Reconsidering "Good Teaching" Across the Continuum of Medical Education

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Abstract: There is no shortage of sustained inquiry into the nature and evaluation of teaching in medical education. For the most part, however, this growing and respectable body of inquiry has uncritically adopted a single model of effective teaching that is assumed to be appropriate across variations in context, learners, and teachers. This article presents five alternative views of "good teaching" and challenges the trend toward any single, dominant view of what constitutes good teaching. Based on 10 years of research, in five different countries, studying hundreds of educators in adult and higher education across a wide range of disciplines, contexts, and cultures, we have evidence of five different perspectives on good teaching: transmission, developmental, apprenticeship, nurturing, and social reform. Each perspective represents a philosophical orientation to knowledge, learning, and the role and responsibility of being an educator. A "snapshot" of each perspective is provided, including an example from continuing medical education (CME), a set of key beliefs, primary responsibilities, typical strategies, and common difficulties. Readers are encouraged to use the five perspectives as a means of identifying, articulating, and revisiting assumptions and beliefs they hold regarding their view of effective teaching. They are also encouraged to resist a "one-size-fits-all" approach to the investigation, improvement, or evaluation of teaching in CME.

Key Words: Continuing medical education (CME), educational models, effective teaching, medical education, philosophies of teaching, teaching perspectives, teaching styles

There is no shortage of sustained inquiry into the nature and evaluation of teaching in medical education as evidenced by the work of Hilliard, Irby, Kelliher, and others. For the most part, however, this growing and respectable body of inquiry has uncritically adopted a single model of effective teaching that is assumed appropriate across variations in context, learners, and teachers. That model, by a variety of names, takes a constructivist view of learning and teaching, wherein knowledge and learning are understood to be products of the way in which a person's mind is engaged during the process of learning (or instruction). As people encounter new experiences, they construct representations of those experiences that are structured by their previous knowledge and beliefs. The interaction of new representations with existing cognitive schemas results in the production of new knowledge, beliefs, and skills. In medical education, this constructivist view is most evident in problem-based learning (PBL).

Although it is laudable for its attempt at bridging the divide between learning in classrooms and learning for the clinical application of knowledge, constructivist-based teaching has become something of an orthodoxy that is without challenge or clarification of its limitations. This is understandable as it is also, in part, a reaction against the teacher-centered instruction that has dominated much of medical education throughout the world.
We do not argue with the basic tenets of constructivism or the benefits of PBL. We do, however, resist the tendency to adopt any single, dominant view of learning or teaching. Unless we are cautious, we may replace one orthodoxy with yet another and promote a "one-size-fits-all" notion of good teaching.

Our caution is derived from 10 years of research, in five different countries, studying literally hundreds of educators in adult and higher education. Across a wide range of disciplines, contexts, and cultures, we found a plurality of good teaching, not all of which rests on constructivist principles of learning. Our findings are not unique. They correspond to those of many other researchers around the world, whose work spans 16 years and several countries. In reviewing most of that research, Kember found a surprisingly high level of correspondence across time, context, and disciplines. No single view of learning or teaching dominated what might be called "good teaching." Our research was a part of that review.

In our research, we documented five different perspectives on teaching, each having the potential to be good teaching. This article introduces those perspectives: transmission, developmental, apprenticeship, nurturing, and social reform. We hope to convince our readers to resist any one-size-fits-all approach to the investigation, improvement, or evaluation of teaching in medical education.

What Is a Perspective on Teaching?

A perspective on teaching is an interrelated set of beliefs and intentions that gives direction and justification to our actions. It is a lens through which we view our work as educators. We may not be aware of our perspective because it is something we look through, rather than at, when teaching. Each of the perspectives is a unique blend of beliefs, intentions, and actions; however, there is an overlap between them. Similar actions, intentions, and even beliefs can be found in more than one perspective.

Educators holding different perspectives may, for example, have similar beliefs about the importance of critical reflection in learning and medical practice. To this end, all may espouse the use of higher-level questions as a means of promoting critical thinking. However, the way in which questions are asked and the way in which medical educators listen and respond when students consider those questions may vary considerably across perspectives. These variations are directly related to beliefs about learning, knowledge, and the appropriate role of an instructor.

