THE HUMAN EDUCATION OF THE PHYSICIAN: TOWARDS A PEDAGOGY OF DECISION-MAKING AND THE PERSONALISATION OF PROFESSIONAL KNOWLEDGE

LA FORMAZIONE UMANA DEL MEDICO: VERSO UNA PEDAGOGIA DEL PROCESSO DECISIONALE E DELLA PERSONALIZZAZIONE DEL SAPERE PROFESSIONALE

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ABSTRACT

English
This paper explores the professional and human education of physicians through John Dewey's philosophy and the perspective of personalisation. It critiques the reduction of medical education to a technical process and proposes instead the cultivation of practical intelligence grounded in experience and reflection. Personalisation is framed as a cognitive and ethical principle guiding professional judgement, integrating scientific, ethical, and human dimensions of care.

Italiano
Questo contributo esplora la formazione professionale e umana dei medici alla luce del pensiero di John Dewey e della prospettiva della personalizzazione. Critica la riduzione della formazione medica a un processo puramente tecnico e propone invece la coltivazione dell'intelligenza pratica, fondata sull'esperienza e sulla riflessione. La personalizzazione è intesa come principio cognitivo ed etico che orienta il giudizio professionale, integrando le dimensioni scientifiche, etiche e umane della cura.

KEYWORDS
Medical education; pedagogy of decision-making; personalisation; reflexivity; practical intelligence

Formazione medica; pedagogia del processo decisionale; personalizzazione; riflessività; intelligenza pratica

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Introduction. Educating the Human within the Professional

Within the contemporary context of medical and healthcare education, the tension between technical-scientific knowledge and the human dimension of care is becoming increasingly evident. While growing specialisation and the standardisation of protocols ensure safety and control, they also risk reducing medical training to an exercise in operational competence, impoverishing the educational dimension of professional knowledge and weakening the physician's capacity to interpret the complexity of reality. As John Dewey emphasised in *Democracy and Education* (1916), to educate means to activate processes of growth that connect knowledge, experience, and responsibility, restoring to the individual the capacity to orient themselves critically within the complex contexts in which they act.

From a Deweyan perspective, education is not confined to the acquisition of established knowledge; rather, it takes shape as a transformative experience in which the subject learns through doing and by reflecting on their own action. Experience, indeed, is not mere contact with reality, but a dynamic process in which thought and action intertwine to generate new meanings. Applied to medical education, such an approach implies that professional learning cannot be exhausted in technical training or in the memorisation and replication of procedures. It must include a reflective and ethical dimension that enables the learner to construct a clinical judgement guided by responsibility, discernment, and humanity (see Eva & Regehr, 2005; Norman, 2005).

Clinical decision-making, in its deepest nature, is never a purely technical or neutral act: it is an interpretive process in which scientific knowledge, experiential insight, ethical sensitivity, and relational capacity converge. As Edmund Pellegrino (1994) reminds us, medicine is a *practical discipline* that demands *phronesis* (practical wisdom) and moral discernment. In this sense, medical education should be rethought as an education of practical intelligence and moral consciousness, capable of integrating the theoretical, cognitive, and affective dimensions of knowledge into a unified horizon of meaning. Dewey's pedagogy of experience is crucial in this regard: it invites us to conceive education not as the transmission of pre-existing truths but as a shared and situated construction of meaning, arising from the constant interaction among the individual, the environment, and action.

The entire development of twentieth-century educational thought follows this trajectory: from Dewey's and Piaget's active pedagogy to Vygotsky's sociocultural psychology, from Schön's reflective epistemology to Morin's theories of complexity, a vision of knowledge emerges as an evolving process, open to dialogue with diversity and uncertainty. In *The Reflective Practitioner* (1983), Donald Schön described the reflective professional as one who learns in and from action, recognising that knowledge can never be fully codified but is continuously regenerated through practice. University education, in this sense, should promote not the reproduction of knowledge but its problematisation, so that the physician may develop a critical reflexivity capable of questioning acquired certainties and opening to new interpretative horizons.

