EDUCATING FOR CARE: THE PEDAGOGICAL CORE IN MEDICAL EDUCATION

FORMARE ALLA CURA: IL CORE PEDAGOGICO NELLA FORMAZIONE MEDICA

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ABSTRACT
The article reflects on the integration of a "diffused pedagogical core" into medical training, considering clinical practice as intrinsically educational. It links therapeutic effectiveness (to cure) to the ethical and relational quality of care (to care), framing the latter as a paradigm of professional identity. In the field of Medical Humanities, storytelling, simulation and counselling emerge as methods for promoting reflexivity and ethical responsibility in healthcare.

L'articolo riflette sull'integrazione di un "core pedagogico diffuso" nella formazione medica, considerando la pratica clinica come intrinsecamente educativa. Esso collega l'efficacia terapeutica (to cure) alla qualità etica e relazionale della cura (to care), inquadrando quest'ultima come paradigma dell'identità professionale. Nell'ambito delle Medical Humanities, la narrazione, la simulazione e il counselling emergono come metodi per promuovere la riflessività e la responsabilità etica nell'ambito dell'assistenza sanitaria.

KEYWORDS
Medical Pedagogy; Health Education; Care; Reflexivity; Medical Humanities. Pedagogia medica; Formazione sanitaria; Cura; Riflessività; Medical Humanities.

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Introduction: Pedagogy and Medicine, a necessary encounter

The medical and healthcare professions - clinical practice in particular - are strongly characterised by an ethical and educational dimension focused on the centrality of the individual. Clinical practice always involves an interpretative, communicative act that responsibly goes beyond the purely procedural aspect. However, academic training does not include compulsory credits in the scientific discipline of pedagogy (Ministerial Decree No. 1649 of 19 December 2023) in single-cycle Master's degree courses in Medicine and Surgery (Ministero dell'Università e della Ricerca, 2023).

This absence is not negligible: in the absence of a formal requirement, training in the care relationship, understood as the ability to listen, empathic communication and professional reflectiveness, depends on the sensitivity of individual departments and risks remaining marginal compared to biomedical and clinical disciplines. Medicine, however, is not limited to technical and scientific expertise. It is, by its very nature, an educational practice, a form of knowledge that is built through encountering and recognising others.

In fact, the dialogue between pedagogy and medicine has its roots in the history of Western thought, where medical knowledge has always been linked to ethical and educational reflection on human care. Since the Hippocratic tradition, medicine has been configured as knowledge that combines scientific knowledge, attention to the body and ethical responsibility towards the sick person (Curi, 2017).

Health cannot be reduced to a mere biological condition, but refers to a dynamic balance between body, mind and environment (Gadamer, 1994): a horizon that medicine alone cannot fully describe or guarantee. It is in this space that pedagogy can offer interpretative tools and educational practices capable of restoring the human and relational dimension to care.

Italian pedagogical reflection has shown the fruitfulness of this encounter on several occasions. Bertolini (1994) was among the first to emphasise that medical training cannot be limited to the acquisition of technical and scientific knowledge but must include work on the very meaning of being a doctor, in a process that dynamically integrates clinical knowledge and human knowledge. Along the same lines, Massa (1990; 1992) proposed a *clinical approach to training,* which he then developed with Bertolini (Bertolini & Massa, 1997) in medical practice, conceiving health, illness and care as processes that have educational value: the patient is not only the object of treatment, but also a subject who brings meanings, narratives and learning experiences that challenge the professional.

A decisive contribution to this perspective comes from the philosophy of care developed in pedagogy (Fadda, 2006; Mortari, 2015, 2018). Mortari (2015) insists on the epistemological value of the category of care, understood as a paradigm capable of guiding educational and healthcare action. Care, in the scholar's

perspective, is not only a *technical act,* but an *existential posture* that implies responsibility, listening and attention to the other in their irreducible singularity. The pedagogy of care (Cambi, 2006) must translate into concrete training practices capable of influencing the process of constructing the professional identity of future doctors and healthcare professionals (Bruni, 2024).

In particular, Mortari (2021) describes the *modes* of educational care as attention, responsibility, presence, reflectiveness, discretion and hospitality. These are not abstract qualities, but concrete attitudes that shape the educational encounter and, in healthcare contexts, make comprehensive care possible. In this sense, educational care translates into an intentional practice that supports growth, accompanies vulnerability and promotes autonomy, showing how the clinical dimension is inseparable from the relational and existential dimensions (Gambacorti-Passerini, 2016). Care should be understood, in the words of Demozzi (2017), not only as the *repair* of biological damage, but also as an educational project that recalls the ethical gesture of 'bending down towards the other', recognising their dignity and building a path to well-being together.

