You Say Tomato, I Say “Tomahto”: the Semantics of Blended Learning

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The notion of a “flipped classroom” has garnered considerable attention in medical education in recent years. Unfortunately, many medical educators find the term confusing. Multiple definitions exist, and instructors across multiple disciplines and education levels (e.g., K-12 to higher education) use the term inconsistently. Further, there is no single authoritative definition of a flipped classroom. Many educators use something similar to the following as their working definition: School work is done at home and home work is done at school. In actuality, the flipped classroom is very similar to other education models including reverse instruction, inverted classroom, hybrid learning, and blended learning; however, the flipped classroom has become the most recognized term. All of these education models are closely related because they share a common feature: students are required to prepare for class through the use of text, videos, or other educational materials.

Ambiguous terminology presents three major problems for medical educators. First, it imposes unnecessary and undesirable constraints on an instructor. Adhering to a single pedagogical approach limits an instructor’s ability to adapt content delivery to the learner’s needs and nature of the content. Specialized terms often compel faculty to think of instructional approaches as a strict dichotomy, as opposed to a continuum that offers maximum flexibility to meet learners in a variety of ways. Second, many medical educators find terms such as reverse instruction, inverted classroom, hybrid learning and flipped classroom to be vague. This results in many medical educators erroneously assuming that these techniques ask students to acquire and understand large volumes of

information independently and/or asynchronously and without any oversight. Third, ambiguous terminology makes the implementation and study of these concepts difficult. Specifically, educators will find it difficult to aptly characterize their instructional approaches when discussing with others, and researchers will find it difficult to conduct comparative and replication studies given the ambiguity. These issues could potentially impede our understanding of these concepts, result in confusion among colleagues, and waste researchers’ time.

Margulieux and colleagues [1] have recognized similar problems with ambiguous terminology and produced a two-dimensional taxonomy that attempts to clarify the distinctions between the terms hybrid, blended, flipped, and inverted learning. While the taxonomy appears promising, it is unlikely that the typical medical educator with minimal formal educational training will use such a taxonomy without considerable faculty development. Thus, even potentially promising solutions for understanding these issues as they are currently framed have substantial limitations in the context of medical education in which most medical educators are medical content experts and practitioners first and educators second.

We believe making a semantic distinction is critical for purposes of objectivity. Given that medical schools have historically relied primarily on lectures to convey instruction, many medical educators have deeply rooted opinions that lectures are the “right” or preferred method of instruction. Terms such as flipped, reverse, and inverted imply a significant deviation from the norm, which could potentially invoke negative emotions among skeptical faculty.

Given the complex and ambiguous terminology, associated instructional constraints, and potential for adverse emotional responses, we believe the term “blended learning” is more appropriate. Graham [2] and Osguthore and Graham [3] precisely define blended learning as “combining online and face-to-face instruction.” Because combining instructional methodologies is not new, this definition acknowledges the

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traditional in-person and classroom instructional systems favored by most medical educators and makes room for the use of technological innovations in learning. We endorse the definition that blended learning is a formal education program that combines online content and instruction with supervised brick-and-mortar lessons. We favor this broad definition because blended learning encompasses the majority of active and personalized instructional approaches and encourages instructors to remain flexible in selecting the most appropriate method given the content and the learner.

In conclusion, we believe the term “blended learning” is more inclusive, less confusing, and less emotionally charged than the many prevailing nuanced terms. We encourage other medical educators to adopt the term blended learning as a blanket descriptor for any instructional approach that incorporates elements of online and brick-and-mortar instruction. Specific details of one’s approach could then be described on a continuum that

illustrates the degree to which instruction utilized various modalities and approaches. This approach would likely help medical educators to better develop a common frame of reference and better understand the many variations of blended learning.

References

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