This critical reflexivity, already rooted in Dewey (1930), becomes the generative principle of a critical epistemology of education. It fosters the awareness that all knowledge is situated, provisional, and dialogical, and that genuine learning arises from the encounter between what one knows and what one does not yet know (see Bruni, 2018). Moving in this direction, Edgar Morin (1999) has insisted on the necessity of *thinking complexity* - that is, of educating the mind to connect rather than to separate, to integrate rather than to reduce. From this perspective, medical education appears as a pedagogy of complexity, where intelligence is called upon to weave connections between disciplinary knowledge, professional practice, and the human dimensions of care. It thereby becomes, to use Boaventura de Sousa Santos's expression (2021), an *ecology of knowledges*, a form of learning capable of valuing the plurality of languages and perspectives that contribute to the construction of medical understanding.

This horizon resonates fruitfully with the philosophical perspective of Jacques Derrida, whose invitation to deconstruct knowledge entails continuous rethinking of it in light of new insights and the unrepeatable singularities of human cases. As Derrida clarifies in *De la grammatologie* (1967) and *Du droit à la philosophie* (1990), to deconstruct does not mean to destroy, but to interrogate critically the assumptions, hierarchies, and oppositions upon which systems of knowledge rest, in order to render them once again available to thought (see Mariani, 2008). Deconstruction is therefore a pedagogical act: it opens the space of radical reflexivity that recognises the fragility and historicity of knowledge, transforming learning into an exercise of epistemic responsibility. In the medical field, this stance implies the capacity to recognise that every clinical

decision is an interpretative act that must account for the singularity, history, and vulnerability of the other. Technical-scientific knowledge, if not continuously rethought in light of these dimensions, risks degenerating into an abstract and dehumanising power.

Medical education, therefore, must educate towards the *deconstruction of knowledge*, understood as a continuous practice of questioning, openness to the new, and attentiveness to difference. Only an education grounded in such epistemic responsibility can prepare professionals capable of confronting the ethical, relational, and cultural complexity of contemporary care. In this view, *personalisation* is not an optional feature but the very condition of medical knowledge: it represents the operational translation of the awareness that there can be no science of the general that disregards the singular. Medicine, so understood, is not merely applied science but a form of human and interpretative knowledge, constructed through dialogue among subjects and disciplines. It calls for a pedagogy that integrates scientific rigour with hermeneutic openness, technical precision with relational intelligence, knowledge with compassion.

It is in this ever-negotiated equilibrium that the ethical and humanistic dimension of the medical profession takes root. As Martha Nussbaum (2010) argues, the life sciences and the humanities must converge in the education of citizens and professionals, for without the capacity to imagine the other and to understand singular human stories, no technical competence can be deemed complete (see Charlin, Boshuizen, Custers, & Feltovich, 2007).

Ultimately, medical education - today and in the years to come - must be rethought as a continuous process of self-formation and knowledge construction, in which reflexivity, doubt, and deconstruction become instruments of both intellectual rigour and humanity. To educate in medicine today means to educate to the *responsibility of thinking*, to the *art of deciding in uncertainty*, and to the *courage to question what one knows* to better understand what remains unknown. It is within this tension between knowledge and non-knowledge, between certainty and openness, that medical education may rediscover its authentically educational and transformative nature: that of a *pedagogy of complexity and care*, which restores to scientific knowledge its human dimension and to the physician their formative vocation (see Goldstein, 1999).

1. Dewey and the Pedagogy of Experience in Medical and Healthcare Education

The contemporary relevance of Deweyan thought emerges in the possibility of conceiving medical education as a reflective, transformative, and continuously interrogative experience, in which technical and scientific knowledge is integrated with the ethical, relational, and human dimensions of care. In *Experience and Education* (1938), Dewey emphasises that every authentic educational experience must possess two essential qualities: continuity - the capacity to connect with past experience and to project itself into the future - and interaction, understood as the dynamic relationship between the individual and the environment, which enables the learner to construct meaning through active engagement with context and practice.

Applied to medical education, these categories indicate that learning cannot be reduced to the mere acquisition of technical skills or codified knowledge. Rather, it constitutes a complex process of meaning-making, in which clinical practice becomes a laboratory for critical reflection, interpretation, and responsibility. Clinical placements, clinical observation, case discussions, observation, and simulation are not simply tools for acquiring procedures; they are educational moments through which learners develop the capacity to interpret the complexity of human life and suffering, to navigate uncertainty, to evaluate the consequences of their decisions, and to integrate scientific knowledge with ethical values and relational awareness (see Gruppen, Frohna, & Anderson, 2010).

