Planning Effective Clinical Teaching Encounters for Occupational Therapy Students
Strategies to Improve Bedside Teaching

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This workshop will enable you to;

- Identify the components of effective clinical skill teaching in the presence of service users, from the point of view of;
  - The student
  - The educator
  - The service user
- Use a 4-step approach when teaching a concrete clinical skill
- Plan an effective clinical skill teaching encounter for a student in your particular clinical area
What is bedside teaching?

- In medical education
  - The process by which a clinician brings (usually) a group of students to the service user’s bedside, listens to their history, elicits physical signs, develops a provisional diagnosis and decides on a therapeutic plan
  - Can also occur in the service user’s home, or in the outpatient clinic
  - Declining in medical education with the rise in the use of the technology in favour of lecture/case based presentations
• Like medical students, Occupational Therapy students learn their craft through an “apprenticeship model”
  • Day to day clinical experience helps the student to develop the required skills and knowledge

• For Occupational Therapists, “bedside teaching” can be understood as the process of active learning by a student in the presence of a service user
  • Focus of today’s workshop will be specifically on this aspect of practice education
Doing a conceptual/thematic review

• “A critical synthesis of a variety of literatures, (which) identifies knowledge that is well established, highlights gaps in understanding, and provides some guidance regarding what remains to be understood”

• “The author should feel bound by a moral code to try to represent the literature (and the various perspectives therein) fairly, but need not adopt the guise of absolute systematicity” (Eva, 2008)(p.853)

• **Question:** What are the components of quality bedside teaching that Occupational Therapy educators can incorporate with their students?
What are some of the difficulties with “bedside” teaching?

Divide into groups of three with a mix of clinical backgrounds. One “student”, one “educator” and one “service user”

Task: “Educator” to carry out a simple intervention or assessment e.g. ROM assessment with the service user.

Work around the student as you normally would.
What are the challenges?

As the educator?
As the student?
As the service user?
4-Step Method (Lake & Hamdorf, 2004)

- **Demonstration** – Educator demonstrates at normal speed, no commentary
- **Deconstruction** – Educator demonstrates while describing steps
- **Comprehension** – Educator demonstrates while student describes steps
- **Performance** – Student demonstrates while student describes steps
Teach the clinical skill again

This time, use the 4-step method to teach a particular skill

This strategy will work best with certain types of clinical skill

**Demonstration** – Educator demonstrates at normal speed, no commentary

**Deconstruction** – Educator demonstrates while describing steps

**Comprehension** – Educator demonstrates while student describes steps

**Performance** – Student demonstrates while student describes steps
Challenges to bedside teaching identified in the literature

- Lack of privacy in ward environments
- Shorter hospital stays
- Service users not being available for therapy
- Teaching being less valued than clinical work (by organisations)
- Educator fear of facing a situation where they do not know the answer in front of a student and service user
What are the benefits?

- Bedside teaching effectively teaches professional skills (Nair et al. 1997).
- Highly valued by students
- Opportunity for mentorship – the student can observe the educator’s professional skills, their warmth towards a service user and their decision making process
- It is effective – research shows that it is more effective than a lecture series in teaching knowledge and skills in physical examination techniques
What strategies can we learn from the literature on Bedside Teaching?
The student perspective

• Students learn better when they are given a role in the session
• The learning environment should be comfortable, free from humiliation “free to ask questions and say ‘I don’t know’”
• Students are acutely aware of the communication with the client, and the client’s comfort in the session
The academic perspective

• Experiences on clinical placement are a vital predictor of the final degree marks of medical students
• Knowledge gained in this setting is retained longer
• Scaffolding learning – linking of new learning to prior knowledge and future situations is very effective
• When basic sciences are referred to at the bedside, the students are more likely to retain this information
The educator’s perspective

• The most effective role models for healthcare students are those that are regularly involved in clinical teaching (Janicik & Fletcher, 2003).

