Bedside Teaching: The Past, Present, and Future of the Bedside in Medical Education

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Abstract

The utilization of bedside teaching in medical education has decreased over the past 5 decades, yet the practice continues to be widely viewed as a necessary part of medical training. Bedside teaching allows for training and evaluation in history-taking, physical examination, professionalism, empathy, communication skills, and the psychosocial aspects of medicine, some of which occurs through role modeling. The goal of this review is to summarize the available literature on the decline of bedside teaching and discuss the cause of this decline. In addition, we attempt to combine expert opinion with a number of published survey results of patients, trainees, and attendings to make recommendations on how to return to the bedside. Future research on bedside teaching should focus on documenting objective evidence of the educational and patient care benefits of bedside teaching.
Introduction

Teaching at the bedside has long been a tradition in medical education. Indeed, many definitions of bedside rounding exist. However, the traditional, and likely the truest, form of bedside rounding involves the attending and trainees at the literal bedside of the patient where the patient’s case is presented to the attending by a trainee in front of the patient, allowing the patient to correct or add historical findings. Bedside rounding can take on many forms, and each session is unlikely to take the same form as prior sessions. Demonstration, focused questioning, observation, role modeling, lecturing, or a combination of these may be employed at the bedside by the teacher to educate trainees.

Some consider bedside rounding to merely be completion of the discussion regarding the patient’s history, physical, and laboratory data in the hallway outside the patient’s room without the patient’s involvement, followed by a brief visit with the patient and confirmation by the attending of trainee findings. Bedside teaching – as opposed to teaching done in a conference room or classroom – has widely been thought to be a necessary and irreplaceable method by which trainees learn history-taking skills, physical examination skills, professionalism, empathy, bedside manner, communication skills, and experience the psychosocial aspects of medicine. In 1679, the father of bedside teaching, Francisucus de le Boe Sylvius, wrote:

“My method, hitherto unknown here, and possibly anywhere else [is to] lead my students by the hand to the practice of medicine, taking them every day 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 the patients and about their thoughts and perceptions regarding the causes of illnesses and the principles of treatment” (Le Boë and Schacht, 1679, Linfors and Neelon, 1980).
The long tradition of bedside teaching has now become more a relic than a norm to the disadvantage of both the current generation of medical trainees and more importantly, the public they will serve.

**Evidence of change**

In 1964, Reichsman et al. observed teaching practices at the University of Rochester School of Medicine and found that the attending physicians rounded at the bedside in seventy-five percent of all patient cases presented during medical student floor rounds. Since that study, most have measured the proportion of time at the bedside during an entire rounding session rather than frequency of patient cases taught at the bedside. This difference in methods has made comparison to later studies difficult and has resulted in disagreements in the literature (Gonzalo, 2010, Peltan and Wright, 2011). One year after the Reichsman study (1964), Payson and Barchas (1965) documented the proportion of time spent at the bedside during rounds by regular attendings (19.2% of 120 minutes), special attendings (11.5% of 120 minutes), and house staff (56.5% of sixty minutes). In total, seventy minutes out of five hours of daily rounds (twenty-three percent of rounding time) was spent at the bedside (Payson and Barchas, 1965). Collins et al. (1978) and Tremonti and Biddle (1982) documented that sixteen percent of teaching rounds occurred at the bedside. Thereafter, Miller et al. (1992) found that only eleven percent of rounding time during ninety-six timed observations was spent at the bedside at Arizona Health Sciences Center. In 2009, Crumlish et al. showed that hospitalists at Brigham and Women’s Hospital spent an average of seventeen percent of rounding time at the bedside. Sixty-one percent of rounding sessions employed teaching at the bedside at least once. (Crumlish et al., 2009) This data has been used to claim that bedside rounds are being utilized at a rate similar to 1964 (Peltan and Wright, 2011). However, as reviewed by Gonzalo (2010) in his letter to Peltan and Wright, if only one of the twelve patients (reported average census) was seen at the bedside in sixty-one percent of rounding sessions, as low as five percent of patient cases presented on rounds may have included bedside teaching. Most recently,
Gonzalo et al. showed that prior to their intervention to increase bedside rounds at Beth Israel Deaconess Medical Center, less than one percent of rounding time was at the bedside (2010). This data shows a clear trend towards less bedside teaching, but to what effect? Are trainees receiving adequate teaching and acquiring adequate skills to be a good doctor in a conference room?

