TRAINING TO CURE: MEDICAL PEDAGOGY AT THE HEART OF HEALTH EDUCATION

FORMARE PER CURARE: LA PEDAGOGIA MEDICA AL CENTRO DELL'EDUCAZIONE SANITARIA

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ABSTRACT

In the current context of increasing complexity of Health Systems, Medical Pedagogy emerges as a fundamental discipline to promote an integrated, humanistic and competent training of health professionals. The article proposes a critical reflection on the importance of training to cure, that is, of investing in the quality of training as the first act of care for the patient. Innovative educational approaches, interprofessional pedagogical models and strategies to enhance the therapeutic alliance through the enhancement of the educational dimension of care are analyzed. The goal is to outline a paradigm in which pedagogy is at the service of health, contributing to the construction of a more aware, empathetic and sustainable health system.essential to ensure an inclusive educational environment.

Nell'attuale contesto di crescente complessità dei Sistemi Sanitari, la Pedagogia Medica emerge come disciplina fondamentale per promuovere una formazione integrata, umanistica e competente dei professionisti della salute. L'articolo propone una riflessione critica sull'importanza della formazione per curare, cioè dell'investire sulla qualità della formazione come primo atto di cura per il paziente. Vengono analizzati approcci educativi innovativi, modelli pedagogici interprofessionali e strategie per valorizzare l'alleanza terapeutica attraverso la valorizzazione della dimensione educativa della cura. L'obiettivo è quello di delineare un paradigma in cui la Pedagogia sia al servizio della Salute, contribuendo alla costruzione di un Sistema Sanitario più consapevole, empatico e sostenibile.

KEYWORDS
Health Systems, Medical Pedagogy, Training

Sistemi Sanitari; Pedagogia Medica; Formazione

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Introduction

The need to recover the human value of care is becoming increasingly evident in an era in which medicine is advancing rapidly thanks to artificial intelligence, robotics and the standardization of clinical processes. Technological innovations, while offering great diagnostic and therapeutic opportunities, risk transforming healthcare into a hyper-specialized system, but devoid of relational warmth, where the doctor-patient relationship is reduced to a simple exchange of information (Topol, 2019; Damasio, 2018). Faced with this scenario, the real challenge is not only technological, but profoundly educational and cultural: to train health professionals capable of combining scientific competence and relational sensitivity, clinical rigor and empathic capacity, standardization of protocols and personalization of care (Hojat, 2016). The care relationship, an essential element of any authentically health intervention, cannot emerge mechanically from the application of guidelines. It is built over time, through training courses that involve not only the cognitive dimension, but also the ethical, emotional and communicative dimension of the future professional (Bleakley, Bligh & Browne, 2019). The idea that "training to cure" is just a slogan is overcome when it is understood that every health act is also an educational moment, in which patient and caregiver learn mutually (Wear & Zarconi, 2017). Educating, in the health sector, therefore means promoting awareness, responsibility, personal and professional growth. In this context, *Medical Pedagogy* acquires a strategic role, a discipline that is still undervalued, but capable of profoundly affecting the quality of training and, consequently, of care. It deals with designing and evaluating educational processes within health contexts, with a focus that goes beyond teaching techniques, embracing the relational, cultural and emotional dynamics that run through every educational situation (Branch & Frankel, 2017). Medical Pedagogy is not limited to improving teaching in Faculties of Medicine or in professional development programs. It represents a real cultural and systemic approach, which considers training as an act of care and care as a continuous educational process (Kelly-Hedrick et al., 2020). In recent years, it has become increasingly clear how insufficient training focused exclusively on technical and scientific knowledge is. The growing needs for soft skills – such as effective communication, empathy, uncertainty management, teamwork and critical reflection – have forced a profound rethinking of traditional educational models (Skelton, 2021). Overcoming a transmissive vision of knowledge and promoting active and reflective pedagogical approaches, capable of integrating theory and practice, emotion and reason, is today both an educational and political priority (Bleakley, Bligh & Browne, 2019; Skelton, 2021).

