PATIENT EDUCATION AND THERAPEUTIC LEARNING: PEDAGOGICAL STRATEGIES, NARRATIVE MEDICINE, AND EMPOWERMENT

PATIENT EDUCATION E THERAPEUTIC LEARNING: STRATEGIE PEDAGOGICHE, MEDICINA NARRATIVA E EMPOWERMENT

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ABSTRACT

English
The increasing prevalence of chronic degenerative diseases in Italy constitutes a significant and growing challenge for the national healthcare system. Therapeutic patient education, extending well beyond the mere transfer of medical knowledge, actively empowers patients to engage in profound self-reflection, reconstruct their personal identities, and adopt meaningful behavioral and attitudinal changes, ultimately improving adaptation, self-management, and overall quality of life.

Italiano
La crescente diffusione delle malattie degenerative croniche in Italia rappresenta una sfida significativa e in costante aumento per il sistema sanitario nazionale. L'educazione terapeutica del paziente, che va ben oltre il semplice trasferimento di conoscenze mediche, consente ai pazienti di impegnarsi in una profonda riflessione su se stessi, ricostruire la propria identità e adottare cambiamenti comportamentali e attitudinali significativi, migliorando in ultima analisi l'adattamento, l'autogestione e la qualità complessiva della vita.

KEYWORDS
Patient education, Therapeutic learning, Empowerment, Clinical storytelling, Health pedagogy

Educazione del paziente, Apprendimento terapeutico, Empowerment, Narrazione clinica, Pedagogia sanitaria

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Introduction

Patient education is a fundamental component of healthcare, particularly in the context of chronic diseases, which are increasingly prevalent in industrialized countries. According to the World Health Organization (WHO, 1998), the primary aim of patient education is to equip individuals with the skills necessary for self-management and to foster familiarity with treatment approaches tailored to their specific conditions. The concept of chronicity, deriving from the Greek term *chronós* (time), has historically referred to long-lasting illnesses. Chronic diseases are characterized by slow progression, persistence over time, and often limited treatability. These conditions encompass a wide spectrum, including non-communicable diseases such as hypertension, diabetes, and chronic respiratory illnesses, as well as communicable diseases with prolonged courses (e.g., AIDS, tuberculosis), psychiatric disorders, physical impairments, and patients undergoing dialysis or organ transplantation (WHO, 2003).

The socioeconomic burden of chronic diseases is substantial. In Europe, they account for 86% of all deaths and impose annual costs approaching seven hundred billion euros. In Italy, projections estimate that by 2028 approximately twenty-five million individuals, nearly half of the population, will be affected by chronic conditions, with fourteen million experiencing multimorbidity. Hypertension will remain the most common chronic condition, followed by arthritis, osteoporosis, diabetes, and cardiovascular diseases, highlighting the growing demands on national healthcare systems. In response, the Italian National Plan for Chronicity, initiated in 2016, seeks to reorganize healthcare services to optimize the management of chronic conditions, emphasizing patient-centered care and the integration of territorial and home-based assistance.

The COVID-19 pandemic has further underscored the limitations of conventional healthcare delivery and reinforced the need for comprehensive territorial care. National initiatives, such as the Recovery and Resilience Plan, aim to establish a network of community-based health services, integrating patients' homes, community centers, and hospitals, while promoting the adoption of telemedicine and e-health solutions. Such strategies are closely aligned with educational interventions, which are critical to managing chronicity. The goals of managing chronic disease extend beyond clinical treatment to minimizing progression, alleviating suffering, sustaining existing resources, and ensuring acceptable living

conditions. Achieving these goals necessitates collaboration between healthcare providers and patients, incorporating biomedical care alongside patients' lived experiences, perceptions, and expectations.

Patient education transcends the provision of medical information or technical training. Its objectives include fostering a positive relationship between patients and their health, enhancing adherence to treatment, and supporting the integration of the disease into daily life (Bodenheimer et al., 2002; WHO, 1998). Effective educational interventions rely on healthcare professionals' communication skills and their understanding of the pedagogical dimension of care, yet this aspect remains underemphasized in formal training programs (Benini, 2021). Traditional educational activities, often delivered by nurses, dieticians, or rehabilitators, focus on "therapeutic education", teaching treatment management and lifestyle adjustments. Research indicates that inadequate education correlates with poor adherence, disease exacerbations, complications, and re-hospitalization, whereas structured educational programs improve compliance, reduce complications, and enhance quality of life (Trento et al., 2010).