**Barriers to bedside teaching**

Although the frequency of bedside teaching is decreasing, bedside teaching remains widely thought to be an important part of medical education among both attendings and students (Mattern et al., 1983, Miller et al., 1992, Nair et al., 1997, Williams et al., 2008). If bedside teaching remains valued, why is its practice decreasing? In order to increase bedside teaching, the barriers to this form of medical education must be examined.

**Documentation and Billing in the United States**

On July 1st, 1996, the Health Care Financing Administration (HCFA), a division of the Department of Health and Human Services, enacted the “1995 Guidelines for Evaluation and Management Services” with the goal of standardizing documentation and billing (Center for Medicare and Medicaid Services, 1996). This guideline, among other achievements, allowed payers to confirm care was performed and was necessary (Center for Medicare and Medicaid Services, 1996). At the same time, Medicare enacted the Teaching Physician Rule (TPR) to standardize billing by teaching hospitals and limit double billing of Medicare by teaching hospitals and their physicians (Paller and Culbertson, 1998). Before the TPR, the Bureau of Health Insurance’s Intermediary Letter 378 (IL-378) stated that hospitals could bill Medicare for resident-provided services only if the attending provided “value-added service” (Paller and Culbertson, 1998, Stevermer and Stiffman, 2001). There was ambiguity in IL-378 such that hospitals were able to receive supplemental funding for resident education and bill Medicare for resident-provided services with or without documented attending supervision (Paller and Culbertson, 1998,
Stevermer and Stiffman, 2001). After enactment of the TPR, hospitals could only bill for resident services if an attending supervised the service and documented this supervision (Paller and Culbertson, 1998). The effects of these guidelines on medical education were evaluated by Fihn et al. (2000) using trainee evaluations of attendings before and after the guidelines were enacted. There was a significant shift in how attendings allocated their time. The number of attendings providing scheduled teaching dropped by thirty percent, and the number of attendings listing their primary focus as teaching dropped by sixty percent (Fihn et al., 2000). Regarding documentation, twenty-seven percent of attendings reported documentation of their patient care activities prior to the new guidelines versus ninety-four percent after (Fihn et al., 2000). After July 1st 1996, ninety-two percent of attendings spent greater than two hours on documentation versus forty-one percent before (Fihn et al., 2000). This study details a shift in the focus of physicians from teaching to supervision for documentation purposes. How this shift affected residency education and specifically bedside teaching has never been investigated. One could postulate that the increased documentation requirement has resulted in not only decreased teaching, but decreased bedside teaching. Conversely, increased requirements for supervision may have forced further presence of the attending during patient care. Whether the attending chooses to have this supervisory role at the bedside or at a conference table – which is widely thought to be less time-consuming (Mattern et al., 1983, Ramani et al., 2003, Williams et al., 2008) – may be the key to answering this question.

Lack of training in bedside teaching

How do faculty feel towards bedside teaching? Ramani et al. (2003) answered this question using focus groups of chief residents, program directors, “skilled bedside teachers,” and other attendings at Boston University. He found a unanimous concern for a feeling of lack of bedside teaching skills (Ramani et al., 2003). Attempts at bedside teaching brought about feelings of lack of control and inability to meet the
standards set by perceived “master clinicians” (Ramani et al., 2003). These feelings culminate in the “Thin-ice syndrome” in which teaching faculty, in the unpredictable environment of the bedside, feel they have too little knowledge to react in an expert way to the patient and their problems “which might draw them onto thin ice” (Linfors and Neelon, 1980). There is a natural feeling of improved control and less risk of displaying one’s shortcomings in a conference room or classroom where the teacher can guide the discussion, as opposed to the spontaneity of reacting to a patient’s problems at the bedside. These thoughts were corroborated by a study by Wang-Cheng (1989) which found that less experienced, younger faculty tended to prefer conference room rounds. Trainees support this conclusion, identifying lack of clinical knowledge and bedside teaching skills of faculty as barriers to bedside teaching (Williams et al., 2008).