The goal, in fact, is not only to train technically competent professionals, but individuals capable of establishing authentic relationships with the patient, recognizing their uniqueness and enhancing the human dimension of the care process (Hojat, 2016; Kelly-Hedrick et al., 2020). Health education must therefore be able to open up to a holistic and relational perspective, capable of holding together clinical knowledge and humanity, guidelines and personal sensitivity.

This paper aims to deepen, from an interdisciplinary perspective, the value and transformative potential of *Medical Pedagogy* in contemporary health education.

The reflection is guided by a pedagogical vision that interprets care as a profound educational relationship, in which shared knowledge, identity, values and responsibilities are at stake. Investing in training in this sense means making an ethical and strategic choice, not only to improve the efficiency of the health system, but to actively contribute to a more just, aware and humane medicine (Topol, 2019; Nussbaum, 2021).

1. The sense of care and quality of life

Health education is a fundamental aspect of life education, since health and life are deeply interconnected goods. One cannot think of a state of authentic well-being without considering the life choices that sustain it (Cicutto & Costanzo, 2010). Educating to health, from an ethical point of view, therefore means educating to respect human dignity, understood not only as the sum of abilities and abilities, but also as acceptance of fragility, openness to reciprocity and availability to give of self (Boff, 2005). In this perspective, personalist anthropology plays a central role, emphasizing the uniqueness of the human person as a bio-psycho-socio-spiritual reality. This vision proposes a concept of holistic health, in which body, psyche, spirit and social relationships intertwine and influence each other (Scandroglio, 2009). Health, therefore, is not only the absence of disease, but a dynamic state of harmony and integration between all the components of the human being. The affirmation of the notion of "quality of life" in contemporary culture highlights a growing sensitivity towards the emotional and relational dimensions of existence, in contrast with the reductionist visions of the past, too often linked to exclusively scientific or mechanistic paradigms (Nussbaum, 2001). This development has allowed medicine to take a significant step forward: not only healing, but also caring, even where healing is no longer possible. It is a question of guaranteeing a dignified quality of life even for chronic or terminal patients, respecting their humanity and their personal experience (Pellegrino & Thomasma, 1993). However, the idea of quality of life can also be ambiguous and risky. In some interpretations, in fact, the very value of life is questioned, especially when it is marked by disability, pain or dependence. One can come to believe that a compromised life is no longer worth living, forgetting that every existence, even marked by suffering, can contain deep meanings, authentic relationships and the possibility of happiness (Ricoeur, 1990). In this reductionist vision, illness is perceived exclusively as a limit, a loss of freedom, a negative event to be removed. However, it omits to reflect on the human condition in its entirety, in which fragility is not an anomaly, but a structural component of our existence (Jonas, 1990). Recognizing fragility also means accepting that we do not have absolute control over life and the body, and therefore opening ourselves to the possibility of a deeper understanding of the self and one's destiny. To change this approach, it is necessary to recover a broader ethical perspective, which includes the question of meaning: why do I suffer? What does this experience mean to me? What relationship do I have with my freedom, even within the limits imposed by the disease? These questions, of an anthropological and moral nature, are indispensable to accompany the clinical and psychological approach with a more existential reflection (Fabris, 2002). Within the care professions, this orientation translates into a practice based on the authentic encounter between caregiver and patient, in which both, by valuing their experiences, memories and cultures, can build a new sense of their own identity. Professionalism, in this context, is not only technical, but also a daily testimony of dedication, care and attention. Even in the most difficult moments, every event can become an opportunity for growth, if welcomed in a dimension of openness and meaning (Boff, 2005). "Feeling good" and "being bad" therefore take on meaning only within a true human relationship. One does not live only to be healthy or avoid illness, but to recognize and be recognized, to love and be loved (Ricoeur, 1990). It is in this horizon that pain and suffering, lived in solidarity with others, can be transformed into generative experiences, capable of shifting the perspective from the negative to the positive. At this point, an essential question arises for anyone involved in the world of care: is it possible to attribute meaning to suffering? It is an existential question, which does not find immediate answers, but invites us to open ourselves to a personal and

relational journey of search for meaning, hope and human depth that goes beyond mere technoctratic models.

