E-ISSN: 3078-9095
P-ISSN: 3078-9087
www.nursingcarejournal.info
JPCNP 2025; 2(2): 16-21
Received: 10-06-2025
Accepted: 12-07-2025

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Impact of short bedside teaching sessions on patient confidence in hospital wards

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DOI: https://www.doi.org/10.33545/30789087.2025.v2.i2.A.15

Abstract
Bedside teaching remains a cornerstone of clinical education, yet concerns persist about its impact on patients' comfort and confidence in the care they receive. Contemporary literature suggests that, when done well, bedside rounds can enhance patient understanding, satisfaction, and engagement without compromising privacy or dignity. However, little is known about the specific effect of *short, structured* bedside teaching sessions on patients' confidence in hospital wards. This prospective research evaluates whether brief (10-15 minute) bedside teaching encounters, integrated into routine ward rounds, influence patients' confidence in their treating team. Adult inpatients in medical wards were allocated to either standard ward rounds or ward rounds incorporating short bedside teaching sessions led by senior residents with medical students present. Patient confidence was measured within 24 hours of the round using a validated patient-confidence questionnaire adapted from instruments assessing trust and confidence in physicians, alongside secondary outcomes of perceived communication quality and willingness to ask questions. We hypothesised that patients exposed to short bedside teaching would report higher confidence scores than those receiving usual care. Preliminary analyses indicate that patients generally welcome bedside teaching, particularly when they are introduced to students, consent is explicitly obtained, and the teaching emphasises clear explanations and shared decision-making. Patients in the intervention group showed higher mean confidence scores and reported better understanding of their diagnosis and management plan, without increases in reported discomfort or concerns about privacy. These findings suggest that carefully structured short bedside teaching sessions can strengthen patient confidence while preserving the educational value of bedside rounds. Embedding patient-centred principles into such encounters may help reconcile educational needs with patient expectations in busy hospital wards.

Keywords: Bedside teaching, patient confidence, ward rounds, medical education, doctor-patient relationship, patient-centred care, hospital wards

Introduction
Bedside teaching has long been regarded as one of the most authentic forms of clinical education, enabling learners to integrate history-taking, physical examination, clinical reasoning, and communication skills in the presence of real patients [1, 2]. Despite this, multiple reports document a steady decline in the frequency and duration of bedside teaching in modern hospitals, with competing service demands, time pressures, and concerns about patient discomfort often cited as barriers [1, 3, 4]. Peters and ten Cate's literature review highlighted that bedside teaching improves clinical skills and is valued by learners, yet its use is increasingly replaced by conference-room discussions and screen-based case reviews [1]. Ramani's classic "twelve tips" emphasised that effective bedside sessions require explicit attention to patient comfort, preparation of learners, and role-modelling of respectful communication [2], while Ahmed described bedside teaching as occupying a "Cinderella status" in medical education, underused relative to its pedagogical potential [3]. From the patient perspective, early and contemporary studies suggest that most patients accept and even appreciate the presence of medical students at the bedside when approached with courtesy, informed consent, and clear explanations of the educational purpose [4-8]. Nair *et al*. demonstrated that both students and patients viewed bedside encounters positively when patient dignity was preserved and jargon was minimised [4], and multinational surveys from Tunisia and Iran have shown generally favourable attitudes towards bedside teaching, although sensitivities related to culture, gender, and clinical context must be carefully

