

## **Pedagogy versus Medicine**

### **For a training and narrative care project in medical-healthcare contexts**

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#### **Abstract**

I have attempted, in this contribution, to explore the possibility of a reciprocally beneficial dialogue between pedagogical/educational and medical/clinical knowledge. Starting from this epistemological premise, I propose a critical examination of the problems surrounding the cognitive, methodological and procedural paradigms underlying most training projects aimed at healthcare professionals, doctors, nurses and so on, who operate excessively, at least in the Italian context, according to an instrumental and technical logic. This also brings into play adult education. In this perspective the proposal advanced here is for training that adopts the paradigm of narrativity and narration, in an auto-reflexive and autobiographical sense, in order to provide clinical care professionals with writing skills that they can, in their turn, propose to their patients. All this within the interpretative channel of existentialist-phenomenology and narrativist constructivism: two conceptual and methodological/practical outlooks that are duly attentive to individuals' representations and experiences.

**Keywords:** pedagogy, medicine, adult education, narrative training, medical/healthcare contexts

#### **Paper**

Is a dialogue between pedagogy and medicine possible? (Bertolini, 1994). If it is, what are its aims and who is it to benefit? The patient, the medical/healthcare professional, the relationship one hopes may develop between them? Or even the organization within which the projected care intervention is to take place? Can adult education and its interrelated question of training aimed at adults – in this case, healthcare professionals – legitimately remain on the sidelines of theoretical speculation, of field research and of experimentation with alternative/innovative procedures in this context? Or

is it, rather, called into play at these three levels? What attitude towards the training of professionals, and consequently towards healthcare, might seem most coherent and pertinent within a perceptual horizon embracing pedagogical/educational knowledge and skills and medical/clinical knowledge and skills?

These are just some the questions this paper intends to raise, advancing the proposal for narrative/auto-reflexive/(auto)biographical orientation (Castiglioni, 2013 a; Zannini, 2008), centred on stories of doctor/patient care (Bert, 2007; Castiglioni, 2013 a, *et al.*) within a wider epistemological and operative framework, such as that of narrative medicine, to be redirected, in its turn, under the perspective of Medical Humanities (Bert, 2007; Charon, 2007; Masini, 2005; Moja, Vegni, 2000; Zannini, 2008).

We may start from the first question and adopt the viewpoint of Piero Bertolini – the major representative of the phenomenological approach on the panorama of Italian pedagogy. As early as the 1990s, Bertolini had examined the idea that the confrontation between pedagogy and medicine, as sciences placing the *human being* and the various situations involving it at the centre of their attention, is inevitably and significantly necessary. Such situations include pain, suffering and illness. Care, as in our own case, clearly plays a significant role (Bertolini, 1994, p.55). The extent and educative significance of the doctor and the various medical/healthcare operators does not seem anomalous, therefore, given that the operative concept of therapeutic education finds increasing legitimization in medical and clinical practice. This in spite of the fact that, more often than not – at least as regards the Italian situation – the question seems not to have been sufficiently and qualitatively asked: what do we really and realistically mean by therapeutic education? What semantic assumption does the term “education” involve? Paradoxically, rather than being assumed pedagogically, as we might reasonably expect, since it belongs to the *proprium* of pedagogy, it risks being associated with an exclusively medical, or at times psychological, language. Thus the

pedagogic/educational outlook in and towards medicine does not constitute, we may say, the normality of medical knowledge and action. As a consequence, when therapeutic education is referred to, the impression is given of improvised projects and operations, excessively dependant upon specific, critical, transitory or even degenerative clinical conditions or situations. Yet, while it cannot be denied that therapeutic education is more helpful with some pathologies than others, it is also true that, even in these same situations, it risks becoming reduced excessively to the informative/prescriptive dimension. In this way it loses its ability to show *how* a comforting and reassuring, and therefore significant, relational container can be constructed. By locating the medical/prescriptive information within this container, it can acquire a meaning, not only from the doctor's point of view, which is not in doubt, but from that of the patient, who needs to comprehend and absorb this communication, not just take in the words. The word-pairing *information-reception* needs to be flanked by the word-pairing *comprehension-signification* (Bertolini, 1994, p.55), exactly as is claimed by the phenomenological perspective and the narrativist constructivism which is guiding our reflections in this paper.

