MENTORING AND MEDICAL HUMANITIES: A PEDAGOGICAL PERSPECTIVE FOR PERSON-CENTRED MEDICAL TRAINING

MENTORING E MEDICAL HUMANITIES: UNA PROSPETTIVA PEDAGOGICA PER LA FORMAZIONE MEDICA CENTRATA SULLA PERSONA

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ABSTRACT

This paper offers an analysis of mentoring as a pedagogical tool consistent with medical humanities, capable of integrating technical skills and humanistic sensibilities. Through theoretical reflection, it discusses the significant educational potential inherent in the mentoring methodology in the context of medical training. In particular, it considers how this methodology can contribute to the development of a professional identity that focuses on the individual, promoting a holistic view of the person being cared for and fostering a therapeutic relationship based on empathy, ethical responsibility and recognition of subjectivity.

Il contributo propone un'analisi del mentoring come dispositivo pedagogico coerente con le medical humanities, in grado di integrare competenze tecniche e sensibilità umanistiche. Attraverso una riflessione teorica, si ragiona sul significativo potenziale formativo connaturato alla metodologia del mentoring nel contesto della formazione medica. In particolare, si considera come questa metodologia possa contribuire allo sviluppo di un'identità professionale che pone al centro la persona, favorendo una visione olistica della persona assistita e promuovendo un rapporto terapeutico basato su empatia, responsabilità etica e riconoscimento della soggettività.

KEYWORDS
Educational mentoring; Medical humanities; medical pedagogy.
Mentoring educativo; Medical humanities; pedagogia medica.

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Introduction

The idea that the training of a healthcare professional can be reduced to the acquisition of technical skills seems increasingly inadequate today, given the complexity of caregiving. It is not only science that defines the quality of clinical practice, but also, and perhaps above all, the ability to understand the other in their entirety, in terms of their biography, relationships and existence. Starting from a growing critical tension towards the traditional medical model, focused exclusively on the biological dimension of disease, a new theoretical and educational space has opened up, in which the demands of the human sciences, the philosophy of care and reflective pedagogy converge (Engel, 1977; Mortari, 2015). The demand for person-centred medicine is not limited to the ethics of good communication or the rhetoric of empathy, but requires a profound revision of the entire educational system, capable of integrating knowledge, languages and attitudes that restore centrality to the subjectivity of the patient (Beck Dallaghan et al., 2022).

In this context, the field of medical humanities has developed with growing interest. It is an area of study and practice that promotes dialogue between medical sciences and humanities, from philosophy to literature, from pedagogy to psychology, with the aim of restoring medicine's profoundly human character (Zannini, 2007; Charon, 2006). Medical humanities are a necessary addition, capable of enriching clinical practice with interpretative, narrative and reflective tools. In fact, from this perspective, the patient is no longer a “clinical case” but a person with meanings, stories, values and vulnerabilities that require listening and understanding. As Charon (2006) points out, the ability to recognise and honour stories of illness is a clinical skill in its own right, as it allows for personalised care and the building of a therapeutic relationship based on trust.

Medical pedagogy, understood as systematic reflection on educational processes in clinical and university contexts, aims to develop training approaches centred on the individual, the ethics of responsibility and self-awareness (Bruni, 2024; Schön, 1983). The goal is not only to transmit knowledge and operational skills, but also to accompany students and young professionals towards a progressive internalisation of the values that underlie medical practice: empathy, respect, listening, reflectiveness, and proximity. In this sense, training must become a transformative experience that involves the mind, body, and conscience.

It is precisely within this scenario that the present contribution is situated, whose objective is to explore the pedagogical potential of mentoring as a device consistent with the assumptions of medical humanities and medical pedagogy. Mentoring, in

fact, is not reduced to a form of study support, nor does it coincide with the more well-known tutoring, focused on the acquisition of disciplinary content. On the contrary, mentoring is an educational practice with a strong relational density, which promotes the emergence of the professional self through an asymmetrical but dialogical relationship based on trust and the sharing of experiences (Kram, 1985; Crisp & Cruz, 2009).

Within university courses in the health sector, mentoring can contribute significantly to the development of transferable skills such as empathic communication, helping relationship management, critical reflection and the ability to deal with uncertainty. Furthermore, in an era marked by increasing organisational, cultural and technological complexity, it is a valuable tool for supporting students' professional identity, accompanying them not only in technical learning but also in processing the emotional, moral and social experiences associated with clinical practice (Sambunjak, Straus & Marušić, 2006; Bruni, 2024).

