



# If health professionals are educators, what are patients?

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I have just seen an advertisement on SBS for Adult Learners Week. Calls for more recognition and support for adult learning seem to still foreground the course participant. If we want to build a learning society, learning cities and so on, promoting courses won't make much difference. A valuable strategic effort would be for the champions of learning cities to reconceive of clients as learners. Imagine if people in a town could boast that they call themselves a learning city because they have radically changed the way health professionals see themselves.

## *What is my idea?*

I used to ask my students of public health to come up with synonyms for the term 'patient'. They would offer 'client', 'customer' and maybe even 'victim' but not 'learner'. But when I asked clinicians if education was part of their treatment, without exception they saw themselves as educators. Clinicians often manage patients who need to learn how to deal with their health problems: a truck driver who is physically inactive and has just survived a heart attack, a Koori woman with diabetes or a rural youth suffering from depression. If patients are people in need of change, how do clinicians assist them to learn? What kind of educator should a clinician be in order to help patients learn and change effectively?

## *What would such clinicians be doing?*

Such clinicians would be listeners rather than doers. They would have an interest in transforming bio-medical problems into solutions that are empowering for their patients. They would understand that responsibility for wellbeing needs to be shared between individuals and communities. They would search for options and choices that would suit their patients' cultural, social, economic and educational needs. Treatment interventions would be negotiated and their effectiveness evaluated in collaboration. The clinician-patient relationship would operate on egalitarian terms with no hidden agenda and desire to control or dominate. Expectations of both parties

would be laid on the table. In short, such a clinician would be a facilitator of emancipatory learning.

## *Why is this a good idea?*

The clinician-patient relationship is in crisis. With the rise of HIV/AIDS and chronic diseases, there is a need to shift from a cure model to a care model. Patients are increasingly diverse and complex. Clinicians are expected to treat individuals within their context rather than treating a diagnosis. Most official patient complaints are caused by communication breakdowns rather than technical malpractice. As the role of patients shifts towards that of the empowered consumer, the role of clinicians shifts from the authoritarian technician to the more responsive facilitator of emancipatory learning.

Some clinicians already facilitate emancipatory learning, however they would be the minority. The literature is sparse on this topic. One of the biggest barriers to transforming clinicians' teaching approaches is time. They claim not to have the time to listen to their patients and negotiate medical management. Listening to a patient's agenda is not the priority, and clinicians think they know best. Another barrier is a lack of training in this pedagogy. When asked what, other than telling, they could do to help their patients learn, the reply is mostly 'don't know'. For most clinicians education means to impart medical knowledge. This approach makes patients dependent. Knowledge is misused as power. Health issues are viewed as biomedical problems that need solving within the natural sciences. Not surprisingly, undergraduate training produces clinicians who reduce learning to the rational understanding of facts.

## *What needs to change and what is my vision?*

One has to address professional power, professional identity and expectations of both clinicians and patients. While these issues are not addressed, the medical curriculum will not prepare future clinicians to be effective facilitators of emancipatory learning.