University of Derna

Faculty of medicine

Bedside teaching logbook

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2024

Student's name

Roll number

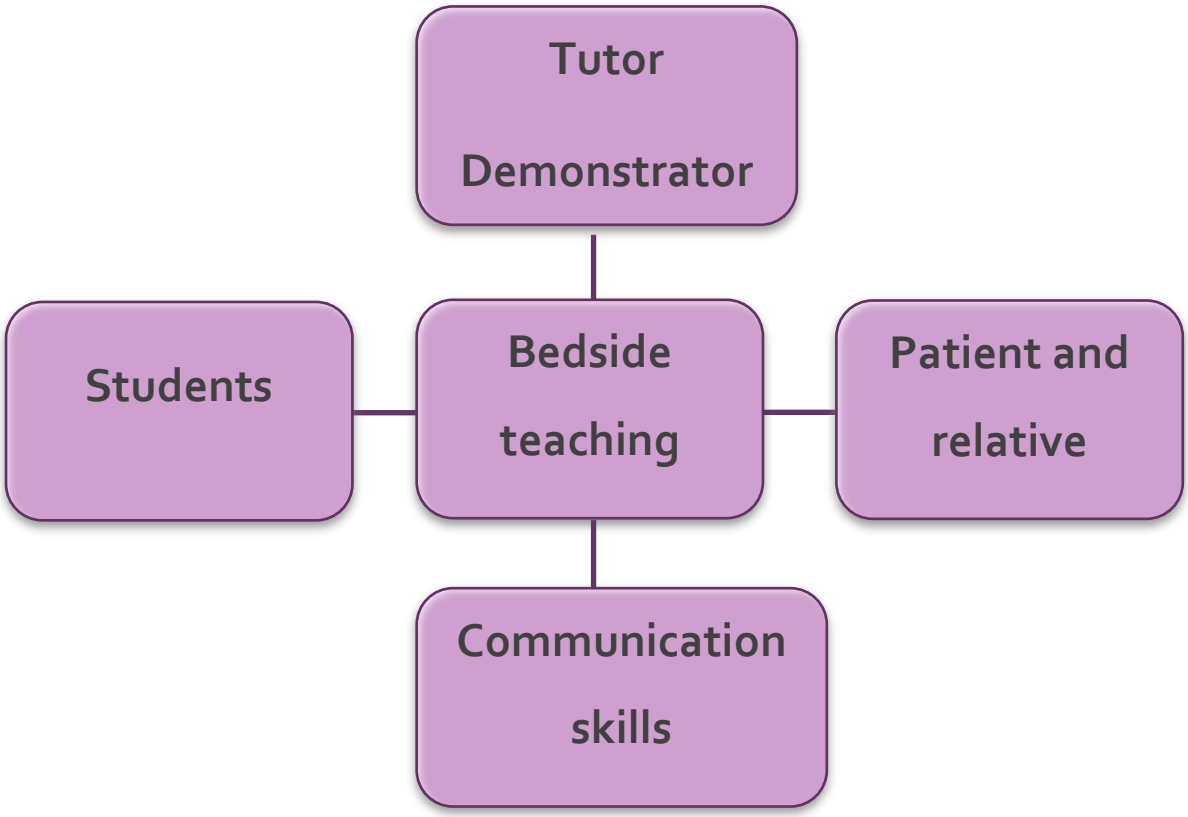
Group

Aims of bedside teaching

Bedside teaching (BST) is a teaching method in medical education which offers students the opportunity to practice history taking and clinical examination with real patients under the supervision of clinical teaching staff.

Aims:

- Allows resident teacher to provide professional role modeling for junior medical learners.
- Allows resident teacher to observe learner's clinical skills and give immediate, direct feedback.
- Facilitates active, case-based learning.
- Can be used in almost any patient care setting – inpatient or outpatient.



General information

Purpose of the Logbook:

1. The bedside teaching Logbook serves as a critical document for recording and tracking a student's clinical activities.
2. It is used by the Clinical Assessor: The logbook is presented to the clinical assessor each time the student observes, assists, or performs a procedure.
3. Student's Responsibility: It is the student's duty to ensure the logbook is provided to the assessor whenever they engage in a clinical session.
4. Completion Requirement: Both the student and the clinical assessor must fully complete and sign the logbook before the student is allowed to take the final examination.
5. Tracking Procedure Frequency: The logbook will record how often each case is observed, history taken, or examined by the student.
6. Review by Clinical Supervisor: The logbook will also dictate how frequently the Clinical Supervisor reviews the student's progress.