In this sense, Bertolini states:

”That there can or even should be a significant meeting between two sciences, or even only between two branches of wisdom, which deal from opposing points of view with man and his way of ‘being in the world’, need not surprise us. Reality, in fact, is always highly complex and strongly unitary, and is for this very reason open to investigation and inquiry on account of the many ‘unities of sense’ with which it is interpreted, ‘read’, or even ‘constituted’ inter-subjectively (...)” (1994, p.55).

Hence, continuing the author's thought, the impossibility for any science, including that of medicine, to propose itself as exclusively absolute and definitive, bearing in mind, above all, that it has to come to terms with daily existence, with dimensions such as the experience of illness, care, assistance, etc., which by the nature of their specific and contextual problems and emotions, distance themselves from an interpretative lens that is only, or excessively, technical or biomedical. Medicine and doctors do not deal with the illness in exclusively *bio-medical* terms but have of necessity to face up to the *question of the illness*, as the patient and his/her family represent it and

experience it in the singular and specific context of their environment and their lives (Bert, 2007; Charon, 2007; Good, 2006). The “object” with which the doctors, nurses and so on are working is something complex that needs to be approached and understood in a similarly detailed, complex and multi-disciplinary manner (Bertolini, 1994, p.65). Bert underlines strongly how the patient can recover from even a serious illness, a tumour for example, without necessarily recovering at the same time from the *illness-problem*. This, we might add, is a *problem for him or her*, and the doctor cannot assume responsibility for it during the therapeutic programme (Bert, 2007, p.37).

We will deal below with this “assumption of responsibility” in an educational and (self-)training perspective for both doctor and patient. This will be part of a specific and alternative training project for professionals, of a constructivist matrix. If this matrix is authentically faithful to its humanistic origins it cannot avoid dealing with adult education as scientific and profoundly generative/transformational knowledge, oriented, among its many manifestations and finalities, at constructing formative devices with the purpose of improving and raising critical awareness of the professional identity of those operating in healthcare establishments, an identity not only and always centred on professionalizing and managing the operator’s professional role. We might add, with pertinence to this epistemological and methodological option, that the “hospital”, where the doctor, nurse and so on spend much of their time, and for long periods of their lives, is *par excellence* “the place that brings us face to face with the pain and death of others and induces *personal* reflections and conclusions. Healthcare professionals are explicitly called upon to show their “humanity” (...)” (Parrello and Osorio Guzmán, 2009, p.290). This does not simply mean being a good, kind, sociable or human doctor (Bert, 2007), though obviously we all hope to find these qualities in a doctor. Rather, it requires them to put technique momentarily on one side and return within themselves, as man or woman, as healthcare professional, to re-discover “the time I was a patient”, “the time I received care”, “the time I experienced pain personally or as a family

member”, “the time I was waiting outside the hospital ward (Bert, 2007; Castiglioni, 2013; Charon, 2007; Zannini, 2008), etc. This may generate a cycle whereby a closer approach to the self can facilitate a closer approach to the patient and a closer approach to the patient can facilitate a closer approach to the self (Virzì e Signorelli, 2007). The relationship the doctor develops with the patient becomes central to the care and attention imparted, according to an approach to care – followed here – that recovers its deeper existential dimension (Iori, 2007; Mortari, 2006; Palmieri, 2008). The care, moreover, is made to structure around the *paradigm of narrativity and narration* (Masini, 2005) which, as we shall see later, are not necessarily synonymous. Hence the centrality of the care relationship as *meeting and confrontation*, at least *between two stories*, that of the doctor and that of the patient, each with its own experiences and meanings (Bert, 2007; Zannini, 2008), which must be able to find a point of *inter-section*, where the suffix *inter*, as we know very well, makes a far from casual reference to the term *relation*. It is therefore only within a relation which, as such, is something phenomenologically and dynamically incarnate, that a process can be co-constructed, that an inter-section of meanings – in this case, between doctor and patient – can take place.

Once again, what is being questioned is the paradigm of medicine within which the key-word – as Bertolini reminds us – is not only “healing”, but also “meaning” (1994, p.19). For this reason the doctor not only possesses knowledge and technical skills which today, fortunately, are also highly refined:

“ (...) but must be able, not only to understand the meaning the illness assumes for the patient and the perspective of his/her healing, but also to ‘work’ on those meanings. He/she must know how to share or reject them, exploit them or minimize them, but always in an understanding manner and with that attitude of maximum openness that derives from genuine respect for the person”.