2. Crisis of technocratic models and the need for humanization of care

In the current model of contemporary medicine, we are witnessing a growing affirmation of the technocratic paradigm, which profoundly redefines the relationship between doctor, patient and clinical knowledge. This approach, strongly focused on efficiency, standardization of processes and intensive use of technology, tends to reduce the complexity of the disease experience to a sequence of data, protocols and algorithms (Palla et al., 2024; Travaline, 2019). The patient's body is thus objectified and treated as the site of malfunctions to be corrected, while subjectivity – i.e. the emotional, relational and biographical experience of the person – is often neglected or excluded from treatment pathways (Suijker, 2023). In this context, the sick person risks being reduced to a "clinical case", on which pre-packaged solutions are applied, with little possibility of active participation in therapeutic decisions (Mold, 2022). Such a reduction not only undermines the quality of care, but also its overall effectiveness, as it excludes fundamental elements such as listening, empathy and dialogue. Among the major critical issues of the technocratic model emerge:

- Patient alienation: standardization can reduce the patient to a sum of objective parameters (tests, images, biological markers), leaving out subjectivity, the interpretation of pain, personal history. In obstetrics, for example, DavisFloyd (2001) highlights how the technocratic paradigm of childbirth (hospital birth) tends to see the body above all as a machine to be monitored, controlled, intervened, while the humanistic or holistic model also considers relational, cultural, and emotional aspects.
- Impaired subjective patient experience: Recent studies show that the clinician's perception of empathy significantly predicts the quality of the doctor-patient relationship and patient satisfaction. For example, a study published in BMC Medical Education in 2025 (Han, Wu, Liu et al.) finds that patients who perceive greater empathy "feel" a better clinical relationship, which affects their involvement in care.
- Effect on clinical outcomes: A meta-analysis of randomized controlled trials – in which the patient-clinician relationship is "manipulated" (i.e., explicitly improved) – shows that even if the effect is small, it is statistically significant. Increasing the positive ratio improves subjective and objective outcomes (e.g., blood pressure checks, pain). (Saueressig et al., 2024).
- Dissatisfaction and conflicts: in contexts where the pressure towards efficiency, productivity and performance exceeds resources (time, staff, space), there are growing phenomena of burnout in professionals, conflicts between patients and operators due to lack of listening or information, and cases of legal disputes related precisely to perceptions of inattention or cold treatment. A study of 1,790 litigation cases in China showed correlations between poor perception of the doctor-patient relationship and increased likelihood of claiming compensation for medical damages. (Li et al., 2024).
- Stress and burnout among healthcare professionals, due to excessive pressure on productivity, reporting and results.
- Dissatisfaction and distrust on the part of patients, who perceive care as cold, standardized, not centered on their real needs.
- Reduction of professional autonomy and social trust: in health systems where management is dominated by targets, benchmarks, quantitative evaluations, DRGs (Diagnosis Related

Groups), etc., clinical autonomy is contracted, and this can generate a distance between what is perceived as "right care" by the professional and what is required by the system. For example, the case of the French system described by Simonet (2019) shows how recent reforms (technocratic centralization, performance-based evaluation mechanisms) have recompacted decision-making power towards the administrative center, reducing professional involvement and patient participation in local decisions (Simonet, 2019).

