P17)

Constructive feedback was most missed when supervised BST did not occur.

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'When you get to a certain point, people stop watching you examine patients because they just assume that you can do it…'

(P13)

'When you get to a certain point, people stop watching you examine patients because they just assume that you can do it…' (P13).

3.2 | Increased valuing of the WR as a site of learning

Participants identified that as they approach graduation, their focus is not just on knowledge and exams but also on preparing to be a doctor. To achieve this, much BST occurs 'on the job', where they can have an active role in patient care, and FY1 doctors were often perceived as good teachers. This active role was perceived as vital for learning.

'…an F1…gave me a lot of responsibility and made me feel like I was contributing and helping…I was an active part of the ward round…I felt like I learned a lot from that experience.'

(P13)

However, second-year participants reported limited exposure to WRs, and their role was observational. This was perceived to be due to their lack of knowledge, which limited their ability to engage with, and learn from, WRs. Other perceived barriers to learning included too many people, a lack of time and low priority for teaching preclinical students and feeling like a passive observer.

'…we found like 'A', we didn't know what was going on, 'B', there was a lot of other students and junior doctors… so the consultant's priority is to teach the junior doctors… you are literally quietly observing…'

(P1)

'…there wasn't any specific teaching about any conditions or anything, it was just how [the ward round] works…the only time I felt I actually learned something when one of the F1s took the time to explain it.'

(P1)

In the later years of the course, with better knowledge, participants reported that learning opportunistically on the ward is a more beneficial experience. However, it is important for learning that students are actively involved, not just observing.

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'…every patient we saw, he would encourage me to do the history, the examination…I just found it so much more beneficial than just watching someone, it's really good to actually do it yourself and get good feedback…'

(P17)

4 | DISCUSSION

Our findings suggest that the structure of BST should be adapted to the learners' stage of the training. During ECE, good teaching is perceived as structured and supported throughout by the clinician. This is contrasted with the experience of students in later years, who are

better able to engage in opportunistic or informal learning. Good teaching in the later years actively involves students in patient care, preparing them for the workplace. While this occurs opportunistically, participants also valued structured teaching and feedback. This suggests that as learners progress, they require a graduated and supervised approach, from a very structured preparation for observation, to authentic, observed participation with feedback.

Our findings suggest that the structure of BST should be adapted to the learners' stage of the training.

The suggestion that teaching during ECE should be structured is in accordance with the literature.[4,13] In this study, second-year participants also valued an initial period away from the patient, which provided a safe environment to ask questions. This is in keeping with recent findings that the majority of time during BST is spent away from the bedside.[11] Participants in this study also valued the opportunity to observe the clinician demonstrating at the bedside and identified the teacher as a role model. Exposure to professional role models has been argued to develop students into more empathetic doctors; such teaching is not usually explicit but is a critical expectation of patients.[17]

Fourth- and fifth-year participants emphasised the value of observation and feedback. The importance of feedback in clinical education is widely discussed; feedback on direct observation is considered crucial for the development of clinical skills[18] and is a key driver of learning.[19] However, most studies report that students are not satisfied with the feedback they receive.[19]

Interestingly, Liljedahl et al.[20] explored the differences in the perceptions of medical and nursing students regarding learning on clinical placement. They found that while nursing students took responsibility for their own learning, medical students *'were grateful for whatever education they got'*. They found that medical students depended on their placement to provide them with learning opportunities and sought the supervision of a doctor who would teach them and provide them with tasks. The authors concluded that whereas nursing students focused their learning on the patient, medical students focused their learning on the doctor.

Morris and Blaney[21] highlight that learning in the workplace is inherently problematic. Potential barriers to effective learning include the large number of learners in the clinical environment, which may lead to a 'learner hierarchy'. Our findings support this. Second-year participants reported barriers to learning on WRs included too many people and a low priority for teaching preclinical students.

Second-year students also reported limited educational value of WRs; this was perceived to be hindered by a lack of clinical competence. Participants reported a largely observational role, yet to learn, students must 'actively engage in, not just observe, the tasks of the clinical workplace'.[22,p.204] This may help to explain second-year participants' preference for structured BST.

However, as students' approach FY1, clinical teaching must address both students' knowledge and the skills required to be a doctor; this is facilitated by an active role in patient care. To achieve this, fourth- and fifth-year participants reported good examples of both formal and opportunistic BST. Their improved clinical competence allowed students to be more involved in ward activities, and they could engage with more opportunistic teaching.

Previous research has also found that final-year medical students valued being part of a clinical team.[23] Collett et al.[24] highlight that WRs may include both formal and informal learning opportunities and argue that while they can provide a rich learning experience, learning on WRs can be 'chaotic, challenging and inefficient'. The behaviour of the team in engaging students was found to largely influence the students' learning experience; students learnt best when they felt part of the team.

