SOFT SKILLS AND MEDICAL EDUCATION: THE CENTRALITY OF THE PERSON BETWEEN UNIVERSITY CURRICULUM REFORM AND PEDAGOGICAL PERSPECTIVES

SOFT SKILLS E FORMAZIONE DEL MEDICO: LA CENTRALITÀ DELLA PERSONA TRA RIFORMA DEGLI ORDINAMENTI UNIVERSITARI E PROSPETTIVE PEDAGOGICHE

Domenico Tafuri
Department of Medical, Motor and Wellness Sciences,
University of Naples "Parthenope"
domenico.tafuri@uniparthenope.it
https://orcid.org/0000-0002-5948-1414

Double Blind Peer Review

Tafuri, D. (2025). Soft Skills and Medical Education: The Centrality of the Person Between University Curriculum Reform and Pedagogical Perspectives. In *Italian Journal of Health Education, Sports and Inclusive Didactics*, 9(4).

Doi:
https://doi.org/10.32043/gsd.v9i4.1640

gsdjournal.it
ISSN: 2532-3296
ISBN: 978-88-6022-528-3

ABSTRACT

The article examines the Bernini Reform (2025) and its impact on medical education, which reintroduces pedagogical courses in Medicine to foster soft skills such as empathy, communication, and interpersonal abilities. Inspired by Engel's bio-psycho-social model, it highlights the role of pedagogical sciences in shaping a holistic medical professionalism. The case of Parthenope University illustrates a person-centered training model grounded in the pedagogy of care.

L'articolo esamina la riforma Bernini (2025) e il suo impatto sulla formazione medica, che reintroduce gli insegnamenti pedagogici nei corsi di Medicina per sviluppare soft skills come empatia, comunicazione e capacità relazionali. Ispirato al modello bio-psico-sociale di Engel, evidenzia il ruolo delle scienze pedagogiche nella costruzione di una professionalità medica integrale. Il caso dell'Università Parthenope mostra un modello centrato sulla persona e sulla pedagogia della cura.

KEYWORDS
Medical Education, Soft Skills, Pedagogy.
Formazione Medica, Soft Skills, Pedagogia

Received 2025-10-13
Accepted 2026-01-07
Published 2026-01-12

Introduction

The education of physicians in the twenty-first century is undergoing a profound cultural and institutional transformation. While for a long time medical knowledge was understood primarily as a technical and scientific domain, there is now a growing awareness of the need to integrate this expertise with humanistic, pedagogical, and relational dimensions. The introduction, in 2025, of the so-called *Bernini Reform*, which has opened access to degree programs in Medicine and introduced significant innovations in university curricula, marks a decisive step in this direction. Among its most innovative features is the inclusion of pedagogical subjects alongside clinical and scientific disciplines, with the aim of fostering the development of soft skills, that is, transversal competencies now considered essential for the practice of medicine.

The degree program in Medicine at the Parthenope University of Naples, which will adopt the new framework beginning in the 2025–2026 academic year, represents an exemplary case. Its curriculum includes modules devoted to pedagogy, communication, empathy, and educational processes, with the explicit intention of training future physicians capable not only of treating illness but also of caring for the person as a whole.

Within this framework, the present paper aims to develop three main areas of reflection:

1. The evolution of the concept of medical education and the influence of the biopsychosocial model;
2. The role of soft skills in clinical practice and the contribution of pedagogical sciences;
3. The rethinking of university curricula and the perspective of the centrality of the person in medical training, with specific reference to recent pedagogical literature.

1. From the Biopsychosocial Model to the Centrality of the Person

George Engel's (1977) insight, that health cannot be understood exclusively in biological terms but must be viewed as the outcome of the interaction between psychological and social factors, paved the way for a paradigm shift that remains remarkably relevant today. The biopsychosocial model made it possible to move beyond a reductionist conception of the patient as a mere "clinical case," reaffirming instead the need to recognize the person in their entirety.

This approach has found a natural field of elaboration within pedagogical studies. Contemporary pedagogy emphasizes the formative value of relationships and the notion of educational care as central processes for the growth and transformation of the individual (Bruni, 2015; 2008). In this sense, medical education cannot be limited to the transmission of technical-scientific knowledge; it must also equip future physicians to establish authentic relationships with patients, relationships that foster trust, participation, and shared responsibility in the care process.

Authors such as Franco Cambi (2010) have clearly highlighted empathy as both a pedagogical and professional category: it is not merely an emotional disposition but a reflective and conscious competence that enables physicians to adopt the patient's perspective, understand their motivations, and construct authentic communication. In this respect, empathy represents both a cognitive instrument and an ethical resource, a bridge between science and humanity.