Beyond procedural knowledge and lifestyle guidance, patient education can facilitate the reconstruction of patients' life plans and identities in the face of chronic illness. Chronic disease is not merely a medical problem but an experiential disruption that challenges individuals' sense of self and daily routines (Palmieri, 2018). Patients often seek to understand the implications of their condition and the meaning of their experiences, highlighting the necessity of interventions that go beyond technical instruction to address psychological and existential dimensions (Bruzzone, 2021). Personalized educational strategies, tailored to individual needs, can thus significantly influence health outcomes, improve patients' quality of life, and alleviate pressures on healthcare systems (WHO, 2003).

In summary, patient education represents a multidimensional approach that combines medical knowledge, practical skills, and reflective engagement with illness experiences. Its integration within territorial and home-based healthcare frameworks offers a promising avenue for the effective management of chronic conditions, emphasizing the active participation of patients in their care and the transformation of healthcare practices to meet contemporary challenges.

1. Language, Learning, and Patient Autonomy

Language functions not only as a tool for human communication but also as a mechanism for shaping meaning. Michael Foucault (1980) emphasized that the vocabulary chosen in discourse can influence, modify, or even create the objects and phenomena discussed. This concept is particularly relevant to patient education, where the selection of words can affect the efficacy of teaching and patient understanding. Patient education traditionally focuses on the transmission of practical information regarding therapy, monitoring, side effects, and medication adherence (Riccio et al., 2004). However, for the purposes of this discussion, education is conceptualized more broadly as a process that empowers patients to develop awareness and autonomy regarding their condition. While traditional education often overlooks the emotional dimension of disease, emerging interventions increasingly address both cognitive and affective aspects. Riccio et al. (2004) note that exaggerated emotional responses often stem from inadequate information rather than disease severity, highlighting the need for healthcare professionals to integrate pedagogical awareness into their practice. Effective patient education requires careful word choice, cultural sensitivity, and attentive listening, acknowledging the patient's individuality and fostering a collaborative, relational approach. Research indicates that although improved patient knowledge can be measured, it does not necessarily correlate with enhanced quality of life, emphasizing the influence of multiple variables such as age, ethnicity, education, disease type, perceived severity, and patient motivation.
Education is an active experiential process in which both the educator and learner contribute their interpretations, emotions, and prior experiences (Dewey, 1938). An educational experience enables patients to reflect on and reinterpret their lived experiences (Palmieri, 2018). Several core characteristics define an educational experience:

- Relational dimension: the educator-patient relationship must balance empathy with authority, ensuring guidance while acknowledging the patient's personal history.
- Intentionality: educational interventions are deliberate, aiming to facilitate meaningful change.
- Awareness: both parties must recognize the transformative potential of the experience, which can result in positive or negative personal growth.

- Art and technique: education requires strategic communication tailored to the learner's subjective context (Cosmacini & Rugarli, 2007).
- Irreversibility: education constitutes an evolving process; once a change occurs, it cannot revert to the prior state.

Education transcends the mere accumulation of knowledge, encompassing holistic personal development. Experiences alone, such as illness or disability, are not inherently educational; intentional reflection and structured engagement with the experience are essential to define it as educational (Massa et al., 1990). Teaching and education are distinct concepts. Teaching primarily involves knowledge transmission, whereas education engages the learner's emotions and facilitates the construction of identity and subjectivity. For example, memorizing a poem exemplifies teaching, whereas reflecting on the emotional impact of that memorization constitutes education. In clinical settings, healthcare professionals often act as teachers, imparting practical skills essential for self-management of conditions, such as monitoring blood glucose in diabetes. The approach to teaching is shaped by the underlying model of learning. Didactics distinguishes between transmissive and active methods, rooted in different theoretical frameworks:

- Behaviorist model: learning results from associations between environmental stimuli and responses. Teaching is guided by observable outcomes, reinforced through repetition.
- Cognitivist model: learning depends on the interaction between the learner's preexisting knowledge and new information. It emphasizes internal cognitive processes and long-term knowledge retention. Jean Piaget's constructivist model further posits that learning occurs through assimilation (integrating new information into existing schemas) and accommodation (modifying schemas to incorporate new experiences).
- Social constructivist model: learning is a socially mediated process, emphasizing collaboration and meaning-making within social contexts.
- Cultural model: Jerome Bruner's (1990) framework integrates prior models, highlighting the role of social interaction and cultural context in shaping knowledge. Learning is conceptualized as a social practice, with narrative and shared discovery central to meaning-making.