It would therefore be appropriate for medical knowledge and pedagogical knowledge to come together, no longer in an episodic manner, but on shared and consubstantial ground: that of care as a formative practice, starting from academic training.

In the exercise of their profession, doctors are not only technicians but also figures who accompany sick people in understanding their condition, reworking it and making informed choices. Medicine is itself a *science of education*, insofar as the therapeutic process involves learning, transformation and awareness (Bobbo, 2012).

Understanding the *person with an illness* (i.e., avoiding reducing them to their pathology) as an active subject in both an educational and clinical journey means recognising the distinction between *to cure* and *to care*, that is, between the act of curing on a technical and scientific level and caring as an ethical responsibility, interpersonal relationship, and existential accompaniment. To *care* is, therefore, both a moral attitude and a mutual educational process: the patient and the doctor learn to recognise otherness and vulnerability as spaces for knowledge and growth. The integration of clinical effectiveness (cure) with relational quality (care) is the essential condition for *good care*, which is measured in the ability to build shared meaning in care pathways (Mol, 2008).

In this regard, the report by Frenk et al. (2010), published in *The Lancet*, called for a global reform of healthcare training, highlighting the urgent need to train professionals who are capable of acting with technical competence but also equipped with ethical sensitivity, communication skills and social responsibility.

This is the context for the pedagogical discourse, which we believe should be freed from its ancillary role in the training of future doctors and healthcare professionals. Education in care, understood as a process of human and relational accompaniment, requires theoretical and practical tools that belong properly to the

field of pedagogy. In this direction, the contribution of *the Medical Humanities* appears increasingly relevant. If the dialogue between pedagogy and medicine restores the centrality of care as an educational category, the *Medical Humanities* (Fieschi et al., 2013) represent the ideal terrain for translating this perspective into training and teaching practices capable of influencing university education.

2. Medical Humanities and the pedagogical and narrative dimension of care

The field of *Medical Humanities* is now one of the most significant innovations in the training of health professionals. Born from the encounter between medicine and the humanities, this field has gradually acquired substantial and non-ancillary value with regard to the rethinking of healthcare professionalism as a whole, also in consideration of the profound anthropological, social and cultural changes that characterise our era.

In fact, in what Colamedici & Gancitano (2022) define as *a performance society*, weakness is not acceptable. There is no longer any objective time for remaining in pain, fragility, or the existential void of encountering one's limits. A *palliative society,* according to Han, in which pain: «[...] is interpreted as a *sign of weakness,* something to be hidden or eliminated in the name of optimisation. It is not compatible with *performance.* The passivity of suffering has no place in an active society dominated by *the power to do.* Today, pain is deprived of any possibility of expression: it is condemned to *silence.* The palliative society does not allow pain to be animated and verbalised, turning it into *a* passion» (Han, 2021, p.7). Hence the need to recover, in the dimension of *κλινική,* the tension of the gaze turned towards the Other immersed in the immobile time of their suffering, without imposing *silence* but welcoming their voice as an ontological and constitutive feature of human experience.

Medical Humanities integrate ethical, aesthetic, narrative and relational skills into training processes in an attempt to counteract the technical hyper-specialisation that can reduce care to a purely procedural act (Wald, McFarland, & Markovina, 2019). They can provide future doctors with useful tools for developing empathy, reflectiveness and critical awareness, supporting the construction of a professional identity predisposed to recognising the complexity of the person.

As Rita Charon (2008) clearly points out, it represents a practice capable of «recognising, absorbing, interpreting and allowing oneself to be touched» (p. 4) by stories of illness: not a simple complement to clinical knowledge, but a cognitive device that allows one to understand subjective experiences and transform them into resources for care.

Kirmayer et al. (2017; 2023) place narrative medicine within the framework of *person-centred medicine:* here, storytelling is understood as a clinical and educational skill that is useful for responding to organisational constraints (tight schedules, technical agendas), recognising the implicit implications of the doctor-patient power relationship and co-constructing, in conversation, meanings that

support *agency,* adaptation and resilience. The story is negotiated in the relationship, situated culturally and socially; for this reason, the clinician's narrative competence includes listening, interpreting and the ability to reformulate, together with the patient, frameworks of meaning that are feasible and practicable.

