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Integrating Medical Humanities into Medical Education: Pedagogical Frameworks and Practical Implications

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Abstract

This contribution reflects on the conscious integration of Medical Humanities (MH) in medical education, through the analysis and operational translation of the four pedagogical rationales identified by Chiavaroli: instrumental, intrinsic, critical, and epistemological. These perspectives offer a valuable theoretical framework for designing transformative training experiences, able to add narrative, emotional, and ethical elements to medical teaching. Medical Humanities, in fact, should not be viewed as supplementary content, but as practice that questions medical knowledge, compelling it to address complex and current issues, within a critical framework that reinforces its relational and reflective dimensions. Through tools such as literature, art, music, history and guided reflection, Medical Humanities contributes to the development of observational, communicative and empathic skills, promoting a holistic understanding of the patient and a person-centred culture of health. In particular, the critical rationale invites us to question the dominant biomedical paradigm, which encourages an ethical and social reflection on the role of the doctor and the dynamics of care. However, the formative effectiveness of Medical Humanities depends on thoughtful pedagogical design and the teacher's expertise, whose strategic role is to create safe, stimulating environments, adapt to emerging outcomes, and guide students in reflecting on their experiences. Multidimensional tools and integrated qualitative methodologies are also essential for evaluating complex outcomes such as empathy or professional behaviour. Considering the growing interest in MH at an international level, we hope to foster the development of the evaluative practices and skills essential for authentic and sustainable facilitation, enabling the training of professionals who are both clinically competent and humanely sensitive.

Keywords: Reflective Practice - Medical Education - Medical Humanities - Pedagogy -Teaching Methods - Ethics

Introduction

In our previous contribution published in *Journal of History of Medicine and Medical Humanities*[1], we provided an overview of recent literature on the *Medical Humanities* (MH), with particular attention to the perspective of Neville Chiavaroli. Chiavaroli represents a new line of inquiry, one that is no longer focused on defending the value or legitimacy of MH in medical training, but rather on advocating for its deliberate and effective integration into medical curricula. Chiavaroli's (2017) perspective is described as epistemological because it focuses on the type of knowledge that MH generates and how it contributes to the construction of medicine's distinctive epistemology. Chiavaroli emphasizes that medicine is not merely an applied science but a complex body of knowledge that combines general evidence with context-specific decisions[2]. Within this framework, MH may help refine the interpretation of clinical experiences, tolerate ambiguity, and integrate narrative, emotional, and ethical dimensions into the decision-making process. Drawing on Aristotle (2011), Chiavaroli distinguishes between T*echné*, technical competence based on general rules and *Phronesis,* the practical wisdom required to decide appropriately in particular circumstances[3]. In this sense, MH offers training in reflective and interpretive thinking that enables learners to examine "*how we know what we know*" fostering metacognitive awareness, essential for dealing with uncertainty and clinical complexity. This epistemological rationale complements and partially overlaps with three other rationales: the instrumental, which aims to develop communication, narrative, relational and observational skills; the intrinsic, which frames MH as a valuable tool for supporting students' professional identity formation; and the critical rationale, which invites learners to question the dominant models and epistemic premises of contemporary medicine. In this second article, we aim to take a further step by showing how each rationale can be translated into concrete educational choices and by identifying the pedagogical models or philosophical and value frameworks that support them. This article presents a methodological proposal, designed to support intentional, evidence-informed choices for teachers and facilitators, who,aware of its potential, can create learning environments that can integrate and enhance emerging outcomes, while guiding students through their developmental process. To our knowledge, existing literature does not provide contributions that systematically explore the translation of the four rationales into methodological and pedagogical choices for a conscious and assessable integration of MH in medical education.

The four rationales and their educational application

Having outlined the theoretical framework, we can now explore the four rationales, highlighting how each can be translated into concrete didactic choices. For each rationale, we present learning goals, pedagogical reference models, examples of activities,

and examples of guiding questions designed to stimulate students' reflection (Table 1). We also provide an illustrative MH workshop based on one of the tools discussed, offering practical ideas for implementation in educational settings.