In order to counteract this drift, a renewed interest in narrative medicine has developed in recent years, which aims to reintegrate the patient's voice into clinical processes, enhancing disease stories as tools for understanding and treatment (Jacobs et al., 2024; Cercato et al., 2023). This approach, which is increasingly recognized also in the academic and health fields, represents a concrete attempt to overcome the limits of the technocratic model and restore centrality to the human dimension of medicine (Table 1):

PatientCentered Care	**Nursing care with "nurse reference"**	**Training interventions on the doctor-patient relationship**
Models that involve sharing decisions, active listening, and recognizing the patient's personal context. The study on online physician-patient interaction during the COVID19 pandemic in China found that emotional comfort increased patient satisfaction in addition to clinical responses	The model in which the patient has a nurse of reference, rather than fragmented visits by many operators, improves the subjective experience of the patient. The study in Tuscany (De Rosis, Barchielli, Vainieri, Bellé, 2022) between nursing care delivery models and patient experience	Training that includes simulation, roleplay, video feedback, ethical reflection; interventions that directly manipulate the quality of the relationship (empathy, listening, communicative clarity) show improvements in both patient satisfaction and clinical outcomes (even if small) in RCTs

Table 1. Humanizing Examples and Models

3. **Educating to proximity, responsibility, dignity**

Educating to proximity, responsibility and dignity means radically rethinking the training of health professionals, directing it towards an integral vision of care, in which technical competence is deeply intertwined with the ethical, relational and human dimension of clinical action. In an era in which medicine risks being increasingly dominated by efficiency, standardization and technology, *pedagogies of care* are affirming themselves as educational approaches capable of counteracting this technocratic drift, promoting a culture of health based on listening, empathy, reflective awareness and shared responsibility. Educating to proximity, for example, means bringing future professionals closer to the patient's lived experience, reducing the symbolic and communicative distance between caregivers and patients. In this direction, the study by Bombard et al. (2024) showed the effectiveness of the direct involvement of patients and caregivers in the co-design of educational activities, fostering a change of perspective in learners and a greater understanding of the patient's experience, with a consequent strengthening of the sense of relational responsibility. At the same time, educating to responsibility implies overcoming a reductionist vision of clinical action based on adherence to protocols, to embrace an ethical awareness capable of recognizing the profound implications of every gesture of care. In this

sense, the scoping review by Bell et al. (2025) on the integration of *trauma-informed care* in medical training highlights how attention to patients' traumatic experiences helps professionals develop sensitivity towards those secondary behaviors that can reactivate previous suffering, fueling not only technical but also relational and emotional responsibility. Finally, education to dignity recalls the need for an explicit pedagogical commitment to promoting respect for the autonomy and intrinsic value of the sick person, even in the most fragile conditions. Pilkington (2022) proposes the use of narrative, simulated and reflective methodologies to help learners recognize and protect the dignity of the patient in critical contexts, while Silva et al. (2021), with their dance workshop in a hospital setting, demonstrate how the artistic experience can activate embodied learning, capable of mobilizing the body, emotions and mind in a single training process. The arts and humanities also play a crucial role: Wangding et al. (2024), in a critical review, highlight how tools such as fiction, painting, poetry and theatre facilitate a deeper understanding of the suffering of others and greater social responsibility in future operators. Interprofessional approaches to dignity education, such as those analyzed by Legault et al. (2015), also show that the sharing of experiences between students from different health disciplines fosters the construction of a common culture of care, based on mutual respect and ethical co-responsibility. Even in digital environments, it is possible to cultivate a pedagogy of care, as demonstrated by Younie and Adachi (2024), who document collaborative and creative training practices capable of generating authentic spaces for reflective learning. Similarly, Cardoso et al. (2025) demonstrate the effectiveness of the SEAGULL method — a humanizing approach to the doctor-patient relationship — in reinforcing students' orientation towards decision-sharing and active patient participation. Ultimately, the pedagogies of care are not a simple set of techniques to be added to technical training, but a real educational posture, which assumes the whole person — body, mind, emotions, values — as the subject and object of the training process. Only in this way is it possible to form professionals capable of living the time of care with authentic proximity, profound responsibility and radical respect for the dignity of the other. In an increasingly efficiency-oriented health system, this educational vision is not a luxury, but a moral, cultural and systemic necessity.