We must add a caution at this point: it is common for people to confuse perspectives on teaching with methods of teaching. Some educators say that they use all five perspectives at one time or another, depending on circumstances. On the surface, this seems reasonable. However, looking more deeply, one can see that perspectives are far more inclusive than methods. In part, this confusion derives from the fact that lecturing, discussing, questioning, and a host of other methods are common activities within all five perspectives. It is how they are used, and toward what ends, that differentiates among perspectives. Based on Pratt’s initial study of more than 250 teachers and on data from another 2,000 educators who have taken the Teaching Perspectives Inventory, we have reasonable evidence that most educators hold one or perhaps two perspectives as their dominant view of teaching and may only marginally identify with one or two others. It could not be otherwise, given that perspectives are com-

*We realize that the phrase "good teaching" is loaded with subjectivity and may be questioned by some. However, the word "good" is probably the most frequently used scale point to indicate an acceptable or expected level of performance in learner and peer evaluations of teaching. In most instances, the qualifier "good" corresponds to a quality of teaching that is more than adequate, although not necessarily outstanding. In our experience, it is also the threshold that all educators are expected to achieve, regardless of their context or disciplinary home.
posed of fundamentally different beliefs about knowledge, learning, and teaching.

What follows is a "snapshot" of each perspective, including a set of key beliefs, primary responsibilities, typical strategies, and common difficulties. As well, we have provided brief examples from continuing medical education (CME). Each snapshot is a composite of many representative people. Therefore, it would be unlikely that any one individual would have all of the characteristics listed for any one perspective. As you read them, try to locate yourself, not by looking for a perfect fit but for the best fit. Which of the perspectives seems to capture your own orientation toward teaching and learning? We expect that you will find parts of each perspective that "fit," but that the overall profile of one or two snapshots will feel more comfortable than others. A much more detailed description of all five perspectives is provided elsewhere.14 For a more systematic analysis of your own perspective on teaching, we invite you to take the Teaching Perspectives Inventory at http://www.TeachingPerspectives.com.

A Transmission Perspective

The transmission perspective is the most common orientation to teaching in most of higher education and much of medical education, including the clinical years. It is also the most evident perspective in continuing professional and medical education (CPME). From this perspective, good teaching is directly associated with content or subject matter expertise. An educator's primary responsibility is to present the content accurately and efficiently. It is the learners' responsibility to learn that content in its authorized forms. Good teachers take learners systematically through a set of tasks that lead to mastery of the content. They are clear and enthusiastic about their content and convey that enthusiasm to their students. They are, for many learners, virtuoso performers of their knowledge or expertise. What follows are other defining attributes of a transmission perspective.

Key beliefs.
- Content should be learned in its authorized form.
- Teachers should present that content accurately and efficiently.
- The process of learning is additive, which means that teachers should take care not to overload students with too much information.
- With proper delivery by the teacher, and appropriate receptivity by the learner, knowledge can be transferred from the teacher to the learner.

Primary responsibilities.
- Be thoroughly prepared.
- Specify clear objectives.
- Provide clear and well-organized lectures and discussions.
- Make efficient use of instructional time.
- Provide answers to questions.
- Correct errors.
- Provide reviews and summaries.
- Set standards for achievement.
- Develop objective means of assessment.

Typical strategies.
- Assume a common/shared starting place for a group of learners.
- Gear one's teaching to the mid-to-high end of the learning group.
- Vary the pace of delivery to accommodate the high and low ends of the group.
- Assess students in relation to a body of knowledge.
- Use feedback to point out errors of understanding or application.
- Use content as a means of dealing with "difficult" learners.

Common difficulties.
- Tendencies to equate talking (lecturing) with teaching, see every student response as an opportunity to talk some more, and focus feedback on what is wrong rather than what is right or good.
Working with people who have difficulty with the content or its logic.
Anticipating where and why learners might have difficulty with content.
Remembering what it was like to "not know" this material.
Thinking that their way of understanding is the best way or the only way.

Most of us can think of negative examples of transmission-oriented teachers, for example, those who were little more than "talking heads." Such teachers taught as though their only role was to disseminate information. We now know that there is little evidence to support dissemination-only strategies if the goal is to improve professional practice (see Oxman et al. for a systematic review of 102 trials of educational interventions to improve professional practice"). As a result, the talking-head approach to teaching has been devalued in CPME, as evidenced by the lower number and value of continuing education credits assigned to these types of educational activities by accrediting bodies.