Tab. 1

Rational	Definition	Learning goals	Learning Methods/ strategies	Pedagogical References	Reflective questions
Instrumental	Use of MH as a resource to develop professional skills (communication, empathy, reflection).	Improve listening, empathy, and ethical sensitivity. Foster narrative and reflective abilities.	Role play Reflective writing Analysis of narrative cases Visual training (arts)	Kolb *Experiential Learning* Dewey *Active Learning* Schön R*eflective Practitioner*	What emotions did you experience? How did you manage them? What have you learned about effective communication with patients? How has this experience changed the way you look at and interpret clinical or narrative cues? What would you do differently in a similar situation in the future?
Intrinsic (or non-Instrumental)	Reflection on the humanistic perspective as a value, in contrast to biomedical dominance.	Reaffirm the centrality of the person. Develop a professional and ethical identity.	Reading books on literature and philosophy. Storytelling workshops Bioethics seminars Artistic and symbolic activities	Nussbaum *Liberal Education* Spinsanti *Values and identity approaches* Mezirow *Transformative Learning*	What helped you discover this experience as a future doctor? What values have you questioned or strengthened? How has this narrative changed your understanding of suffering and care? What responsibilities do you feel you have towards patients and society?
Critical / Intellectual	MH as a critical lens for revealing hidden tensions (power, market, limits of medicine).	Develop critical thinking. Making visible the "dark" sides of medicine (abuse of power, inequalities).	Ethical debates Analysis of films/artistic works Interdisciplinary discussions Seminars focusing on controversial cases	Freire *Critical Pedagogy* Mezirow *Transformative Learning*	What implicit values emerge in the clinical practices or health policies discussed? Which patients are included or excluded from the healthcare system? Has this story or depiction changed your mind about what justice or fairness means in medicine? What alternatives or proposals would you suggest to make this system or this decision fairer? How do these reflections affect the doctor you want to become?

Rational	Definition	Learning goals	Learning Methods/ strategies	Pedagogical References	Reflective questions
Epistemological	MH as a soul integrated into phronesis and its ability to manage doctor ambiguity.	Integrate technical knowledge (T*echnè*) and practical wisdom (P*hronesis*). Train in complexity and clinical judgment.	Talking about complicated cases Comparison with guidelines vs clinical reality Observation activities (art, storytelling)	Aristotle (*Technè e Phronesis*) Situated Learning (Lave & Wenger) *Communities of practice*	What does this episode teach you about how medical knowledge is built? What have you learned about becoming part of the professional community? What knowledge was used (guidelines, doctor's experience, intuitive decision)? Have you noticed contradictions between protocols and decisions made?

We would like to highlight that the pedagogical models presented in Table 1, such as Kolb's experiential learning cycle[4], represent transversal approaches applicable in different training contexts. In this work, these models have an illustrative value: they demonstrate the formative potential of the analysed cases and theoretical perspectives.

1. The instrumental rationale

The instrumental rationale views Medical Humanities as a means to develop skills directly applicable to clinical practice. Its principal purpose is to enhance observable and professionally relevant abilities in medical practice, including patient communication, empathy, the capacity to listen to and interpret verbal and non-verbal signals, accurate observation, reflection on clinical experience, and teamwork within the healthcare team. Several studies have shown that activities such as art observation can significantly improve medical students' skills of visual description and diagnostic accuracy[5,6,7], and that reflective writing and simulation-based activities help to enhance empathy and communicative sensitivity[8,9,10,11]. The teaching strategies most frequently associated with this rationale include: reflective writing on clinical experiences or patient stories to promote self-awareness and empathy[12,13,14,15,16]; simulation of medical interviews (role-playing) to improve communication and the management of emotions; art observation workshops to train precision of description and the ability to notice clinically relevant details, and finally, small-group discussions of narrated clinical cases facilitated by a teacher to foster mutual listening and shared understanding about the patient's story (e.g., using parallel charts)[17]. This rationale is based on experiential and reflective approaches, which allow experience to be transformed into meaningful learning from a pedagogical perspective. In this sense, MH workshops can be designed following the four phases of Kolb's (1984) experiential learning cycle: concrete experience (for example, observing a work of art, reading an illness narrative, or participating in role-