Lack of value of teaching by academic departments

Many academic institutions reinforce the lack of bedside teaching skill of attendings by valuing financial productivity over teaching (Ramani et al., 2003). There has been an overall transformation of academic medical centers from smaller scholarly institutions to larger corporation-like entities that rely on research funding and patient care to grow and succeed (Berkow and Cohen, 2005). In the wake of this change in size, budget, and funding sources, non-teaching clinical and research duties of attending faculty have taken priority over teaching (Berkow and Cohen, 2005). The attendings, chiefs, and program directors from Ramani et al.’s (2003) study expressed this concern noting that master teachers are taken away from teaching to other duties and junior faculty educate in their place:

“I come from a background where the icons of academic medicine are the great teachers. Teaching is the pinnacle of academic life...being a great diagnostician, to elicit a history no one else has elicited...great skills...equal to getting an NIH grant...that’s the
 ethic one needs to create so that residents and students view that as a worthwhile goal."

Trainees are not blind to these competing priorities, identifying “low initiative for teaching, low teacher and learner expectations, inadequate institutional recognition of teaching, deficient institutional expectations and incentives for teaching, and competing responsibilities of faculty” as barriers to bedside teaching (Williams et al., 2008).

**Trainee anxiety at the bedside**

In addition to faculty being uncomfortable teaching in the unpredictable environment of the patient’s bedside, Wang-Cheng (1989) found that only two percent of residents and four percent of medical students were comfortable with case presentations at the patient’s bedside. Learners cited patient comfort, privacy, and a feeling that education on medical topics not directly associated with the patient was better accomplished in a conference room. Further, trainees are uncomfortable asking questions and being asked questions at the bedside (Landry et al., 2007, Wang-Cheng et al., 1989). Trainees expressed a fear of embarrassment and humiliation along with a fear of compromised doctor–patient relationships when rounds are done at the bedside (Williams et al., 2008). LaCombe (1997) recognizes this fear as a result of the patient losing trust in the trainee when the trainee is found to be wrong during a bedside conversation. Despite this anxiety, trainees appreciate the value of bedside rounds. Nair et al. (1997) found that fifty-two percent of trainees felt they had not received enough bedside teaching, and one hundred percent felt that bedside teaching was the best way to learn clinical skills.
Concern for patient comfort

Concern for patient comfort and potential for patient embarrassment related to case presentation and teaching at the bedside has been a prominent reason for not bedside rounding in the literature (Landry et al., 2007, Mattern et al., 1983, Ramani et al., 2003, Wang-Cheng et al., 1989, Williams et al., 2008). However, the majority of patients and their families are more satisfied with bedside rounding than conference room rounding (Gonzalo et al., 2010, Landry et al., 2007, Lehmann et al., 1997, Linfors and Neelon, 1980, Nair et al., 1997). In a randomized trial by Lehmann, patients experienced bedside or conference room rounds. The patients perceived that their doctors spent significantly more time when bedside rounds were conducted (Lehmann et al., 1997). Nair (1997) found in a survey of one hundred patients that eighty-three percent felt bedside teaching did not make them anxious, and eighty-eight percent felt bedside teaching did not cause a loss of confidentiality. Wang-Cheng et al.’s 1989 study revealed similar findings with eighty-five percent of patients preferring bedside case presentations with only 8 percent of patients embarrassed by bedside case presentations. Despite this data, patient comfort remains a significant perceived barrier to bedside teaching.

Lack of time

With ever-stricter work hour restrictions, competing demands on faculty, and increased patient turnover in today’s hospitals, lack of time has become a major perceived barrier to bedside teaching (Mattern et al., 1983, Ramani et al., 2003, Williams et al., 2008). To date, only two studies with differing results have investigated whether bedside rounds take longer than conference room rounds. Crumlish et al. (2009) showed that bedside rounding takes longer than conference room rounding, while Gonzalo showed the opposite (2010). If bedside
rounding were to be proven to take longer, this time could likely be attributed to an increase in actual teaching and learning as compared to conference room rounds.