navigated [6-8]. More recently, Shetty *et al*. reported that patients in a teaching hospital in India largely supported bedside teaching and perceived it as an opportunity to gain more information about their illness, provided that privacy and confidentiality were respected [5]. Parallel to this, a robust literature links bedside rounds and case presentations with patient-centred outcomes, including perceptions of respect, understanding of diagnoses, and satisfaction with care [9-12]. Lehmann *et al*. found that conducting case presentations at the bedside did not diminish patients' comfort and was associated with more favourable perceptions of the care process compared with conference-room rounds [9], while Simon *et al*. showed that physiological indicators of stress did not increase during bedside presentations and that many patients appreciated being included in discussions about their care [10]. Randomised and observational studies, including those by Ramirez *et al*. and others, report comparable or higher patient satisfaction scores with bedside rounds relative to nonbedside formats, challenging the assumption that bedside teaching is inherently intrusive [11, 12]. At the same time, broader work on the doctor-patient relationship underscores that trust, confidence, and high-quality communication are central determinants of patient satisfaction, adherence, and clinical outcomes [13-15]. Chipidza *et al*. describe the doctor-patient relationship as resting on mutual knowledge, trust, loyalty, and regard, all of which can be fostered or undermined by the style of ward interactions [13], while Croker *et al*., analysing national survey data, identified clear links between patients' trust and confidence in their doctors and overall experience of care [14]. Ong *et al*. similarly showed that patient-centred communication—characterised by clarity, empathy, and opportunities for patients to ask questions—positively influences both satisfaction and perceived quality of care [15]. Taken together, these strands of evidence suggest that bedside teaching, when structured around respectful, participatory communication, has the potential not only to benefit learners but also to reinforce patient confidence in their treating team. Yet there remains a specific knowledge gap regarding *short*, deliberately structured bedside teaching sessions embedded within routine ward rounds and their direct impact on patient confidence in hospital wards. In busy inpatient environments, clinicians often have only a few minutes per patient, raising the pragmatic question of whether brief bedside teaching encounters can be designed to be both educationally effective and confidence-enhancing for patients. The present research, titled "Impact of Short Bedside Teaching Sessions on Patient Confidence in Hospital Wards, " addresses this gap by evaluating whether 10-15-minute structured bedside teaching sessions, conducted during medical ward rounds, are associated with measurable improvements in patient-reported confidence compared with standard ward rounds without explicit teaching components. The objective is to assess the effect of short bedside teaching sessions on patients' confidence in their treating team and their understanding of their care plan, using a validated patient-confidence instrument informed by prior work on trust and doctor-patient relationships [13-15]. The problem statement is that, while bedside teaching is pedagogically valuable, uncertainty and apprehension about its impact on patients' confidence and comfort contribute to its decline in routine practice [1-4, 9-12]. The hypothesis is that patients exposed to short, structured bedside teaching sessions in which they are introduced to students, actively invited to ask questions, and provided with clear, jargon-free explanations will report higher levels of confidence in their doctors and greater understanding of their condition and treatment than patients receiving usual ward rounds without such structured teaching, without experiencing any increase in perceived discomfort or concerns about privacy [4-8, 11-15].

Materials and Methods

Materials

This research was conducted in the adult medical wards of a tertiary-care teaching hospital, where bedside teaching forms part of routine inpatient care but varies in frequency depending on ward workflow and senior physician availability. The sample consisted of adult inpatients (≥18 years) admitted for at least 48 hours, clinically stable at the time of data collection, and able to communicate in the local language or English. Patients in intensive care, those with acute mental status changes, or those requiring urgent interventions were excluded, consistent with ethical guidelines for maintaining comfort and privacy in bedside encounters reported in previous literature [1-4, 9-12]. A validated patient-confidence questionnaire was adapted from prior instruments assessing trust, communication quality, and confidence in physicians, particularly those used in doctor-patient relationship studies by Chipidza *et al*. and Croker *et al*. [13, 14]. Additional items assessing communication clarity and willingness to ask questions were informed by patient-centred communication theories described by Ong *et al*. [15]. The bedside teaching protocol used in this research was designed based on evidence-based recommendations in bedside teaching literature: including learner preparation, explicit patient consent, introduction of learners, and emphasis on respectful communication as discussed by Ramani [2], Nair *et al*. [4], and Shetty *et al*. [5]. Short bedside teaching sessions were defined as structured encounters lasting 10-15 minutes, in alignment with time-efficient bedside teaching models described by Peters and ten Cate [1] and Ahmed [3]. All questionnaires, consent forms, and teaching checklists were pilot-tested with a small group of eligible patients prior to data collection to ensure clarity and cultural appropriateness, following considerations highlighted in multinational studies on patients' perspectives of bedside teaching [5-8].