4. **Relational and reflective skills in health training**

In the health training course, relational and reflective skills such as active listening, empathy and self-awareness play an essential role not only for the quality of care, but also for the well-being of the operator himself. They are built through didactic tools that make explicit the work on emotions, interpersonal dynamics and the formation of the professional self. Recent studies show that differentiated listening styles, measured through tools such as the *Jefferson Scale of Empathy* and the *Listening Styles Profile–Revised*, show significant correlations with empathy among medical students. In particular, a study by Beheshti, Arashlow, Fata et al. (2024), published in *BMC Medical Education*, highlighted how relational listening styles — which privilege the patient's story, emotional experience and narrative dimension — are associated with higher empathy scores. The authors point out, however, that there is no "perfect listening" valid for every context, suggesting that flexibility in modulating the listening style according to the clinical relationship is itself a fundamental skill to be cultivated (Beheshti et al., 2024). In parallel, experiential courses that integrate "mindbody skills" practices — such as meditation, mindful breathing, reflective writing, and sharing groups — have been shown to be effective in promoting self-awareness, stress regulation, and a more stable empathic attitude over time. Van Vliet, de Jong and Jong (2018), in a study published in *SAGE Open Medicine*, observed that medical and nursing students who participate in structured mind-body medicine pathways report improved self-perception, greater mental presence and deeper interpersonal

connection. Confirming this, Motz et al. (2012), in their work presented in *BMC Complementary and Alternative Medicine*, showed that an 11-week course based on mind-body practices at Georgetown University significantly reduced perceived stress among medical students while increasing their mindfulness and empathic awareness (Motz, Graves, Gross, Saunders, Amri & Haramati, 2012). Tools such as *role-playing*, high-fidelity simulation with simulated patients, post-exercise debriefing and mentoring oriented towards the humanization of the relationship have also proved to be fundamental for the development of relational skills. These devices provide safe spaces for students to experiment, reflect, engage with authentic feedback, and explore their emotions in a non-judgmental atmosphere. An innovative example is the "Zoom Improv" study, conducted by Timlin et al. (2024) and published in *BMC Medical Education*, which showed how online theatrical improvisation sessions are effective in improving active listening, emotional expression and empathy: after only 90 minutes of the workshop, participants reported a significant increase in perspective taking and imaginative capacity (fantasy), as well as a reduction in personal distress related to empathic stress (Timlin, I., Tavakol, M., Kelly, M. & Ryan, A., 2024). Finally, narrative practices play an important role: narrative medicine, autobiography, reflective writing and the encounter with patients' stories contribute to strengthening professional identity and recognition of the other as a person. According to Fornetti, Barbosa et al. (2024), medical students regularly involved in artistic and narrative activities show significantly higher levels of empathy and attention to the subjective dimensions of the disease. The study, also published in *BMC Medical Education*, confirms that the integration of liberal arts into healthcare education can serve as a pedagogical lever for the humanization of care (Fornetti, M., Barbosa, M., Martinez, A., Rego, G. & Costa, M. J., 2024). Ultimately, an education in authentic care requires teaching practices that foster reflection, presence, listening and relational ethics as fundamental professional skills.

5. **Towards the future: human medicine as an ethical horizon**

In outlining the future of health education, it becomes increasingly crucial to affirm human medicine as an essential ethical and educational horizon, capable of combining technical-scientific excellence with a profound moral responsibility. As already pointed out, the rapid advancement of digital technologies, artificial intelligence and the increasing standardization of clinical procedures, while on the one hand offer opportunities for precision and efficiency, on the other hand risk marginalizing the relational and subjective dimension of care, reducing the patient to a simple set of data to be processed (Topol, 2019). In this context, the educational challenge consists in training professionals capable of keeping the doctor-patient relationship alive and central, based on proximity, empathic listening and respect for human dignity, essential elements for a truly curative practice (Cassell, 2017). The literature underlines how the integration of technical, communicative, ethical and reflective skills must represent the fulcrum of a training course that is not limited to the acquisition of notions, but favors the maturation of a deep human sensitivity (Kleinman, 2015; Wear, 2008). This requires a critical review of traditional educational models, introducing active methodologies, such as narrative medicine, role-playing, simulation and debriefing, which promote ethical reflection and the elaboration of emotional experience. It is also essential to cultivate the self-awareness and self-reflection capacity of operators, in order to prevent burnout and professional alienation, phenomena now widespread and recognized as obstacles to the quality of care (Charon, 2006). Training must also embrace an intercultural and inclusive approach, recognizing and valuing the diversity of patients and communities, thus promoting equitable medicine that respects multiple identities (Wear, 2008). A central aspect of this future perspective is the role that technologies must assume: not simple substitutes for human relationships, but tools that enhance the professional's ability to connect with the patient, to listen to his or her story