This brings into play, in the writer’s opinion, pedagogical knowledge and, even more specifically, adult education and a possible and desirable reciprocal collaboration between Departments of Medicine and Departments of Educational Science, at least as regards the current Italian situation, where these entities remain fairly separate. This in the perspective – we might say, according to the

Bruner method – of a cycle of “loans” of knowledge and viewpoints, where medical knowledge may stimulate pedagogic-educational knowledge to inhabit, increasingly realistically, the places of clinical care, moving between limitations and genuine opportunities. While, conversely, pedagogic knowledge may stimulate medical/clinical knowledge to recover its matrix of knowledge from the “human” face. Which means reconsidering the education of future generations of doctors, nurses, etc., as well as of serving professionals. This is a question involving both medicine and the adult education sector of pedagogy.

On this matter, Ignazio Marino writes:

“No university course (...) teaches what you feel when you become part of the medical or surgical staff of a hospital. You learn at your own expense, at the sick person’s expense, facing daily people who are ill, who often have their days counted or who are undergoing incredible suffering. Nor does anyone teach you how to relate to the patients’ family members who ask for news but above all for certainties, even when there is practically nothing certain to tell them. In other words, doctors are not prepared and equipped to deal with patients’ physical and psychological suffering, and this is probably one of the reasons why relations between doctors and relatives, and at times even between doctors and patients, are so complex. Maybe it is this incapacity, this limit, that inclines doctors to detach themselves emotively from human situations, rather than excessive self-defence or indifference” (2005, p.24).

In view of the premises of this paper, it is to be hoped that adult education, in universities as well as in other training institutes – entities that unfortunately remain substantially separated in Italy – might introduce:

“within the range of its theoretical investigations and research – to a much greater degree than at present – the central relationship between medical knowledge and clinical action. It should conceive the latter as covering care and (self-)training and (self-)educational processes regarding adult individuals. It should include this central relationship in a project which – involving as it does (self-)training, (self-)education, care of oneself and others – would undoubtedly be broad, complex and problematic. A project that would nevertheless be of vital importance – both for “those receiving care” and “those providing it” – insofar as it takes upon itself, reflexively and operatively, the experience of a sick man or woman as an experience of profound existential meaning, and as a possible condition – with legitimate and comprehensible emotive flutterings – for (self-)learning, greater awareness of the self, of one’s own resources, fragility or limits. A possible condition, too, for inner consolidation and evolutionary reinforcement, where clinical conditions and the progress of the illness provide the practical opportunities for this wholly individual, subjective and profoundly intimate pathway/process” (Castiglioni, 2013, b, p.10)

The dimensions and orientations outlined so far may constitute the salient points around which to structure a proposal for narrative, auto-reflexive and autobiographical education for healthcare professionals within the wider perspective of Medical Humanities, of which Narrative Medicine is a part.

What are the Medical Humanities? More than just a body of disciplines, or even more than just a series of “innovative” practices and tools for professionals use, the Medical Humanities constitute something profoundly more complex, and in some ways more difficult. They coincide, in fact, with a knowing assumption by the provider of medical-clinical-type care that translates into an inescapable certainty that care – understood existentially – is necessarily and inevitably given within and by means of that relationship (Palmieri, 2000). The care is undoubtedly of a medical/therapeutic nature but it is equally the relationship the doctor is able to build with the single, specific patient. A relationship that is more or less clinically demanding, more or less emotionally problematic. The *care* is also the *quality* of the *relationship* – as stated by Palmieri (2000) – and as such it is, above all, a *mental choice* by the professional (Bert, 2007, p.15) which reveals, we may even say, what sort of operator he/she really is *inside*. Certainly he/she will reveal ambivalences, contradictions and critical aspects that can be eliminated and need always to be contextualized. Medical Humanities, therefore, are inspired by the theoretical and methodological/procedural principle proper to *Narrative Medicine*, also known as *bio-psycho-social* medicine, which is differentiated from traditional, or *bio-medical*, medicine in that it puts the *doctor/patient relationship*, and not just the pure *biological-medical data*, at the centre of its attention (Moja e Vegni, 2000).