In this sense, mentoring also takes on an inclusive meaning: not only as support for "excellent" profiles, but as a personalised training opportunity for all students, particularly those experiencing difficulties, disorientation or vulnerability in their university careers. Several studies have highlighted its positive impact in enhancing key competences for lifelong learning, showing how mentoring can act as a lever to promote equity, empowerment and educational success (Scarano & Martiniello, 2025; Selmi, Sorrentino & Martiniello, 2024).

Based on these premises, the authors believe that mentoring in medical and healthcare training could strengthen the holistic view of the person and medical humanities in terms of curriculum design and continuing and professional training.

1. Medical education and medical humanities

It is not technical progress that is lacking in contemporary medicine, but the perspective that guides its use. The fundamental question that permeates medical education today is not only what to know or what to do, but who we are becoming as we treat others. At a time when clinical competence is necessary but probably no longer sufficient, there is an urgent need for a form of medicine that can interpret illness as a biographical event, a relationship of trust, a moment of existential crisis. Training in care, therefore, does not simply mean imparting professional knowledge, but cultivating an ethical, reflective and deeply human attitude (Engel, 1977; Borrell-Carrió, Suchman & Epstein, 2004). It is in this scenario that the medical humanities are configured not as a cultural ornament, but as a structural component of medical pedagogy: a bridge between technical knowledge and relational wisdom, between science and narrative, between protocols and

biographies. This horizon gives rise to the need to recognise and develop new training practices, including mentoring, capable of valuing the learner not simply as a recipient of knowledge, but as a subject undergoing transformation.

This is the context in which medical humanities has emerged, an interdisciplinary field that aims to enrich clinical practice with the tools and sensibilities of the humanities: from philosophy to ethics, from pedagogy to psychology, from literature to anthropology. The medical humanities are not simply a "humanistic" complement to medical education, but a genuine reformulation of its meaning, centred on understanding the patient as a unique being with a history, emotions and meanings. Narrative medicine, as formulated by Rita Charon (2006), has highlighted how listening to stories of illness is not a secondary or accessory act, but an integral part of care. Through storytelling, patients reclaim their identity and doctors can build an authentic therapeutic relationship based on trust, empathy and sharing.

This paradigm shift points to the need for broader reflection on the educational models that support the training of future professionals. From this perspective, medical pedagogy can be understood not as a teaching technique, but as a cultural and planning horizon that invites us to question the aims, methods and tools of training in medicine and the health professions. Medical pedagogy assumes that care is not only transmitted through lectures or simulations, but is also cultivated through transformative experiences, meaningful relationships and reflective practices. It does not seem sufficient, therefore, to introduce isolated courses in bioethics or communication into the curriculum: a cross-cutting rethinking of training programmes seems necessary, in which the centrality of the person and professional responsibility should be the guiding criteria for educational planning (Bruni, 2024; Mortari, 2015; Frenk et al., 2010).

In the context outlined here, the concept of competence tends to take on an important role. Training in care can mean promoting a structured set of skills that includes not only theoretical knowledge and technical expertise, but also the ability to listen, self-regulation, reflectiveness, empathy, management of complexity and awareness of one's role. These are skills that are often referred to as strategic and are increasingly recognised in the healthcare sector, as they seem to facilitate the management of uncertain situations, understanding other people's points of view and building ethical and responsible professional relationships. Medical pedagogy, in line with medical humanities, tends to be a potentially generative field for such skills, provided that appropriate educational tools are put in place, capable of enhancing the subjectivity of the student, the experiential dimension and educational dialogue.

Given these premises, mentoring often stands out for its relational and transformative nature: it is not only technical or academic support, but also an educational space in which the mentee can confront the complexity of their own

path, build their professional identity and develop a habitus oriented towards care and responsibility (Kram, 1985; Crisp & Cruz, 2009). The mentoring relationship, based on trust, listening and personalised support, can provide a favourable context for the development of reflective, communicative and ethical skills, in line with the objectives of medical education. Furthermore, the inclusive value of these mechanisms should not be underestimated. At a time when educational pathways are marked by inequalities, disorientation and often invisible forms of marginalisation, mentoring offers a tool that can help bring out individual potential and promote educational success even in the presence of structural or biographical obstacles. The integration of mentoring into university courses can help to support the development of key skills and promote educational equity (Scarano & Martiniello, 2025; Selmi, Sorrentino & Martiniello, 2024). In the healthcare sector, this translates into the possibility of training professionals capable of reading and interpreting diverse needs, building non-standardised care relationships and restoring dignity to vulnerable individuals.