**Technology**

Both attendings and students identify technology as a barrier to bedside teaching. Attendings, program directors, and chief residents felt that technologic advancements resulted in excessive amounts of data which required ever-increasing amounts of time to review in place of evaluating the patient (Ramani et al., 2003). Trainees felt that technology has decreased the value of clinical skills, and therefore has taken priority over the bedside where these skills are learned (Williams et al., 2008). Arguably, without solid clinical skills, physicians are more likely to order unnecessary and excessive testing that could contribute to our current economic woes and ever increasing need for funding in healthcare.

**Why return teaching to the bedside?**

With so many obstacles, why should trainees, faculty and academic departments focus on rediscovering the bedside? Though widely thought to be beneficial and necessary for medical education, there is an unfortunate paucity of objective data to demonstrate the benefits of bedside teaching with respect to educational outcomes. Thus, a review of the available expert opinion and qualitative data on bedside teaching must serve as our primary support for returning to bedside teaching.

**Advantages to bedside teaching**

As stated previously, the majority of patients prefer bedside rounding over other forms (Gonzalo et al., 2010, Landry et al., 2007, Lehmann et al., 1997, Linfors and Neelon, 1980, Nair et al., 1997). Though untested, Linfors and Neelon (1980) compiled a list of advantages of bedside rounding
including: 1. the patient can be seen as an individual; 2. the role of the doctor as a patient educator can be demonstrated; 3. contact with the patient results in further observations which then result in inquiry and excitement; and 4. the psychosocial aspects of medicine can be demonstrated. Morgan (1982) felt the advantages of bedside teaching were the opportunity to “1. Teach attitudes and interpersonal skills; 2. Enhance observation; 3. Teach the skills of interview and physical diagnosis; and 4. Confirm clinical data”. Nair (1997) quantified the extent of trainees’ attitudes and found that ninety-nine percent felt bedside teaching was an effective way to learn the physical examination, ninety-three percent to learn history taking, ninety percent to learn communication, and eighty-one percent to learn basic sciences.

Though these advantages may seem obvious, educational outcomes have been difficult to prove in the literature. In lieu of objective data, many experts have attempted to explain the advantages of bedside teaching.

LaCombe (1997) writes,

“Acquired skills in history taking and in physical diagnosis are the obvious benefits of bedside teaching. But there are other, less apparent fruits of this endeavor. At the bedside, one is discouraged from using medical jargon. And in this era in which house staff too often refer to patients as “dirt balls, train wrecks, last night’s hits, and gomers,” as though such phrases are elevated prose, pejoratives are discouraged...One begins to learn respect for the patient. At the bedside, the house staff begin to see disease as an illness happening to a human being. In other words, one learns to be professional. And one learns communication”.

Joseph St. Geme (1987) wrote of pediatric medical education:
“One cannot find the inspiration of the child, or pediatrics, in the abstract comfort of the conference room. In the classroom, medical students and residents cannot find the role models for the style and grace of pediatrician-patient-parent interaction, the skills of physical examination of an anxious child or adolescent, or the ability to complete an agenda of evaluation, management, and caring. Communication can be taught only at the bedside. I suspect but cannot prove that the most powerful stimuli of intellectual curiosity and clinical scientific discovery emanate from the bedside”.

Perhaps William Osler’s words, as paraphrased by William Thayer, describe the advantage of the bedside most accurately:

“Use your five senses. The art of the practice of medicine is to be learned only by experience; ’tis not an inheritance; it cannot be revealed. Learn to see, learn to hear, learn to feel, learn to smell, and know that by practice alone can you become expert. Medicine is learned by the bedside and not in the classroom” (Bryan, 1997).