At the training level, narrative enters the curriculum through reflective writing workshops, readings, case discussions and *illness narratives*. These practices support the processing of emotions, empathy and tolerance of uncertainty (Charon, 2008; Charon et al., 2017; Wald et al., 2019; Garrino, 2015; Milota et al., 2019), contributing to a more conscious professionalism.

If it is true that: «Pain *is reality*. It has a real effect. We perceive reality above all from the resistance that pain provokes. [...] Pain sharpens self-perception. It surrounds the self. It draws its contours. [...]» (Han, 2021, p.41), then the *suffering self* represents a *self in the making,* in the form of a definition, in search of its own existential design, a limit that defines the field of reality of human experience. An experience that, through words, allows the identity affected by pain to reclaim its own history, to historicise itself and to exist fully. The narration of pain is the beginning of the healing process.

From the patients' point of view, therefore, storytelling allows them to reclaim their own biography and to *represent* suffering in a non-reductive way: words become, as Castiglioni (2016) points out, *a gesture of healing*, because they make it possible to share what would otherwise remain unspoken. The doctor-patient relationship is the meeting point of these two trajectories: a doctor trained in storytelling knows how to recognise and value stories, integrating them into the therapeutic process and strengthening the healing alliance (Palla et al., 2024).

Yet limitations remain: the systematic review by Fioretti et al. (2016) identifies only ten studies that explicitly declare adherence to narrative medicine, while noting a significant heterogeneity of designs, samples, clinical settings and modes of intervention, not linked by a common protocol. For the authors, the field needs clearer protocols, comparable *outcomes* and shared methodological frameworks to further investigate the impact of storytelling on clinical practice and patients' lives. This is also a valuable reminder for educational design: integrating storytelling into curricula requires solid assessment criteria so that it is not relegated to an unmeasurable appendix.

Not all experiences can be immediately expressed in the form of a story (Kirmayer et al., 2023). Importance must also be given to metaphors, silences and body postures that represent the field of *the unsaid*. Furthermore, recognising the asymmetries of the clinical relationship – and the contexts that generate them – is *a sine qua non* for not falling back into an exclusively biomedical representation.

Narrative, therefore, does not coincide with medical history, with pure and aseptic quantitative data (Han, 2024). It becomes an ethical and educational exercise that makes the patient an active subject in the care process and the doctor a reflective, responsible professional capable of clinical imagination.

Medical Humanities, therefore, should not be understood simply as an attempt to *humanise* medicine, but as a transformative practice (Bleakley, 2015), capable of redistributing *voice* and *power* in healthcare training and institutions.
They reveal the centrality of narrative and experience in healthcare training, where the doctor-patient relationship is the privileged space in which these skills find concrete expression.
In this scenario, medical pedagogy can provide the epistemological basis for understanding the experience of the limits of fragility and vulnerability, how reflective capacity is cultivated, and how the relational skills that give ethical meaning *to clinical practice* are formed.

3. The doctor-patient relationship: the pedagogical field of the clinical relationship

In *the doctor-patient relationship*, communication becomes an integral part of the care process, rather than a mere corollary of clinical decisions (Virzì, 2007).
Pedagogical and medical research has shown that the quality of the relationship directly affects therapeutic outcomes and patient satisfaction. For example, the clinical interview cannot be left to free improvisation but must be understood as a set of observable and teachable skills. *Active listening, managing silences, conscious use of non-verbal language, empathic feedback* and *asking open questions* are practices that can be learned and refined and contribute to creating a climate of trust and collaboration (Kurtz, Silverman & Draper, 2005).
In the same vein, Rider and Keefer (2006) identified *essential communication skills* as a foundation of medical professionalism. Communication skills do not only involve taking a patient's medical history or conveying diagnostic information, but also include the ability to manage emotions, build trust and accompany the patient. Communication, understood in this sense, is a true educational act: the doctor helps the person to *understand* their condition, to make informed decisions, and to recognise and structure their own resilience.
The doctor-patient relationship can therefore be interpreted as a process of mutual adaptation, in which cognitive, emotional and communicative factors come into play that influence both therapeutic adherence and the patient's perceived quality of life (Guerra, 2021).
In this sense, the clinical encounter becomes a dynamic and shared place for the co-construction of meaning, a fundamental tool for supporting the person in their journey of existential re-elaboration. Attention, responsibility and reflectiveness take shape in presence and listening, which are necessary to inhabit the therapeutic distance without cancelling it out (Mortari, 2021).
Pedagogy helps to highlight the profound educational and formative value of the care relationship, a relationship to be understood as a shared space of clinical and human knowledge, a space of experience of the Self and the Other-than-Self. A

dynamic space in which it is possible to merge technical responsibility and ethical possibility to give life and substance to *the principle of responsibility* (Jonas, 2014). Integrated into the healthcare dimension, it can contribute to training and supporting professionals, working to promote conscious proximity in care pathways and supporting continuity between the healthcare, local and family spheres (Castiglioni, 2022).