In conclusion, medical pedagogy and medical humanities outline an educational horizon in which care is not only content, but also form and method of education. In this context, tools such as mentoring are privileged instruments for promoting genuinely person-centred learning, capable of integrating science and humanism, technique and responsibility, knowledge and values. This is not an optional addition, but a necessary rethinking of healthcare training, capable of producing competent, aware and fully human professionals.

2. Mentoring and tutoring in training courses

Within university education in the medical-health field, practices for supporting students and young professionals play a fundamental role in fostering skills development, integrating theory and practice, and building a conscious professional identity. However, despite the widespread use of the terms tutoring and mentoring, pedagogical and professional literature highlights the need to clearly distinguish between the two approaches, both theoretically and operationally. Tutoring is primarily an activity focused on technical, disciplinary, or methodological support, aimed at facilitating learning and solving specific problems. In medical training, it often takes place in clinical internship contexts, where the tutor guides the student in the application of procedures, the management of complex situations and compliance with protocols. Its main objective is to ensure technical correctness and the gradual acquisition of the skills required by the curriculum.

Mentoring, on the other hand, takes on a broader and more transformative role. It is not limited to the transfer of knowledge or operational support, but is based on an asymmetrical educational relationship, oriented towards the personal and

professional development of the mentee. Unlike a tutor, a mentor does not provide ready-made solutions, but accompanies the person on a journey of exploration, reflection and growth, supporting their autonomy, awareness and ability to deal with complexity. Kram (1985), in his classic definition, distinguishes between the career and psychosocial functions of mentoring, highlighting how this relationship goes far beyond academic support to become a place for identity building and meaning negotiation. Empirically, structured programmes show outcomes in engagement, communication skills and identity maturation (Frei et al., 2010; Burgess et al., 2018).

In the medical field, a systematic review of the literature by Sambunjak, Straus and Marušić (2006) suggests that mentoring can promote the development of communication, relational and empathic skills and be associated with greater engagement and well-being in young doctors.

The introduction of mentoring into undergraduate and postgraduate medical courses therefore responds to the need to train professionals who are not only technically competent, but also capable of dealing with the human dimension of care, sustaining complex relationships and reflecting critically on their own practices. In this sense, mentoring can be perfectly consistent with the assumptions of medical humanities, as it contributes to the training of aware, responsible and reflective individuals who are able to integrate knowledge, values and emotions into their daily clinical practice. Compared to tutoring, which tends to remain confined to the formal educational sphere, mentoring expands over time and in the depth of the relationship, becoming a place of situated and transformative learning.

The effectiveness of mentoring is particularly evident when it is structured within intentional pathways, designed with clear pedagogical criteria and aimed at developing complex skills. Recent experiences show how forms of personalised support, including in their digital form (e-mentoring and e-tutoring), can have a positive impact on students' self-regulation, motivation and ability to manage new or critical situations. In particular, in higher education and telematic contexts, digital mentoring has proven to be a resource for strengthening the sense of belonging, reducing the risk of dropout and promoting processes of reflection and empowerment (Selmi, Sorrentino & Martiniello, 2024; Martiniello, Selmi & Turconi, 2023). Although this evidence has been gathered in contexts other than strictly healthcare, it also offers relevant insights for the design of medical courses and postgraduate specialisations, where personalised learning and attention to professional subjectivity are becoming increasingly central.

Mentoring also fits perfectly into the paradigm of continuing education, which is now essential in order to respond to developments in medical knowledge and changes in society. As a flexible and adaptable tool, it can accompany professionals throughout their lives, supporting processes of updating, critical review of practices and adaptation to organisational and cultural changes in the healthcare system. In

this sense, mentoring is not only an educational methodology, but also a cultural perspective capable of renewing the very meaning of medical training: from a technical act to a relational and generative experience.
The enhancement of mentoring in training courses also makes it possible to respond to one of the fundamental challenges highlighted in the call: that of the centrality of the person. In training that is truly person-centred, understood as both patient and student, the educational relationship takes on strategic value. The mentor, with their attitude of listening, support and testimony, embodies a figure of professional proximity who can make a difference at crucial moments in the training process. In this way, mentoring is proposed as one of the best ways to integrate clinical knowledge and care knowledge, in the name of a more humane, reflective and sustainable medicine.