Reflection on error, diagnostic doubt, and clinical decision-making thus becomes a central component of the educational process, transforming every practical experience into an occasion for deep and conscious learning. In this sense, Dewey anticipates the conception of the *reflective practitioner* developed by Schön (1983), according to which professionalism is founded on the capacity to think *in* and *about* action, transforming concrete situations into opportunities for cognitive re-elaboration, identity development, and moral growth. This perspective challenges transmissive views of knowledge, in which learning is reduced to the memorisation of protocols and procedures and invites recognition of the educational dimension implicit in everyday clinical practice.

The encounter with the patient, the management of uncertainty, interprofessional collaboration, and empathic communication constitute forms of *situated learning*, where technical competence intertwines with

ethical awareness, moral discernment, and relational capacity (see Charon, 2006). As Benner (1984) observes, the transition from novice to expert is not a mere enhancement of operational skills, but a process of identity transformation: a physician truly becomes one not only when they know *what* to do, but when they understand *why* and *how* to act responsibly, integrating scientific knowledge with human experience and moral values.

From a Deweyan standpoint, medical education must therefore be conceived as an open and dynamic system, capable of valuing inquiry, reflexivity, active participation, and critical awareness. Learning unfolds as a circular movement of observation, action, and revision, progressively constructing a professional intelligence that unites competence, discernment, and moral responsibility - an intelligence able to address the complexity of contemporary clinical contexts.

Alongside this pedagogical dimension, the Derridean perspective introduces the notion of *deconstruction of knowledge* as a fundamental formative principle for medical professionalism. As Derrida reminds us (1967; 1990), to deconstruct does not mean to destroy, but to question continuously the assumptions, hierarchies, and oppositions on which knowledge is based, transforming it from a closed structure into an open, dialogical, and critical process. Applied to medicine, deconstruction invites the recognition that every certainty acquired through university education or clinical practice must be interrogated in light of new evidence, the plurality of knowledges, and the irreducible singularity of human cases. No protocol, however rigorous, can replace the physician's ability to interpret the complexity of each person as a unique and unrepeatable story.

Reflective doubt, in this sense, becomes not only a cognitive tool but an epistemic responsibility, as it entails the willingness to re-examine one's own knowledge, to integrate diverse forms of understanding, and to modulate professional action according to contexts that are constantly changing and resistant to generalisation. Medical education thus ceases to be mere technical training and becomes a continuous exercise in discernment, practical wisdom, and situated intelligence - an integration of scientific rigour, hermeneutic openness, and attentiveness to singularity.

Within this perspective, *personalisation* emerges as an epistemic principle: to know is always to interpret, to integrate, to compare, to question, and to re-signify, transforming learning into a living and responsible process. The pedagogy of complexity, when integrated with Derridean deconstruction,

restores to the physician the centrality of critical thought and moral intelligence, recognising that care is not merely the application of protocols but a profoundly human practice that requires judgement, responsibility, and the capacity to construct shared meanings. Authentic education, in this view, is realised only when it renders technical knowledge *alive*, *situated*, *dialogical*, and *continuously renewed*.

2. Personalisation as an Epistemic and Pedagogical Principle

Within contemporary educational perspectives, personalisation cannot be reduced to a mere methodological adaptation or a didactic tool aimed at accommodating individual differences. Rather, it constitutes a structural epistemological principle, recognising singularity as the foundational condition of knowledge and action. In medicine, this entails that every clinical encounter must be interpreted as a unique and unrepeatable event, whose understanding requires the practitioner to combine scientific rigour with situated discernment, acknowledging that illness is not merely a biological phenomenon but a lived, complex, and contextualised experience. Personalisation, both pedagogically and epistemically, involves the capacity to hold together dimensions of universality and singularity, generalisation and context, rule and flexibility. A physician exercises personalisation when interpreting a clinical situation considering the patient's biographical, social, and cultural history, integrating theoretical knowledge, scientific evidence, and ethical values. Moreover, while the Derridean perspective encourages the continuous deconstruction of acquired knowledge - questioning scientific certainties and reconsidering every decision in the light of new evidence and the singularity of each clinical case, thereby promoting a dynamic and innovation-oriented education - Martha Nussbaum (2010) has emphasised that ethical formation of the professional requires the capacity for empathetic imagination: the ability to comprehend the other in their entirety and uniqueness, developing a form of knowledge that is not only technical, but also moral, emotional, and reflective.