At the same time, many of us have positive memories of transmission-oriented educators who were passionate about their content, animated in its delivery, and determined that we go away with respect and enthusiasm for their subject. Such individuals may have inspired us to take up a particular subspecialty. Their deep respect and enthusiasm for what they did was infectious. It is the memory of those educators that must be preserved if we are to see transmission as a legitimate perspective on teaching in CME.

Developmental Perspective

The constructivist orientation to learning mentioned earlier is the foundation for this perspective on teaching. From the developmental perspective, good teaching must be planned and conducted from the learner's point of view. Good teachers therefore understand how their learners think and reason about the content. Their primary goal is to help learners develop increasingly complex and sophisticated cognitive structures related to the practice of medicine. The key to changing those structures lies in a combination of two things: (1) effective questioning that challenges learners to move from relatively simple to more complex forms of thinking and (2) "bridging knowledge," which helps learners link previous ways of thinking and reasoning to new, more complex, and sophisticated forms of reasoning and problem solving. Within this perspective, good teachers adapt their knowledge to the students' experience and ways of understanding.

Key beliefs.
- Learning is a search for meaning.
- Learners search through association.
- Prior knowledge influences the search.
- Less (coverage) can be more (understanding).
- The desired outcome is more complex reasoning strategies.

Primary responsibility.
- Understand learners' prior conceptions.
- Activate students' prior knowledge.
- Adapt expertise/knowledge to the learners' level.
- Plan for active learning (in and out of class).
- Keep assessment consistent with learning tasks.
- Assess for reasoning, not just answers.

Typical strategies.
- Start with the learner's point of view.
- Introduce new ways of thinking through problems or cases.
- Use examples, stories, and metaphors to bridge between students' experience and the desired ways of reasoning.
- Provide more questions than answers.
- Let students construct their own understanding.
- Challenge students' ways of understanding.
- Involve students in evaluation/assessment.
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Common difficulties.

- Asking higher-level questions
- Letting students figure it out
- Constructing good "bridges" to students' experience.
- Developing learning and assessment tasks that are congruent.

It is not easy to teach from this perspective. Those who have tried to make the shift to a developmental perspective from transmission-like orientations will appreciate the difficulties associated with that change, particularly in relation to how we use our clinical knowledge. For example, in the process of implementing PBL, some medical educators have felt that the case or problem has replaced them as teacher, leaving them at a loss for how to use their clinical knowledge. The justification for this is based on the false assumption that active teachers who ask probing questions and provide bridging knowledge cause their students to become passive learners. The assumption that active teaching results in passive learning confuses physical activity with cognitive engagement. In the developmental perspective, "active" and "passive" refer to the process of thinking rather than the act of doing.

In CPME, the growing legitimacy and power of the developmental perspective parallels the devaluing of "talking-head" activities. An example of the pressure to develop small-group, interactive activities can be seen in the College of Family Physicians of Canada's (CFPC) decision to place these activities at the top of the learning hierarchy by assigning them the highest value and requiring a set number of such credits to maintain CFPC certification. Developers of CPME must follow strict guidelines if their courses are to receive the coveted MAINPRO-C accreditation. McMaster University's "small-group practice-based learning" seminars are examples of accredited activities rooted in the developmental perspective.

In a developmental orientation, learners and their teachers must be active, that is, cognitively engaged. Students are actively engaged when they are inquiring and problem solving; teachers are actively engaged when they ask good questions, the kind of questions that require time to think and to reason before answering. After asking a question, teachers are active when they listen patiently while waiting for students to think through and to voice their thoughts. Teachers are active when they listen closely to the forms of reasoning that students use as they negotiate understanding through an open discussion. In tutorial groups, it is difficult to refrain from telling students what we know and shortening their path to an answer. However, doing so only puts them back into a passive cognitive role, expecting that we will give them answers rather than letting them figure it out for themselves.