Aim of the Logbook

- The primary goal of the logbook is to document the student's learning experiences and clinical training, ensuring they develop the competencies and skills necessary to meet the standards of a registered scope of practice.

Instructions before taking history and examination

1. To earn and maintain patients' trust and confidence, doctors and medical students must adhere to specific behavioral standards.
2. Consider the clinical aspects of your training as preparation for your future professional role as a doctor.
3. Maintaining a certain standard of appearance is essential, both for your benefit and, most importantly, for the comfort of your patients.
4. Patients come from diverse backgrounds, and those who are ill or anxious may become concerned over minor details.
5. Many will view you as they would a fully-trained doctor.
6. By maintaining professional and relatively conservative standards of dress and behavior, you are less likely to cause offense or anxiety, leading to smoother relationships with both patients and hospital staff.
7. Students should dress smartly in a manner that is both appropriate and professional, adhering to infection control policies when on hospital wards, at GP surgeries, during clinical skills sessions with patients or simulated patients, and at OSCEs.
8. No denim, low-cut tops, or bare midriffs.
9. No trainers or stilettos.
10. No wristwatches, bracelets, Limited jewelry.
11. Ties should be secured inside shirts, unless a specific consultant asks you to remove them.
12. Fingernails should be short and clean, with no false nails.
13. Identification must be visible at all times

Taking History

As a medical student, learning effective history taking is crucial for providing quality patient care. Here are some high-yield tips from experienced doctors:

1. **Find a Suitable Seat:** Choose a chair to sit in rather than sitting on the bed or standing over the patient.
2. **Assess the Environment:** Consider factors like ambient noise and privacy to ensure that your conversation cannot be overheard.
3. **Be Friendly and Approachable:** Start with a smile and use an icebreaker, such as a comment on a non-medical topic, to make the patient feel comfortable.
4. **Greet the Patient Respectfully:** Use the patient's title and surname, and confirm that you're using their preferred form of address.
5. **Introduce Yourself:** State your full name and role, such as "fourth-year medical student."
6. **Explain the Purpose of the Interview:** Clarify that the interview is for practice in gathering information.
7. **Obtain Consent:** Ask for the patient's consent to proceed. If they decline, thank them and respectfully leave.
8. **Request Permission to Take Notes:** Explain that the information will be shared with the doctor.
9. **Show Respect and Care:** Pay attention to the patient's comfort and privacy, for example, by asking if they would like the curtain drawn.
10. Use open-ended questions: Start with broad, open-ended questions like "What brings you in today?" or "Can you tell me more about your symptoms?" This encourages the patient to share their narrative.
11. Actively listen: Pay close attention to the patient's verbal and nonverbal cues. This helps you identify important details and tailor your questioning.
12. Organize your approach: Follow a structured format, such as the OPQRST (Onset, Provocation, Quality, Radiation, Severity, Time) mnemonic, to ensure you cover all relevant aspects of the patient's chief complaint.
13. Explore relevant history: Inquire about the patient's past medical history, family history, social history, and any pertinent review of systems. This provides important context.
14. Use reflective questioning: Periodically summarize what you've heard and ask clarifying questions to ensure you understand the patient's concerns.

15. Document thoroughly: Take detailed notes during the interview, including the patient's exact words, to create a comprehensive medical record.

⇒ Practice: History taking is a skill that improves with experience. Seek out opportunities to conduct mock interviews, observe experienced clinicians, and receive feedback.

⇒ Tailor your approach: Adapt your communication style and questioning based on the individual patient's needs, cultural background, and level of understanding.

⇒ Maintain empathy: Approach each patient with genuine care and concern, acknowledging their experiences and validating their perspectives.

Performing examination

1. Wash your hands.
2. Introduce yourself to the patient.
3. Obtain consent for the examination.
4. Explain that you wish to examine.
5. Ask the patient if they are in any pain and to tell you if they experience any during the examination.
6. Expose the necessary parts of the patient.
7. Taking care to ensure the patient is not cold or unnecessarily embarrassed.
8. Keep privacy.
9. Explain what are you going to do in each step.

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