THE EDUCATION THAT CARES: TOWARDS THE UNIVERSITY OF THE FUTURE

LA FORMAZIONE CHE CURA: VERSO L'UNIVERSITA' DEL FUTURO

Alessandra Lo Piccolo
University of Enna "Kore"
alessandra.lopiccolo@unikore.it

Letizia Pistonne
University of Enna "Kore"
letizia.pistone@unikore.it

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ABSTRACT

Within contemporary university education, particularly in healthcare programmes, the pedagogy of care offers a perspective that integrates technical knowledge with relational awareness. This paper explores models and educational practices that promote empathy, reflexivity, and the wellbeing of the person, outlining a vision of the university of the future as a human and transformative learning environment.

Nel contesto della formazione universitaria, e in particolare dei percorsi sanitari, la pedagogia della cura offre una prospettiva che integra sapere tecnico e consapevolezza relazionale. Il contributo esplora modelli e pratiche formative che promuovono empatia, riflessività e benessere della persona, delineando una visione dell'università del futuro come spazio di apprendimento umano e trasformativo.

KEYWORDS
Medical pedagogy; Healthcare education; Care; Empathy; Reflexivity.

Pedagogia medica; Formazione sanitaria; Cura; Empatia; Riflessività.

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1. Introduction. The education that cares: between technical knowledge and relational awareness

In recent years, the international pedagogical debate has increasingly emphasized the need to rethink university education in the medical and healthcare fields in light of the profound social, technological, and cultural transformations of our time. The challenges of contemporary complexity—ranging from the acceleration of digitalization processes to the crisis of welfare systems and the growing medicalization of everyday life—demand professionals capable not only of technical and scientific excellence, but also of ethical depth, reflexivity, and relational awareness.

Today, medical pedagogy emerges as an indispensable field of research and practice, aiming to integrate clinical competence with the communicative, empathic, and educational dimensions of the care relationship (Zannini, 2002; Mortari, 2015; Bruni, 2024). Medical knowledge cannot be reduced to a set of procedures; rather, it should be understood as an embodied form of knowing, constructed through dialogue, listening, and the recognition of the other. From this perspective, university education must become a genuine *laboratory of humanity*, where one learns both to care and to take care.

The biopsychosocial model developed by Engel (1977) and later expanded by Borrell-Carrió, Suchman, and Epstein (2004) represents a crucial reference for overcoming reductionist views of medicine. This model recognizes the interdependence of body, mind, and social context, placing the person at the center of the therapeutic and educational process. In the same vein, narrative medicine (Charon, 2008) restores meaning to language, subjective experience, and life stories as essential therapeutic and formative dimensions. To tell one's illness story ultimately means to reclaim one's identity and to reframe vulnerability as a space for learning and renewal.

Rethinking an "education that cares" entails a profound transformation of the university's educational paradigm. It is not merely a matter of introducing courses in pedagogy or psychology into medical curricula, but of building a genuinely interdisciplinary academic culture—one capable of integrating medical, humanistic, and social knowledge into a unified project of education for the person. The challenge lies in combining scientific rigor with human sensitivity, uniting technical expertise with awareness, competence with conscience.

As Schön (1983) reminds us, professional competence does not arise from the mere application of theoretical models but from reflective experience and the ability to question one's own actions. In this direction, university education must teach students to embrace uncertainty, to listen, and to act responsibly—fostering an ethics of care that is also an ethics of relationship. The well-being of the person—understood as a dynamic balance between physical, psychological, and social dimensions—thus becomes the ultimate goal of healthcare education and the guiding principle of a pedagogy truly centered on the human being.

At a time when knowledge risks fragmenting into isolated competencies, an "education that cares" restores to the university its original vocation: to be a place of dialogue, transformation, and meaning-making. It invites us to conceive of care not merely as a medical act, but as an educational attitude—as a way of inhabiting the world and recognizing in the other the opportunity for mutual learning.

2. Medical Pedagogy and the Medical Humanities: integrating science and humanity in healthcare education

In the contemporary landscape of healthcare education, a profound shift in perspective is taking place: care is no longer conceived merely as a technical act, but as a human, dialogical, and relational experience. Medical knowledge is thus enriched by interpretive depth, ethical sensitivity, and an ability to listen—restoring to medicine its original vocation as an encounter with the other.

