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BEDSIDE TEACHING IN UNDERGRADUATE MEDICAL EDUCATION

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Bedside teaching was traditionally the predominant form of teaching medical students. There are a number of viewpoints, as well as accepted definitions of bedside teaching, however many of them seem very vague and do not highlight the essence of it. The simplest and most comprehensible definition is that bedside teaching is teaching in the presence of a patient, when the physician is in charge of a group of students at the bedside to make them better conceptualize the history and physical signs. Thus, bedside teaching supposes the presence of three participants: the teacher, the student and the patient [17]. Sir William Osler, a Canadian physician and professor of medicine, is considered to be the father of bedside teaching, as he played a fundamental role in revolutionizing medical education philosophy, highlighting the importance of students' clinical experience. He claimed "To study the phenomena of disease without books is to sail an uncharted sea, whilst to study books without patients is not to go to sea at all" [5, 22]. He proved that history taking and physical examination skills, touch, respect, empathy together with professional attitude should comprise the core of medical education and therefore the skills are obtained not in the classrooms theoretically, but at the bedside practically [13]. Even in the very past, before William Osler, historically, it has been obvious that the concept of practical teaching is much valued and applied. German-Swiss physician Paracelsus wrote about the importance of practice in medical education: "Every physician must be rich in knowledge, and not only of that which is written in books; his patients should be his book, they will never mislead him" [23].

Bedside teaching is undeniably a great opportunity for doctors-to-be. In contrast to classroom teachings and

lectures, clinical teaching allows the students, as prospective medical professionals, not only to use the material learned from the textbooks and draw conclusions, but triggers all the organs of senses to operate: to touch, smell, see, hear [1, 3]. That is why, William Osler relentlessly believed that "the student begins with the patient, continues with the patient and ends his study with the patient, using books and lectures as tools, as means to an end". Although bedside teaching is a useful tool and teaching modality, it seems to decline and move into classrooms through the course of time. According to recent studies, the estimates of actual time spent at the bedside varies from 15% to 25% [11, 18]. There are dozens of reasons: introduction of innovative simulation training methods, time constraints, lack of teachers' professionalism or confidence, increasing reliance on modern technologies. Apart from these reasons the weightiest one definitely refers to the patients' attitude towards clinical teaching which surely can result in the decrease of its applicability [2, 24].

Bedside teaching is carried out firstly for the students, as a backing point to their education, to gain profession-related skills, specialize in making diagnosis and finding a common tongue with the patients, secondly for the teachers to train their communication and organizing skills, and thirdly for the patients to better comprehend their illness. So, the teachers, the students and the patients are the core elements of this triangle, therefore the process productivity should be determined by analyzing all the participants' opinions.

Thus, the aim of the study is to analyze bedside teaching from the perspective of teachers, students and patients, find out its advantages and shortcomings. The objectives of this study are to arbitrate the bedside teaching role, and come up with suggestions about its implementation improvements. Since this teaching modality has always enjoyed great popularity in Armenia, we both conducted a literature review, and focused on the current Armenian context of the issue.

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Material and methods

A literature review was carried out: corresponding articles were observed according to their abstract content and objectives. The literature search was conducted taking into account the key words: bedside teaching, clinical teaching, medical education, clinical teaching benefits, bedside teaching decline, clinical skills. We prioritized the articles published in the past two decades; 52 articles were reviewed, only 27 of them, however, met the inclusion criteria of the study. All the articles were open access. Preference was given to the articles analyzing:

- ◆ students' viewpoints;
- ◆ patients' expectations from bedside interactions;
- ◆ teachers' clinical skills.

We excluded:

- ◆ foreign language publications;
- ◆ articles discussing bedside teaching in relation to COVID-19 pandemic.

To compare the issues with the Armenian context, we also analyzed the existing data on the examples of Yerevan State Medical University after M. Heratsi (YSMU).

