

THE CLINICAL EDUCATOR AS A NEUROEDUCATIONAL MEDIATOR: TOWARDS A PEDAGOGY OF CONSCIOUS CARE

L'EDUCATORE CLINICO COME MEDIATORE NEUROEDUCATIVO: VERSO UNA PEDAGOGIA DELLA CURA CONSAPEVOLE

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ABSTRACT

English

This contribution explores the role of the clinical educator as a neuroeducational mediator, capable of integrating scientific rigour and relational sensitivity into a pedagogy of conscious care. Neuroeducation is proposed as an epistemological paradigm to support clinical reasoning and orient university education towards experiential, reflective and transformative models, including through innovative teaching methodologies.

Italian

Il contributo esplora il ruolo dell'educatore clinico come mediatore neuroeducativo, capace di integrare rigore scientifico e sensibilità relazionale in una pedagogia della cura consapevole. La neuroeducazione viene proposta come paradigma epistemologico per sostenere il ragionamento clinico e orientare la formazione universitaria verso modelli esperienziali, riflessivi e trasformativi, anche attraverso metodologie didattiche innovative.

KEYWORDS

Higher education training; Neuroeducation; Clinical reasoning;

Formazione universitaria; Neuroeducazione; Ragionamento clinico.

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Introduction

In recent decades, the education and healthcare professions have undergone a profound epistemological transformation that has progressively redefined the nature and meaning of the knowledge that guides educational and care activities, opening a space for reflection on the traditional boundaries between care, education and learning. This redefinition stems from the need to overcome the dichotomy between a predominantly technical-instrumental logic, oriented towards the application of standardised protocols and models, and a logic that places the complexity of the person in their bio-psycho-social (Lucidi, 2021) integrity at the centre of the intervention.

From this perspective, education is seen as a form of care (Mortari, 2017), aimed at promoting well-being, autonomy and emancipation of the individual and recognising human dignity. The caring relationship, in fact, is not limited to assistance or therapy, but is rooted in an ethical and reflective stance that recognises fragility as a constitutive dimension of humanity and relationships as a space for generating meaning (Bruni, 2024; Cambi, 2014). From this point of view, caring for the person becomes caring for the experience, understood as attention to the way in which each individual lives, interprets and gives meaning to their own existence (Palmieri, 2011).

This epistemological transformation has redefined the boundaries between different professional fields of knowledge, promoting the emergence of hybrid and interdisciplinary figures capable of inhabiting spaces at the intersection of education, health and rehabilitation. This is the context in which the clinical educator operates, a professional who embodies the need to combine scientific rigour with the relational, reflective and ethical sensitivity that characterises the care relationship in an educational perspective. The clinical educator works based on situated knowledge, which is constructed in relationships and experience, and which is nourished by the continuous dialogue between theoretical knowledge and observation of lived experience. The competence of the clinical educator in educational practice lies not so much in the application of predefined models as in the ability to develop *clinical reasoning* (Higgs & Jensen, 2019), understood not only as a logical-deductive process aimed at defining a diagnostic or decision-making framework, but as a complex reflective act that allows the signs of educational experience to be interpreted and intervention to be guided in an intentional and well-founded manner. In this sense, clinical reasoning is an epistemic competence that involves the ability to read situations of fragility in their uniqueness, to recognise the links between personal experience and context, and to modulate the educational response according to criteria of responsibility, intentionality and care.

It is a process that develops according to the rules that guide care (Tronto, 2020): from approaching and showing interest, to recognising the needs of others, to verifying that those needs have been effectively understood and met. The clinical educator's know-how is therefore intertwined with a reflective approach, aware of the ethical dimension implicit in every educational decision. In fact, a solid body of scientific literature demonstrates how reflexivity represents a privileged path to authentic care, capable of generating meaning and restoring dignity to the person in their experience of fragility (Cunti, 2014; Mortari, s.d., 2013; Schon, 2024; Striano, 2018; Zannini & D'Oria, 2018).