• Bedside teaching helps educators:
  • Keep up to date
  • Stay observant of their own work
  • Make tacit knowledge explicit
  • Highlight their own knowledge gaps

• Peer observation and feedback can be helpful
The service user’s perspective
The positives

• In one study, 77% of service users stated they enjoyed bedside teaching, and 83% confirmed that it did not make them anxious
• It can increase time spent by clinicians with service users
• Service users welcome;
  – Being able to ask questions during/after the teaching session
  – Advance notice
  – Efficient use of time
  – The explanation of any procedures/interventions
  – The clinician returning afterward to clarify any issues
The service user perspective
The challenges

- In the same study, only 37% of service users felt adequately forewarned about the bedside teaching

- Educators should;
  - Seek full consent
  - Avoid the use of jargon
  - Avoid discussing potentially worrying rehabilitation potential or prognosis information in front of the service user

- Students should;
  - Ask permission before sitting down
Structuring an effective clinical teaching session

Cox (1993)
Step one: Preparation before clinical experience

- Select the service user carefully – it is most helpful for students to build up basic skills first before moving on to complex situations
  - Try to plan to teach one skill in the session
- If the student is going to carry out the intervention, the educator should be sure that the student is fairly adept at it
- Have an understanding of the curriculum, but be aware that this doesn’t necessarily mean that the students will know it!
  - Ask them what they already know
  - Assess what a student already knows – can they try the assessment or intervention on you or another student beforehand?
Step two: Briefing before seeing the service user

- **Review;**
  - the client’s background
  - what is going to be addressed in this session
  - give guidelines
  - decide a time limit

- **Give guidance on;**
  - any issues that could upset or distract the service user
  - how they should behave in the session
  - how much autonomy they will have

- **If students are just going to observe, they need to be told what information they will be asked for afterward**

- **Brief the service user**
  - Permission
  - What to expect
  - Thanks and acknowledgement
Step three: Clinical experience with the service user

• Observation. Students need to know beforehand:
  – What to observe
  – How to observe
  – What indicates improvement/lack of improvement?
  – What is important/unimportant?

• Role modelling:
  – Rules of propriety
  – Checking/asking
  – Seeking feedback
  – Clinical skills

• Self-evaluation:
  – Did I teach well?
Step four: Debriefing after leaving the service user

- Most effective when the experience is still “fresh”
- Feedback VS Evaluation – the distinction should be made clear to the student
- Encourage the student to self-evaluate first
- “praise in public, criticise in private”
- Provide concrete examples of what the student did well, and where improvement was needed
- Make a learning plan for the future
Step five: Reflection on the experience and findings

- Moving from debriefing of the visible, external clinical events,
- To reflection on their invisible, internal, personal meanings
- Moving from “what went on” ... To “what did that mean?”
- Can occur after a period of time e.g. End of the day
- To encourage reflection, questioning can move from concrete observations to the deeper, more complex meanings
Step six: Explication of the experience

- “how can I unravel and explain what went on?”
- The process of stimulating of critical thinking and critical reasoning.
- Linking the clinical experience back to theory, and possible explanations for what was observed
- The educator can start this process, then the student can independently review textbooks or journals to link what they saw back to theory
Step seven: Working knowledge extracted from the “examined experience”

- Helps the student develop working rules for use in practice
- Allow the student freedom to come up with ideas for the next session
  - Students learn when they are able to bring out all their speculations and work out the pros and cons for themselves
- Students value the opportunity to practice writing notes after a session, and studies show that note-writing practice helps students to improve their skills for the next session
Step eight: Preparation for future service users

- Bedside teaching is effective when combined with independent learning projects to consolidate learning.
- Can be integrated with evidence based practice;
  - The service user’s occupational problem informs the search for evidence and the evidence-based intervention is brought back to the bedside.
Planning a clinical teaching session in your setting

Form a group with others who work in the same clinical area

Using the 8 step model presented, design a teaching session to be carried out with one or two students in the presence of a service user
The 8-step process

1. Preparation
2. Briefing
3. Clinical Encounter
4. Debriefing
5. Reflection
6. Explication
7. Working Knowledge
8. Preparation for Future
Any questions or comments?
Key References