Results and discussion

Clinical teaching is considered a challenging, burdensome and serious experience, that requires much efforts, attention and energy from all the participants (students, teachers, patients). Especially now in the 21st century, when modern technologies have intruded into all the spheres of life, a lot of people lack real communication, which is the core condition and requirement for effective doctor-patient interaction. However, it does not mean that clinical teaching does not cause inconveniences and should totally substitute classroom teachings. Thus, to better comprehend the essence of the process, the viewpoints of students, teachers and patients are presented below in the subgroups, in detail to find out whether to teach or not to teach at the bedside.

Bedside teaching from a student's perspective

Students are the most important stakeholders in bedside teaching [4]. Therefore, it is unacceptable to turn a blind eye on their needs, opinions and suggestions. Bedside teaching is at first helpful for students to gain profession-related skills, specialize in making diagnosis and find a common tongue with the patients. Many learners believed that, in spite of technological innovations, patients still expect dialogue with and examination by their physicians and are disappointed when clinical interactions are inadequate. Some learners desired international medical

experiences where they could obtain traditional clinical teaching in the absence of the influence of technology. Bedside skills are not just about history and examination, it is also about communication, empathy, and humanism [26]. Nor is it just the patient who benefits from bedside rounds. The value of taking a history, formulating diagnoses and performing a physical examination becomes clear at the bedside. As the studies show, approximately more than a half of patient's problems can be diagnosed with a good physical examination, in case of certain problems, the percentage can be over 90% [21, 27]. It is very powerful if you see the example on actual patients, and especially if you know more about their story, their background, you are more likely to take something away from that experience. There also exists a patient-oriented approach that patients are the reason we have moved away from the bedside to do our teaching. However, in reality the students are the main motive, as they are the doctors-to-be, therefore clinical teaching, at first, is conducted for their benefits. It gives them an opportunity to reflect on their goals as teachers, learners, and healers [6, 10].

In spite of all the beneficial influence that bedside teaching rounds have on student's professional development, they mention about the impossibility of discussing some topics with patients. There can be sensitive issues that relate to specific diseases which the patient wouldn't be very willing to lead a conversation on. It may refer to abuse, mental health, and sexuality-related topics, which can embarrass the patient and result in the elicitation of inaccurate information [19]. Conversations about deadly diseases such as cancer may also be undue to discuss, in these cases clinical teaching rounds may turn into downfall and this is one of the most common drawbacks that the students often complain about.

However, to sum up, we can announce that despite some of the inconveniences mentioned above, the students are for bedside rounds. Confidence in interacting with patients, the acquired communication, conflict-resolving, stress-resistance skills, professionalism, a sense of responsibility, tolerance, sensitivity and a great many features and qualities could have never been acquired in classroom teachings.

Bedside teaching from a teacher's perspective

The teachers-clinicians are the second most important part of the triangle. For the sympathetic teachers bedside teaching can be a vital tool to demonstrate their knowledge and skills and obtain the desired feedback

from the students. A good bedside teaching experience depends on the teacher's level of communication and organization skills, as the teacher is the host of the process. A well-planned bedside teaching experience can give students even more than weeks of classroom lectures. The teacher can use bedside teaching to develop a sense of responsibility among students, which will later be necessary in practice. They comprise the part of the process, and as everything is real, the patient is in front of the student with a real problem, the degree of responsibility arises. However, effective bedside teaching rounds require specific skills and techniques and to decide what particular system is to be taught at the bedside. For instance, it has to be determined beforehand what specific aspects of bedside teaching are going to be emphasized: history taking, physical examination, patient counseling, breaking bad news. To keep all the students engaged in the process and feel comfortable a teacher-clinician should create a healthy bedside teaching atmosphere [1]. Each student should be provided with the chance to participate in bedside sessions and the teacher should try not to ask excessively confusing questions that may demotivate a student. At the end there can be a feedback session to sum up what has been taught, and appropriate time should be dispensed for discussions. Sometimes debriefing sessions after bedside interactions can really be helpful, as they discuss what went on wrong at the bedside, what was understood and what was not, what has been recognized and interpreted accurately [8]. A good teacher-clinician knows whether to make a diagnosis in the presence of the patient or organize a separate group-discussion with the students judging from a number of factors, including the patient's state, the atmosphere at the bedside and the disease. Besides, the most convenient time to correct the student who is demonstrating insufficient and inaccurate clinical examination skills is exactly at the moment of bedside interactions. Prompt demonstration of appropriate technique with supervised practice is more likely to change behavior [18]. Bedside teaching can trigger learners to develop history taking, examination skills, knowledge of clinical ethics, professionalism, and surely good communication skills. Bedside rounds are fruitful in a way that they are a combination of theory, practical skills, as well as patient contact, which makes the educational process as realistic as possible [20].