This epistemological approach finds a natural extension in the training of education and care professionals. In this sense, universities are called upon to become a generative context for experiential learning, in which knowledge is constructed through active participation, dialogue and intentional experimentation. In this direction, a theoretical framework that can serve as an interpretative lens to guide the practice of clinical reasoning in university education is *neuroeducation* (Jolles & Jolles, 2021; Liparoti, 2023; Rivoltella, 2012). The latter, bringing together the sciences of education, psychology and neuroscience, offers an interpretation capable of integrating the cognitive, affective, relational and physical dimensions of human learning (Immordino-Yang, 2015; Tokuhamma-Espinosa, 2010). It helps to recognise how educational and care processes are rooted in the concepts of brain flexibility and dynamism, emotional memory and the relational dynamics that support personal development (Siegel, 2020). From this perspective, the clinical reasoning implemented by the clinical educator can be interpreted as a neuro-pedagogical process, in which knowledge of human functioning is never separated from an understanding of subjective experience and the socio-relational context in which it takes shape. Clinical reasoning thus becomes a circular movement between experience and theory, between interpretation and transformation, based on knowledge that is both scientific and relational.

Applying the principles of neuroeducation to the higher educational training of clinical educators means promoting teaching models that value experience, reflection and the emotional dimension of learning. This implies a rethinking of training courses capable of activating the cognitive and affective engagement of students, promoting the integration of theory and practice and the construction of embodied professional knowledge. From this perspective, the university becomes a laboratory for transformative learning, in which future clinical educators learn to think of educational action as a complex, dynamic and situated process, in which scientific knowledge is intertwined with the ethical and experiential dimensions of care.

In accordance with these premises, this contribution aims to explore the role of the clinical educator as a neuroeducational mediator, a figure capable of integrating scientific knowledge, relational sensitivity and reflective awareness into an

educational care perspective. The objective is to explore how neuroeducation, understood as an epistemological and methodological paradigm, can support and redefine clinical reasoning, orienting it towards a deeper understanding of the processes of learning and personal transformation. Finally, the study aims to highlight how the adoption of teaching practices in university training contexts consistent with this paradigm can foster the development of the reflective, metacognitive and relational skills necessary to navigate the complexity of care.

1. The clinical educator and clinical reasoning in the context of contemporary professional pedagogy

In current complex times, the profession of clinical educator is shaped as that of a reflective intellectual (Schon, 2024) and educational care professional, capable of integrating epistemological, methodological and ethical dimensions into an approach characterised by a shift from a technical-procedural logic to a reflective and relational logic, rooted in situated, dialogical and transformative knowledge. In this sense, the clinical nature of educational action does not coincide with the therapeutic dimension in the strict sense, but rather with an epistemological and deontological attitude that implies “bending towards” the other, according to the greek etymology *kliné*, in a movement of attention and proximity (Canevaro, 2015, 2018). This gesture, symbolically and concretely, translates into an ethical stance based on empathetic listening, suspension of judgement, and the pedagogical intentionality of the encounter. The clinical educator acts as a mediator between the subject and their world, oriented towards accepting the complexity of experiences and fragilities, but also towards recognising the resources and potential of each subject through processes of understanding, re-signification, and self-training. In this perspective, reflexivity becomes the distinctive element of educational professionalism. It allows educators to constantly question their work, to deconstruct automatisms and routine practices, and to build dynamic professional knowledge capable of adapting to the changing configurations of contemporary complexity. Reflection, understood as the practice of critical and self-reflective thinking, transforms experience into knowledge and the educational relationship into a space for mutual learning. At the same time, the relational dimension of clinical action is a privileged place for education understood as care (Mortari, 2006; Noddings, 1984). The term “care” derives from the latin *cura*, which means both “to be concerned” and “to worry about”. The clinical educator, therefore, does not intervene on the other, but with the other, recognising their subjectivity, vulnerabilities and potential. In this sense, the relationship is not simply an operational tool, but a genuine *formative matrix*, where meanings, identities and possibilities for change are co-constructed. However, clinical educators can only fully express their potential if supported by a training

programme that promotes critical awareness, reflective competence, the ability to interpret educational contexts hermeneutically and, at the same time, the ability to transform the asymmetrical relationship between caregiver and care recipient into an authentic, dialogical encounter. In fact, only a training process geared towards the construction of embodied, experiential and relational knowledge allows knowledge to be translated into intentional action and relationships into tools for growth and care.