Such orientation is not innate but is cultivated through specific educational devices that foster reflexivity, situated awareness, and the capacity to deconstruct and critically rework acquired knowledge. Tools such as clinical diaries, narrative case analyses, complex simulations, interprofessional workshops, and ethical reflection seminars enable the development of integrated cognitive, emotional, and moral competences, transforming

learning from mere knowledge acquisition into a dynamic process of meaning construction. In this regard, as Joan Tronto (1993) highlights, care is never a neutral act but an educational and political process that values mutual responsibility, attentiveness to the other, and awareness of vulnerability as a constitutive dimension of human experience.

Personalisation thus represents a point of equilibrium between technical knowledge and practical wisdom, between information and judgement, between competence and responsibility. It transforms knowledge into discernment, rule into situated decision-making, action into reflective experience, and experience into critical learning. On a broader scale, personalisation entails openness to diverse forms of knowledge, interdisciplinarity, and the continuous deconstruction of one's own paradigms, as Derrida suggests, recognising that the singularity of each clinical case and emerging scientific evidence must be integrated into a living, dynamic, and responsible knowledge framework.

Medical education, therefore, is not a mechanical exercise in protocol application but a complex process of holistic education, in which knowledge, values, experience, and context are interwoven systemically. This enables the practitioner to act with technical competence, ethical discernment, and empathic sensitivity, cultivating a professionalism capable of responding responsibly, reflectively, and humanistically to the complexity of contemporary clinical contexts.

In this framework, current Italian university programmes exemplify how a pedagogy of personalisation and reflexivity can be translated into practice. The Sapienza University of Rome has implemented the AI-LEARN project, in which tutor avatars and intelligent simulations allow students to experience interactive and reflective clinical scenarios, evaluating the consequences of their decisions in simulations replicating real-world complexity. The University of Milan offers courses in Personalised Medicine, focused on molecular and aetiopathogenetic bases of chronic diseases, integrating scientific knowledge with understanding of patients' individual characteristics. Similarly, the University of Padua provides programmes in Pharmacoeconomics and Personalised Therapy, combining risk–benefit and cost–effectiveness analysis with multidisciplinary practical training, preparing professionals for responsible decision-making in real clinical contexts. These experiences demonstrate that personalisation of learning enables not only the acquisition of advanced technical competencies, but also the development of ethical awareness, critical judgement, and situated

intelligence, effectively addressing the complexity of contemporary medical practice.

Considering these perspectives, the education of physicians must be conceived as an integrated process, in which scientific knowledge, practical reflexivity, and ethical sensitivity are constantly intertwined. Training thus becomes an experiential and transformative pathway, in which the learner constructs meaning through interaction with the environment, with patients, and with emerging knowledge. Deweyan pedagogy, integrated with Schön's reflections on reflective practice and Derridean perspectives on knowledge deconstruction, provides a coherent theoretical framework to reconceive medical education as a continuous, personalised, and responsible learning process - capable of producing professionals who are not only competent but also ethically aware, reflective, and equipped to care for the human complexity of their patients.

3. Educating for Decision-Making: Reflexivity and Phronesis in Medical Practice

The decisional dimension represents the privileged arena in which medical training intersects with the pedagogy of reflexivity and personalisation. Every clinical choice unfolds within a field of open possibilities, where scientific knowledge engages in dialogue with the uncertainty of reality and the singularity of human cases, requiring a discernment that transcends the mere application of protocols. In this context, education is not limited to the acquisition of knowledge but involves the cultivation of practical intelligence, or *phronesis*, which allows practitioners to navigate not only based on empirical data but also according to the values implicit in care and therapeutic relationships. Morin (1999) emphasises that education for complexity entails the capacity to connect and integrate information, to engage with the unforeseen, and to recognise the interdependencies among diverse bodies of knowledge; applied to medicine, this perspective calls for training physicians in a decision-making process grounded in critical judgement, responsibility, and ethical reflexivity, wherein every choice becomes an educational act.

Clinical decision-making is never neutral or mechanical: it emerges from the intersection of scientific knowledge, personal experience, and awareness of professional and social values, integrating technical skills, ethical sensitivity, and the capacity to interpret complex contexts. Contemporary educational

practices provide concrete tools to translate this theory into lived educational experience. Programmes such as narrative medicine, in which the study of patients' stories stimulates reflection and discernment, and case-based learning, founded on the collaborative analysis of complex clinical cases, enable students to confront real-world complexity, develop empathy, and recognise that professional competence is measured not only by technical efficacy but also by the ability to read contexts, attribute meaning to decisions, and integrate diverse forms of knowledge.