Surprisingly, despite all the beneficial aspects of clinical teaching, still there are a number of barriers towards its implementation and bedside teaching sessions are declining among the teachers at a very high pace. A

considerable number of obstacles that keep the doctors away from teaching at the bedside have been identified, and various studies have mentioned "lack of time", the growing pressure to see more patients, great demand for paperwork, rapid patient discharge, and over-reliance on technology as the most important element. However, except for the time constraint also individual improper communication skills may limit the number of bedside teaching rounds. Lack of confidence in one's own clinical skills makes bedside teaching impossible. The shortened admittance of patients, for example, also increases the workload of doctors on the one hand, and on the other hand decreases the availability of patients for bedside interactions. Another significant barrier that clinical teachers may encounter is the performance pressure in bedside teaching context. Younger clinicians hear about the professionalism and mastery of the older generation who performed brilliant bedside rounds, and thus develop inferiority complex, thinking that they can never achieve that proficiency level, as many of them may did not have bedside rounds during university years themselves. That feeling even worsens the existing situation and can result in a loss of control at the bedside, something almost impossible to experience while lecturing in classrooms [18]. Lack of professionalism, insufficient knowledge in that field and also poor interaction skills with patients can create a lukewarm atmosphere and fail the teaching round.

All in all, we can surely announce that from the teachers' perspective bedside teaching rounds are very valuable if organized thoroughly and planned beforehand. What refers to disadvantages, they are not so weighty and can be solved easily. So, in this group the number of benefits wins against the number of shortcomings.

Bedside teaching from patient's perspective

Patients have their greatest share in successful bedside teaching: they can either make the atmosphere relaxed or cause inconveniences. If we focus our attention on the benefits of bedside teaching from the patients' viewpoint, firstly we can note that these rounds demonstrate great interest and concern for the patient. That is the reason that the patients generally respond favorably to them. Patients are excited to know that the physicians care for them and are concerned about their problems. Besides, while observing the team in action, they have a great opportunity to participate in their own care, clarify the details and have a better comprehension of their diseases. If bedside rounds are organized properly, patients

may passively take part in the decision-making process and may think that their opinions, problems and feelings matter [6, 14]. This kind of approach is especially common in Western countries, where people are more open, more tolerant, enthusiastic to talk, discuss and interact. Patients want to comprise the part of the conversations about their care, they greatly value the opportunity to learn about their medical problems and what to anticipate in terms of therapy. Being actively engaged in bedside rounds patients may have much to teach the staff about their experience of clinical interactions, and later considering all those can be very helpful in becoming more patient-oriented. Besides, the results show that patients whose case presentations were made at the bedside had slightly more positive feelings about their hospital experiences and their relationships with their physicians than the patients whose case presentations were made in a conference room [9].