3. Mentoring as an inclusive practice

In the context of university and postgraduate education in the medical and healthcare field, the issue of inclusion represents a fundamental challenge that is still too often overlooked. Educational inequalities are not only expressed in terms of access to resources, but also manifest themselves in the difficulty many students have in finding a recognised space to express their potential, tackle the complexities of their studies and develop an authentic professional identity. From this perspective, mentoring can be seen as an educational practice that embodies the principles of inclusion, as it is based on individualised relationships, mutual trust and recognition of the mentee's uniqueness.
Far from a standardised approach, mentoring creates a space where the individual can be listened to in their entirety and supported in their growth through a non-judgmental, dialogical and transformative process. This type of relationship is particularly important in highly selective and emotionally demanding training programmes, such as those in the medical field, where the risk of isolation, burnout or personal failure is real and growing. It is precisely in these contexts that mentoring proves to be an effective educational response, because it acts preventively rather than correctively, supporting the development of internal resources, self-efficacy and resilience (Crisp & Cruz, 2009; Schön, 1983).
These dynamics are even more significant when considering the growing cultural, social and generational diversity that characterises university classrooms and healthcare training environments today. Mentoring, with its flexibility and ability to adapt to individual trajectories, is a strategic tool for promoting equity and educational proximity. By fostering non-hierarchical relationships based on testimony, mentoring can help overcome implicit barriers, stereotypes and

insecurities that hinder full and informed access to the medical profession. In this sense, inclusion should not be understood as compensation for fragility, but as the enhancement of differences as an educational resource.

Emerging evidence confirms the value of mentoring even for students at risk of disaffection or marginalisation. Recent studies have highlighted how mentoring, especially when integrated into intentional structures and supported by reflective tools such as portfolios or logbooks, promotes the development of key skills and the prevention of functional illiteracy, helping to reduce dropout rates and improve the quality of participation (Scarano & Martiniello, 2025).

The inclusive value of mentoring is therefore twofold: on the one hand, it supports those who are struggling to approach their educational path with greater awareness; on the other, it promotes the creation of more open, relational educational environments that are capable of recognising the subjective complexity of students.

In the medical field, this translates into the possibility of training professionals who are more attentive not only to protocols but also to patients' experiences and contexts. The practice of mentoring, in fact, performs a mirror function: by teaching how to take care of oneself and others within an educational relationship, it simultaneously trains in care in both a clinical and relational sense. This is where the perspective of medical humanities meets that of inclusive education: both recognise relationships as a generative place of learning, as a space in which skills are developed, meaning is constructed and the other is recognised in their irreducible uniqueness.

Conclusions

In recent years, university education in the medical-health field has certainly undergone a profound rethinking, requiring not only technical and scientific excellence but also the integration of pedagogical knowledge for education centred on the individual and overall well-being.

Medical humanities, in particular narrative medicine (Charon, 2006), restore medicine's humanistic and ethical dimension, and it is in this context that medical pedagogy fits in as an essential and fundamental area for combining clinical competence with relational, ethical and communicative dimensions (Zannini, 2007).

Promoting a philosophy of care and ethical responsibility requires training that must necessarily include listening, communication and relational management skills, and there is an urgent need to integrate pedagogy and clinical knowledge across university curricula (Frei, Stamm & Buddeberg-Fischer, 2010).

The teaching of communication skills, which is essential for medical training, is significantly reinforced through innovative methodologies such as mentoring, which promotes the development of complex interpersonal skills and critical reflection. Mentoring, in fact, is not limited to teaching communication techniques, but supports professionals in building a practice centred on empathic listening, emotion management and the ability to adapt to complex and often intercultural communication contexts. This experiential and relational approach can help train doctors to establish trusting relationships with patients, improving not only therapeutic effectiveness but also the overall well-being of those receiving care, in line with the requirements of humane and integrated medicine, a holistic view of the person, and the dignity of the person receiving care.

Authors Contributions

This article is the result of joint work; scientific responsibility is as follows: Angelina Vivona — Introduction and Section 1; Guido Scarano — Sections 2–3; Lucia Martiniello — Conclusions and scientific lead.

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