Recent trends in patient education favor active, constructivist approaches that integrate social engagement, reflective processes, and narrative techniques. Such

approaches not only facilitate knowledge acquisition but also contribute to the patient's self-identity development. Pedagogy, as the science of education, examines educational processes and seeks to develop theories that enhance future practices. While educational sciences encompass disciplines such as didactics, psychology, sociology, and anthropology, pedagogy uniquely focuses on fostering self-identification and autonomy in learners. Unlike didactics, which can rely on experimental studies for efficacy, pedagogy requires qualitative analysis due to the individualized nature of educational interactions. In clinical contexts, applying pedagogical principles allows healthcare professionals, particularly nurses, to establish effective, reflective communication strategies tailored to the patient's subjective needs. Through continuous evaluation of their communication, spatial arrangements, and teaching tools, healthcare providers can guide patients toward reconstructing their self-identity, especially following chronic or degenerative diagnoses. Narrative methods enable educators to gather essential insights into patients' perspectives, facilitating tailored interventions that promote acceptance, adaptation, and empowerment in managing their conditions.

2. Patient education: from teaching interventions to educational pathways

The concept of patient education emerged in the late 1970s, alongside the introduction of health promotion by the World Health Organization (Hoving et al., 2010). Health promotion requires a multidisciplinary approach aimed at reducing risk factors and encouraging protective behaviors. Through this process, patients gain empowerment by actively participating in decisions regarding their own health. Before this shift, healthcare primarily focused on compliance, emphasizing adherence to medical instructions rather than active patient involvement, making patient education largely unnecessary.

The increase in chronic-degenerative diseases, driven by longer life expectancy and economic well-being, made patient education essential. Chronic diseases require continuous management and self-care, positioning education as a key intervention. In Italy, patient education began in the 1970s to reduce complications and healthcare costs, but active patient engagement developed only in the 1990s. This marked a transition toward greater patient engagement and empowerment,

recognizing patients as individuals entitled to participate in healthcare decisions rather than being blamed for their condition.

The rise of the Internet has further facilitated patient education, enabling access to information and peer support, though it also introduces risks such as misinformation and digital inequalities. Telemedicine supports both therapeutic and educational goals, while the European Charter of Patients' Rights in 2002 emphasized patients' rights to information and involvement, promoting shared decision-making. In 2003, the WHO, through "Adherence to Long-Term Therapies: Evidence for Action," replaced the concept of compliance with adherence, encouraging collaboration between patients and healthcare professionals to reach shared therapeutic plans (Anderson & Funnell, 2000). This shift promotes a conversational rather than directive approach, allowing patients to actively negotiate disease management.

Therapeutic patient education (TPE) evolved from general health education, initially defined as a social intervention aimed at modifying attitudes toward health problems. Early approaches were prescriptive, offering rules rather than engaging patients. Later, disciplines such as psychology and sociology were integrated to better understand patient's behavior. According to Ricciardi et al. (2018), modern health education aims to generate motivation, skills, and self-esteem, fostering behaviors that improve quality of life. While general health education focuses on prevention, TPE targets individuals with chronic illnesses, promoting independence and meaningful attitudinal change, including lifestyle modifications such as diet, exercise, and substance use. Patient motivation is crucial: the educator's role is to support and guide rather than persuade (Bergh et al., 2014). The WHO (1998) defines TPE as training patients in self-management, effective coping, and maintaining or improving quality of life, producing therapeutic effects complementary to other interventions.

Patient education can occur in formal, non-formal, or informal contexts. Formal education takes place in structured settings with defined times and methods, while non-formal education is semi-structured and often arises from patient inquiries, occurring, for example, at the bedside or in an outpatient clinic. Informal education occurs in daily life through interactions with family, friends, or media, often less recognizable as a formal learning process. Social pedagogy helps distinguish these forms by highlighting the intentionality and context of learning. Nurses play a

central role in non-formal interactions, providing explanations, demonstrations, and support to help patients achieve their care goals (Honan et al., 1988; Marcum et al., 2002; Park, 2005; Liu et al., 2018). Educational diagnosis is fundamental in formal patient education, identifying gaps between current behaviors and desired health management. It evaluates cognitive, motivational, physical, and communicative deficits. Factors influencing adherence include patient characteristics (age, education, culture, social network, socioeconomic status), disease characteristics (complexity, severity), therapeutic aspects (side effects, administration challenges), and healthcare accessibility (Palmieri, 2005; Bobbo et al., 2020).