The *doctor* or *narrative operator*, as we have defined him in previous papers (Castiglioni, 2013, a), makes his own, therefore, the *paradigm of narrativity* (Masini, p.11), as style and inner posture, explicated in the care relationship and subsequently – even in the presence of certain essential variables belonging to a number of levels, as we shall see briefly below – assists the patient in

producing a narration, or story, about himself/herself, about his/her illness, about the therapeutic project, and so on (Bert, 2007). *De facto*, the doctor supports the patient in producing points of view, representations, emotions, experiences, concerning what is happening, concerning this event/illness that may prove a sort of watershed in the lives of each one of us: the “before” and the “after”. An “after” that almost certainly, but not necessarily and always, involves loss and involution. All this is aligned with Bruner’s constructivist teachings but also with the phenomenology which, as we have already had the opportunity to note, constitutes our conceptual scenario of reference.

In order to do this the doctor and the professional must have experimented upon themselves, during their training, what it means to narrate, to narrate oneself, to put into words, orally or in writing, one’s professional and healthcare practice, to record one’s personal memory of the “care received”. Within the educational projectuality, advanced herein, of a narrative/auto-reflexive/autobiographical type.

There is much to be gained, in my opinion, from similarly-oriented training. For lack of space I summarize the arguments only partially (those interested are referred, in particular, to Bert, 2007, Castiglioni 2013 and Zannini, 2008). I wish to make it clear at once that writing is the favoured tool, according to the orientation of the Demetrio research group, of which the writer is part. Here, then, are the principal points:

- leading the doctor towards a writing practice that is not technical/scientific, that of anamnesis, of diagnosis, of the clinical case, to which he/she has obviously been accustomed since his/her university years (Bert, 2007; Good, 2006); a writing practice that is always comprehensible and, while fully professional as regards clinical practice and care, takes into account emotions, questions, doubts, reconsiderations, shifts and changes of focus, reflections as to what the patient and/or his/her family members may be thinking and experiencing, but also as to what the doctor, generally disinclined to face up to his/her

personal emotions, is thinking and feeling. A writing practice that produces relational awareness and, for the relationship with the patient, sentimental awareness (Iori, 2007). For the sentiments chiefly known and elaborated, this will result in reciprocal sharing of experiences, those of the doctor and those attributed to the patient, albeit in dubitative form since, as Bruner reminds us (1992), narration always moves within the range of probabilities, of the “maybe yes” and the “maybe no”;

- carefully considered use of the word “medical”, which not infrequently gives rise to fears, anxieties, worries or even panic (Bert, 2007). If the word is needed for written communication, it should be critically assessed, refined, explained and defined so that it can convey to the patient a thought that is more narratively open, precise, coherent, pertinent and attentive towards his/her needs, desires and expectations. It is here, on this page of professional writing, that the doctor should ask himself how this “uncomfortable”, emotionally taxing word would be best used as part of a relational dialogue with the patient, for the word “medical”, if narratively prefigured and consolidated, can help the patient to view it more positively and accept it with less difficulty;
- opportune reflection on the word most used, or, conversely, that which is least used, to narrate that specific patient, the uniqueness of the relationship established with him/her. This means an ability to reflect on the image the professional has of the patient and of the relationship between himself/herself and the patient;
- familiarization with tools of the narrative type that can help to redimension the *existential gap*, or *autobiographical gap* (Charon, 2007), between the doctor and the patient: for example, the *parallel file* used by Rita Charon (2007), which gathers the patient’s viewpoints and experiences relating to his/her illness, the emotions involved, information on the context where he/she lives and works, his/her auto-reflexive diary, etc.;

- development of narrative sensibility and sensitive listening;
- bridge-building between one's own world and that of the patient (Bert, 2007, p.63);
- strengthening of *imaginative* propensity and skill, or rather, as Martha Nussbaum has defined it, albeit in relation to another reflexive area, that of *narrative imagination*, “the ability to be an intelligent reader of other people's stories, that is to say the capacity to put yourself in another person's shoes” (2011, p.111) “after first putting yourself in your own shoes”, as Tramma reminds us (2003, p.27);
- .....