Furthermore, Engel's biopsychosocial model demonstrated that medical knowledge cannot be confined to its technical-biological dimension. Clinical experience shows that patients with the same diagnosis may respond in radically different ways depending on their personal, familial, and social contexts. From this perspective, soft skills function as the hinge that allows physicians to translate scientific knowledge into person-centered care practices (Borrell-Carrió, Suchman, & Epstein, 2004).

Contemporary pedagogy insists on the need for an integral education that does not reduce the person to a mere "subject-object" of intervention but rather values their dignity and uniqueness (Cambi, 2000). The centrality of the person implies that the educational process, including medical education, should aim to develop not only knowledge but also critical awareness, dialogical capacity, and relational competence. Within this framework, empathy is not an emotional accessory but a cognitive and ethical device that enables the understanding of the other's perspective and the modulation of clinical action accordingly (Decety & Jackson, 2004).

Research in medical education confirms that physicians' communicative and empathic competence has a direct impact on therapeutic outcomes: it improves treatment adherence, reduces medico-legal disputes, and enhances patient satisfaction (Rider & Keefer, 2006; Kurtz, Silverman, & Draper, 2016). Empathy, from this viewpoint, constitutes an integral part of the pedagogy of care, understood as holistic attention to the person, their lived experience, and their

capacity for self-development. Integrating this dimension into medical education means fostering responsibility and awareness that every clinical act is also an ethical and relational act.

2. Soft Skills and the Medical Profession: A Pedagogical Approach

The so-called *soft skills*: communication, active listening, empathy, conflict management, leadership, and collaboration, now constitute a strategic axis for the effectiveness of medical practice. According to data from the Stanford Research Institute International, 75% of long-term professional success depends on mastery of these transversal competencies, while only 25% can be attributed to strictly technical skills.

In the medical context, this means that the ability to convey complex information clearly, to listen attentively to patients, to work effectively in interdisciplinary teams, and to communicate under conditions of stress and uncertainty are abilities just as crucial as knowledge of pathophysiology or pharmacology. Pedagogy contributes to this framework by offering both theoretical reflection and practical guidance. The paradigm of *educational care*, as emphasized by Bruni (2024), places the dignity of the person at the center and calls health professionals to adopt a stance of continuous formative engagement, in which the relationship with the patient becomes an opportunity for reciprocal learning. It is therefore not a matter of adding a merely external "humanistic framework" to medical competence, but rather of recognizing that the professional identity of the physician is also built through the quality of the educational relationship established with the patient.

This orientation also responds to the new challenges posed by digital technologies and Artificial Intelligence in healthcare. While automation and data analysis enrich diagnosis and therapy, they simultaneously make it even more urgent to enhance those human capacities that distinguish the personal from the technical: the ability to care, to interpret complex needs, and to communicate values.

This assumption recalls the notion of the *centrality of the person*, which has become a fundamental reference in educational and training studies throughout the twentieth century. Education is never mere transmission of content but rather a process of relationship, encounter, and mutual recognition (Mortari, 2015). The pedagogy of care, developed in the tradition of authors such as Nel Noddings and, in Italy, Franco Cambi, emphasizes that the educational act consists in a practice of

care that values the singularity of the other and promotes the integral development of their potential (Cambi, 2000; Mortari, 2002).

Transposed into medical education, this perspective implies that the medical student should not be viewed as a passive recipient of knowledge, but as an active subject who learns through relationships, constructs professional identity through meaningful experiences, critical reflection, and dialogue with peers and instructors (Schön, 1983). It also means that teaching should integrate cognitive, affective, ethical, and social dimensions, promoting transversal competencies such as listening, empathy, resilience, and responsibility.

International research has shown that curricula introducing modules on communication, ethics, teamwork, and early reflection lead to improved clinical performance and a reduction in errors in complex contexts (Frenk et al., 2010; van der Vleuten et al., 2015). In this sense, medical education should adopt active teaching methodologies, such as simulations, role-playing, and reflective portfolios, that foster student participation and encourage them to *think with* rather than merely *think about*.

Pedagogy, for its part, is centered on the idea and practice of "care" in human formation, in which knowledge is always intertwined with responsibility toward the other. This approach finds a direct correspondence in contemporary medical education, where reference frameworks such as CanMEDS and WFME place communication, collaboration, and professionalism on the same level as scientific competence.