Medical pedagogy arises from the need to bridge the fracture between clinical and human knowledge. As Zannini (2002) observes, it does not constitute a cultural supplement to medicine, but rather its ethical and epistemological condition of possibility. To care, in this perspective, means to interpret, to understand, and to engage in dialogue; it means welcoming the vulnerability of the other without reducing it to pathology, but recognizing it as a space of meaning and relationship. The pedagogy of care is therefore not merely an educational methodology, but an epistemological paradigm that redefines medical knowledge as situated, embodied, and self-aware.

Within this horizon, the Medical Humanities emerge as a fertile meeting ground between medicine, philosophy, literature, art, and pedagogy. They restore to healthcare education its most authentically human dimension, turning the experience of illness from an object of diagnosis

into an opportunity for personal and professional growth. The narrative approach proposed by Charon (2008) is emblematic: through the practice of narrative medicine, the clinical history becomes a story, and the patient moves from being a case to becoming a person—a bearer of experience who demands to be heard. Language, in this sense, assumes therapeutic value, as it allows pain to be re-signified and new connections to be built between experience and knowledge.

Numerous studies (Mortari, 2015; Bruni, 2024) have highlighted the reflective dimension as an essential component of the competence of care. The ability to question one's actions, to dwell within complexity, and to tolerate uncertainty constitutes a form of expertise as vital as technical mastery. As Schön (1983) notes, reflective capacity is not an accessory activity but the very condition that allows experience to become learning and practice to become knowledge. In this way, medical pedagogy positions itself as a field of research aimed at forming professionals who are critical, responsible, and aware of the educational value of relationships.

The integration of the Medical Humanities into university healthcare curricula requires a rethinking of both teaching and assessment models. It is not enough to add courses in ethics, communication, or psychology; rather, it is necessary to build a transversal approach capable of permeating the entire educational process. High-fidelity simulations (Issenberg et al., 2005) and workshops on empathic communication represent effective tools for fostering reflection and awareness. These experiences enable students to engage with complex clinical situations in safe environments, promoting the development of emotional, communicative, and decision-making skills.

Equally significant is the role of language in learning to care. As Castiglioni (2019) points out, words themselves are part of the therapeutic process: the way one communicates, listens, and gives meaning to the experience of illness directly influences the quality of care and the trust between doctor and patient. Educating future professionals in the ethics of language—precision in expression, empathy in communication—means educating them in the ethics of relationship, restoring to medicine its profoundly dialogical nature.

Moreover, the inclusion of narrative, artistic, and theatrical practices in medical and nursing education has yielded positive outcomes in fostering empathy and intercultural awareness. Experiences such as narrative-based learning, dramatized readings of clinical cases, autobiographical workshops, and reflective writing serve as powerful tools to connect

theoretical knowledge with lived experience, nurturing the ability to recognize each person's uniqueness.

This perspective—woven between pedagogy and the Medical Humanities—leads toward a model of healthcare education oriented to the formation of an integral professional identity: one that does not separate technique from ethics, nor care from caring for. The university of the future cannot limit itself to the transmission of competencies; it must become a space for relationship and critical thought—a place where fragility is not seen as a limitation, but as a constitutive condition of being human.

3. Formative experiences and reflective models in the development of caring competence

Within university programmes in the healthcare field, formative experience plays a foundational role in the development of caring competence. Care is not learned solely through theoretical study or clinical observation; it takes shape through conscious practice, encounters with others, and the capacity to transform experience into professional awareness. From this perspective, healthcare education cannot be reduced to the transmission of knowledge but must become a space of inquiry, dialogue, and identity formation.

Reflective practice (Schön, 1983) represents one of the most effective models of professional learning. It is based on the idea that professional expertise develops through a constant dialogue between action and reflection—through the ability to question the meaning of one's practice. In medical and nursing programmes, the introduction of reflective journals, narrative supervision, and clinical case discussions fosters metacognitive processes and emotional awareness, helping students to recognize the complexity of care situations. As Mortari (2015) reminds us, dwelling within uncertainty means acknowledging doubt not as a failure of control but as a generative condition of knowledge.

Among the most significant formative experiences, high-fidelity simulation occupies a central place. It allows students to engage with realistic clinical scenarios in protected environments, where errors can be experienced as opportunities for learning (Issenberg et al., 2005). In these settings, the emotional dimension is valued as a cognitive resource: affective involvement does not hinder clarity of thought but enhances it, fostering empathetic understanding and a deeper sense of responsibility. The debriefing sessions, which conclude each simulation, serve as collective laboratories of reflection, where experiences are analysed and shared to be transformed into critical competence.