play), reflective observation (describing what was noticed and what emotions were felt, individually or collectively), abstract conceptualization (connecting the experience to theoretical concepts such as empathy, care and caring, communication), and active experimentation (deciding how to apply the learning in future clinical practice). This cycle helps consolidate students' learning and develop metacognitive awareness. John Dewey's active learning (1938) provides further support for this approach, emphasizing that the learning process is a social and relational experience that requires contact with others and the surrounding environment[18]. In this sense, students' experiences become truly educational and meaningful development occurs only when they are inserted into a dynamic, interactive process that uses reflection to foster personal and social growth. In the context of MH, the proposed experiences are therefore valuable not only for the skills they develop but also for their contribution to the construction of the student's professional identity. MH enables students to question who they aspire to become as physicians, the values of clinical practice, and, specifically in relation to the instrumental rationale, how to translate those values into concrete behaviors in the doctor-patient relationship. Finally, Donald Schön's (1983) concepts of *reflection-on-action* and *reflection-in-action* are particularly relevant. *Reflection-on-action* can be facilitated through group discussions or reflective writing after the experience, helping students make sense of events and improve subsequent actions, for example, by repeating a role-play while considering insights from the debriefing (Table 2 provides sample reflective to guide debriefing). *Reflection-in-action,* on the other hand, can be practised during the activity itself: for example, during a role-play, students can modify their language or attitude in real time in response to the reactions of others, thereby learning to adapt clinical communication as they act[19]. MH offers a safe and encouraging atmosphere for students to experiment with these dynamics, which are crucial for future professional practice. Below, we propose a reflective writing workshop to develop empathy. Given the quality of the questions and the structure of the workshop we believe it is suitable for students in the early years of medical training. (Table 2).

Tab. 2

Reflective writing workshop	**Description**
Learning goals	Develop the ability to read and interpret patients' stories; enhance the capacity to listen to oneself and recognize one's emotional responses; develop better communication and interpersonal skills for clinical practice.
Methods	Presentation of a short illness narrative (text or video). 2. Reflective writing: "Put into words what the patient might feel and what you feel when listening to him/her" 3. Small group discussion supported by reflective questions 4. Debriefing with the facilitator to link experience to clinical communication and the importance of empathy.

Reflective writing workshop	Description
Pedagogical tool	Individual reflective writing session about students' experience of listening to patient narratives followed by guided small-group discussion.
Debriefing questions	What have you discovered about yourself through this writing? How has this activity changed your perception of the patient? How could you use this awareness in your future clinical interaction with a patient?
References	Charon (2001)[17]; DasGupta & Charon (2004)[20]; Chen & Forbes (2014)[8].

2. The intrinsic rationale

The intrinsic rationale acknowledges that MH has educational value that is beyond its immediate practical usefulness. Its aim is to cultivate the humanity of future physicians, accompanying them in the construction of their professional and ethical identity. From this perspective, MH is not merely a means to enhancing communication or empathic skills, but a space in which students can question the deeper meaning of the medical profession and the role they wish to play in society, as highlighted by literature[21,22,23,24]. The main aim is the moral, professional identity formation of the future doctor through a path that cultivates critical thinking, ethical responsibility, and self-awareness as both caregiver and citizen. In this perspective, MH is a laboratory where students can examine the meaning of the caring process and explore their own emotional reactions. The primary theoretical references underpinning this rationale are not exclusively pedagogical, but also philosophical and bioethical, providing a framework of meaning to guide curriculum design. The first reference points to Martha C. Nussbaum's work on moral philosophy (1997; 2010). In *Cultivating Humanity* (1997), Nussbaum proposes three pillars of humanistic education: Socratic self-examination to interrogate values and assumptions, narrative imagination to understand different perspectives and develop empathy, alongside the formation of a world citizenry to act responsibly in an interconnected world[25]. In *Not for Profit* (2010), Nussbaum warns against education being reduced to mere productivity, emphasizing that Humanities are essential to train citizens and professionals capable of critical judgment, moral sensitivity, and social responsibility[26]. According to Nussbaum (1986), emotions are not merely feelings but rather real forms of knowledge that enable us to grasp the significance of events and the individual's actions involved in them. Emotions are the foundation of ethical reasoning as they inform us of the worth we place on people and events, and how these values shape our actions[27]. In conclusion, Nussbaum provides a philosophical foundation for MH, offering conceptual tools to explore human nature, emotions, and suffering in care contexts, thus enriching both the practice and understanding of medicine. The work of Sandro Spinsanti, who is considered one of the most authoritative voices on MH and Bioethics in Italy, is another important reference. His thinking is characterized by a broad vision of humanistic education in