Structured interviews (Bobbo et al., 2000) and validated tools support the assessment of patient knowledge, habits, social networks, and attitudes. Models such as PRECEDE-PROCEED (Green & Kreuter, 1999) and the stages of change (Prochaska & DiClemente, 1983) help identify motivation and factors facilitating or hindering change. Predisposing, enabling, and reinforcing factors guide the design of personalized educational plans, with ongoing and adaptive evaluation. Following the educational diagnosis, teaching activities are designed with clear objectives in the cognitive, affective, and psychomotor domains (Beghelli et al., 2015). Patient-centered teaching integrates emotional, social, and informational aspects, emphasizing shared expertise between nurse and patient. Educational planning includes defining objectives, analyzing resources, selecting strategies, organizing logistics, and evaluating outcomes.

Pedagogical goals can focus on safety or patient-specific needs. Practical training involves demonstration and supervised practice (Show-Me Method), while role-playing develops relational and affective skills. Effective teaching promotes empowerment, increasing patient engagement and autonomy (Pedrotti & Saiani, 2011). Formal education can be delivered individually or in groups, while non-formal interactions are typically individual. Group education encourages experience sharing, creates a positive environment, and facilitates simulations and practical exercises (Musacchio et al., 2018). Studies demonstrate the difference between short-term teaching and long-term education: Liao & Hunter (1998) conducted brief interventions on menopause, whereas Trento et al. (2005) followed type 1 diabetes patients for two years using a Group Care model, integrating teaching, real-life application, and empowerment-focused education.

Zannini (2012) developed a visual map to guide healthcare professionals, indicating the type of intervention, target audience, methods, timing, and objectives, useful for structuring patient-centered education in formal, non-formal, individual, or group settings.

For effective education, healthcare providers need intrinsic and extrinsic competencies. Intrinsic skills include clinical, pedagogical, communicative, and empathic abilities (Honan et al., 1988; Pétré et al., 2017). Extrinsic factors include dedicated space, sufficient time, organizational support, and access to educational tools (Bergh et al., 2012; Moret et al., 2008). Formal interventions require educational diagnosis, evidence-based planning, and validated evaluation tools. Group education demands additional skills in moderation, facilitation, reassurance, and cultural translation, along with teamwork capabilities (Bergh et al., 2014). In conclusion, patient education is a multidimensional process integrating formal, non-formal, individual, and group interventions. It requires patient-centered approaches, effective communication, relational skills, evidence-based planning, and continuous evaluation, all aimed at promoting empowerment, self-efficacy, and improved health outcomes.

3. Narrative and Psychoeducational Strategies for Chronic Patients

To evaluate the effectiveness of educational interventions, this article integrates a patient case, as an illustrative example. Anna, a 27 year-old woman, was diagnosed with type I diabetes at age 16. She lives with her husband, who is often away on military duty. Her mother, a nurse, has always managed Anna's diabetes, assisting with check-ups and therapy, which has hindered Anna's independence. Anna expresses a desire to have a child, which partly motivates her to take more responsibility for her health. After a recent move to a new city, she experiences nocturnal hypoglycemic episodes, resulting in a hospital admission where she is enrolled in a new educational program led by a nurse, Elisa. During an hour-long interview, Elisa explores Anna's habits, family influences, and misbeliefs about glucose control, particularly that sustained hyperglycemia prevents hypoglycemia. Elisa designs a therapeutic plan addressing insulin dosing, diet, and self-monitoring, asking Anna to maintain a food and activity diary with concurrent glucose measurements (Rankin et al., 2005).

Throughout the process, Elisa observes Anna's growing autonomy and frequent communications regarding her treatment. Recognizing the importance of internalizing her competence, Elisa introduces Anna to a pregnant nurse with diabetes who maintains good glucose control, reinforcing the belief that she can manage her condition independently. Anna is further encouraged to join a self-help group, highlighting how peer interaction and social support play crucial roles in non-formal patient education. This case demonstrates that non-formal educational interventions are relational, continuous, and intentionally designed to scaffold self-efficacy and independence.