Another key dimension is represented by autobiographical and reflective practices, which give voice to subjective experiences and allow meaning to emerge from personal narratives. The use of narrative medicine (Charon, 2008) in university education promotes active listening and empathic communication, encouraging students to read patients' stories as living texts in which fragility, hope, and identity intertwine. In various academic contexts, reflective writing workshops and autobiographical activities have been implemented to foster self-awareness, perspective-taking, and emotional regulation within the care relationship.

Equally relevant is formative tutoring, which serves as a bridge between theoretical learning and clinical practice. The tutor, understood as a figure of pedagogical mediation and accompaniment, does not merely assess performance but supports the student's personal growth, helping them to process experiences, recognize limitations, and transform them into resources. In this sense, the educational relationship acquires a therapeutic value: trust, reciprocity, and recognition become constitutive elements of the formative process.

Experimental projects conducted in several European and Italian universities (Bruni, 2024; Bobbo, 2020) have shown that integrating reflective workshops, narrative supervision, and simulation practices promotes the development of transversal competences such as empathy, collaboration, critical thinking, and stress management. Experiential learning stimulates not only the knowledge of *what to do* but also the awareness of *how to be* within the care relationship, shaping professional identity as both relational and reflective.

Along these lines, *service learning* projects combine academic training with social engagement. Through experiences of volunteering and collaboration with healthcare institutions, students concretely encounter the ethical dimension of care and the responsibility toward the community. These experiences, accompanied by guided reflection, allow them to understand care as an act of citizenship and solidarity—moving beyond a technical vision toward a pedagogy of proximity.

At the international level, models such as *competency-based education* (Ten Cate & Scheele, 2007) and the *integrated curriculum* proposed by van der Vleuten (2015) have redefined approaches to healthcare education, promoting continuous and formative assessment of competences. These frameworks emphasize the development of integrated capacities—clinical, relational, and communicative—that are built through meaningful and reflective experiences. Evaluation thus becomes an integral part of the educational process, not as a mechanism of control but as an opportunity for dialogue and self-awareness.

Clinical placements and simulation settings, finally, constitute privileged spaces for *embodied learning*, where knowledge is rooted in the body and the gesture. Contact with patients, attention to non-verbal communication, and the management of physical proximity and emotional distance are essential elements in the construction of caring competence. As Mortari (2021) affirms, "the body is the first place of the caring relationship," and learning to read its languages means being educated to presence and deep listening.

Reflective formative experiences, therefore, represent not only a didactic methodology but a genuine philosophy of education. They restore to the university its generative mission: to form individuals capable of caring and self-care, recognizing vulnerability as a site of encounter and reflection as an act of educational responsibility.

Conclusions. Towards a new humanism in healthcare education

Rethinking healthcare education through the lens of the pedagogy of care means questioning the very meaning of medical education and restoring to knowledge its relational and reflective dimension. To care is not merely to apply procedures, but to inhabit the complexity of human encounter—transforming technical competence into ethical competence. In this perspective, medical pedagogy and the medical humanities outline a formative paradigm capable of integrating clinical expertise, inner awareness, and social responsibility.

To respond to contemporary challenges, the university must become a laboratory of humanity and critical thought, a space for experience and interdisciplinary dialogue. The integration of narrative practices, high-fidelity simulations, and *service learning* pathways demonstrates that caring competence is built through reflective experience, participation, and the ability to dwell within uncertainty. Healthcare education thus emerges as a transformative process in which students learn not only to treat, but to care—to recognize the other as an interlocutor rather than an object of intervention.

The pedagogy of care, in this sense, does not represent an accessory form of knowledge, but the epistemological and ethical foundation of healthcare practice. It grounds a new humanism in education—one capable of uniting scientific rigour with relational sensitivity, technique with empathy, knowledge with responsibility. Only through such integration will it be possible to form professionals who embody a conscious, reflective, and genuinely person-centred medicine, oriented toward the well-being of the individual in their wholeness.

Authors' contributions

A. Lo Piccolo: Introduction and Conclusion; L. Pistone: Section 1 and Section 2. All authors approved the final version of the manuscript.

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