Scholars LITERATURE

La Prensa Medica Argentina

Letter to the Editor

DOI: https://doi.org/10.47275/0032-745X-386
Volume 109 Issue 1

Is there an Affiliation between Higher Education and the Construction of a More Just Society Model/that Respects Human Rights?

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Abstract

In this article, we start with two questions, that enable us to rethink educational practices and learning processes in higher education. And more specifically in the undergraduate training of medical professionals. We ask ourselves then, what (is) to teach? And what to teach? ... far from answering these questions, we seek to open new ones.

The field of cultural pedagogical invites us to think of education and pedagogy as praxis, as an action, from our place, from our practices as concrete, historical subjects, with power (s) to transform and dream new worlds.

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Citation: Trupa NS, Mendes Diz AM (2023) Is there an Affiliation between Higher Education and the Construction of a More Just Society Model/that Respects Human Rights?. Prensa Med Argent, Volume 109:1. 386. DOI: https://doi.org/10.47275/0032-745X-386

Received: December 21, 2022; **Accepted:** January 20, 2023; **Published:** January 25, 2023

The commitment is to recover and value the affective and supportive links that are committed to an education that respects socio-cultural diversity and recognizes others in all their diversity. It is a commitment to a pedagogy that recovers the value of sharing stories and experiences. Education, pedagogical practices, and therefore the university are sustained in beliefs, ideologies, and values that guide them, which have changed throughout history, leading to the coexistence of different cultural projects and inheritances, with the most diverse didactic and pedagogical objectives and proposals. We know that pedagogical relationships that occur in the privacy of the classroom are crossed by the presence of very complex and contradictory emotions, and always affect the teaching-learning process.

Unraveling the plot of that staging which is the class, will favor the pedagogical task. Learning about the possibilities and limitations derived from each pedagogical style can help humanize our tasks in the classroom. Imagining other scenarios is also interesting [1].

"Pedagogical action always tends to modify behaviors, affections, representations of students [2], builds links What is a classroom without pedagogical links?" [3].

For this work, we did an imagination exercise assuming similarities that may appear when analyzing the teacher-student relationship, with the medical-patient relationship. Even recognizing the uniqueness of each case, we allow ourselves to make generalizations.

Both the teaching and doctor profession are chosen by vocation, in most cases, and this implies that since the beginning, these professions resemble. There is altruism, among other motivations, in that choice. Before the question of why they made that choice of profession, there are many who answer: "I was born to be ...".

There is no doubt that the link between teacher and student occurs in a framework of power relations. The teacher holds knowledge that students recognize, which does not mean that the student lacks knowledge, but holds other knowledge that the teacher should also recognize, even if they are different. The same happens in the patient's medical relationship. In both cases, the communication is interrupted, for example, when both the teacher and the doctor use an incomprehensible "jargon" that acts as a breakdown of the link. While this situation occurs more frequently in the patient-medical relationship, there are also teachers, especially in the faculty, who give their classes in an unattainable language, which is nothing more than a sample of power. This situation, like so many others, places the student and the patient in a place of helpless treatment.

These structured pedagogical relationships are based on the passivity of a teacher and dependent student, which is the transmitter of knowledge, is the one who has the place of power. Knowledge is power.

We could assume students and therefore, doctors, disciplinators and transmitters of information, which would also see their patients as mere recipients of information and medical action. In both cases they would be passive people, who cannot build themselves, as doctors or as patients. These doctors would "build" patients who would only be put in the hands of medical action without assuming an active role in their healing. According to this model, that passive student will build a passive and also a-social patient. And why a-social? For having been formed with a logic away from their experiences and concerns.

In the case of doctors thus trained, perhaps they tend to ignore the beliefs and living conditions of patients, their impossibility of buying medications, and having adequate spaces and temperatures to keep rest indicated by the doctor.

Perhaps those doctors would not know the patient's needs regarding the medical relationship, in aspects such as the following. The need for your doctor to explain with accessible language about your illness, your treatment, and the time that your healing would demand (at least approximately), to receive a good treatment (kindness, respect for modesty), that shows interest and dedication time; and achieve continuity in the link, which generates trust (essential to achieving a good diagnosis and treatment). And surely the list continues.