Analyzing Anna's situation through the framework of educational diagnosis, her condition, actions, knowledge, identity, and goals are considered. Anna's predisposing factors for change include awareness of mismanagement, motivation to become pregnant, and prior participation in education programs, which help build self-efficacy. Hindrances include her dependence on her mother and misinformation regarding her treatment. Enabling factors include prior knowledge, access to specialized healthcare, and dedicated educational time with a nurse. Reinforcing factors include the therapeutic relationship with Elisa, peer interaction, and group participation (Prochaska & DiClemente, 1983). This example illustrates the integration of clinical care with pedagogical strategies: scientific information, practical tools, and psychosocial support converge to enable progressive patient autonomy.

Chronic diseases affect not only physical health but also personal identity. The first encounter with a chronic illness often disrupts life narrative, generating what Bury et al. (1982) described as a "biographical disruption." Patients may experience anger, denial, resignation, social withdrawal, fear, or depression. The disease forces a reevaluation of past and future plans, affecting self-perception and social relationships. Some experience "self-dissolution," a separation between the self and the body (Charon et al., 2006), while others achieve an "identity shift," integrating the illness into their conception of self, often more easily in older patients (Borsari & Mancini, 2015). Factors such as time since diagnosis, physical impact, stigma, social support, age, comorbidities, and cultural background influence the integration process. In type I diabetes, reactions include rejection, acceptance, overwhelm, or enrichment, with enrichment correlating with better therapy adherence (Rassart et al., 2021).

Patient education aims not only to provide information but also to empower patients, fostering self-efficacy and promoting integration of the illness into identity. Strategies include differentiating self from disease, reintegrating the "sick" identity socially, adjusting expectations, and engaging in meaning-making through narrative (Aujoulat et al., 2008). Narrative practices help patients reconstruct meaning, integrate the disease, and redefine personal identity. The social dimension is central: sharing written or oral illness stories with others provides feedback and new perspectives, reinforcing empowerment. Autobiographical and narrative approaches have been shown to help patients express emotions, develop problem-solving skills, identify personal goals, reduce stigma, and build social networks (Gucciardi et al., 2016; Formenti et al., 2017).

In psychiatric care, education plays a similarly fundamental role, though psychiatric disorders differ because not localized to a single organ, but they emerge from complex interactions between genetics and environment. Patients often lack a clear biomedical explanation and may be reluctant to share narratives, particularly in groups. Both psychiatric and chronic-degenerative diseases influence patients' sense of self and autonomy. Effective care must move beyond disease-centered approaches to patient-centered approaches, linking treatment with educational interventions that support recovery and autonomy. Recovery is defined as a deeply personal process of developing new attitudes, values, goals, and roles, allowing a satisfying life despite illness limitations (Anthony et al., 1993).

Rehabilitation in psychiatry focuses on correcting functional consequences rather than curing the disease itself, promoting skills necessary for autonomous living. Educators and clinicians co-design plans with patients to enhance awareness, acceptance, and self-determination. Nurses play a pivotal role in facilitating therapy adherence by identifying and addressing reluctance, exploring motivational factors, and encouraging self-management, including medication self-administration. Understanding the patient's life context, including spaces, objects, relationships, routines, thoughts, and emotions, is essential to effective intervention. In residential communities, daily life provides an educational environment, structured by rules that organize time, space, and relational dynamics. These rules are flexible and relationally interpreted to encourage socialization, autonomy, and habit formation (Pietropolli et al., 2001; Pozzo et al., 2019).

Rules and routines help patients regain temporal, spatial, and relational order disrupted by mental illness, creating a balance of stability and flexibility (Nuzzaci, 2009). Through careful observation, dialogue, and adaptation, educators turn daily activities into pedagogical opportunities, facilitating reintegration into social life. Educational interventions intentionally construct experiences that allow patients to reflect, explore meaning, and re-stage their existence with illness. These experiences consider material, relational, procedural, and symbolic dimensions (Palmieri et al., 2018). Such interventions, while difficult to evaluate with conventional psychometrics, aim at existential redesign rather than immediate symptom reduction (Castiglioni et al., 2016; Zannini, 2008).

We emphasizes that education in chronic and psychiatric illness is inseparable from identity integration, empowerment, and autonomy. Effective educational strategies combine clinical knowledge, relational support, narrative practices, and structured environments to help patients reconstruct their lives, incorporate illness into their identity, and regain agency over their existence. Healthcare professionals must carefully design, facilitate, and adapt educational interventions to the unique contexts and needs of each patient, creating conditions for both self-discovery and social reintegration.