3. University Curricula, Integral Education, and Future Perspectives: The Case of the Parthenope University of Naples

The reform of university curricula, as previously highlighted, has placed the quality of medical education at the center of attention. The opening of access to medical degree programs has not entailed a lowering of educational standards, but rather a rethinking of the modes of student selection and support, introducing tutoring systems and personalized learning pathways. As Bruni (2025) observes, university curricula can no longer be understood merely as bureaucratic structures of regulation, but rather as dynamic spaces of research, teaching, and Third Mission engagement, capable of responding to the challenges of contemporary society. Within this framework, the inclusion of pedagogical sciences in the medical curriculum is not a marginal choice but a strategic one: it represents the recognition

that medical education is, first and foremost, a process of human formation (Bruni, 2017; 2008).

A crucial issue in today's design of medical curricula concerns the role assigned to pedagogical and psychological disciplines. Too often, these fields are perceived as marginal or as simple "academic credits" to be acquired, as though they were optional complements to the technical-scientific core of medical training. Such an approach risks diminishing the educational significance of these areas, confining them to an ancillary and disconnected status. By contrast, the pedagogical perspective calls for their transversal integration throughout the entire course of study, in close connection with clinical, biological, and technical knowledge. As emphasized by Franco Cambi (2006) and later developed by Elsa Maria Bruni (2015, 2017, 2024), education can never be reduced to an autonomous compartment; rather, it pervades and orients formative practices, giving them meaning in relation to the growth of the person. Applied to medical education, this means that communicative competence, empathy, active listening, and the management of the care relationship should not be viewed as "additional" to clinical skills, but as constitutive and indispensable dimensions of medical professionalism itself.

From this perspective, the teaching of pedagogy and psychology should not be confined to a few theoretical modules but should permeate the various medical disciplines. For example, in the study of internal medicine or surgery, future physicians can be guided to reflect not only on diagnostic and therapeutic techniques but also on patient communication, the transmission of complex information in situations of vulnerability, and the capacity to value the person as a whole. Such an integrated form of education fully realizes Engel's (1977) biopsychosocial vision, demonstrating that technical competence and educational sensitivity are not parallel domains but interwoven dimensions of a single professionalism devoted to the comprehensive care of the patient.

Ultimately, the current challenge is not to add pedagogical and psychological content alongside biomedical knowledge, but to reconceptualize the medical curriculum in a genuinely interdisciplinary and formative way, in which the centrality of the person serves as the organizing and unifying principle of medical knowledge.

The experience of the medical degree program at the Parthenope University of Naples thus assumes paradigmatic value. The decision to combine clinical and pedagogical disciplines reflects an integral vision of education-one that does not separate technical and humanistic knowledge but views them as interdependent.

The physician trained in this context is not only a competent professional but also an individual capable of cultivating a pedagogical culture of care, grounded in dignity, listening, and empathy.

This perspective, endorsed by numerous contemporary educational theorists, responds to the pressing need for a profound renewal of the healthcare profession, which must redefine itself within the framework of a complex and plural society. The future of medicine, from this standpoint, can only progress through a pedagogy of the person.

Under the Bernini Reform, the *open semester* becomes a strategic educational space: not merely a filter for access, but a genuine pedagogical bridge where students can develop transversal skills alongside foundational disciplines. The University of Parthenope has established a clinical network that includes centers of excellence such as Monaldi, Cotugno, and CTO hospitals, providing real-world contexts for situated learning. In these environments, students can develop from the outset the ability to communicate with patients, understand interprofessional dynamics, and reflect on the ethical dimensions of clinical practice. The integration of pedagogical instruction, such as modules on clinical communication, ethics, teamwork, and the responsible use of digital technologies, translates the vision of the person's centrality into concrete educational practice.

From a methodological standpoint, the use of high-fidelity simulations, standardized patients, and assessment tools such as progressive mini-CEX and OSCEs allows for the systematic measurement of soft skill development (Issenberg et al., 2005). The goal is to construct a longitudinal pathway in which scientific competence is constantly intertwined with relational and professional competence, forming physicians capable of acting effectively in complex contexts and caring for the person in their entirety. This approach not only aligns with the pedagogical foundations of the *pedagogy of care* but also meets international standards (CanMEDS, WFME, AAMC EPAs) and the expectations of a healthcare system that requires physicians who can combine technical excellence with human sensitivity. In this sense, the *Parthenope model* may serve as a blueprint for the broader Italian university system, demonstrating how admission reform can become an opportunity for pedagogical and cultural renewal.