This progression is in keeping with Lave and Wegner's[25] communities of practice, which views learning as a social and situated process. People learn through participation in communities of practice in a process of legitimate peripheral participation; this participation is key for learning. Newcomers to a community begin with an observational role; as newcomers gain knowledge and skills, they move towards its centre. Formal teaching is one resource for learning in this community, and informal, opportunistic and experiential learning can all also occur in this context. Sfard's[26] metaphor of learning-as-participation is in keeping with this theory of learning.

Kauffman and Mann[27] suggest numerous implications for this in medical education. Situated learning is important for 'professional socialisation'; this socialisation may occur through both the formal and informal curriculum. To learn effectively, students must participate in the authentic daily activities of the workplace. It is thus vital to facilitate a role for all students on placement, which is appropriate for their place within this community.

Our findings also suggest that in the later years, there is a tension between learners seeking autonomy and yet the need to be supervised. Previous research has found that final-year medical students valued a high level of supervision, working with junior doctors, and formal BST.[23] Effective supervision is key.[21,23,28] Reasons for this include the provision of direct guidance, role modelling and feedback.[28] However, potential barriers to this include increasing student numbers, which leads to '*increasing constraints on educational time and value for each student*',[23] and a perceived lack of motivation for teaching.[28] Junior doctors were also described as good teachers in our study. This may be due to their role as a near-

peer, which has been suggested to allow FY doctors to better facilitate teaching.[29]

In the later years, there is a tension between learners seeking autonomy and yet the need to be supervised.

Morris[30] argues that to redevelop medical education from the view of learning-as-participation, we must fundamentally reconsider the curriculum. Kauffman and Mann[27] also suggest that to take advantage of situated learning, we must rethink the students' experience and consider ways to promote learning, which involves '*thinking of learners as contributing members of our learning environment, rather than as temporary adjuncts to it*'. Exploring this is beyond the scope of this study, and perhaps a much bigger shift is required in how we view teaching in the clinical environment and the role of the student. This is an area for future research.

BOX 3 Recommendations for clinical teachers.

1. Adopt a structured approach, appropriate to the learner's stage of training.
2. Ensure that all learners are given the opportunity to be observed and provided with constructive feedback.
3. Prepare a quiet teaching space away from the clinical environment, where students are able to ask questions away from the bedside, and feedback can be discussed. This could be a conference room, office and so on.
4. Create opportunities for junior doctors to conduct BST.
5. Plan BST that actively involves students in patient care through authentic, observed clinical contact with real patients, particularly in the later years.
6. Ensure an appropriate number of students are allocated to each clinical area so that all students have the opportunity for both formal and opportunistic BST.
7. Encourage the wider ward team to involve students and help to create a feeling of belonging within the team.

4.1 | Limitations

This study used a self-selected sample, where participants may have experiences that are not representative of the population. However, we do not aim to make generalisations, and as Willig[31] highlights, neither representativeness nor generalizability is meaningfully applicable to qualitative research. However, all participants were from the same University, and the findings may be influenced by how their clinical placements are structured, reducing the transferability of the findings.[31] Also, this study does not provide empirical evidence for the effect of teaching on competence or exam performance, and our model of good BST may not always be feasible. However, with a lack of empirical evidence, student reports are vital.[8]

4.2 | Conclusion

From this research, a number of recommendations for clinical teachers were produced (Box 3). Clinical teachers should be encouraged to adopt a structured approach, adapted to the learners' stage of training. While early patient contact should be supervised throughout, a more participatory, observed and feedback-driven approach should be adopted in the later years. Clinical teachers should be encouraged not to forgo observation and feedback in the later years of the course. Students' lack of clinical knowledge during the early years makes it difficult to meaningfully observe and partake in ward activities. As students progress and approach FY1, clinical teaching must address both students' knowledge and the skills required to be a doctor; this is facilitated by an active role in patient care (Box 3).

While early patient contact should be supervised throughout, a more participatory, observed and feedback-driven approach should be adopted in the later years.

AUTHOR CONTRIBUTIONS

Lydia Edwards: Conceptualization; data curation; formal analysis; investigation; methodology; project administration; resources; visualization; writing—original draft; writing—review and editing. **Naomi Quinton:** Conceptualization; formal analysis; methodology; supervision; validation; visualization; writing—original draft; writing—review and editing.

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CONFLICT OF INTEREST STATEMENT

The authors have no conflict of interest to disclose.

DATA AVAILABILITY STATEMENT

Data available on request from the authors.

ETHICAL APPROVAL

Ethical approval was granted by the University of Leeds, School of Medicine Ethics Committee. All participants gave signed consent for their anonymised data, including direct quotations, to be used in the publication of this research.

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