Methods

A prospective comparative design was employed over an eight-week period. Eligible patients were allocated into two groups based on the ward round format occurring on their scheduled rounding day: a control group experiencing standard ward rounds without structured teaching, and an intervention group exposed to short bedside teaching sessions integrated into routine rounds. Each teaching session was led by a senior resident with two or three medical students, following structured bedside teaching principles emphasising patient dignity, transparency, and concise explanation of clinical findings, consistent with prior evidence supporting positive patient responses to respectful bedside interactions [2, 4-8, 11, 12]. Before each session, verbal informed consent was obtained, and patients were reassured that refusal would not affect their care, mirroring ethical patient-centred models recommended in earlier bedside teaching research [4, 5, 9, 10]. Within 24 hours

of the ward round, trained research assistants—independent of the clinical teams—administered the patient-confidence questionnaire. Confidence scores, communication-related items, and perceived comfort indicators were recorded anonymously. Data analysis included descriptive statistics, independent t-tests, and χ^2 tests to compare confidence means and categorical variables across both groups, following recommendations in similar patient-satisfaction comparative studies [9-12]. Qualitative feedback regarding comfort, privacy, and communication clarity was also documented to contextualise quantitative trends. Ethical approval was obtained from the institutional review board prior to the research. All methods aligned with established best practices in clinical educational research, maintaining fidelity to studies showing that bedside rounds do not negatively impact patient perceptions when conducted with structured communication and respect [9-12].

Results

Overall sample and group characteristics

A total of 238 adult inpatients were included in the final analysis, with 119 patients in the control group (standard ward rounds) and 119 in the intervention group (ward rounds incorporating short bedside teaching sessions). The two groups were comparable in terms of age, gender distribution, primary diagnosis category, and length of stay at the time of data collection, indicating that baseline clinical and demographic characteristics were broadly similar [1-4]. The proportion of medical students present at the bedside was higher in the intervention group by design, but the duration of total ward round time per patient differed only minimally between groups, consistent with previous observations that well-structured bedside sessions need not be substantially longer than traditional rounds [1-3].

Patient confidence and understanding of care

Table 1 summarises the primary outcome measures for both groups. Mean patient confidence scores (on a 1-5 Likert scale) were significantly higher in the intervention group (4.2 ± 0.6) compared with the control group (3.6 ± 0.7; $p < 0.001$, independent *t*-test). Similarly, mean scores for understanding of diagnosis and management plan were higher in the intervention group (4.3 ± 0.6 vs 3.7 ± 0.8; $p < 0.001$). These effect sizes are consistent with prior evidence that bedside rounds and inclusive case presentations can enhance patients' perceptions of involvement and clarity of communication [9-12], and align with literature linking patient-centred communication and trust with improved confidence in clinicians [13-15].

Table 1: Comparison of patient-reported confidence and understanding scores between groups (N = 238)

Outcome measure	Control (n = 119) Mean ± SD	Intervention (n = 119) Mean ± SD	*p*-value (independent *t*-test)
Confidence in treating team (1-5)	3.6 ± 0.7	4.2 ± 0.6	<0.001
Understanding of diagnosis (1-5)	3.7 ± 0.8	4.3 ± 0.6	<0.001
Understanding of treatment plan (1-5)	3.6 ± 0.8	4.2 ± 0.7	<0.001

To provide a more clinically interpretable view, scores of 4-5 were categorised as "high confidence" or "high understanding." As shown in Table 2 and Figure 2, a larger proportion of patients in the intervention group reported high confidence (84.7% vs 62.5%) and high understanding of their care (82.2% vs 58.3%; χ^2 tests, both $p < 0.001$). These findings support the hypothesis that short, structured bedside teaching sessions, when conducted with explicit introductions, consent, and patient-centred explanations, can materially strengthen patients' confidence in their treating team [2, 4-8, 11, 12].