and to personalize care. Topol (2019) highlights how artificial intelligence can free up time and resources for operators, allowing them to devote more time to the human dimension of care, as long as technological adoption is accompanied by adequate ethical and relational training. Ultimately, the future of medicine cannot be separated from a vision that focuses on the person in his or her entirety and complexity, considering treatment not only as a clinical intervention, but as an ethical and human act. The training challenge is therefore to build learning environments in which technical skills are integrated with deep listening skills, authentic empathy and a sense of moral responsibility, to prepare professionals capable of embodying a medicine that is truly human, inclusive and sustainable (Coulehan & Block, 2006). The training pact between universities, the health system and civil society represents an indispensable strategic model to ensure truly integrated, relevant health education oriented to the contemporary needs of the community. This pact implies a structured and continuous collaboration that goes beyond the traditional boundaries of academic education, actively involving the different social actors in the definition of the contents, skills and values to be transmitted to health professionals (Duffy & Chenail, 2015). The synergy between universities, health services and civic representatives makes it possible to develop flexible, interdisciplinary curricula rooted in social reality, fostering the training of professionals capable of responding to complex challenges such as health inequality, the humanization of care and the promotion of public health (Boelen & Woollard, 2009). In addition, the involvement of civil society in training activities, through community experiences, co-design and continuous feedback, contributes to making training more attentive to the real needs of patients and to promoting a participatory and empowering model of medicine (Frenk et al., 2010). This pact, therefore, not only strengthens the effectiveness of learning but strengthens the link between scientific knowledge and civic engagement, positioning health education as an open, dynamic and responsible process towards the community.

Conclusion

In conclusion, the challenge of contemporary health education lies at the crossroads between technological innovation, social complexity and profound humanity. Rethinking medicine as an art of care that combines technical knowledge and empathic relationship is not only an ethical requirement, but an imperative to ensure efficacy, sustainability and dignity in future clinical practices. The new generations of professionals are called to become not only clinical experts, but custodians of a holistic vision of health, capable of embracing the complexity of the person in his or her social, cultural and emotional context. This requires a solid and inclusive educational pact between universities, the health system and civil society, which knows how to translate values and skills into daily care practices. In the light of these reflections, an important question emerges: how will it be possible, in an era of increasing digitization and automation, to maintain and cultivate the human dimension of medicine? Perhaps the answer lies precisely in training, which must become a permanent laboratory of critical reflection, empathy and ethical responsibility. Only in this way will it be possible to prevent technology from becoming a barrier instead of a bridge and that care remains an act of true proximity. We therefore invite educators, professionals and policy makers to constantly rethink training courses, experimenting with innovative approaches that never lose sight of the human face of the patient, the ultimate and essential protagonist of every treatment process. This educational challenge also represents an extraordinary opportunity to rethink medicine not as a simple applied science, but as a profoundly human, inclusive and transformative practice. In this sense, the future of health will depend on the ability of new generations of professionals to combine technical skills, ethical sensitivity and relational skills, to build more just, sustainable and humanized health systems. It is therefore an open invitation

to all those who work in the field of education and care to put the human being at the centre, not as an abstract ideal, but as a concrete and daily horizon.

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