medicine that goes beyond the individual dimension to include the institutional and cultural responsibility of making care more humane. According to Spinsanti, humanizing medicine is not just a decorative act but rather a method of restoring medicine's original purpose of caring. In this perspective, MH is not an optional addition to the curriculum, but rather a tool to bring the sick person back to the center. Caring means recognizing the person, not just the clinical case, and giving dignity to emotions, language, symbols, and spirituality[28,29]. A distinctive feature of Spinsanti's approach is the centrality of narration: medicine "needs narration" to become truly personalized. As when we turn to a tailor to obtain a tailor-made suit, not a suit that is the same for everyone, but adapted to our needs, in the same way the caring process must be aimed at exploring and understanding in depth the needs of that specific patient (*Ibid.)*. The patient's story is not a secondary element but rather a form of clinical data that must be heard, interpreted, and integrated into the treatment process. This implies giving students experiences that cultivates deep listening skills and the ability to interpret the symbolic and emotional language of illness in education. Nussbaum and Spinsanti do not propose a technical teaching model, but rather provide an ethical, cultural, and valued-based framework for MH. Teaching strategies aligned with this rationale include reading and discussion of illness narratives to exercise narrative imagination and empathy[30]; reflective writing and journaling[31] for following personal growth over time; cinema and theatre workshops to explore ethical and existential themes[32]; bioethics seminars to address real moral dilemmas and raise awareness of personal frames of reference and finally patient or caregiver testimonies to facilitate direct engagement with vulnerability and the complexity of illness[17]. This transformative process shifts the focus of pedagogical intentionality from "learning by doing" to "becoming someone," as articulated in Mezirow's theory of transformative learning. His learning theory (1991) explains how such experiences can induce profound changes, as students faced with disorienting dilemmas and powerful narratives, re-examine their assumptions, elaborate new meanings, and reconstruct their professional identity[33]. A "disorienting dilemma" is an experience that challenges previously internalized frames of reference, for example, an illness narrative that exposes systemic discrimination, and questions the neutrality of the health system; a film that reveals ethical conflicts, undermining blind trust in standard rules; or the direct testimony of a patient that elicits empathy and compassion, evoking an inner sense of the responsibility that care entails. This process requires the teacher/facilitator to design activities that enable students to descend towards deeper self-understanding and prompt reflection: "What do I feel when confronted with this situation?"; "What thoughts does this evoke in me, and what actions or attitudes does it provoke?"; "How might I act differently?"; "What could be the first step toward a different attitude?". Within this process, we also recognize the enduring pedagogical relevance of Kolb, Dewey, and Schön, whose emphasis on reflection (individual and group), shared discussion, con-

ceptualization (linking to professional principles and theory), and redesign represents a transversal matrix across all four rationales. We propose a narrative workshop designed to foster professional identity formation through the lens of the intrinsic rationale. The workshop is particularly suited to first-year students, for example as part of the Introduction to the Medical Profession courses (Table 3).

Tab. 3

Workshop on professional identity formation	**Description**
Learning goals	Stimulate reflection on students' professional identity; Explore values, motivation and fears related to the future role as adoctor; Cultivate narrative imagination and the ability to give meaning to experience.
Methods	1. Shared reading of an autobiographical narrative of a patient or doctor. 2. Writing a short personal text: "Tell an episode that made you reflect on why you want to become a doctor." 3. Group sharing in a protected setting. 4. Guided discussion to connect the themes that emerged concerning the values of the profession and the construction of identities.
Pedagogical Tool	Reading patient narratives and writing a short professional self-portrait ("the doctor I would like to become").
Debriefing questions	How did the narrative we read influence the story you wrote? What similarities or differences do you find between your motivation and that of your colleagues? How can these tales help prepare you for the tough times in the profession?"
References	Moniz et al. (2021)[22]; Spinsanti (2016)[28]; Nussbaum (1997)[25].