Increasingly, we are seeing medical educators at all levels espousing a developmental perspective on teaching. It has become the new orthodoxy. The central commitment to the learners' level of knowledge/skill as a starting point is laudable. However, the progression from espousing to enacting the developmental perspective involves much more than a repertoire of techniques for engaging learners in problems and discussion. It also means that educators must use their knowledge and expertise in ways that do not undermine the goal of helping learners actively construct their own forms of understanding. Indeed, from this perspective, sometimes less telling means more learning.

Apprenticeship Perspective

Most of us have "apprenticed" under a range of preceptors and mentors in medicine. Some were marvelous teachers, allowing us entry to their skillful practice and guiding us as we grew in our own competence and confidence. Others held us in virtual servitude as we worked long hours with little appreciation, waiting for the chance to move on to a different rotation. This view of teaching is as old as medicine itself and second only to the
transmission perspective in the breadth of its use in medical education; surprisingly, it may be the least understood.

As we learn more about why so little classroom instruction transfers to clinical settings, the apprenticeship perspective becomes increasingly relevant. This view starts with the assumption that learning is facilitated when students work on authentic tasks in real settings of application or practice. In medical education, this is one of the most common and important forms of training; yet, it is fraught with difficulty because it is often misunderstood. How often have we heard someone say "I was so busy today that I did not have time to teach." Embedded in this statement is an assumption that teaching is done in the time when we stop the clinical practice to talk and tell. Then, when the "teaching" is done, we return to work. This is antithetical to the apprenticeship perspective, where both teaching and learning are rooted in the doing of work, not just in talking about it. The fact that there is no time to talk about the work is not as important as having students alongside us in the process of doing the work, which includes coping with a heavy workload.

Within this perspective, however, good teaching is more than demonstrating and having learners observe our skillful practice. It is also a process of enculturating students into a set of social norms and a professional identity. From this point of view, educators must be experienced and highly skilled practitioners of what their students are to learn. In fact, they are usually selected to teach precisely because of their expertise and experience. Ironically, as they make the transition from working as a skilled practitioner to teaching about skilled practice, their experience and expertise must be rendered in forms that are accessible and meaningful to novices. What they used to do without thinking they must now do with thought to how it is understood by those watching and/or participating. As they work, they must translate that work into steps and language that help learners understand not only the skill of doing but also the inner workings of "what is going on here." In effect, they must articulate the inner workings of skillful performance.

Vygotsky argued that much of the work of teaching is a matter of engaging learners' within their zone of development, the learning space that falls between what they can do on their own and what they can do with expert guidance. "As learners mature and become more competent, their zones of development move, and the teacher's role changes. Learners are still assigned tasks based on their level of maturity and skill development. But, over time, apprenticeship teachers offer less direction and give more responsibility as students progress from dependent learners to independent workers.

**Key beliefs.**

- Learning is a process of enculturation into a community of work.
- Knowledge is constructed while interacting and participating in the work.
- Knowledge is best learned in the contexts in which it is to be used.
- The product of learning is of two kinds: competence or skilled performance and identity in relation to a profession.

**Primary responsibilities.**

- Model and demonstrate competent practice as it is done within the community or profession.
- Teach by using authentic, relevant tasks, problems, and assignments.
- Teach for transfer of learning to contexts of application.
- Uphold the standards of the profession or community.

**Typical strategies.**

- Demonstrate skillful and appropriate ways of working.
- Identify the learner's zone of development.
- Have learners enter the work within their zone of development.
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- Fade direction and feedback based on the learner's progress and maturity.
- Reveal the teacher's strategic thinking and moments of uncertainty.
- Model appropriate ways of working with others.
- Assess learning based on standards of the community of practice.

**Common difficulties.**
- Finding relevant and authentic tasks for classroom instruction.
- Teaching those who want quick access to the community of practice.
- Matching the learner’s capability with legitimate tasks.
- Putting one’s craft, knowledge, or skill into words.

Some readers may see the apprenticeship perspective as synonymous with residency and fellowship training and having little to do with CPME. Although it is true that this is a rare form of CPME, several examples exist, and more are likely to appear as accrediting bodies continue to shape continuing education with specific requirements for maintaining professional certification. Hands-on, practical courses, with an opportunity to work alongside experts, are common means by which surgeons learn to use new technologies such as laser skin resurfacing and the ultrasonic cannula technique in liposuction. Slowly, courses rooted in an apprenticeship perspective are cropping up within various specialties. For instance, one of our local teaching hospitals offers refresher courses in internal medicine, where physician attendees participate in the daily activities of expert clinicians and have the opportunity to practice bedside skills in addition to attending seminars and lectures.