Different social practices may also be unknown or not respected, or those "different" patients are stigmatized. And then what place would there be for creativity? And why not, for play and tenderness? ... in the student-teacher relationship and, therefore, in the patient-medical relationship. Social sensitivity is essential in both relationships, the teacher should approach the student enough to know him and achieve a good link. It should be an essential function of education to reorient students in that sensitivity, and perhaps then medical students-thus trained will do the same with their patients.

In this sense, we adhere to other more innovative pedagogical models, arising in the second half of the twentieth century, which rescue the active participation of the student in the construction of knowledge from the valorization of their previous knowledge and experiences. He is the teacher who allows us to show not only what he knows but also what he does not know. This process is also given in the patient's medical relationship. On the one hand, with the birth of a patient with rights and with the autonomous decision on diagnostic and therapeutic procedures that are offered, and on the other, the deep transformation of the doctor, of being a "priest" father to become a technical advisor of his patients, with their knowledge and advice [4].

These transformations humanize both roles and stimulate personal involvement in learning in one case, and in health (healing) in the other. It is not about installing a unique truth, but about discussing ideas and promoting critical thinking.

Being a teacher as well as being a doctor have been professions with social recognition, we would say "stop" from the place of knowledge, and also both, in the current times they are being questioned regarding the power they had in their beginnings.

We are therefore emphasizing the importance of affection in educational experiences, since "in their daily bond, both educators and students learn to respect and listen, to commit to the other when he needs it, to dissent, to live together, to live, To be supportive, in short- and why not say it-to love it" [5].

It is to consider the classroom as a "space for improvisation, to questions, to the need to think about each situation as a possibility of transgressing what is established or preserving what serves" [5]. Teaching to respect the patient's beliefs is to empathize with him, never show anger from healing practices different from those of official medicine, rather share that knowledge, and if they are considered to affect health, "negotiate" with the patient within a frame of respect for different looks.

We consider that the teacher plays an ethical-political role where care and trust are key in learning, and the same should happen in the relationship of those doctors we form, with their patients.

We try to generate reflective and critical practices and knowledge in students. That the student appropriated the concepts, of knowledge from their own social reality, from their own experience. And so they can put themselves patiently and understand their realities.

Understanding the interests and concerns of the students will enable them to do the same with their patients. "Educating is not to accumulate more ideas about things, but something very different: Learn to look, to listen, to think, feel, to imagine, to believe, to understand, to choose and desire" [6]. And for this, confidence, solidarity, and commitment in the relationship-students relationship is fundamental, without which the teaching process is empty, meaningless, and without pedagogical interest.

Getting students, to ask questions, is to train doctors who enable their patients to ask, express themselves, to listen to their arguments and even their silences. The patient-medical relationship is a meeting, sometimes, disagreement, between two cultures, but it is important to accept that both have different knowledge, as well as different explanations regarding the same diseases. The more they listen and empathize with patients, the closer they will be to a good diagnosis and even prognosis. It is interesting to think about how didactic and pedagogical practices are part of certain learning matrices [7], which refer to an internal learning model in which each subject organizes and means the universe of their experience and knowledge. These learning matrices build our learning trajectories, synthesize and contain our limitations as well as our potentialities [7].

The country needs a university where the student is an active part of society and that incorporates concern about the needs of the community, and the desire to solve them, and that, consequently, does not see in the technique the end, but the means to achieve it.

Bárcena asks "What makes a pedagogical legacy big?" The teacher transmits that inheritance, but does not belong to him. He is a mediator, a passage of time. It represents the world to which students are initiated, but it is not the world. (…). Education is an experience in which there is no "method", but rather a trajectory. And this journey, and its way of touring it, are not determined based on previous objectives (...), but through the interest that the experience of the path is raised in the subject of the experience [6]. And in that journey, we agree with Assmann that "the pleasure of education requires a union between social sensitivity and pedagogical efficiency" [8]. Humility, tolerance, courage, the joy of living, and why not a sense of humor, are qualities that educators cannot do without [9], especially if they are going to be the example of the doctors who are forming.

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