3. The critical rationale

We now come to critical/intellectual rationale, which sees MH as a tool for questioning the practices, assumptions, and power structures that underline modern medicine. While this rationale may include skill development and identity formation as transversal objectives, its primary focus is on fostering critical thinking, epistemic awareness, and the ability to interrogate dominant patterns and inequities in healthcare. These are fundamental points for the training of professional physicians, fostering an ethical awareness of the choices and decisions they will make in practice. Critical thinking consists of the ability to analyze arguments, distinguish facts from opinions, recognize biases, and make informed decisions. Skills that are essential in an era of overabundant and sometimes contradictory information. Critical thinking enables the development of care that is personalized to the patient's needs and allows for the evaluation of scientific evidence, rather than adhering to clinical protocols mechanically and uncritically[34]. For example, when faced with a post-operative patient, what questions can the student ask to evaluate which approach to pain is best for the patient? What risks does it entail? What patient preferences should be considered? Epistemic consciousness is the awareness that medicine is always shaped by historical and cultural contexts, and therefore

must be continuously verified and updated to avoid dogmatism and promote humility and critical reflection of one's certainties[35]. Finally, a critical attitude allows students to identify and question the power structures and inequalities present in the healthcare system, moving from simple observation to a commitment to change[36], preparing them to advocate for the most vulnerable patients and promote fairer health policies. In summary, the critical rationale therefore does not limit itself to developing empathy or communication skills (instrumental rationale) or cultivating personal values (intrinsic rationale), but promotes the capacity to question what exists, to identify inequalities and inclusive alternatives. Paulo Freire's critical pedagogy and Jack Mezirow's transformative learning theory are the main theoretical sources for this rationale. The Brazilian Pedagogist Paolo Freire (1970) conceives education as a practice of freedom: students are not passive vessels of knowledge, but active subjects who, through dialogue and the problematization of reality, develop *conscientização,* an awareness of conditions of oppression becoming promoters of action to transform them[37]. Applied to medical education, this perspective advocated designing learning experiences that help students recognize inequalities of access, power dynamics in the doctor-patient relationship, and the ethical and political implications of clinical decisions. In this highly transformative process, Mezirow (1991; 2000) offers an essential framework of reference[33,38]. An MH laboratory that offers testimonies from discriminated patients or films that depict health injustices can generate that disorienting dilemma which pushes students to re-examine beliefs and attitudes, to the point of integrating new, more inclusive and just perspectives into their professional identity. Once again, we underline that the critical rationale cannot be isolated from other learning processes, consequently, many of the activities designed for the critical rationale can also resonate with the other rationales. Such activities can promote instrumental learning (e.g., developing communication skills during debates), identity reflection (intrinsic), and even epistemological awareness (e.g., questioning the production models of medical knowledge, thereby aligning with the epistemological rationale). Below is the proposed laboratory on care models (Table 4).

Tab. 4

Workshop Rethinking care and caring	**Description**
Learning goals	Recognize the implicit assumptions of the biomedical model; stimulate reflection on how the dominant model can marginalize the patient's experience; engage in improvement actions to incorporate perspectives that are focused on the patient illness experience
Methods	1. Brief introduction to models 2. Presentation of a clinical cartoon in a biomedical and patient-centered version. 3. Small group discussion of differences and implicit assumptions. 4. Facilitator-led problematization plenary. 5. Creating and generating ideas about clinical applications.