Conclusions

Medical education today is entrusted with an unprecedented task: integrating technical-scientific knowledge with the pedagogical capacity to care for the person

in their entirety. The 2025 *Bernini Reform*, through the opening of medical degree programs and the introduction of pedagogical subjects, has initiated a process that marks a true paradigm shift in university teaching.

Soft skills are not an accessory component but a constitutive part of the physician's professional identity. They enable the translation of scientific knowledge into meaningful clinical practice-one that responds to the real needs of individuals. Pedagogy, with its foundational concepts of care, empathy, the centrality of the person, and the formative nature of relationships (Bruni, 2008; 2015; 2024), provides the conceptual tools necessary to interpret this challenge and to construct an integral, humane, and competent medical education.

The future perspective is that of a physician who is not only a technician of health but also an *educator of care*, capable of generating trust, dialogue, and shared responsibility. In this sense, pedagogy emerges as an indispensable resource for the future of medicine.

The centrality of the person, a core pedagogical principle, becomes today the key to rethinking medical education. Soft skills are not "soft" in the sense of being secondary; they are essential for the quality of care and for the very meaning of medical professionalism. The biopsychosocial model, contemporary pedagogical reflection, and the growing body of evidence in medical education all converge in affirming that university training must integrate technical, relational, and ethical dimensions.

The new medical degree program at the University of Parthenope represents a unique opportunity to put these principles into practice, offering a learning pathway in which the physician of tomorrow will not only *know*, but also *care*, *communicate*, *listen*, and *build authentic relationships*.

References

Borrell-Carrió, F., Suchman, A. L., & Epstein, R. M. (2004). The biopsychosocial model 25 years later: principles, practice, and scientific inquiry. *Annals of Family Medicine, 2*(6), 576–582.

Bruni, E. M. (2008). *Pedagogia e cura: Percorsi di formazione e responsabilità educativa*. Roma: Carocci.

Bruni, E. M. (2015). *Pedagogia della cura: Dalla relazione educativa alla responsabilità professionale*. Napoli: Liguori.

Bruni, E. M. (2017). *La formazione come cura: Linee di pedagogia umanistica*. Milano: FrancoAngeli.

Bruni, E. M. (2024). *Educare alla cura: Prospettive pedagogiche nella formazione dei professionisti della salute*. Bologna: Il Mulino.

Bruni, E. M. (2025). *Università e formazione integrale: Pedagogia, ricerca e Terza Missione*. Napoli: Editoriale Scientifica.

Cambi, F. (2000). *Le pedagogie del Novecento*. Laterza.

Cambi, F. (2006). *Le pedagogie del Novecento*. Roma-Bari: Laterza.

Cambi, F. (2010). *La cura di sé come processo formativo*. Laterza.

Decety, J., & Jackson, P. L. (2004). The functional architecture of human empathy. *Behavioral and Cognitive Neuroscience Reviews, 3*(2), 71–100.

Engel, G. L. (1977). The need for a new medical model: a challenge for biomedicine. *Science, 196*(4286), 129–136.

Frenk, J., et al. (2010). Health professionals for a new century: transforming education to strengthen health systems. *The Lancet, 376*(9756), 1923–1958.

Issenberg, S. B., et al. (2005). Features and uses of high-fidelity medical simulations that lead to effective learning: a BEME systematic review. *Medical Teacher, 27*(1), 10–28.

Kurtz, S., Silverman, J., & Draper, J. (2016). *Teaching and Learning Communication Skills in Medicine*. CRC Press.

Mortari, L. (2002). *La pratica dell'aver cura*. Bruno Mondadori.

Mortari, L. (2015). *Filosofia della cura*. Raffaello Cortina.

Noddings, N. (1984). *Caring: A feminine approach to ethics and moral education*. Berkeley: University of California Press.

Rider, E. A., & Keefer, C. H. (2006). Communication skills competencies: definitions and a teaching toolbox. *Medical Education, 40*(7), 624–629.

Schön, D. (1983). *The Reflective Practitioner*. Basic Books.

Ten Cate, O., & Scheele, F. (2007). Competency-based postgraduate training: bridging theory and practice. *Academic Medicine, 82*(6), 542–547.

van der Vleuten, C. P. M., et al. (2015). Twelve tips for programmatic assessment. *Medical Teacher, 37*(7), 641–646.

Tartwijk, J. (2015). A model for programmatic assessment fit for purpose. *Medical Teacher, 37*(7), 738–746. https://doi.org/10.3109/0142159X.2015.1009026