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The Scholarship of Teaching: Who is the truth teller?

Janet Grant[1,2]

[1]Centre for Medical Education in Context (CenMEDIC), United Kingdom; [2]University College London Medical School, United Kingdom

I. TO BEGIN WITH MY VIEW

Medical education is a social science which addresses how people learn and teach medicine. The practice of education and training is therefore fundamental to its epistemology, whereby knowledge, and so scholarship, derives from practice. Where that practice is subject to social, contextual and cultural factors, we must question whether the tenets that are put forward are generalisable beyond the context from which they were derived (Fendler & Cole, 2006). This lack of automatic generalisability has implications for both the scholarship of the medical educationalist, and for the relationship between medical educationalist and teacher. Where educational practice is primary, and is contextually informed, then the teacher, the practitioner of medical education, must be the leader in developing scholarship, while the medical educationalist can support that development by enabling each teacher, context or culture, to tell their own truth well (Grant & Grant, 2022).

II. WHY IS THIS MY VIEW?

A. Scholarship and the Primacy of Practice

The term 'scholarship' implies special knowledge that is derived from research or academic analysis. While we can argue that learning has a research basis in educational and cognitive psychology, the same cannot be said of teaching. We can think, for example, of the churn of new teaching methods (sometimes erroneously presented as new ideas about learning) that sweep into medical education, find little evidence of consistent effect, and fade into the ever-expanding menu of teaching options. We can think of problem-based, task-based, case-based, resource-based, peer-assisted, blended, team-based, and e-learning, the flipped classroom, and more broadly, active learning and learner-centred learning. And there are more, changing with fashion and social values.

Are these changes based on generalisable knowledge derived from robust research? Although there might be published papers, they rarely constitute a consistent body of scholarly knowledge that enables claims about predictable effects of different teaching methods in different contexts. That is the nature of social science (Fendler & Cole, 2006). It is this lack of generalisability of the social practice of teaching that places the epistemology of medical education not in theories or fashion, but in widely variable, and contextually tailored, practice.

Although the practice of teaching is socially bound, we can say that the fundamental cognitive basis of learning, how knowledge is effectively organised in memory and accessed when needed, is the same for everyone. Knowing that short-term, working memory should not be overloaded, and that long-term memory should be well-organised with structured, generalisable and accessible knowledge, is the simple baseline against which a medical educationalist can ensure that teaching and learning methods are designed and judged. Many which demand complex processes (sometimes termed 'learner-centred') would fail that test.

There is a parallel literature demonstrating that the social, personal and interpersonal processes that cause knowledge to be stored and used effectively, and motor and cognitive skills to develop, are different depending on culture, content and context. Teaching that seems applicable and relevant in one cultural or content context may not apply in another. So it seems important to begin from practice, observe successes and problems, and build theories, if that seems helpful.

These uncertainties underpin our practice-based epistemology, where the teacher is the key person. Accordingly, we have argued (Grant & Grant, 2022) that medical education is not an academic discipline at all, but is an examination of instrumental practice, trying to relate educational activities to purposes, making its means relate to its ends, and making decisions about that on the basis of context and judgement.

This view places the teacher at the heart and in the vanguard of relevant medical education development. This is social science where generalisable scholarship in teaching is difficult to attain. So, there is an ethical responsibility borne by those who claim to know what effective teaching is.

This leads to the next question.

B. What might be the Relationship Between the Teacher and the Medical Educationalist?

Definitionally, I take a medical educationalist to be someone who claims special expertise by virtue of, for example, having completed a Master's degree in health professions education. Some teachers have done this too, but most have not. Teachers, here, are the subject specialists who actively help others to acquire necessary knowledge and skill.

What might be the relationship between these two?

To answer this, we turn to Lawrence Stenhouse, a British educational thinker who sought to promote an active role for teachers in educational research and curriculum development. Stenhouse argued that the teacher might lead quality development, becoming an 'extended professional', supported by trained technical expertise: 'It is not enough that teachers' work should be studied: they need to study it themselves' (Stenhouse, 1976, p143).

In this endeavour, the medical education specialist is a resource, knowing the theories and fashions, and their critiques, summarising where there is and is not evidence, guiding analysis, offering options in relation to the teacher's practice. The teacher is an equal partner in this 'mutually supportive co-operative research' (Stenhouse, 1976, p159), learning to be a researcher, simply because knowledge comes from and is tested in its performance. The medical educationalist will be a crucial support in this process.