Workshop Rethinking care and caring	**Description**
Pedagogical Tool	Comparative analysis of care models (biomedical vs. biopsychosocial) through clinical cartoons.
Debriefing questions	Which aspects of the patient's experience remain excluded in the biomedical model? How does the dominant model influence clinical language? What effects does the recognition of psychosocial factors have on the caring process? In which case is the biomedical model useful, and in which case is it likely to be reductive? How can you contribute to a more integrated approach?
References	Engel (1977)[39]; Freire (1970)[37]; Mezirow (2000)[38]; Hodges et al. (2019)[35]; Morin (2001)[41]

4. The epistemological rationale

We finally turn to the epistemological rationale. This rationale invites us to reflect on the nature of medical knowledge: where such knowledge originates, how it is constructed, and what its limits are. To understand the meaning of this approach, it is helpful to begin by recalling a classical philosophical distinction and then connecting it with a contemporary educational perspective. Aristotle, in the Nicomachean Ethics (Book VI, 1140a–1141b), distinguishes between *Techné* and *Phronesis*[39]. *Techné* refers to technical skill knowing how to "do" something according to general rules. In modern medicine, we might think of guidelines, protocols, or decision-making algorithms. *Phronesis*, by contrast, is practical wisdom: the ability to evaluate the concrete situation and make the right decision for that patient, in that context. The epistemological rationale recovers this distinction and reminds us that medicine is not simply the application of abstract rules but requires an integration of theoretical knowledge with contextual judgment. It invites students to reflect not only on "what we know" but also on "how we decide" when working under conditions of uncertainty. A second key reference is the concept of situated learning proposed by Lave & Wenger (1991). They argue that knowledge is not merely transmitted through lectures but is acquired through progressive participation in a community of practice: observing, imitating, and experimenting within a professional community[40]. In this light, the MH laboratory becomes a place where students can reflect on the process of entering the professional community, acquiring not only knowledge but also its languages, values, and epistemic standards. Medical knowledge is thus situated: it emerges within a specific context such as the clinical environment, the research laboratory and carries the values, priorities, and language of that context. These two perspectives help us understand how MH can support students in recognizing the assumptions and limits of their knowledge, in applying technical knowledge with practical wisdom, and in becoming aware of how the professional context shapes what is considered "true" or "normal." Unlike the critical rationale, which focuses on problematizing power relations and inequalities, the epistemological rationale highlights the situated and dynamic character

of knowledge, fostering an awareness that biomedical knowledge is not absolute but contextual and therefore subject to ongoing revision. This rationale can be translated into concrete educational choices through a variety of strategies. For example, medical history seminars can illustrate how central concepts such as disease, contagion, and risk have evolved over time, while discussions of ambiguous clinical cases can stimulate reflection on uncertainty and clinical judgment. A comparative analysis of guidelines from different periods can show how recommendations have changed as new evidence becomes available, and workshops on philosophy of science can teach students on concepts like falsifiability, causality, and bias in research. Finally, reflective observation during internships, for example, through narrative writing can help students examine how they learn within the clinical environment, what implicit norms they absorb, and which values guide their decisions and actions. In this way, the epistemological rationale encourages learners to see knowledge as a living, situated process, and to develop reflective practitioners who can handle the complexity and uncertainty of actual clinical settings. A proposal for an observation-and-reflection lab that focuses on clinical internships can be found below (Table 5).

Tab. 5

Observe and reflect on clinical intership	**Descrizione**
Learning goals	Develop awareness of how daily practices convey knowledge and values; distinguish between what is formally taught and what is implicitly learned (Hidden Curriculum); strengthen the ability to integrate t*echné* and *phronesis* into clinical practice.
Methods	1. Introduction: explain to students what to observe (e.g. clinical decisions, language, uncertainty management, department rituals). 2. Keep a diary for 1-2 weeks noting significant episodes. 3. Debriefing meeting: small group discussion facilitated by a teacher, to identify implicit messages and reflect on how they influence the way they think and act.
Pedagogical Tool	A diary for reflexive observation during clinical internship with guided debriefing in small groups.
Debriefing questions	What is the knowledge that is transmitted between formal lessons and informal lessons? Where do you detect the use of prudential judgment beyond the application of protocols? What values or assumptions did you perceive in the community of practice in which you were inserted? How do you evaluate this experience from the point of view of your professional growth?
References	Lave & Wenger (1991)[41]; Hodges et al. (2019)[35]; Cruess et al. (2015)[42].

