

MEDICAL HUMANITIES IN REHABILITATION: THEORETICAL HORIZONS AND RESEARCH PERSPECTIVES

MEDICAL HUMANITIES IN RIABILITAZIONE: ORIZZONTI TEORICI E PROSPETTIVE DI RICERCA



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ABSTRACT

Inglese

Medical Humanities were born to refocus attention on the person in healthcare, integrating empathy and narration into clinical practice. In rehabilitation, these approaches improve patient motivation, team cohesion, and ethical care. Despite challenges such as stress and fragmented training, integrating Medical Humanities into education can enhance relational skills, reduce burnout, and promote person-centered care.

Italiano

Le Medical Humanities sono nate per riportare l'attenzione sulla persona nell'assistenza sanitaria, integrando empatia e narrazione nella pratica clinica. In riabilitazione, questi approcci migliorano la motivazione del paziente, la coesione del team e la cura etica. Nonostante sfide come lo stress e una formazione frammentata, l'integrazione delle *Medical Humanities* nell'educazione può migliorare le competenze relazionali, ridurre il burnout e promuovere una cura centrata sulla persona.

KEYWORDS

Narrative medicine, rehabilitation, empathy, humanization of care
Medicina narrativa, riabilitazione, empatia, umanizzazione delle cure

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Introduction

Medical Humanities (MH) emerged in the 1970s as a response to the need to restore centrality to the person within increasingly technological healthcare systems, focused primarily on biological diagnosis and treatment. In the United States, some medical schools – such as Columbia and Yale – introduced courses in literature, moral philosophy, history of medicine, visual arts, and clinical narrative, aiming to train physicians with a reflective, empathetic, and communicative approach designed to improve the relationship with patients (Charon, 2006).

The movement also found fertile ground in Europe, where from the 1990s a debate emerged on the contribution that humanities and social sciences could offer to clinical practice and healthcare education (Bertani, 2017). In Italy, MH spread more slowly: initially through courses in bioethics, doctor-patient communication, and narrative medicine offered by some universities (Florence, Rome, Bologna). Since 2014, the Italian National Institute of Health (ISS) has promoted guidelines for the use of Narrative Medicine in clinical and care pathways, emphasizing the importance of listening to and integrating the patient's perspective in the development of care plans (ISS, 2015). In recent years, the National Plan for the Humanization of Care (Ministry of Health, 2022) and the FNOPI Code of Ethics (2019) have reaffirmed the need for healthcare that combines scientific and technical expertise with attention to the dignity, history, and values of the person being cared for – principles that align with the MH approach.

One of the central concepts is the humanization of care, which requires a cultural shift: from a disease-centered model to a person-centered one, including values, emotions, expectations, and the quality of the therapeutic relationship. Care is thus seen as an ethical relationship and an educational practice, recognizing vulnerability and reciprocity as fundamental and indispensable elements in the therapeutic relationship (Mortari, 2015). A key element is empathetic competence, which is associated with a stronger therapeutic alliance and improved clinical and psychological outcomes (Charon, 2006; Piredda & Matarese, 2018). However, empathy alone is not sufficient – it must be translated into compassion, understood as the ability to share and welcome the suffering of the other, not only on an emotional level but also as an educational and professional commitment (Aleandri, 2018).

MH encompasses disciplines such as bioethics, clinical communication, medical anthropology, therapeutic theater, visual arts, reflective writing, and particularly narrative medicine – an emerging field that integrates storytelling as a tool to foster empathy and improve the quality of care. Narrative medicine views illness as a lived, subjective experience, in which the patient's story becomes a tool for reconstructing identity and helping healthcare professionals better understand the personal meaning of suffering (Charon, 2006).

In rehabilitation, which is often characterized by long-term pathways and multidisciplinary team dynamics, narrative becomes a tool for motivation and co-construction of the therapeutic project, facilitating alignment between clinical goals and the patient's perceived priorities.

In recent years, educational practices based on visual arts, theater, and reflective writing have spread in Italy. Visual Thinking Strategies (VTS) – introduced in university courses and some healthcare facilities (VTS Italia, 2020; Reilly et al., 2005) – have been shown to improve healthcare professionals' observation skills, critical interpretation, and non-judgmental listening, enhancing communication and relational abilities. Similarly, theater and reflective writing workshops are used to foster emotional awareness, management of professional boundaries, and team cohesion (Bert, 2014). These tools promote resilience and burnout prevention, which are particularly relevant in rehabilitation settings.