A fundamental theoretical issue in this context is clinical reasoning, understood as the cognitive, reflective, decision-making and transformative process through which professionals interpret complex situations, integrate objective data and subjective dimensions, and formulate action-oriented educational judgements. Clinical reasoning is structured as a situated reflective practice that combines rational analysis of problems with empathetic understanding of the people involved (Higgs & Jensen, 2019). From a pedagogical perspective, it becomes a dialogical reasoning process based not only on evidence and theoretical knowledge, but also on the ability to interpret contexts, experiences and relationships in a dynamic and responsible manner.

This concept is particularly significant when compared with new forms of clinical reasoning mediated by artificial intelligence, which are based on algorithmic models of analysis and prediction (Cabral et al., 2024; Schwartzstein, 2024). While artificial intelligence technologies can offer powerful tools for data processing, pattern identification and decision support, they also risk reducing the complexity of reality to purely descriptive and probabilistic dimensions. Clinical educators, on the other hand, exercise reasoning that is not limited to the logic of efficiency but is rooted in the logic of understanding (Ricoeur, P. 1988; 1994) and caring for relationships, first interpersonal, then intrapersonal, then educational and, ultimately, formative (Boffo, 2020). The comparison between human clinical reasoning and algorithmic reasoning highlights the humanising sphere of educational professionalism: clinical educators possess a relational and ethical intelligence that no algorithm is currently capable of replicating. It is in this profoundly human dimension that clinical reasoning finds its highest expression, becoming a tool for healing and promoting humanity.

In view of these considerations, a fundamental question arises: how can university education promote the development of truly reflective, competent and responsible clinical-educational professionalism, capable of exercising authentically human clinical reasoning in the digital age?

This involves rethinking educational pathways not only in terms of the technical and disciplinary knowledge of the curriculum, but also as spaces for experience, reflection and identity building, in which theory and practice are intertwined in a continuous dialogue. Training a clinical educator, in fact, means promoting

transformative training (Mezirow, 1999, 2009), capable of integrating cognitive, ethical and emotional dimensions, guiding future professionals towards a critical and responsible stance in the face of the complexity of reality.

In this sense, the university is called upon to become a pedagogical research laboratory, where experiential learning, reflection on practices, self-improvement and educational supervision become fundamental tools for building authentic clinical-educational skills. Only through a training approach that intertwines knowledge, being and doing can educators embody that “clinical relationship” which translates into care, support and promotion of humanity in all its forms.

2. Neuroeducation as a theoretical framework for clinical educator training and interpretative paradigm of conscious clinical reasoning

The training of clinical educators cannot be limited to the acquisition of technical or methodological skills but must be rooted in a solid theoretical framework capable of integrating the different levels of scientific, ethical, relational and reflective knowledge that underpin educational practice. In this work, neuroeducation is proposed as a privileged epistemological framework to guide the construction of complex professional knowledge, capable of combining the scientific rigour of neuroscience with the humanistic depth of the pedagogy of care. It offers an interpretative model of learning and educational relationships that recognises the interdependence between the brain, body, emotions and environment, restoring education to its embodied and relational character.

Placing clinical educator training within a neuroeducational paradigm therefore means conceiving clinical reasoning as a process that is not only cognitive but also neuroeducationally situated. From this perspective, clinical reasoning is not limited to the ability to analyse or solve educational problems but is configured as a form of complex reflective thinking that integrates neurocognitive, metacognitive and relational processes (Damasio, 1994; Siegel, 2020; Tokuhamma-Espinosa, 2010). Neuroeducation shows how meaningful learning, and consequently the ability to interpret complex situations, depends on factors such as sustained attention, emotional regulation, affective memory and the quality of interpersonal relationships, that are the constituent elements of clinical reasoning itself. The neuroeducational perspective allows us to recognize that the educator's clinical reasoning is based on a fundamental skill: attentional capacity (Mortari, 2016; Noddings, 1984), which is not simply a cognitive function, but rather a form of conscious presence and an ethical disposition towards others (Biggeri et al., 2011). It constitutes the neurobiological and relational condition that makes deep listening, accurate observation, and empathic understanding of educational situations possible. From this perspective, educating for attention means training future clinical educators in the ability to maintain an intentional and reflective gaze

on the subject and the context, regulating their emotional and cognitive states to construct calibrated and responsible educational responses.