A necessary resource for guiding and educating communication, facilitating the encounter between different types of knowledge and giving patients and their families a form of *agency* and active control over their care pathways and their existential and meaningful trajectories.

The need to educate professionals who are aware of the pedagogical dimensions of care, of its relational dynamics, and of the educational meanings embedded within them can be expressed through the cultivation of a reflective stance that enables the integration of clinical knowledge and relational competence, acknowledging both the limits and the possibilities inherent in every encounter — an essential aim of professional formation.

4. Training perspectives and methodological implementation: from simulation to counselling

In line with the reflection on the need for healthcare training that integrates theoretical knowledge, practical skills and relational dimensions, it is essential to consider the teaching methodologies that make such integration possible by operationally declining the *pedagogical core* of the care relationship.

The use of training strategies based on experience and reflection is a valuable tool for facilitating the acquisition of technical skills and, at the same time, promoting the development of critical thinking, emotional awareness and the ability to collaborate responsibly in care contexts.

Simulation practices are now recognised as fundamental tools in contemporary healthcare training. These devices promote the development of decision-making awareness, emotional self-control and collaborative skills, as well as providing valuable technical tools. Simulation is characterised as an experiential learning environment where students can experiment, reflect and learn safely, receiving immediate and targeted *feedback* (Issenberg et al., 2005; Motola et al., 2013).

High-fidelity simulations, in particular, allow for the recreation of realistic clinical scenarios that stimulate relational readiness, the ability to work in interdisciplinary teams, and technical competence. Through guided *debriefing*, students are invited to review the decisions they have made, recognise their cognitive automatisms and reflect on the emotional and communicative aspects of clinical action (Rudolph et al., 2006). Simulation, understood in this sense, takes the form of a reflective laboratory in which error becomes an opportunity for effective and situated learning.

In addition to simulation, *guided discussion of clinical scenarios* is a methodology of great pedagogical and educational value. By discussing ambiguous and complex

situations, students can stimulate critical thinking, the ability to argue therapeutic choices and evaluate ethical and relational implications (Moghadam et al., 2024). In other words, these extremely realistic scenarios allow students to explore the emotional dimension of care, reflecting on the impact of communication methods in the diagnostic and therapeutic process.

When incorporated into case-based learning programmes, *role play* can offer further opportunities for educational experimentation. The representation of clinical or relational situations allows students to practise empathic listening, conflict management and the conscious use of verbal and non-verbal language (Abdel-Wahed et al., 2024; Nestel & Tierney, 2007).

The analysis of clinical cases remains one of the most established and validated methodologies in medical and healthcare training. It allows for the integration of theoretical and practical knowledge, the exercise of clinical reasoning, and the development of a situated understanding of professional knowledge (Thistlethwaite et al., 2012).

From a pedagogical point of view, casework represents a true unit of *situated learning*, as it requires the connection of data, values, emotions and decisions, restoring the intrinsic human, contextual and experiential dimension to clinical practice (Schön, 1983).

One methodological approach that could be integrated into university curricula with interesting prospects is that of *medical counselling*.

Effective communication and empathy, which are at the heart of *counselling* processes, are extremely useful tools for achieving clinical objectives in a manner that is satisfactory for both the doctor and the patient.

These skills are crucial for sustaining the therapeutic relationship: they contribute to building a personal relationship of quality and mutual trust, an indispensable element for tackling clinical work, which can often prove arduous and distressing. In his work *Counselling skills for doctors,* Smith (1999) highlighted the importance of considering *counselling* skills not as separate specialist knowledge, but as an integral and intrinsic part of everyday clinical practice.

As proof of this, Jacob (2000) provided a clear picture of the concrete benefits of *counselling* in the medical field. His studies confirm that these skills have a direct impact on clinical effectiveness and resource optimisation. On the one hand, they improve diagnostic accuracy by increasing efficiency in obtaining relevant information; on the other hand, they increase patient adherence to treatment plans and cooperation; finally, they contribute to greater patient satisfaction, reduce anxiety and allow for cost containment and increased efficiency in the use of resources.