When teaching from the apprenticeship perspective, many professionals find it difficult to put their "craft" knowledge or skill into words. They often say, "I know what to do, but it is difficult telling others how I do it." This is most common in skill-based occupations; it is also a common difficulty in professions that require complex reasoning. The longer we have been doing complex tasks, the more routine they become. The more routine they are, the less we need to articulate what we do. We just do it. Yet, that is precisely what learners need: someone who can reveal the inner workings of skilled performance.

Medical educators working from this perspective are often encumbered by competing demands between work and teaching. This discussion is often framed in terms of education versus service, where issues of workload and time compete with teaching. In medical education, there will always be a tension between education and service. However, to frame it as a question of balance or tradeoff is to miss the underlying premise of this perspective: education and service are the same thing. There is no separation between the "pedagogic curriculum" of education and the "work curriculum" of service. In this way, it would be wrong to "stop and teach." Instead, the teaching should be a part of the work as it is happening.

From an apprenticeship perspective, the work curriculum can teach far more than can be stated in the pedagogic curriculum. When we lose sight of this, for example, when substituting simulated patients for real patients, we risk losing the context as a teacher. We seem to know this but do not quite make the best of it, as evidenced by the extent to which we place students in contexts of work but have them watch far too long before having them authentically engaged in the work we do. For these reasons, apprenticeship is a common perspective, but one in which it is uncommon to find truly good teaching.

**Nurturing Perspective**

The nurturing perspective assumes that long-term, hard, and persistent efforts to achieve come from the heart, not the head. People are motivated and productive learners when they are working on issues or problems without fear of failure. Learn-
ers are therefore nurtured by the knowledge that (1) achievement is within their reach, (2) when successful, achievement is a product of their own effort and ability rather than the benevolence of an educator, and (3) their efforts to learn will be supported by their teacher and their peers. The more there is pressure to achieve, and the more difficult is the material to be learned, the more important it is that there be such support for learning.

Good teachers care about their students. They understand the relationship between heart and head, but they make no excuses for learners. Rather, they encourage significant effort by challenging students to do the very best they can. To do this, nurturing educators promote a climate of caring and trust, helping people set challenging but achievable goals, and supporting learners' efforts and their achievements. Good teachers provide encouragement and support, along with clear expectations and reasonable goals for all learners.

Key beliefs.

- Knowledge (knowing) and emotion (feeling) are interactive.
- When anxiety is raised too high, learning is seriously impaired.
- Threats to a learner's self-concept interfere with learning.
- High standards must be matched with a high level of support.
- Teaching requires a balance between caring and challenging.

Primary responsibilities.

- Promote a supportive learning environment.
- Do not harm or reduce learners' self-esteem. Build confidence while guiding students through content.
- Promote success in learning.
- Challenge ideas while caring about people.
- Foster a climate of trust and respect.

Typical strategies.

- Get to know people as more than students.
- Listen and respond to emotional needs.
- Provide encouragement and support.
- Encourage expressions of feeling.
- Reinforce effort as well as achievement.
- Encourage collaborative approaches to learning and achievement.
- Promote positive interdependence and individual accountability.

Common difficulties.

- Providing feedback to those who are failing.
- Setting boundaries between teaching and counseling.
- Defending to others that nurturing is a part of teaching.
- Finding a good balance between challenge and caring.
- Wanting (too much) to be liked.

Many nurturing educators feel the need to defend themselves against their colleagues' criticisms. The very word "nurturing" may suggest a soft approach and lower standards. Yet, for those who are most exemplary of this perspective, there is no lowering of standards. Instead, there is a matching of standards with support. They make reasonable demands and set high expectations for their learners while providing an equal amount of emotional and intellectual support. Caring does not negate high expectations. For effective nurturing educators, the primary goal is helping people to achieve yet also to understand that their achievements are the result of their own effort and ability. These are the keys to self-efficacy and are essential to lifelong learning. Because of this, these educators are never willing to sacrifice self-efficacy on the altar of achievement.