In this regard, contemporary pedagogical literature proposes an ecological reconfiguration of educational contexts, understood as relational spaces that nurture presence, slowness, and listening, which are essential conditions for conscious and embodied learning (Shin, 2025; Sorrells & Madrid Akpovo, 2024). These practices are not limited to guiding methodology, but operate as neuroeducational devices of care, generating a relaxed and conscious learning space. Through slowness and listening, they promote emotional and cognitive tuning, allowing the future clinical educator to develop the reflective presence necessary for authentic, empathetic, and situated clinical reasoning.

In this perspective, attention takes on a central role in the neuroeducational training of clinical educators. It is not configured as a higher-order cognitive function, but as a form of relational presence, a disposition to listen to others and to the context (Weil, 1994). Attention, in fact, should be understood as a shared and situated practice that arises in environments capable of nurturing trust, silence, and reciprocity (Mortari, s.d.; Noddings, 1984). This view resonates with the neuroeducational perspective, as it recognizes that learning and clinical reasoning processes develop in a relational space where mind, body, and emotion constantly interact.

The neuroscientific studies of Siegel (2012) and Damasio (1994) provide a scientific basis for this view, showing how higher cognitive functions, including reflective thinking, working memory, and behavioral regulation, depend on the dynamic interaction between cortical and subcortical areas, particularly between the prefrontal cortex and the limbic system. This integration, which Siegel calls the “relational mind,” forms the neurobiological basis of the human capacity to resonate with others, to self-regulate through relationships, and to construct shared meanings. From this perspective, the quality of attention and the depth of empathic listening depend not only on cognitive abilities, but also on a process of neuro-affective integration involving the body, emotions, and thought. It is precisely this integration that makes fully human clinical reasoning possible, capable of combining analysis, sensitivity, and ethical intentionality. This neuroscientific evidence confirms, on a biological level, what the pedagogy of care has long maintained: that the educational relationship is based on processes of integration between mind, body, and emotion, which make learning a deeply embodied and intersubjective experience. Cultivating attention, in this sense, means educating people to be cognitively and emotionally caring, training professionals who can deal with complexity with empathy and reflection. This is an essential prerequisite for sensitively interpreting fragility and developing educational interventions based on intentionality, responsibility, and ethical awareness.

If attention is a relational practice that arises in environments capable of nurturing trust, silence, and presence, then the body acts as the primary mediator of this practice. The quality of breathing, muscle tone, prosodic rhythm, and gaze affects the ability to tune in to others and, consequently, influences the depth of clinical reasoning. In neuroeducational terms, bodily regulation broadens the window of attention and makes affective memories and sensory patterns available that are useful for situated interpretation. It is in this ecological space of embodied attention that the future clinical educator can integrate what they see, hear, and know, transforming observation into understanding and understanding into educational decision-making.

In this context, the figure of the clinical educator emerges as a neuroeducational mediator, that is, as a competent person capable of inhabiting the threshold between science and experience, between objective knowledge and intersubjective experience. Their competence does not simply consist in applying neuroscientific principles to educational practice, but in transforming them into relational knowledge, in translating knowledge about the neuro-affective functioning of human beings into practices of presence, listening, and care. The neuroeducational mediator acts as a hermeneutic bridge between the languages of science and those of experience, restoring education to its reflective status and guiding processes of authentic meaning-making.

This has specific implications for training. In university courses, embodied clinical reasoning requires methodologies that bring together body, emotion, and cognition, so that attention is not trained as performance, but rather educated as a caring attitude, a reflective presence that makes clinical reasoning more sensitive to context and more faithful to the dignity of others.