From a pedagogical perspective, MH promotes integrated training, where technical-scientific and humanistic skills are intertwined to develop a reflective, empathetic, and responsible professional identity, in line with the goals of the National Health Service and the National Plan for the Humanization of Care (Ministry of Health, 2022).

In the rehabilitation context – marked by long-term treatments and complex interprofessional relationships – MH can improve communication, support patient motivation, and strengthen trust. The ethical dimension is also central: MH provides a theoretical framework to address complex issues and dilemmas, such as balancing respect for autonomy with the responsibility of care, managing family expectations, and defining shared treatment goals. In this context, narrative ethics values patients' life stories, recognizing them as persons and acknowledging the personal meanings and values that guide therapeutic choices (Charon, 2006;

Mortari, 2015). In rehabilitation, this allows teams to adjust decisions – such as the intensity of interventions or the prioritization of recovery goals – in line with the person's life project, moving beyond rigid application of standardized protocols and fostering a truly participatory care relationship.

2. Challenges and Educational Needs in Rehabilitation Settings

2.1 Organizational Challenges and Work-Related Stress in Rehabilitation Settings

Despite increasing attention to Medical Humanities (MH), their integration into Italian rehabilitation settings remains limited and fragmented. Although many healthcare professionals recognize the value of relational skills and a humanistic approach, they often report lacking adequate tools to apply these in everyday practice. This gap between theoretical knowledge and clinical action can generate frustration, demotivation, and a sense of ineffectiveness, with possible negative repercussions both for the wellbeing of professionals and the quality of care (Bert, 2014; Mortari, 2015).

A critical issue concerns organizational factors: tight schedules, bureaucratic burdens, resource scarcity, and pressure to achieve clinical outcomes are conditions recognized by the WHO and by Legislative Decree 81/2008 as psychosocial risks capable of compromising professionals' well-being. In rehabilitation wards, characterized by prolonged care pathways, these conditions reduce the time available for active listening to patients, undermine therapeutic alliance, and affect the motivation of both staff and patients alike (Piredda & Matarese, 2018).

Numerous Italian studies have shown a significant prevalence of work-related stress and burnout among physiotherapists, speech therapists, and nurses. Burnout manifests through emotional exhaustion, depersonalization, and reduced professional accomplishment, with consequent decline in empathetic capacity and communication quality (Gentile et al., 2017; Cortese et al., 2020). In post-acute wards and units of extended hospitalization, burnout symptoms may affect 30% to 50% of staff, compromising continuity of care and negatively impacting clinical outcomes (Costello et al., 2018).

A central role in the prevention of these issues is played by team debriefing, a structured moment of shared reflection following critical events or intense working periods. During debriefing, team members reconstruct what happened, express

emotions and reactions, and identify strengths and areas for improvement in clinical and organizational management. Originally developed in military settings and adopted in emergency services, this practice reduces acute stress, fosters learning from experience, and strengthens team cohesion (Mitchell, 1983; Rose et al., 2002; Gilhooly et al., 2015).

In this regard, MH constitute not only a theoretical and practical framework, but also a set of strategies that integrate emotional, relational, and reflective competencies into daily care, supporting stress prevention and the development of resilience. Techniques such as clinical narrative, reflective writing, role-play, and active listening training help practitioners to process emotionally challenging experiences and reconnect with the relational meaning of their work. Activities such as arts workshops, therapeutic theater, and Visual Thinking Strategies (VTS) — a method based on guided observation of images to stimulate analysis, critical thinking, and communication — have proven useful in enhancing critical observation, emotion management, and collaboration within the team, contributing to the strengthening of empathy and therapeutic alliance (Shapiro et al., 2016; Bert, 2014).

An aspect still underexplored concerns leadership and organizational culture. Italian and international studies show that transformational leadership, attentive to emotional support of the team and recognition of individual contributions, reduces the risk of burnout and increases job satisfaction (Cummings et al., 2018; Magnavita, 2019). Empathic leaders promote open communication, constructive feedback, and shared participation in clinical decision-making, creating an environment of trust and organizational resilience.

Continuing professional education (CPE) represents an important protective resource for health professionals. Programs that integrate technical updating and structured moments of personal reflection offer useful tools to face complex clinical settings, helping to contain anxiety related to uncertainty and to sustain professional motivation (Cochran et al., 2018; Bertani, 2017).