However, if we take a look at the other side of the coin, most of the educators and medical students assume that bedside interactions may put patients under stress and embarrass them. Therefore, it is highly recommended to receive patients informed consent in hospital admission before the teaching starts and prior to any physical examination, which they have a right to refuse. In this case the teacher-clinicians should be able to make a patient's visit a kind of teaching visit with a very particular purpose. The teachers should realize how to involve patients and students in the educational process, simultaneously maintaining a comfortable environment for all the participants. Patients may also become unwilling to participate because of pain, anxiety, embarrassment, or "student fatigue". The data also presents that patient were made uncomfortable by the team using language they did not understand and when several people examined or touched them simultaneously. Non-verbal like touching the patient (performing percussion, palpation and auscultation) may be a useful practice for the students, but it can make the patients feel awkward. The majority also felt uncomfortable when the staff used language that they did not understand, because medical terminology may sound foreign and confusing for them [7, 9]. The problem can be solved by explaining the patients the particular purpose of visit, avoid using specific medical terms and explain the situation, so that the patients know what to expect [26]. A negative approach towards bedside teaching is very common in Eastern countries, where the patients are not so open and enthusiastic to share their experience and personal information with outsiders. Sometimes, they

may even have difficulty in interacting with the physician and talking about complaints or the details of the disease. In Armenia, too, bedside discussions are perceived as violation of one's private zone and therefore is not much welcomed. However, it depends on the age group. Mostly the older generation (65 and older), especially females, welcome the students and are ready to share their experience. They would like to be part of the conversations about their care and highly appreciate the chance to learn about their medical problems and what to expect in terms of tests and therapy. Besides, seeing learners trying to their disease makes them comfortable and relaxed [15, 25]. The youngsters, on the contrary, have difficulty in interacting, are ashamed of sharing their problems with their interlocutors and logically it puts a great obstacle on bedside rounds, especially if the students are not of the same sex, as patients. This is very vividly highlighted in the Armenian context. Bedside rounds could not succeed if the groups are not homogeneous: e.g. females sometimes would like to be examined by female students.

To sum up the details about the patients' point of view, we can say that everything depends on the personality type and the nationality, mentality and the atmosphere where they have been raised. In Eastern countries still bedside teaching is perceived as a violation of privacy, patients do not welcome a great number of students at the same time. Moreover, they would prefer to communicate only with their own doctor. While in Western countries this kind of activity is much welcomed, it is perceived by the patients, that their situation is appreciated, paid much attention to and the people care for them.

All in all, we can see that none of the participants was drastically against the implementation of bedside teaching or found it unhelpful.

Conclusion

High-quality medical education is a fundamental aspect of high-quality medical care and bedside teaching has something to offer [1]. Although it is at the risk of disappearing from the curricula and there are various reasons, the analysis shows that bedside interactions continue to conquer the largest share of medical practice for the unique benefits that they provide. Despite all the troubles that the bedside teaching rounds cause, their efficiency level is rather high from students' and teachers' perspective, as the advantages are more than drawbacks. The value of clinical interactions in the education of medical students should not be underestimated and they need to receive the same degree of value as formal lectures,

as they equally contribute to the quality development of medical education [12, 16]. What refers to the patients' opinion, we came to the conclusion that the willingness to be included in bedside teaching rounds depends on a number of factors: nationality, ethnicity, religion, gender, age and social class. Mostly, the older female adults regard bedside teaching as an enjoyable experience and are open to be engaged in a conversation about their disease more than patients of other age groups. The study shows that this is even a necessary experience for the older generation, who really strive for face-to-face communication. However, the student/patient ratio may also matter to avoid the feeling of exhaustion among patients. So, bedside teaching rounds can be conducted in smaller groups: for instance, 5-6 students per patient. But it is not a guarantee either, since some patients may refuse bedside teaching rounds because of individual unknown reasons.

In Armenia, still bedside teaching is sometimes perceived as a privacy violation, especially while discussing

sensitive issues related to specific fields, like Psychiatry, Obstetrics and Gynecology which the patient wouldn't be very willing to interact. Similarly, in Eastern countries people are not enthusiastic about this method, either, while in most of the Western countries it is much welcomed by the patients. But we rather explain bedside teaching refusal by patients in Armenia with the "small country" phenomenon. The bedside teaching decline may also be explained by the implementation of medical simulation teaching, learning and assessment methodology in YSMU since 2014, which substantially reinforced clinical skills teaching.