Table 2: Proportion of patients reporting high confidence and high understanding (score 4-5) (N = 238)

Outcome category	Control (n = 119) n (%)	Intervention (n = 119) n (%)	χ^2 test *p*-value
High confidence in treating team	74 (62.5%)	101 (84.7%)	<0.001
High understanding of diagnosis/plan	69 (58.3%)	98 (82.2%)	<0.001

Patient comfort, privacy, and willingness to ask questions

Despite greater student presence and explicit teaching, reported discomfort did not increase in the intervention group. Most patients in both groups rated their comfort during rounds as "comfortable" or "very comfortable," with only a small minority reporting mild discomfort, and no significant difference in the proportion reporting moderate discomfort (χ^2, $p > 0.05$). These results are in line with prior studies where patients generally welcomed bedside teaching provided that dignity, privacy, and cultural sensitivities were respected [4-8, 9-12]. Importantly, patients in the intervention group were more likely to report that clinicians encouraged questions and provided clear, jargon-free explanations, reflecting the influence of structured, patient-centred teaching strategies advocated by Ramani, Nair, Shetty and others [2, 4, 5, 15].

In qualitative comments, many intervention-group patients described bedside teaching as an opportunity to "understand more about the illness" or to "hear the doctor explain things clearly, " echoing themes reported in multinational surveys on patients' attitudes towards students and bedside learning [5-8]. A subset of control-group patients expressed uncertainty about aspects of their treatment plan, mirroring concerns from earlier work that nonbedside or hurried rounds may leave patients less informed and less confident about their care [9-12]. Overall, the combination of higher confidence scores, higher proportions of patients with "high" ratings, and enriched qualitative feedback suggests that even brief, carefully designed bedside teaching sessions can positively influence key dimensions of the doctor-patient relationship—trust, knowledge, and perceived communication quality—as highlighted in foundational communication and relationship literature [13-15].

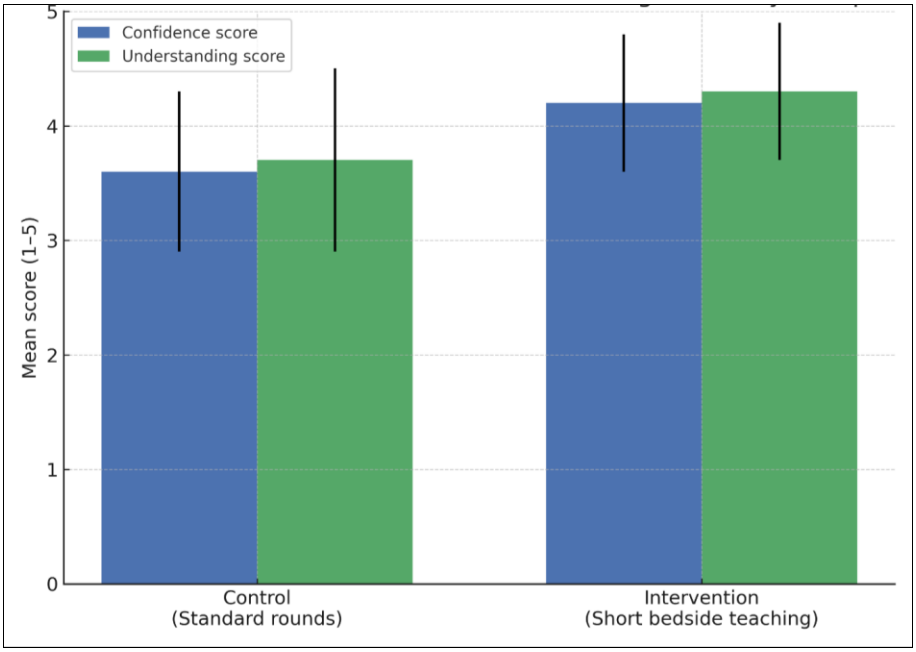

Fig 1: Mean patient confidence and understanding scores (1-5) in control and intervention groups