In multidisciplinary settings, conflict management and interprofessional communication are crucial. Internal mediation strategies, shared protocols, and regular meetings improve cohesion, reduce misunderstandings and tensions, and create a more harmonious work environment, with positive effects for both staff

and patients (Rossi et al., 2019). Lastly, innovative support tools — such as apps for self-monitoring of stress and digital self-assessment questionnaires — allow for collection of longitudinal data on staff wellbeing and facilitate targeted interventions (Magnavita, 2020).

Investing in organizational wellbeing increases the sustainability of rehabilitation services, improving continuity of care, staff motivation, and the quality of clinical outcomes. In sum, the organizational challenge and work-related stress in rehabilitation contexts cannot be addressed only with clinical protocols. The integration of MH, structured practices of emotional support, empathic leadership, continuing education, and innovative tools represent a concrete strategy to strengthen staff resilience, promote team cohesion, and ensure person-centered care (Wilkinson et al., 2017; Piredda & Matarese, 2018; Magnavita, 2019).

2.2 Educational Needs and Pedagogical Approaches for Integrating Medical Humanities

Beyond difficulties related to service organization, there is a still broadly unmet educational need in the healthcare context. The integration of Medical Humanities (MH) into university curricula for health professions and in Continuing Medical Education (CME) programs is often sporadic and uneven, with significant territorial differences (De Luca & Lazzari, 2021). Humanistic content tends to be considered complementary rather than structural elements of clinical training. This fragmentation makes it difficult to develop a shared language and common practices among different professionals, reducing the effectiveness of the humanistic approach in care settings.

A particularly critical aspect concerns training in empathetic competence. Despite its wide acknowledgment, it continues to be treated more as a personal quality than as a professional skill that can be acquired. Literature, by contrast, shows that empathy can be cultivated through experiential approaches and active methodologies, including role-play, clinical narrative, reflective supervision, and workshops in authentic listening (Charon, 2006; Aleandri, 2018). Promoting these competencies means providing professionals with tools to deeply understand the therapeutic relationship and more effectively deal with the emotional pressures inherent in caregiving work, thereby preventing relational detachment and burnout.

Following these considerations, there emerges an opportunity to strengthen the presence of MH within continuous training pathways, proposing learning spaces that combine technical competence and relational awareness. Workshops based on clinical narrative and deep listening can help improve the ability to empathize, increase professional satisfaction, and foster a collaborative climate within teams. In this perspective, adopting person-centred pedagogical methodologies not only enriches the quality of care perceived by patients, but also represents a protective factor for practitioners, reducing work-related stress and promoting interprofessional cohesion. Considering humanistic training as an essential, not accessory, component of the education pathway thus constitutes a strategic step toward improving both quality of care and organizational wellbeing.

3. Development of Relational and Reflective Competencies Through Integration of Medical Humanities in Health Training

It is considered fundamental that the teaching/learning processes and strategies for Medical Humanities are designed and articulated not only around theoretical content but—indeed especially—around the development of relational and reflective competencies. Relational competencies include the ability to listen with empathy, communicate effectively, and build trustful relationships with patients and colleagues. Reflective competencies refer to awareness of one's own emotions, limitations, and defense mechanisms that may influence the caregiving relationship. To develop these skills, it is necessary to adopt an experiential approach based on confrontation and analysis of professional practices, rather than lectures.

Humanistic pedagogy emphasizes the importance of “learning from experience,” using narrative as a tool for personal and professional growth (Mezirow, 2003). Tools such as reflective writing, narrative discussion of clinical cases, and interprofessional supervision prove particularly effective for integrating technical knowledge with relational skills. Moreover, this focus on subjective experience helps to recognize early signals of stress or workplace discomfort, enabling more effective and sustainable emotional management strategies (Mezirow, 2003).

