The benefits of teaching at the patient’s bedside have been well documented and described. Ramani et al.\(^1\) identify these as being the demonstration of communication skills, the findings of the physical examination, the teaching of humanistic aspects of clinical medicine, and the opportunity to role-model professional behaviour. These qualities cannot be as effectively demonstrated in the classroom. In addition, bedside teaching also gives the teacher the opportunity to observe the learners.\(^2\)

Despite the fact that bedside teaching is acknowledged for the unique benefits which it brings to the student’s learning, the time allocated to bedside teaching has been shown to be on the decline. El-Bagir and Ahmed\(^3\) report a decline from ‘75% of teaching time 30 years ago to just 16% by 1978’ and note that it is much lower now. Ramani et al.\(^1\) report that estimates of actual time spent at the bedside vary from 15% to 25%. Several barriers to bedside teaching have been identified: new technology, increased workloads,\(^3\) and the fact that teaching is not as highly valued in our academic settings as is research. El-Bagir and Ahmed\(^3\) go on to say that bedside teaching ‘has been neglected and rendered haphazard, mediocre and lacking in intellectual excitement, so much so that the clinical examination skills of young doctors have been seriously compromised’. This is of some concern when one considers the findings reported by Nair et al.\(^4\) Only 48% of learners reported that they had been given enough bedside teaching during their undergraduate training, while 100% thought that bedside learning was the most effective way of learning clinical skills.

In the first 2 years of study of the graduate entry medical programme (GEMP) at the University of the Witwatersrand, the key approach to teaching and learning is problem-based learning. This teaching and learning approach uses trigger scenarios to stimulate learning. In addition, students are introduced to the clinical environment and spend one day a week in hospitals or community clinics. In the 3rd and 4th years of study, these trigger scenarios are replaced by actual cases in the wards, and bedside teaching then forms the core approach to teaching and learning. Students in the third and fourth years of study of the GEMP are divided into groups and rotate through ‘blocks’ of study in the various clinical disciplines. There are approximately 30 students in each of these blocks at any one time. The students are divided between 3 teaching hospitals, so that there are approximately 10 students allocated to a hospital for a particular clinical discipline at a time. Bedside teaching forms the core teaching and learning strategy during these rotations. The bedside teachers are usually members of the faculty staff, who are in joint appointments with the provincial health departments and have a teaching responsibility to the university. Rewards

---

**Summary**

**Background.** Bedside teaching is the core teaching strategy in the clinical study years of the medical undergraduate degree at the University of the Witwatersrand. The quality of this teaching strategy has not been formally evaluated by students as other teaching strategies have been.

**Method.** A quantitative, descriptive study was undertaken in the final year of study of the graduate entry medical programme (GEMP). The sample comprised medical students who were completing their surgical block during September and November 2008. There were approximately 30 students in each of these 2 blocks. A bedside teaching evaluation questionnaire was developed, based on previously validated peer review questionnaires used in evaluating small group formal classroom-based lectures. The purpose of the study was to determine the reliability of the instrument for evaluating bedside teaching.

**Results.** A sample of 112 evaluations was obtained and the constructs and sub-constructs were subjected to an analysis using Cronbach’s alpha.

**Conclusion.** The overall Cronbach’s alpha was 0.9627, demonstrating that the instrument is reliable and can be used to evaluate bedside teaching.
for good teaching are limited, and remaining motivated to teach is teacher-dependent. The purpose of the bedside teaching instrument is to motivate good teaching. During the first 2 years of study, attention is given to evaluation of a number of aspects of the teaching-learning process, such as the case used in the trigger, the facilitator, the week’s activities and the system block. However, little or no attention has been given to the evaluation of bedside teaching.

**Problem statement**

While bedside teaching forms a core component of a problem-based learning curriculum for medical students at the University of the Witwatersrand, there was no formal evaluation of this teaching-learning modality and therefore no information as to whether this learning strategy was achieving its objective in terms of developing understanding about content and interpersonal skills. Therefore, the purpose of this pilot study was to determine the quality of bedside teaching in one group of students in the medical curriculum with a view to validating an instrument for evaluating bedside teaching.

**Methods**

A quantitative, descriptive study was undertaken in the final year of study of the GEMP. The sample comprised medical students who were completing their surgical block during September and November 2008. There were approximately 30 students in each block.

The objectives of the study were to determine:

- whether the tutor gave attention to establishing interpersonal relations with both the students and the patient
- the quality of the teaching and the learning experience for the student
- the reliability of the instrument.

The bedside teaching evaluation questionnaire (Fig.1) was adapted from similar peer review questionnaires evaluating small-group formal lectures. It comprised 23 questions. Five questions related to the learning climate, 4 to the student’s learning, 10 to the actual tutorial at the bedside, and 4 to the student’s perceptions of the tutorial.

The students were asked to rate each of the 23 questions on a scale of 1 - 5, with 1 meaning ‘not done’ and 5 ‘excellent’.

One of 2 study co-ordinators made the students aware of the study prior to the tutorial and gave the forms to the students. The bedside teacher was aware that the study was being undertaken, and one of the study co-ordinators attended each session evaluated by students. Students were asked to complete the questionnaires immediately after the tutorial without the teacher being present, and to place the completed questionnaires into an envelope which was sealed by the study co-ordinator once all the forms had been returned. The sealed envelopes were returned to the study co-ordinator’s office where they were kept in a locked cupboard.

Permission was granted by the Head of Surgery to undertake this pilot study in the surgical block. Participation in the study was voluntary – participants were assured that their responses would be treated confidentially and that the completed evaluation forms would not be shown to the teachers. The bedside teachers were told about the study and individual permission for the study co-ordinator to attend the teaching session was obtained from each teacher before commencement of the teaching session. Permission to
The evaluation.indd   52

...