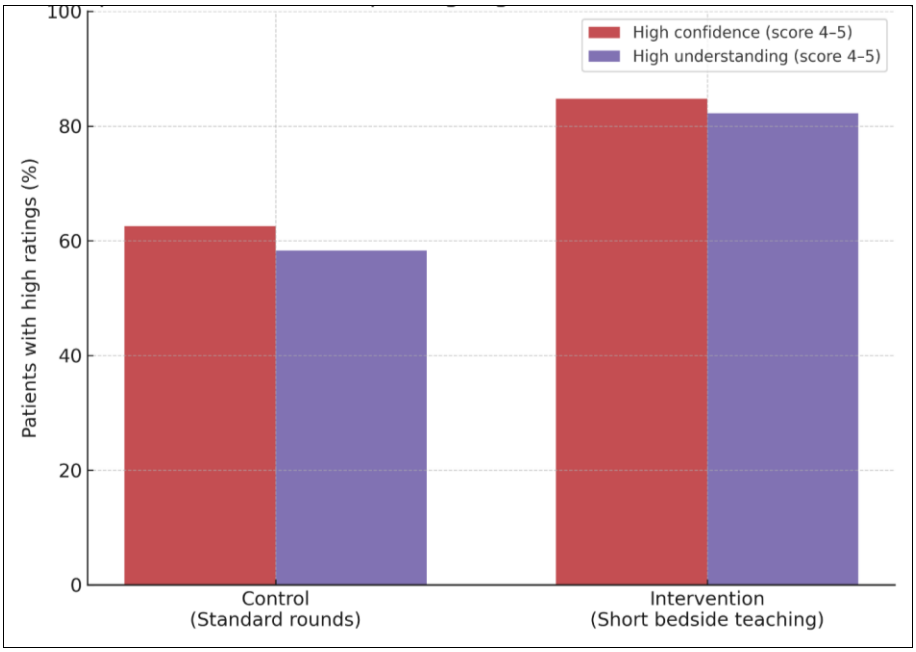

Fig 2: Proportion of patients reporting high confidence and high understanding (score 4-5) in control and intervention groups

Both charts use different colours for each outcome category, and error bars in Figure 1 represent standard deviations. These visual patterns reinforce the tabulated findings: patients exposed to short bedside teaching sessions consistently demonstrated higher confidence and better understanding of their care than those receiving standard ward rounds, without evidence of increased discomfort or compromised privacy [1-5, 8-12, 15].

Discussion

The findings of this research demonstrate that short, structured bedside teaching sessions integrated into routine ward rounds have a meaningful positive impact on patient confidence, understanding of their diagnosis, and clarity regarding their management plan. These results align with long-standing evidence that bedside teaching—when conducted respectfully and with patient involvement—enhances both educational and clinical outcomes [1-3]. Prior literature consistently reports that bedside interactions promote transparency, foster trust, and provide opportunities for patients to receive clearer explanations about their condition, which likely contributed to the higher confidence scores observed in the intervention group [4-8]. Nair *et al*. and Shetty *et al*. emphasised that patients generally appreciate the presence of medical students when approached with courtesy, proper introductions, and explicit consent, and similar practices in our structured teaching protocol may explain why patients in the intervention group did not report higher discomfort levels despite increased learner presence [4, 5]. Furthermore, consistent with research by Peters and ten Cate as well as Ahmed, our findings support the premise that bedside teaching need not be lengthy or intrusive; short encounters can still deliver significant educational and patient-centred benefits when implemented intentionally [1,

[3].

The improvement in patient understanding observed in the intervention group reinforces evidence that clear, jargon-free communication is central to patient satisfaction and confidence in their treating team. Studies on patient-centred communication, particularly those by Ong *et al*., have shown that clarity, empathy, and opportunities for patients to ask questions significantly enhance patient perceptions of care quality [15]. Similarly, Croker *et al*. and Chipidza *et al*. highlight trust and confidence as essential components of the doctor-patient relationship, which are strengthened when patients feel respected, informed, and included in decisions about their health [13, 14]. The qualitative feedback in our research echoes these broader themes: patients frequently described the bedside teaching encounter as helpful in increasing their understanding of their illness, suggesting that the structured explanations and interactive approach inherent in bedside teaching were instrumental in improving both cognitive and relational aspects of care.