Some may wonder whether this is a viable perspective within medical education. After all, the achievement bar is set so high for entry to medicine that only the very brightest get in, and they tend to do well regardless of what their teachers do. This may be true, yet we know the stress and fatigue that accompanies not only medical school
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but internships and residencies as well. Even the most advanced learners in medicine are often pushed to the limits of their ability to cope, sometimes suffering under the additional stress and fatigue of being on call for extended periods of time. These stresses are made all the more potent when a student is trying to balance personal and professional obligations. In other words, these people bring to their learning needs that go beyond the intellectual and that reach into the personal and emotional realms of self. It is here that the nurturing perspective is vital. Medical educators who exemplify a nurturing perspective take on a role that focuses on removing barriers or blocks to student learning. With a bright, highly motivated group of students, there is less need to direct learning. As a result, these teachers can focus more on removing obstacles and providing supportive and safe environments for learning. In combination with one or more of the other perspectives, this can be a powerful and effective orientation to teaching.18

Finally, attention to the nurturing perspective will become increasingly relevant to developers of CPME as new and innovative courses aligned with the developmental and apprenticeship perspectives are established. Those who attend such courses are unlikely to tolerate the same disregard for the nurturing perspective that many medical students and residents are exposed to on a daily basis. Enrolment for such courses will wither unless explicit attention is paid to preserving the self-esteem of participants, allowing them to risk and participate in such an ego-intensive environment.

Social Reform Perspective

Social reform is the most difficult perspective to describe because it is rare and diffuse. In our initial research, we found social reform educators in community development, Native education, AIDS awareness, Mothers Against Drunk Driving, the civil rights movement, environmental education, women's health, labor union education, religious education, and even within such established occupations and professions as automotive repair and medical education.14

From a social reform perspective, good teaching is intended to change medical practice and/or society in substantive ways. From this point of view, the collective, rather than the individual, is the object of teaching. Social reform educators awaken students to the values and ideologies that lie hidden in the texts and common practices in medicine. They challenge the status quo and encourage students to consider the ways in which they and their patients are positioned and constructed within particular discourses and medical practices. Common practices within medicine are deconstructed for the ways in which they reproduce and maintain conditions that are considered untenable. Discussion often focuses not only on the skills and knowledge of effective practice but also on a host of underlying issues. Texts are analyzed for what is said and what is not said, what is included and what is excluded, and who is represented and who is not represented in the dominant discourses within medicine. The purpose of encouraging students to take a critical stance is to give them power to take social action to improve society and the practice of medicine. Critical deconstruction, although central to this view, is not an end in itself.

Key beliefs.

• Professional practices are saturated with ideals and values.
• Those ideals and values must be examined and raised to question.
• Ideals and values should not be adopted without critical examination.
• The goal of education is not just to learn about the world but to change it.

Primary responsibility.

• Consistently represent the teacher's ideals, in both words and actions.
• Clarify the relationship between the ideals and goals of the curriculum.
• Make problematic what is taken for granted.
Justify and defend their ideals against challenges.
Focus on the collective rather than the individual.

**Typical strategies.**
- Draw out what people think, believe, or know in relation to the ideals.
- Develop both cognitive and political insight into the content/work.
- Direct teaching toward the learner as a representative of social structures.
- Develop awareness of political and ideological aspects of content.
- Integrate ideals and content with the lives of the learners.
- The goal is to look at the familiar in new ways and to give students a critical view.
- Assessment is based on moving individuals toward commitment and action.

**Common difficulties.**
- Accommodating those who just want to learn "content."
- Accepting those who object to the teacher's ideals.
- Having patience with learners who assume content to be value neutral.
- Dealing with those who want to maintain the status quo.

Educators who embody the social reform perspective are few and far between. But those who do are very likely to have a lasting impression on us. We may have had an educator who caused us to question things we took for granted, about ourselves or about society at large. It may have been the first critical theory course we took, a feminist educator we knew, or a spiritual leader who caused us to rethink our deepest assumptions and convictions. In any case, such teachers are usually unforgettable.