Discussion

The proposal to link the four rationales of Medical Humanities to pedagogical references, tools and debriefing questions responds to a growing need in international literature to clarify how MH can contribute in a targeted and measurable way to medical training. Several authors have underlined the risk of a superficial or merely decorative

use of MH, reduced to optional moments of "humanization" without a clear pedagogical framework[2,22]. In line with these concerns, recent studies[43,44,45] highlight that the effectiveness of MH depends on an intentional pedagogical structure, which includes trained facilitators, safe learning environments and adequate times within the curriculum. To prevent MH from being perceived as marginal or extracurricular activities, it is imperative that they are integrated early and systematicallywith the support of Institutions and skills-based design. Offering a model that explains learning goals, theoretical references, and teaching strategies helps to transform MH into a conscious pedagogical lever, capable of impacting the future professionalism of doctors. From an educational point of view, this approach increases pedagogical transparency: teachers and students better understand why a certain activity is proposed, what skills or provisions they intend to develop and how the results can be observed and discussed. The ability to connect multiple rationales to the same activity, for example using reflective writing both to train empathy (instrumental rationale) and to explore deep motivations (intrinsic rationale), invites flexible and multi-level design. This also implies an evolution of the role of the facilitator, who becomes a reflective guide, able to orient the experience according to educational goals and adapting the debriefing to the students' responses[46]. In fact, a critical point that has emerged in literature is the training of the facilitator, who must be able to shape reflection, manage complex discussions and promote trust to provide a safe environment for shared discussion. This role goes beyond simply conducting activities: the facilitator becomes a reflective guide, capable of adapting the debriefing to the educational goals and responses of the students (*Ibid*).

The impact of MH can be difficult to measure due to the lack of standardized tools and shared theoretical frameworks in Evaluation. Literature proposes frameworks based on qualitative and mixed research skills and methodologies, capable of capturing transformative effects on professional identity, empathy and critical thinking[44,47,48]. Intentional integration of the humanities early in the curriculum, along with strong institutional support, is essential to maximize student engagement and ensure that these programs are not perceived simply as optional enrichments[43]. Furthermore, without careful consideration of the time spent on these activities within an already challenging curriculum, student engagement and value perception may remain low. This highlights the need for systemic integration and greater visibility of humanistic initiatives, going beyond superficial introductions to truly incorporate these principles into Medical Education (*Ibid*). A solid, structured and explicit pedagogical theoretical frame of reference is vital to overcome superficial involvement and cultivate a deep understanding of the human condition and its intersection with medical practice, contributing to the training of more reflective and person-centered healthcare professionals[44]. Furthermore, maintaining such educational initiatives requires dedicated institutional support and training of the teaching staff, so that educators are adequately

prepared to facilitate complex discussions and reflective practices[43]. Overcoming the perception of MH as simple supplements requires a reevaluation of their role within the curriculum, moving towards a competence-based integration that offers immersive and longitudinal experiences[47], when unfortunately, they are often present more in the preclinical years of training. Therefore, to strengthen the integration of MH in medical curricula, a more sophisticated approach in the evaluation process is needed[44], for example from incorporating qualitative and mixed research designs, to deeply grasp the learning outcomes of the humanistic side of students' professional growth (*Ibid*). In this way, Medical Humanities-based training will not remain only at an Instrumental level, but through a guided, conscious and structured way,become an essential component of the educational path of future generations of doctors. Taken together, these findings highlight that the integration of MH is not only a matter of curricular inclusion but of epistemological reconfiguration redefining what counts as valid knowledge and competent practice in medical education

Conclusion

This contribution systematically translates Chiavaroli's four pedagogical rationales into a detailed, operational framework, offering a practical blueprint for the intentional integration of MH within medical education. By meticulously outlining educational strategies, specific pedagogical models, and reflective inquiries tailored to each rationale, this paper provides educators with a clear methodological guide. Only through coherent and sustainable teaching planning, and a multidimensional evaluation conducted by competent teachers, will it be possible to consolidate a MH pedagogy rooted in medical curricula. Such a pedagogy can form thoughtful, critical, and compassionate professionals oriented towards patient-centred care and the complexity of contemporary practice

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