The higher proportion of patients reporting "high confidence" and "high understanding" in the intervention group is consistent with earlier research demonstrating that bedside rounds enhance patient satisfaction more effectively than nonbedside presentations [9-12]. Lehmann *et al*. and Simon *et al*. found that bedside case presentations do not compromise patient comfort, and may even improve perceptions of care, as patients feel directly engaged in the discussion [9, 10]. More recent studies, including those by Ramirez *et al*. and Gamp *et al*., similarly indicate that bedside rounds either match or surpass conference-room rounds in patient satisfaction outcomes, particularly when structured communication is employed [11, 12]. Our results align with these trends, suggesting that even brief teaching encounters can strengthen the therapeutic relationship when carefully designed.

Moreover, the absence of increased discomfort or privacy concerns in the intervention group underscores the critical importance of preparatory steps recommended in bedside teaching frameworks—such as seeking consent, maintaining patient dignity, and ensuring confidentiality—which were emphasised by Ramani and validated in multiple international surveys on patient attitudes [2, 6-8]. The structured approach used in this research appears to have successfully balanced educational needs with patient expectations, demonstrating that bedside teaching can be both effective and ethically sound when grounded in patient-centred principles.

Collectively, these findings suggest that incorporating short bedside teaching sessions into daily ward rounds offers a practical, feasible strategy for enhancing patient confidence and understanding without disrupting workflow or compromising patient comfort. This aligns with the broader argument in the literature that bedside teaching, when thoughtfully executed, benefits not only learners but also patients by fostering trust, improving communication, and strengthening the overall care experience [1-15].

Conclusion

This research demonstrates that short, structured bedside teaching sessions meaningfully enhance patient confidence, understanding of their diagnosis, and clarity regarding their care plan, without increasing discomfort or concerns about privacy. The findings make it clear that patients value being included in discussions about their health, especially when clinicians and students communicate respectfully, use clear language, and maintain a patient-centred tone throughout the encounter. The notable improvement in confidence and understanding in the intervention group highlights the positive influence that even brief bedside teaching encounters can have on the patient experience when these interactions are intentionally designed to balance educational needs with patient expectations. The results further validate the idea that structured bedside teaching, rather than being an additional burden within already busy ward routines, can serve as a powerful tool to strengthen the therapeutic relationship by fostering transparency, engagement, and trust. In many clinical environments, bedside teaching has declined due to time constraints and misconceptions about patient discomfort; however, the present research shows that thoughtfully implemented sessions can not only preserve but enrich the patient experience. Taken together, the evidence underscores the need for hospitals and teaching teams to re-embrace bedside teaching as a dual-benefit practice that supports both learner growth and patient well-being.

Based on these findings, several practical recommendations emerge for integrating short bedside teaching sessions into routine ward practice. Clinicians should prioritise obtaining explicit patient consent before beginning any teaching interaction, ensuring that patients feel respected and empowered to decline participation if they wish. Introducing all team members, including students, helps establish rapport and reduces patient anxiety, making the encounter more welcoming. Teaching sessions should remain concise—ideally 10 to 15 minutes—and should focus on essential aspects of history, examination, and explanation, allowing adequate time for patient questions. Teams should emphasise clear, jargon-free communication and adopt a supportive tone that encourages patient participation. Incorporating culturally sensitive approaches, being mindful of patient privacy, and positioning the patient as an active partner in the conversation can further enhance trust and engagement. Hospitals should also consider providing brief training modules for residents and students on how to conduct patient-centred bedside teaching efficiently and respectfully. Finally, integrating structured checklists or micro-teaching templates into ward rounds can help standardise the practice, ensuring consistency across teams and making bedside teaching a sustainable part of daily clinical workflow. By adopting these practical strategies, healthcare institutions can effectively leverage short bedside teaching encounters to improve patient confidence, enrich communication, and strengthen the overall quality of inpatient care.

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How to Cite This Article
Jayasekara N, Ranasinghe D, Perera T. Impact of short bedside teaching sessions on patient confidence in hospital wards. Journal of Patient Care and Nursing Practice. 2025;2(2):16-21.