Again, some may wonder whether this is a viable perspective in medical education. We would argue that it is not only viable but, in many settings and instances, essential. Because it is such a rare and difficult perspective to define, we offer two quite different examples. The first example is about changing students' values and beliefs related to gay and lesbian patients in a large, inner-city hospital. The second is about a long-term and gradual change in the basis for medical practitioners' decision making.

In teaching a course called "Alternative Lifestyles," a local medical educator was concerned about two issues: (1) the stereotypes of gay and lesbian patients held by students, and (2) the way in which the discourse of "alternative" lifestyles perpetuated a sense of difference rather than similarity in how students perceived this group of patients. As he planned this course, the educator decided that it would be helpful for students to deal not with individuals but with couples. After advertising for volunteers, he chose several gay and lesbian couples from the community, screening for those who would be willing to give a sexual history and talk about life as a gay couple. As the course proceeded, students learned how to take a sexual history. They also learned to be more comfortable with sexual language. But they learned much more. In feedback to the instructor, students exclaimed how "ordinary and regular" these couples were, much like any heterosexual couple. This was precisely what the instructor intended. They also said that now they understood why he changed the title of the course from "Alternative Lifestyles" to "Nontraditional Family Units." The discourse of "alternative" had been replaced with a discourse of "family." This, in turn, engendered a very different kind of discussion about the ways in which they were similar to, rather than different from, any other couple presenting for health care.

The point here is that one educator held a core ideal that was as important to his teaching as was the learning of a skill or a body of knowledge. He found ways in which he could allow the context of authentic work help him teach toward multiple levels of purpose at one and the same time. What is important and central to a social reform
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Perspective is that he knew precisely where he was going with the change in course title, the soliciting of gay and lesbian couples, and the ways in which he asked students to reflect on what they were learning. It is important to remind readers that these students learned more, not less, than they would have normally learned. They learned all of the requisite skills of taking a sexual history. But they also changed from thinking about one segment of society as different to learning more about how they are similar. This was an important shift both in the students and in the curriculum.

The second example is briefer but is likely more relevant to CPME. Beginning in the 1990s, the trend toward evidence-based medicine gained momentum as the Evidence-Based Medicine Working Group published the first of their JAMA series, Users'Guides to the Medical Literature. The international working group, with their central office at McMaster University, sought to narrow the gap (and variability) between standard practice, as defined by clinical experts (opinion leaders), and evidence-based standards. Despite intense debate and opposition in the medical literature, evidenced-based medicine has arguably become the gold standard in medical practice. What began as a social reform in medical education and CPME has become an accepted standard. This is often the case and documents why we must include the social reform perspective as a viable and essential perspective on teaching in medical education.

Conclusion

Teaching perspectives are neither good nor bad. They are simply philosophical orientations to knowledge, learning, and the role and responsibility of being an educator. Therefore, it is important to remember that each of these perspectives represents a legitimate view of teaching when enacted appropriately. Conversely, each of these perspectives holds the potential for poor teaching. How, then, might these perspectives help continuing medical educators improve their teaching?

For several years now, those in CME have been admonished to reflect critically on their teaching. For many of us, this is not an easy task. On what are we to reflect? If it is the underlying values and assumptions that direct and justify our approach, how should we identify them? How are we to identify what is hidden from view and most often taken for granted? The objects of critical reflection are not self-evident. Indeed, it is something of a twist to look not only at our teaching but also at the very lenses through which we view our teaching.

In our work with continuing medical educators, we use these perspectives as a means of helping people identify, articulate, and, where necessary, justify their approaches to teaching. In this process, it also helps them thoughtfully revisit assumptions and beliefs they hold regarding learning, knowledge, and teaching. This is what faculty development should be, rather than simply the mastery of techniques. Throughout the process, preconceived notions of good teaching are challenged as educators are asked to consider what teaching means to them. In every case, we try to remind our participants that each perspective on teaching can be wonderful or dreadful, depending on the quality of its implementation and our readiness to embrace its underlying values. There is no one best way to view teaching. When we reflect on our own teaching, and especially when we are required to evaluate others’ teaching performance, we must remain open to the fact that excellent teaching is a pluralistic notion and occurs in multiple forms. In the end, we hope that our participants and readers will expand their views of what is good teaching in CME.

References

3. Irby DM, Ramsey PG, Gillmore GM, Schaad D. Characteristics of effective clinical