The best teachers teach at the bedside

Perhaps an alternative way to decide whether to make the effort to return to the bedside is to examine how the perceived best teachers teach. In 1984, Schor and Grayson took on the question of how outstanding clinical teachers teach. Using chief residents’ opinions, they identified the characteristics of great medical educators from a nationwide pool (Schor and Grayson, 1984). These teachers were noted to spend twenty-three percent of their rounding time at the bedside (Schor and Grayson, 1984). They saw ninety-two percent of their patients with the team and spent eighty-two percent of their teaching time on assessment and diagnosis (Schor and Grayson, 1984). Trainees also strongly associate perceived high quality teachers with bedside teaching. In a nationwide survey of
medical students on internal medicine rotations, Guarino et al. (2006) found that patient visits with the attending were highly correlated with student satisfaction.

**Effective bedside teaching**

If the available literature has been convincing enough to resume bedside teaching, where would one start? Several authors have described how to bedside round. These methods have been summarized in Table 1 (Preparation) and Table 2 (Teaching at the Bedside).

**How to institutionally increase bedside teaching**

**Breaking down barriers**

The focus groups of Ramani et al. and Williams et al. gave strategies to overcome the previously discussed barriers. In order to renew bedside teaching skills and eliminate the feelings of inadequate knowledge among faculty, institutions must focus on training faculty in both clinical skills and bedside teaching methods (Ramani et al., 2003, Williams et al., 2008). Faculty and residents must receive training in evidence-based physical diagnosis to ensure clinical skills are valued and used with technology (Williams et al., 2008). A more supportive learning environment must be fostered in which teachers and learners could admit their own deficiencies. Flexibility, efficiency, and time limits should be incorporated into bedside rounds to conform to current patient loads and work hour limitations including reduction of team census caps and an increase in nonteaching services to handle extra patients. In order to increase how departments are perceived to value teaching, institutions should provide clear teaching expectations and objectives, incentives for faculty to teach, and clear learning objectives for trainees (Ramani et al., 2003, Williams et al., 2008). Faculty’s other responsibilities – i.e., clinic and research duties – should be limited during ward attending periods (Williams et al., 2008).
Interventions to increase bedside teaching

As above, one way to increase bedside teaching is for institutions to emphasize its importance and provide initiatives to improve faculty bedside clinical and teaching skills. Several studies have attempted to show the effect of such interventions (Gonzalo et al., 2010, Janicik and Fletcher, 2003, Mooradian et al., 2001). Mooradian et al. (2001) successfully increased rounding sessions that included a bedside visit from thirty to seventy percent. Their intervention included giving faculty feedback about their bedside teaching, regularly presenting the literature regarding bedside rounding, and asking that residents prepare patients for visits (Mooradian et al., 2001). Gonzalo et al. (2010) increased the proportion of rounds that were done at the bedside from less than 1 percent to forty-one percent by giving residents a one hour workshop on the definition, history, advantages, and barriers to bedside rounds including a video showing an example of a resident-led bedside rounding session.

In addition to the above interventions, the ACGME could lead change by defining stricter expectations of time allotted to bedside teaching. Of note, the 2007 ACGME Internal Medicine program requirements asked that bedside teaching be done three days of the week for at least four and a half hours per week (Accreditation Council for Graduate Medical Education, 2007), but in 2009 asked only that bedside rounds be “conducted with a frequency and duration sufficient to ensure a meaningful and continuous teaching relationship between the assigned teaching attending and resident” (Accreditation Council for Graduate Medical Education, 2009). The reason for this change in language is unclear, but the statement appears to allow academic departments to subjectively determine what amount of bedside teaching is necessary. Returning to a stricter time standard may assist academic departments in returning to the bedside.
Conclusion

Bedside teaching is an irreplaceable part of medical education and a tradition of our profession. Further research into bedside rounds should attempt to evaluate the efficacy of bedside rounding on successful achievement of educational objectives. It is our suspicion that bedside rounds may improve patient safety, quality measures, and patient outcomes in addition to educational benefits. If these theories prove to be true, we may discover that bedside rounds have financial as well as educational benefits and thus encourage implementation of more strict policies on bedside rounding by academic medical centers. As technology continues to progress, we must realize that expertise in data analysis, interpretation of diagnostic tests, and treatment with medication does not by default imply expertise in patient care. History-taking, physical diagnosis, patient communication, empathy, touch, respect, and professionalism – these skills are the skills of master clinicians. These skills are not learned in a conference room or a lecture hall. These skills are learned at the bedside. We must return to the bedside.
Table 1: Effective Bedside Teaching: Preparation