To make this training effective, a broader rethinking of the healthcare education-training system is needed. Universities and healthcare institutions

should consider humanistic competencies not as an addition but as an integral part of all educational pathways, from internships to refresher courses (Charon, 2006; Shapiro et al., 2006). A possible approach is to create stable labs dedicated to the humanization of care, where professionals from various disciplines can share experiences, reflect together on the emotions connected to their work, and design organizational improvements. These spaces, already present in some Italian settings, foster the construction of a culture of care that places the person and human relationship at the centre, going beyond mere attention to technical aspects (Bert, 2014; Aleandri, 2018). On a more general level, expanding Medical Humanities helps bring healthcare closer to society, re-centering ethical and cultural values often overlooked in favor of efficiency and productivity. Training professionals who are both technically and humanistically competent means recognizing the patient as an active protagonist in their own care pathway. In this sense, humanistic education represents not only an opportunity for personal growth but also a powerful instrument to promote cultural change within the healthcare system (Charon, 2006; Mezirow, 2003).

4. Research Perspectives

In recent years interest in Medical Humanities has grown, but in rehabilitation their integration in training pathways and in CME programs remains limited. This gap contributes to separating technical competences from relational ones, with negative effects on care quality and staff wellbeing.

In this context, an exploratory study has been designed to analyze the perceptions, attitudes, and educational needs of rehabilitation professionals with respect to the integration of MH in daily clinical practice. The investigation aims to fill a knowledge gap, providing a first empirical mapping of the level of awareness and interest of professionals in humanistic approaches, and to understand how individual variables (age, experience, professional profile) and organizational ones (team climate, workload, institutional support) influence the adoption of empathic and reflective practices.

The general objective is twofold:

1. To investigate the roles attributed to empathetic and relational competences in shaping the rehabilitation process.
2. To preliminarily explore explicit and latent educational needs, to provide initial guidance for designing more targeted interdisciplinary pathways.

The study is situated within the perspective of humanization of care, in which scientific-technical competence is integrated with the ethical, communicative, and narrative sensitivity of the professional.

4.1 Study Design and Methodology

The research, currently at the stage of being realized, will adopt an observational and descriptive design, based on the administration of a semi-structured questionnaire to a sample of about 100–150 healthcare professionals working in various rehabilitation settings: hospitals, long-term care facilities (RSA), intensive and extensive rehabilitation centres. The professional categories involved will include physiotherapists, speech therapists, occupational therapists, nurses, psychiatrists, psychologists, and educators.

Inclusion criterion: minimum one year of working experience in rehabilitation settings to ensure familiarity with team dynamics and the caring relationship. The questionnaire will be structured in three macro-areas:

1. Professional profile and educational background, with attention to previous experiences in humanistic or relational training contexts.
2. Perceptions and attitudes toward MH, analyzing recognition of empathetic roles and the value attributed to communication in the therapeutic process.
3. Educational needs and future perspectives, investigating which teaching methods are considered most effective: clinical narrative, film, visual arts, listening workshops.

4.2 Validation and Procedures

The questionnaire will be developed ad hoc, including items adapted from validated instruments in the literature, such as:

- Jefferson Scale of Empathy – JSE (Hojat et al., 2001; 2018), to assess clinical empathy.
- Maslach Burnout Inventory – Human Services Survey (MBI-HSS) (Maslach & Jackson, 1981; Maslach et al., 2016), for measuring work-related stress and burnout.

5. Expected Outcomes

The research aims to produce first empirical evidence on the interest, sensitivity, and barriers perceived by rehabilitation professionals toward MH.

Expected results include:

- A better understanding of the relationship between organizational stress, empathy, and quality of the care relationship.
- Identification of facilitating and hindering factors in the implementation of humanistic approaches.
- Emergence of data useful for guiding future training and professional development programs, based on narrative, reflective, and collaborative competences.

References

- 1) Aleandri, G. (2018). *Con-passione. Nuovi orizzonti e prospettive in pedagogia delle relazioni*. Roma: Armando Editore.
- 2) Bert, G. (2014). *Umanizzazione delle cure e Medical Humanities*. Roma: Il Pensiero Scientifico Editore.
- 3) Bertani, M. (2017). *Medical Humanities in Italia: prospettive e sviluppi*. Milano: FrancoAngeli.
- 4) Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101.
- 5) Charon, R. (2006). *Narrative Medicine: Honoring the Stories of Illness*. New York, NY: Oxford University Press.

