

# Bedside teaching: everybody's but nobody's responsibility

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**Abstract:** Evidence shows dwindling levels of bedside teaching for medical students in the UK, especially in district general hospitals. Lack of individual responsibility has resulted in disengagement in teaching. Based on a quality improvement project (QIP) at a District General Hospital, we suggest some ways this could be addressed. We suggest here that harnessing support from the medical education lead, incentivizing teaching, allocating student-junior doctor groups to harbor personal responsibility, providing a supportive framework, and educating about barriers to teaching can all be used to develop an effective teaching program.

**Keywords:** bedside teaching, quality improvement, junior doctor

## Introduction

The difficulties facing medical students in hospitals mirror those of the wider National Health Service (NHS). Resource deficiencies and overburdened health care professionals have resulted in reduced training opportunities for both foundation trainees and their medical student counterparts. The number of junior doctors moving directly into speciality training has fallen year on year from 71% in 2011, to 42.6% in 2017, alongside a deepening frustration of doctors in training about NHS pressures. Whilst feeling undervalued by seniors and dissatisfied with hospital politics,<sup>1</sup> it is hardly surprising that the supervision of medical students has been compromised.

The gradual loss of bedside practical experience for medical students is well documented, despite good evidence that students themselves would like more.<sup>2</sup> With the demise of a firm structure, there has also been a loss of a consistent responsible junior clinician to motivate and guide.<sup>3</sup> Increasingly, therefore, medical students are looking for alternative ways to find meaningful on-ward experiences, such as health care assistant work.<sup>4</sup> As a result, medical schools are demanding better and more standardized education for their students on the ward. But how can you control the quality of teaching in a district general hospital in the current climate, with overstretched staff and limited resources, and no allocated time for teaching? The question of improving the quality of bedside teaching is one for every doctor in the NHS, but a shared responsibility means no individual responsibility for anyone.

We all know about the value of bedside teaching, which is not just for students.<sup>5</sup> For junior doctors, bedside teaching is well understood to improve understanding, confidence, and communication skills;<sup>6</sup> whilst preparing them for later careers in

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education. Additionally for patients, time spent teaching at the bedside can increase confidence in the service, facilitate rapport building, and understanding of illness narrative, and has been shown to be a positive experience both in adult and pediatric care.<sup>5,7</sup> With such wide-ranging benefits, the delivery of bedside teaching should be seen as a must rather than a maybe; an individual responsibility rather than a buck that can be passed.

Doctors have a professional obligation to contribute to the training of other doctors, medical students, and non-medical health care professionals, as set by the General Medical Council. Despite this, with increasing strain on consultants, registrars, and senior house officers, a significant burden of the responsibility for teaching has been transferred to foundation trainees.<sup>8</sup> This may be a positive change, with medical students rating enthusiasm for teaching and constructive feedback more important than clinical grade.<sup>9</sup> For this group of doctors, whilst being wrapped-up in the problem solving, administrative side of ward life, it can be difficult to prioritize and practice education.

The question is: how do we go about inspiring, engaging, and recruiting our workforce into providing quality bedside teaching for juniors? Previous suggestions have involved teaching guidelines, protected time for teaching, and the development of teaching skills at undergraduate level.<sup>8</sup> From experience of trialling methods in an East London District General Hospital, we have some further practical ideas.

## 1. Develop a network

Forge strong links with the medical education leads and administrators of your local medical school. The efficiency of the program will rely upon their help with access to timetabling and student placements. Proactively recruiting students through this route prior to placement induction galvanises both students and foundation doctors to take personal ownership over their teaching.

## 2. Incentivize teaching

Demonstrate and facilitate the professional benefits that junior doctors may accrue through teaching medical students. For example, ensure that there is a transparent and standardized process for acknowledging contributions (certificates and awards etc.) and that there is a structured feedback system to ensure quality and provide monitoring but also to make sure teaching is formally recognized in junior doctors' portfolios. Moreover, encourage innovation by providing opportunities to present teaching programs at a local level.

## 3. Allocate individual responsibility for a group of students

Cultivate ownership and mentorship for a small group of students and increase investment in the quality of teaching delivered. Commitment is enhanced when doctors and students arrange a series of teaching sessions, rather than ad hoc learning opportunities. Shared responsibility is fostered through encouraging doctors and students to have initial meetings at which they agree 'learning contracts' and decide shared objectives for the teaching time.

## 4. Provide a supportive and structured framework for delivering teaching

As previously suggested,<sup>10</sup> a supportive framework can nurture busy teachers to overcome many barriers to teaching. We have found that steps such as providing standardized and centralized electronic forms of feedback collection, promptly providing the names and details of students, and making student timetables easily available has significantly increased participation in teaching. Furthermore, developing an electronic toolkit can make the program sustainable over academic years and replicable at other sites.

## 5. Give junior doctors' advice about barriers to teaching at the bedside

Recent evidence has suggested that a large proportion of junior doctors would have liked some teacher training before commencing teaching within a teaching program, and it is possible that without it poor practice can develop.<sup>11</sup> Education and advice about delivering teaching, including obtaining timely consent, avoiding patient protected meal times, and juggling clinical and teaching responsibilities will standardize and improve the value of teaching for both doctor and student. This can be provided at foundation year induction, delivered by education fellows. Additionally, education about teaching methods, session design and facilitation could supplement the formal medical teaching for junior doctors already provided throughout foundation years.

## Conclusion

With a large portion of the responsibility of teaching medical students now firmly in the hands of junior doctors, it is high time we supported them to deliver the practical and real-life teaching called for by medical students across the country. With dwindling allocated time for teaching, we need to find new and dynamic ways of engaging the workforce. From our experience, junior doctors would love to be educators; but in

the absence of any structure for encouraging participation, they do not feel supported and appreciated to do so. These five ideas could be of benefit to doctors, medical students in training, and patients alike if implemented to bolster junior doctor-led teaching.

## Authors

Dr Amy Gimson, Dr Shagayegh Javadzadeh, and Dr Akash Doshi; junior doctors who designed and implemented a foundation doctor-lead medical student teaching program whilst working for Barts Health NHS trust.

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## Author contributions

All authors contributed to data analysis, drafting and revising the article, gave final approval of the version to be published, and agree to be accountable for all aspects of the work

## Disclosure

The authors report no conflicts of interest in this work.

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