In this scenario, among the various methodologies applied in healthcare training processes, the paradigm of gamification (Rutledge et al., 2018) has gradually established itself. This method does not simply use playful dynamics to increase motivation but contributes to an epistemological transformation of the way learning is understood. Play, in its symbolic and relational dimension, becomes a form of embodied knowledge, capable of integrating emotion, thought, and action into a meaningful experience. In this way, gamification fits fully into the paradigm of neuroeducation, which recognizes the centrality of emotional and motivational experience in learning processes and in the construction of reflective awareness.

International research highlights the effectiveness of gamification in promoting motivation, participation, and active learning in healthcare training contexts, showing how the playful dimension can stimulate attention and encourage the development of practical and decision-making skills.(Hamari et al., 2014; Malicki et al., 2020; Rutledge et al., 2018) However, despite positive results in terms of engagement and experiential learning, little research has been done on how gamification influences the mental processes underlying clinical reasoning. Most

studies focus on motivational and behavioural aspects (Zainuddin et al., 2020), neglecting the cognitive and neuro-affective dimensions that underpin the formation of reflective clinical thinking.

A recent study by Lee et al. (2025) analyses the use of gamification specifically related to clinical reasoning processes in healthcare. The authors note that, although 88.7% of research refers to at least one theoretical framework, only 11.3% uses cognitive theories specifically related to clinical reasoning processes. This evidence confirms a structural theoretical gap: gamification is often applied as a motivational tool, without an adequate epistemological framework capable of explaining the cognitive and metacognitive mechanisms involved. Furthermore, the study highlights the lack of shared design models and standardized measures to assess the impact on clinical reasoning, thus limiting the possibility of drawing generalizable conclusions.

In this sense, neuroeducation offers a possible theoretical and interpretative framework. It provides a perspective that makes the cognitive, emotional, and relational processes activated by educational games intelligible, allowing us to understand how motivation and engagement are not external factors, but structural dimensions of reasoning and embodied learning. Within a neuroeducational context, gamification can become not only a means of stimulating participation, but also a neurocognitive space for conscious learning, in which attention, emotion, and reflection work in synergy.

Neuroeducation would restore theoretical depth and educational value to gamification. The former provides tools to motivate and engage, while the latter offers the epistemological key to understanding and guiding the processes that make such engagement truly transformative. In this sense, the convergence of these two perspectives could give rise to healthcare training capable of producing knowledgeable, empathetic, and reflective clinical educators who are able to combine scientific expertise with the relational depth of care.

3. Conclusion

The contribution proposed a reflection on the role of the clinical educator in neuroeducation, positioning them as a mediator between scientific knowledge and the humanistic dimension of care. In this perspective, educational professionalism is configured as a reflective and relational competence, capable of integrating mind, body, and emotion in intentional and conscious action. The study shows that promoting a pedagogy of conscious care means training professionals who can combine scientific rigor and relational sensitivity, transforming knowledge into the practice of humanization and responsibility.

In this perspective, neuroeducation has been understood as an epistemological and methodological paradigm, offering an interpretative key to understanding clinical

reasoning as a practice of embodied attention and complex thinking, restoring the experiential and transformative nature of training. The university, therefore, is called upon to become a generative context for reflective learning, where theory and practice interact through experiential and relational devices. Within this horizon, the use of gamification has been analysed as an innovative methodology useful for promoting engagement and awareness in the field of healthcare education. However, its effectiveness depends on the ability to place it within a coherent theoretical framework that enhances its cognitive, emotional, and metacognitive dimensions, avoiding purely instrumental or performative drifts. This study proposes considering neuroeducation as a theoretical framework for integrating these methodologies, allowing training programs to be geared towards conscious and relational learning experiences. Looking ahead, it would be desirable to develop integrated training models that make explicit the links between neuroeducation, clinical reasoning, and educational care, promoting professional knowledge capable of combining science and relationships, competence, and ethical responsibility.

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