To hold this supporting role demands being critically informed about medical education theory and practice. Medical education seems replete with largely unexamined terms such as 'adult learning', 'learner-centred' or the oxymoronic 'passive learning'; or with handy mnemonics, and frameworks that have ever-decreasing academic credibility such as 'learning styles'. Medical educationalists must be more securely rooted in the critical approach of social science, beyond the constantly metamorphosing rhetoric of medical education. That authenticity will be gained in equal partnership with teachers.

Stenhouse's position is unequivocal: the expert is the teacher, the practitioner who understands the individual context. The 'teacher as researcher' was Stenhouse's ground-breaking view of the basis of rational educational development (Stenhouse, 1976, pp. 142-165).

How different is the implication of this view of the teacher, not as a person to be studied or developed, but the person who should be the scholar, reaching, and sharing, their own conclusions in their own classroom. Agency then belongs to the teacher who enacts the curriculum.

In this model, the role of the medical education specialist is to provide knowledge of developmental potential, and of how to develop practice-based, contextual scholarship around methods of reflective action research, perhaps. The medical educationalist is no longer the primary source of knowledge, or the impartial researcher, but is the means of supporting authentic practice development, helping each teacher to find their own truth.

C. And What of the Scholarship of Teaching?

The literature on the scholarship of teaching addresses its derivation in research and reflection on practice, and its use in theory building and educational development. In that literature, the meaning of scholarship in relation to actual teaching is ill-defined.

The importance of this for medical education is that scholarship can easily be thought of as the domain of those who have taken medical education as their

speciality, rather than the domain of the teacher who is primarily a scientist or a clinician. This creates a particular relationship where ideas such as 'faculty development' suggest that the scholarship of teaching is garnered elsewhere and then shared with the teacher.

But I have argued that the scholarship of teaching will come from the experience of the teachers. Others argued, before me, that knowledge comes from social practice, and then returns to serve and enhance that practice (Mao, 1937). In that, there must be a mechanism for gathering that knowledge derived from social practice and returning it to practice. This may be the role of the medical educationalist, or of medical educationalists collectively, pooling their knowledge gained through working with teachers, reflecting their experience.

This role of gathering together knowledge generated in practice, is especially important in these days when the controversial idea of 'globalisation of education' often passes without critique. But 'Globalisation initiatives must be tempered by 'cultural humility' in recognition of the likelihood that, rather than there being one exclusive, universal and 'superior' model, there may be many models of effective teaching and learning in medical education around the world' (Wong, 2011, p. 1218). For Wong, in opposition to the neo-institutionalist, perhaps neo-colonialist, view, '…the culturalist perspective focuses on the enduring ability of different cultures and ways of knowing to re-interpret, transform and hybridise education practices to best suit local context' (Wong, 2011, p. 2010).

This view recognises those contextual imperatives: scholarship must derive from the domain of the teacher, supported, not driven, by the medical education specialist. This is true both of ideas on teaching methods, and of the theoretical and conceptual frameworks that shine and fade in parallel.

In this view, the teacher would become an extended professional who has 'a capacity for autonomous professional self-development through a systematic self-study, through the study of the work of other teachers and through the testing of ideas by classroom research procedures' (Stenhouse, 1976, p. 144). In other words, scholarship reverts to the teacher. Support for that scholarship belongs to the medical education specialist, working by the practitioner's side, in the classroom, enabling that person to advance the contextual practice of medical education.

Note on Contributor

Janet Grant wrote the script, discussed it with Leo Grant and Professor Ahmed Rashid, and wrote the final version.

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Declaration of Interest

The author declares that there is no conflict of interest.

References

Fendler, L., & Cole, J. (2006). Why Generalisability is not Generalisable. *Journal of Philosophy of Education*, *40*(4), 437–449. https://doi.org/10.1111/j.1467-9752.2006.00520.x

Grant, J., & Grant, L. (2022). Quality and constructed knowledge: Truth, paradigms, and the state of the science. *Medical Education*. https://doi.org/10.1111/medu.14871

Mao, Z. (1937). *On Practice*. https://www.marxists.org/reference/archive/mao/selected-works/volume-1/mswv1_16.htm

Stenhouse, L. (1976). *An Introduction to Curriculum Research and Development*. Heinemann.

Wong, A. K. (2011). Culture in medical education: Comparing a Thai and a Canadian residency programme. *Medical Education*, *45*(12), 1209–1219. https://doi.org/10.1111/j.1365-2923.2011.04059.x

*Janet Grant
27 Church Street,
Hampton, Middlesex
TW12 2EB,
United Kingdom
Email: janet@cenmedic.net