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<th>Patient preparation</th>
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<tr>
<td><strong>Verify the patient’s understanding that parts of the discussion will be theoretical and may not pertain to the patient’s illness</strong></td>
<td>(LaCombe, 1997, Ramani, 2003)</td>
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<th>Trainee preparation</th>
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<td><strong>Set a time limit</strong></td>
<td>(Janicik and Fletcher, 2003, Ramani, 2003, Ramani et al., 2003)</td>
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<td><strong>Give each member of team a task</strong></td>
<td>(Ramani, 2003, Ramani et al., 2003)</td>
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<td><strong>Instruct trainees to delay discussion of frightening or embarrassing topics</strong></td>
<td>(LaCombe, 1997, Ramani, 2003, Morgan, 1982)</td>
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<th>Attending preparation</th>
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<td><strong>Decide on the educational focus of the bedside session beforehand</strong></td>
<td>(Fitzgerald, 1993, Ende, 1997, Ramani, 2003, Ramani et al., 2003)</td>
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<td><strong>Ask questions of the team and not the patient’s primary caregiver to avoid undermining the established doctor-patient relationship</strong></td>
<td>(LaCombe, 1997)</td>
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<td><strong>Never ask questions of a junior member of the team after a senior member has missed the question</strong></td>
<td>(LaCombe, 1997, Ramani, 2003, Ramani et al., 2003)</td>
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<td><strong>Unrequested answers from junior team members should not be allowed when a senior team member was asked the question</strong></td>
<td>(LaCombe, 1997)</td>
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Table 2: Steps and Tips for Teaching at the bedside

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<td>2. Repeat goals of visit to the patient – education and patient care</td>
<td>(LaCombe, 1997)</td>
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<td>3. Allow family and friends to stay in the room dependent on patient wishes</td>
<td>(LaCombe, 1997, Ramani, 2003)</td>
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<td>4. Presentation by the primary caregiver on the team with corrections and additions from the patient</td>
<td>(Janicik and Fletcher, 2003, LaCombe, 1997, Morgan, 1982)</td>
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<td>6. Attending may then asks additional questions of the patient, demonstrating and role modeling history-taking skills, empathy, professionalism, communication</td>
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<td>7. Allow the primary caregiver on the team to examine the patient and demonstrate findings</td>
<td>(Morgan, 1982)</td>
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<td>8. Attending may then examine the patient to confirm findings and further evaluate the patient</td>
<td>(Morgan, 1982)</td>
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<td>9. Using available findings, demonstrate bedside physical diagnosis</td>
<td>(Fitzgerald, 1993)</td>
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<td>10. Allow the patient the final word before leaving the room</td>
<td>(Fitzgerald, 1993, Mooradian et al., 2001, Ramani et al., 2003)</td>
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<td>11. After leaving the patient’s room, debrief the team</td>
<td>(Fitzgerald, 1993, Ramani, 2003, Ramani et al., 2003)</td>
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<td>a. Allow trainees to ask questions or make comments</td>
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<td>b. Review the learning points of the session</td>
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<td>c. Ask the team for feedback on the session</td>
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<td>d. Self-reflect on the session</td>
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<td>12. One member of the team should return to the bedside to answer further patient questions</td>
<td>(Fitzgerald, 1993)</td>
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Practice Points

1. Bedside teaching is widely considered to be an irreplaceable part of medical education, yet the frequency of bedside teaching is decreasing.

2. Many pressures limit bedside teaching including financial, time, technology, and comfort level.

3. Both patients and trainees prefer bedside rounding.

4. Bedside teaching requires preparation by the trainees and the attending, and guidelines exist to make bedside teaching successful.

5. Returning to the bedside will require institutional initiatives, faculty training, an encouraging educational environment, and continued research to objectively prove the education benefits of bedside teaching.
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