A crucial element shared by these scholars is the training paradigm for the acquisition of *counselling skills*, which must go beyond traditional teaching models to focus on experiential learning and active practice. This methodological approach is detailed in Burnard (2005), who proposes a *step-by-step* training programme structured like a *Lego-style guide,* that is to say, a step-by-step, building-block

training guide using *dialogues, case studies* and *reflective exercises* to universalise access to this skill.

A further perspective for innovation is represented by interdisciplinary and interprofessional training, which brings together students of medicine, nursing, physiotherapy and educational sciences in shared learning contexts. It is not simply a matter of *learning together* but, as Barr et al. (2005) and the World Health Organisation (WHO, 2010), it is about *learning from and about each other,* recognising that professional knowledge is built through relationships, listening and comparing different perspectives (Reeves et al., 2016; Oandasan & Reeves, 2005). Interdisciplinary workshops, simulations and co-analysis of clinical cases allow students to engage early on with the complex and systemic dimensions of healthcare contexts. These experiences foster the development of the coordination, negotiation and communication skills that are essential for structuring the ability to work in a team (Hammick et al., 2007; Thistlethwaite, 2012).

What has been stated so far highlights the need to re-examine *formative and programmatic assessment practices*. Their role is decisive in the context of continuous and reflective learning, going beyond the mere procedural and summative assessment of knowledge or technical skills. Tools such as competency rubrics, *portfolios* and narrative *feedback* allow for the enhancement of often implicit dimensions of healthcare professionalism, such as empathy, communication and reflectiveness (van der Vleuten et al., 2012). In this sense, *programmatic assessment* is an effective approach for integrating different types of assessment evidence – observations, narratives, self-assessments – with primarily formative purposes (Bok et al., 2013). Narrative *feedback* provides a pedagogical perspective on awareness and orientation processes and contributes to professional development, including with regard to the quality of assessment decisions (Nair et al., 2024; de Jong et al., 2022).

From an organisational perspective, these practices promote autonomy, responsibility and ethical awareness (Baartman et al., 2022), making assessment processes an integral part of care.

Conclusions: towards a pedagogy of care

In light of what has emerged so far, the pedagogy that underpins and structures the approach of the *Medical Humanities* can be understood as an epistemological and cultural lens through which to orient both the identity of the professional and the very nature of the healthcare profession. Its methodological articulation within training practices for healthcare professionals takes shape through experiential and reflective activities that generate meaning and possibility, standing on equal ground with clinical competence. Ethical and technical knowledge are dynamically interwoven in the expression of ethical responsibility, shaping the development of

medical professionalism as an evolving identity sustained by scientific rigor and pedagogical sensitivity.

In order to reclaim the human dimension of medicine, generating awareness, shared responsibility and proximity, it is necessary to address a twofold challenge: on the one hand, the design of integrated curricula in which human dimensions can play a significant role; on the other, the need to understand the healthcare institution as a meeting place between clinical technique and the art of human relations.

Based on these considerations, it is necessary to reflect on the configuration of a *widespread pedagogical core* capable of fully encompassing the medical training path. This pedagogical focus cannot be translated into a single teaching practice, nor can it be quantified in a reasonable number of university credits.

It represents an *organising principle* that permeates academic curricula and directs teaching experiences towards new possibilities opened up by narration, reflection and the value culture of care. If it is true that to educate is to educate oneself (Gadamer, 2014), then every educational act is an act of care towards oneself and others. Every clinical action is an educational action.

Medical training, reinterpreted through the epistemological lens of pedagogy, could reveal the possibilities, still largely implicit for now, of a life-giving process of *education in care*. At the same time, it could restore the profound meaning of the *humanising* experience of pain (Han, 2021).

This is in order to restore medicine to its most authentic purpose: to welcome humanity *into the human*, respecting its complexity, to make the experience of limitation and vulnerability an integral part of the identity construction of the person and the professional.

Author contributions

The article is the result of a collaborative effort between the authors, who contributed to the drafting of the following sections: Claudia Maulini, 4. Training perspectives and methodological implementation: from simulation to counselling and Conclusions; Antonio Cuccaro, 2. Medical Humanities and the pedagogical and narrative dimension of care; Chiara Gentilozzi, 3. The doctor-patient relationship: the pedagogical field of the clinical relationship; Enrico Miatto, Introduction.

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