Conclusions

Throughout this paper, we have referenced numerous documents from health organizations, as well as scholarly essays and articles, all of which underscore the critical need for pedagogical training of healthcare professionals (WHO, 1998). As evidenced in the literature, such training often emphasizes primarily the content and methodology of educational interventions, effectively constituting a didactic preparation of care providers. While this focus is certainly valuable, we argue that, in the coming years, all healthcare professionals will need to acquire at least foundational teaching competencies, particularly in the use of digital and technological tools. This is increasingly important given the growing necessity to communicate diagnoses, treatment plans, and rehabilitation processes to patients, thereby promoting maximal autonomy in managing their health within daily life contexts, such as the home environment.

As emphasized throughout this paper, patients with chronic conditions not only require explanations, but also often need support in learning to live with their

illness and integrating it into their sense of identity. This need cannot be entirely delegated to psychology or psychiatry professionals, nor solely addressed through self-managed activities such as support groups, since, for many patients, the primary point of contact is the physician and/or nurse. In the context of long-term care relationships, healthcare professionals must develop the capacity to respond not only to informational needs, but also to broader educational needs, which often constitute the implicit requirement of many patients. The competencies required to meet these needs cannot be fully acquired through university coursework or conventional continuing education programs.

These competencies must be developed through practical, field-based experience, as professional expertise, while grounded in specialized knowledge, is always context-dependent and influenced by personal factors such as motivation and attitudes (Spencer et al., 1993). Competence is inherently context-specific and requires experiential engagement for its development (Zannini, 2015). Wenger (1998) conceptualized a "community of practice" (CoP) as a group of individuals defined by mutual engagement, participation in a shared enterprise, and the collective development of a repertoire of practices. Communities of practice consist of professionals who address a problem—or a series of problems—with dedication and commitment, sharing not only knowledge and actions, but also narratives, routines, and symbolic frameworks that shape problem-solving within a particular domain of practice. Importantly, such sharing does not presuppose harmonious interactions; on the contrary, disagreements, challenges, and even competition can emerge, and, as Wenger (1998) notes, these tensions themselves can be a form of participation.

A fundamental aspect of communities of practice (CoPs) is accountability, which is grounded in mutual relationships and entails the negotiation of actions and meanings. Learning within a CoP is therefore a collective phenomenon, deeply embedded in daily practices. As Palma et al. (2021) note, it is in fact practice that constitutes the basis of the construction of knowledge, understood as a social phenomenon. Knowledge is thus constructed not only through action but also through socialization and active participation, enabling individuals to build understanding within an organizational context.

Within a CoP, encouraging motivated members to share personal narratives and developmental journeys, using storytelling to contextualize their experiences, foster learning. Experiential knowledge does not emerge simply from participation in practices; it presupposes the intervention of reflective reasoning, which is being thoughtfully present with respect to experience (Mortari, 2003). Reflective thinking has its roots in Dewey's pedagogy (1933), who argued that its function in education is to transform a situation in which one has experienced darkness, a doubt, a conflict, or a disturbance of some sort, into a clear, coherent, resolved, harmonious situation.

Narration is a crucial tool for organizing and structuring experiences, attributing meaning to them, and making tacit knowledge explicit. However, narration alone is insufficient for effective learning from educational experiences; it must be complemented by reflective competence. It is also important to distinguish between thought and reflection: thought occurs in the moment of action ("How can I respond to this patient's question so that they understand and remain reassured?"), whereas reflection entails a deliberate examination of what was done and what was considered ("In response to the patient's question, I considered that… and therefore answered in this way").

Reflective practice is particularly challenging in healthcare contexts, primarily due to the chronic lack of time. Nevertheless, the educational benefits derived from reflective training aimed at developing pedagogical competence appear to justify the effort (Mortari, 2015). We argue that pedagogical training for healthcare professionals should provide a structured opportunity to develop reflective skills, employing not only narration but also writing. Topics for such reflective practice may include routine daily activities, as well as "critical incidents," the solutions implemented, and the experiences accompanying the educational work of healthcare professionals. As discussed previously, narration, reflective writing, becomes a powerful learning tool when coupled with group sharing, which facilitates the identification of implicit cognitive and affective elements emerging from the narrated experiences.

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