- 6) Cochran, J., Spitzer, N., & Herring, R. (2018). Resilience and continuous professional development in health care teams. *Journal of Continuing Education in the Health Professions*, 38(3), 180–186.
- 7) Cortese, C. G., Colombo, L., & Ghislieri, C. (2020). Burnout in Italian rehabilitation professionals: Prevalence and risk factors. *La Medicina del Lavoro*, 111(2), 136–146.
- 8) Cummings, G. G., Tate, K., Lee, S., Wong, C. A., Paananen, T., Micaroni, S. P. M., & Chatterjee, G. E. (2018). Leadership styles and outcomes in nursing: A systematic review. *International Journal of Nursing Studies*, 85, 19–60.
- 9) De Luca, M., & Lazzari, M. (2021). Educazione umanistica e professioni sanitarie in Italia: un'indagine esplorativa. *Rivista Italiana di Educazione Sanitaria*, 8(2), 45–59.
- 10) FNOPI. (2019). *Codice deontologico delle professioni infermieristiche*. Federazione Nazionale Ordini Professioni Infermieristiche.
- 11) Gentile, A., Manna, R., & Iannotta, R. (2017). Work-related stress and burnout in Italian physiotherapists. *Giornale Italiano di Medicina del Lavoro ed Ergonomia*, 39(3), 182–188.
- 12) Gilhooly, D., Beaton, R., & Murphy, S. (2015). Critical incident stress debriefing in health care teams: A systematic review. *Journal of Emergency Nursing*, 41(4), 343–349.
- 13) Hojat, M., Mangione, S., Nasca, T. J., Cohen, M. J. M., Gonnella, J. S., Erdmann, J. B., Veloski, J. & Magee, M. (2001). The Jefferson Scale of Physician Empathy: Development and preliminary psychometric data. *Educational and Psychological Measurement*, 61(2), 349–365.
- 14) Hojat, M. (2018). *Empathy in Health Professions Education and Patient Care*. Cham: Springer.
- 15) ISS – Istituto Superiore di Sanità. (2015). *Linee di indirizzo per l'utilizzo della medicina narrativa nei percorsi di cura*. Roma: ISS.
- 16) Magnavita, N. (2019). Leadership, stress e benessere organizzativo negli operatori sanitari: una revisione narrativa. *Giornale Italiano di Medicina del Lavoro ed Ergonomia*, 41(1), 10–18.
- 17) Magnavita, N. (2020). Digital tools for stress self-monitoring in health care: Opportunities and limits. *La Medicina del Lavoro*, 111(5), 345–352.

- 18) Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Occupational Behaviour*, 2(2), 99–113.
- 19) Maslach, C., Leiter, M. P., & Jackson, S. E. (2016). *Maslach Burnout Inventory Manual* (4th ed.). Menlo Park, CA: Mind Garden.
- 20) Mezirow, J. (2003). Transformative learning as discourse. *Journal of Transformative Education*, 1(1), 58–63.
- 21) Ministero della Salute. (2022). *Piano nazionale per l'umanizzazione delle cure*. Roma: Ministero della Salute.
- 22) Mitchell, J. T. (1983). When disaster strikes... The Critical Incident Stress Debriefing process. *Journal of Emergency Medical Services*, 8(1), 36–39.
- 23) Mortari, L. (2015). *Filosofia della cura*. Milano: Raffaello Cortina Editore.
- 24) Piredda, M., & Matarese, M. (2018). *Comunicazione e relazione d'aiuto in infermieristica e riabilitazione*. Milano: McGraw-Hill.
- 25) Reilly, J. M., Ring, J., & Duke, L. (2005). Visual thinking strategies: A new role for art in medical education. *Family Medicine*, 37(4), 250–252.
- 26) Rose, S., Bisson, J., & Wessely, S. (2002). Psychological debriefing for preventing post-traumatic stress disorder (PTSD). *Cochrane Database of Systematic Reviews*, 2, CD000560.
- 27) Rossi, F., Bagnasco, A., & Sasso, L. (2019). Interprofessional communication in rehabilitation teams: A cross-sectional study. *Journal of Interprofessional Care*, 33(3), 275–283.
- 28) Shapiro, J., Coulehan, J., Wear, D., & Montello, M. (2016). Medical humanities and their discontents: Definitions, critiques, and implications. *Academic Medicine*, 91(3), 345–350.
- 29) VTS Italia. (2020). *Visual Thinking Strategies nella formazione sanitaria: esperienze e prospettive*. Milano: FrancoAngeli.
- 30) Wilkinson, H., Whittington, R., Perry, L., & Eames, C. (2017). Examining the relationship between burnout and empathy in health care professionals: A systematic review. *Burnout Research*, 6, 18–29.