From this perspective, medical education approaches what Pellegrino and Thomasma (1994) described as "education in wisdom," wherein virtue, responsibility, and justice become fundamental components of professionalism, and where scientific knowledge and technical expertise are integrated with the capacity to make ethically grounded decisions, attentive to the singularity of each patient and open to dialogue with new knowledge and perspectives. Such approaches, implemented in innovative university contexts—such as the personalised medicine programmes at the University of Milan, interactive laboratories and intelligent simulations at the University of Rome La Sapienza, or multidisciplinary courses in pharmacoeconomics and personalised therapy at the University of Padua—demonstrate concretely how education for decision-making can be translated into formative experience, enhancing reflexivity, active participation, and the ability to integrate scientific data, ethical values, and contextual interpretation into an increasingly conscious, complex, and humanised clinical practice.

Ultimately, the pedagogy of clinical decision-making highlights the importance of an education that not only transmits knowledge but also fosters practical wisdom, moral responsibility, and the capacity to face uncertainty, making each learning experience an opportunity for professional and personal growth. This approach is coherent with Dewey's principles of continuity and interaction, Schön's reflections on reflective practice, and Derrida's critical and deconstructive approach, which calls for a constant interrogation of acquired knowledge in light of the singularity of cases and emerging new insights.

Conclusion: Towards a Pedagogy of Care and Dignity

Rethinking medical education from a pedagogical perspective entail recognising that care is, above all, an educational relationship, and that professionalism is constructed through meaningful, reflective, and situated learning experiences. Professional learning, as Dewey (1916, 1938) teaches, is not the accumulation of technical knowledge but a continuous process of reconstructing experience: knowledge is renewed through dialogue with reality, with patients, and with colleagues, via reflexivity, ethical deliberation, and decision-making as responsible action. In this sense, medical training is not limited to transmitting procedures or protocols but aims to cultivate discernment, practical intelligence, and moral wisdom - conditions necessary to navigate the complexity and uncertainty inherent in clinical practice.

The centrality of personalisation here assumes both epistemological and pedagogical significance: the physician learns to interpret each clinical case in its singularity, integrating scientific knowledge with personal experiences, ethical values, and the sociocultural context. As Nussbaum (2010) emphasises, empathy and moral imagination are cognitive and ethical competences that must be nurtured through reflexivity and narrative, tools that allow knowledge to be transformed into responsible judgement. In parallel, Derrida encourages the continuous deconstruction and rethinking of knowledge, opening medical education to new insights, perspectives, and singular cases, thus avoiding methodological rigidity and fostering a medical knowledge that remains questioning, flexible, and dialogical.

Intertwined with this perspective is the scientific and pedagogical significance of dignity, which constitutes both a premise and a challenge for education. Dignity, as highlighted by Bertagna (2023), Canevaro and Ianes (2022), and Mortari (2013), guides the design of educational pathways in which the learner is not a passive recipient but an active participant, capable of exercising their ontological vocation and contributing to the construction of communities of care and learning. Dignity calls for mental and relational experiences that value social, cognitive, and human complexity, fostering inclusive and flexible educational contexts capable of addressing the diversity of individual needs. In this sense, care becomes the operational paradigm of dignity: a principle that directs educational actions, promotes mutual responsibility, and enables integral training centered on the interaction among the individual, knowledge, and environment (cf. Bruni, 2024).

Integrating the pedagogy of care with attention to dignity implies reconsidering the entire healthcare education system as a space in which knowledge, ethics, and relationality converge. Training is not limited to the development of technical-scientific competences; it seeks to cultivate practical wisdom, reflexivity, awareness of the consequences of one's actions, and the capacity to interpret complex and singular contexts. Conceived in this way, medical education becomes a lifelong process accompanying the physician throughout their professional life, stimulating both human and intellectual growth, so that they may care for others authentically, competently, and respectfully.

Ultimately, educating for complexity means educating for one's own humanity: the centrality of relationships, reflexivity, responsible decision-making, and attention to dignity and personalisation constitute the pillars of a professional humanism that recognises the physician as a subject in perpetual formation. Only those who develop self-awareness and openness to others can exercise care as an educational practice, transforming science into experience, technique into ethical judgecment, and knowledge into wisdom. From this perspective, the pedagogy of care and dignity is not an optional component of training but the fundamental matrix of a medicine that remains humane, responsible, and capable of addressing the complex challenges of contemporary society.

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