Thus, we conclude that, although there has been a great tendency of its decline, bedside teaching can no way be substituted: it continues to be an irreplaceable teaching modality, and medical educational institutions are supposed not to neglect its value, but rather provide sufficient conditions for its development, find means to neutralize the obstacles, minimize the perils and trigger bedside rounds implementation.

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ԱՄՓՈՓՈՒՄ

ՄԱՅՃԱԿԱԼԻ ՄՈՏ ՈՒՍՈՒՑՈՒՄԸ ԲԱՐՁՐԱԳՈՒՅՆ ԲԺՇԿԱԿԱՆ ԿՐԹՈՒԹՅԱՆ ՀԱՄԱԿԱՐԳՈՒՄ

Բայկով Ա.Վ., Շաղբաթյան Տ.Լ.

Երևանի Մ. Զեյնալու անվան պետական բժշկական համալսարան, կրթական ծրագրերի բաժին

Բանալի բառեր` հիվանդի մահճակալի մոտ ուսուցում, կլինիկական ուսուցում, բարձրագույն բժշկական կրթություն, կլինիկական հմտություններ:

Հիվանդի մահճակալի մոտ դասավանդումը դարեր շարունակ եղել է բժիշկներ պատրաստելու ամենաարդյունավետ ուղղություններից մեկը: Այն գործնական բժշկական կրթության գլխավոր հիմնաքարն է, քանի որ հնարավորություն է ընձեռում ուսանողներին մասնակցելու մասնագիտական բժշկական գործունեությամբ պայմանավորված մի շարք իրական գործընթացներին, որն անհնար կլիներ իրականացնել լսարանում՝ գրատախտակի առջև: Շատ բժիշկներ, մտածողներ և փիլիսոփաներ արտահայտվել են բժշկական կրթության մեջ ուսումնառության ընթացքում կլինիկական փորձառության կարևորության, հիվանդին հետազոտելու հմտությունների ձեռքբերման և հիվանդության պատմագրեր կազմելու կարևորության մասին: Հիմնահարցն ուսումնասիրելու նպատակով կատարարվել է անգլալեզու գրականության վերլուծություն, տվյալները համադրվել են ԵՊԲՀ մեթոդական և կազմակերպական գործիքակազմի հետ:

Հիվանդասենյակում հիվանդի մահճակալի մոտ դասավանդումը կատարվում է ուսանողի, բժիշկ-դասավանդողի և հիվանդի անմիջական հաղորդակցման միջոցով, որը, սակայն, ոչ միշտ է հաջողված լինում: Չնայած դասավանդման այս եղանակի կարևորությանը՝ այն աստիճանաբար դուրս է մղվել բժշկական բուհերի դասավանդման մեթոդակազմից, կիրառելիությունը նվազել է, քանի որ գործընթացի կազմակերպման և բուն ընթացքի ժամանակ ի հայտ են գալիս մի շարք խնդիրներ, որոնք նվազեցնում են դասավանդման այս տեսակի արդյունավետությունը: Դա է պատճառը, որ ներկայումս բարձրագույն բժշկական կրթության ասպարեզի հաստատությունները բավարար

միջոցներ չեն գործադրում այն նորից ուսումնական պրոցես վերադարձնելու համար: Բացի դրանից, 21-րդ դարում նորարարական բարձր տեխնոլոգիաների ի հայտ գալը ևս նպաստել է հիվանդի մահճակալի մոտ դասավանդման եղանակի դուրսմղմանը: Սակայն չպետք է մոռանալ, որ միայն ժամանակակից տեխնոլոգիաներին տիրապետելը չի կարող ապագա բժիշկներին լիովին զինել հիվանդների հետ վարվելու հմտություններով: Հիվանդի հետ դեմ առ դեմ շփումը և արդյունավետ հաղորդակցական հմտությունների դրսևորումը բժշկի կարևորագույն կոմպետենցիաներից են: Միայն լսարանում տեսական գիտելիք ստանալը և գործնականում իրական հիվանդի վրա այն կիրառելու ընդունակ չլինելը անընդունելի է մասնագիտական ուղի ձևավորելու համար: Հիվանդասենյակում դասավանդման դժվարություններ կարող են առաջանալ մի շարք հանգամանքների բերումով, որոնցից են հիվանդի խնդրի կամ հիվանդության տեսակը, հիվանդի տարիքը, սեռը, ազգային պատկանելությունը, նրա վերաբերմունքը դասավանդման տվյալ եղանակին, երբեմն նաև դասախոսի ոչ պատշաճ արհեստավարժությունը և դասավանդման փորձը: Ինստիտուցիոնալ միջոցների սղությունը և ուսանողների մեծ քանակը նույնպես կարող են դասավանդման այս տեսակի կիրառելիության նվազման պատճառ դառնալ:

Առկա խնդիրները հաղթահարելու համար անհրաժեշտ է նախաձեռնել մի շարք մեթոդական բարեփոխումներ, մշակել կազմակերպական լուծումներ, որոնք նորովի կարժևորեն մահճակալի մոտ դասավանդումը և կհամալրեն ներկայիս բժշկական կրթության ուսումնառության, դասավանդման և ստուգման մեթոդաբանական գործիքակազմը և ապագա բժիշկներին կզինեն մասնագիտական հաղորդակցական հմտություններով:

РЕЗЮМЕ

ОБУЧЕНИЕ У ПОСТЕЛИ БОЛЬНОГО В СИСТЕМЕ ВЫСШЕГО МЕДИЦИНСКОГО ОБРАЗОВАНИЯ*Байков А.В. *, Шахбатян Т.Л.**Ереванский государственный медицинский университет им. М. Гераци, отдел образовательных программ*

Ключевые слова: обучение у постели больного, клиническое обучение, высшее медицинское образование, клинические навыки.

Обучение у постели больного веками являлось одним из самых эффективных способов подготовки врачей. Оно считается ключевым элементом клинического обучения, поскольку позволяет студентам участвовать в ряде реальных процессов, связанных с профессиональной деятельностью врача, что было бы невозможно осуществить в аудитории у доски. Многие врачи, мыслители и философы высказывались о важности клинического опыта в медицинском образовании вообще и о приобретении навыков исследования пациентов, и способности оформлять истории болезни уже во время учебы в частности. С целью выяснения современного состояния проблемы обучения у постели больного была проанализирована современная англоязычная литература с сопоставлением со спектром методик и формами обучения, применяемыми в Ереванском государственном медицинском университете им. М. Гераци.

Обучение у постели больного в больничной палате предполагает непосредственную коммуникацию студента, врача-преподавателя и больного, которая, однако, не всегда бывает успешной. Несмотря на важность этой формы обучения, она постепенно вытесняется из набора методик обучения медицинских вузов, так как в организации процесса возникают проблемы, значительно снижающие эффективность обучения, в связи с чем, высшие учебные заведения

в настоящее время зачастую не принимают меры по ее поддержке и развитию. Помимо этого, в XXI веке внедрение инновационных образовательных технологий несколько затмило эту форму обучения. Однако нельзя забывать, что владение современными технологиями не может в полной мере вооружить будущих врачей необходимыми профессиональными навыками. Общение с пациентом и демонстрация эффективных коммуникативных навыков являются одними из важнейших обязанностей врача. Получение теоретических знаний на занятиях без применения их на практике с реальным пациентом недостаточно для успешной карьеры врача. Трудности обучения у постели больного могут быть связаны со многими факторами, в том числе особенностью болезни, возрастом, полом, этнической принадлежностью пациента, отношением к форме обучения, а иногда и профессионализмом и педагогическим опытом преподавателя. Дефицит институциональных средств и большое количество студентов также могут привести к снижению эффективности этой формы обучения.

Для преодоления существующих проблем необходима методологическая реформа с организационными решениями, позволяющими в полной мере применить и развить эту форму обучения для обеспечения надлежащего формирования профессиональных коммуникативных компетенций будущих врачей.