These dimensions were taken into consideration when planning the educational programme intended by the writer for medial/healthcare volunteers and professionals of the *Associazione di Volontariato Oncologico Triangolo* of Lugano (Dr. M. Varini and Dr. O. Varini) and the Clinica S. Anna of Lugano (Dr. M. Varini). The programme began in 2008 and has a duration of five years.

At this point, we need to decide what may be the advantage or effectiveness of the practice of writing with the patient, specifying the pathologies for which it is used and which are discussed in the literature, such as tumours, degenerative diseases such as ALS, AIDS, chronic diseases such as diabetes, psychosomatic or depressive symptomatology, minor or frequent as the consequence of a major physical disease, to cite just a few of the most-reported cases (Charon, 2007; Bert, 2008; Solano, 2007; Zannini, 2008).

Before examining, even briefly, the repercussions of the exercise of writing by the patient, we need to remember that, like all the tools available to us in relation to help and support, the practice needs to be carefully and sensitively contextualized. We must ask ourselves, therefore:

- ✓ what type of familiarity the patient has with writing;
- ✓ which autobiographical themes it is preferable to deal with and, consequently, which writing exercises it is best to propose, delay or even avoid (Pepe, 2007);
- ✓ who is the best person to conduct a writing laboratory (a volunteer? a nurse? an expert in autobiographical methodology?) (Castiglioni, 2013 a; Zannini, 2008);
- ✓ in which phase of the disease or the therapy it is preferable to propose a space for writing, bearing in mind that we are dealing with major pathologies and with therapies that may be invasive (Castiglioni, 2013);
  - ✓ where should the writing device be placed. In the hospital? In a neutral space? As part of home assistance? (Castiglioni, 2013).

All this implies particular care in forming the group of patients to whom the writing project and conduction of the laboratory is to be addressed (Castiglioni, 2013; Zannini, 2008).

But why we should propose writing to the patient, always within the perspective of an agreed proposal and never in the absence of minimal interest, motivation or curiosity on the part of the patient? I believe the reasons are numerous. Let us consider at least a few (Castiglioni, 2013):

- ❖ the opportunity to exploit a *space and time for oneself*, well sheltered from the external (as well as internal) dis-orientation to which the patient is exposed, and for a time that may be far from short if the disease and the therapy are demanding. The patient may need/wish to have be surrounded by silence, *restorative silence*, that will allow him/her to re-discover himself/herself, at least a little;
- ❖ the opportunity to *re-observe* oneself, since one can find one's own reflection in a story/image of oneself, felt from within, which may provide a sense of *re-composition* where the disease can generate a breaking-down, a dis-integration, even a loss of the self;

- ❖ the opportunity to experiment a generative and lenitive *shifting of thought*, starting with the act of writing, its opening words and – “while I write” – a shifting also of the experience of the disease and its care;
- ❖ the opportunity to exploit a sort of *pathway/path* with which to record and conserve emotions, including positive ones, steps ahead, re-conquests, a sort of *emotive diary* of one’s personal story of illness and therapy;
- ❖ the opportunity to give oneself an *anchorage*, a place where one can even put a *full stop* followed by *new paragraph*, *we re-commence*, starting right there;
- ❖ the opportunity to give oneself, simply, a commitment/project for the day, maybe shared with others experiencing the same situation;
- ❖ .....

These, for example, were the aims of the writing laboratory activated by two volunteers of the Associazione Triangolo of Lugano after experimenting with the writer – as mentioned above – a training programme of about five years on autobiographical methodology, also involving doctors, a psycho-oncologist, a nurse and a social assistant of the Clinica S. Anna, also in Lugano. This was a writing workshop, still operating, aimed at a small group, homogenous by age and stage of disease, of the association’s tumour patients, for whom the proposal met with their wishes.

Now that we are reaching the final part of our reflections, we would like to describe, if only partially, the results, or repercussions, of this proposal with professionals and patients. It needs to be emphasized that this represents, in Italy, an entirely initial and limited training project involving care and research. Limited, among other things, by the number of experiences activated and monitored, by the temporal dimension and by its fragmentation on the national territory. Even the writer’s experience, which took place, as already mentioned, in Italian-

speaking Switzerland, allows us to advance no more than the positive response to the training by those professionals – not all of them – who were able to experiment the practice of writing with the patient or patients, after experimenting it upon themselves; in a couple of cases they added system and methodological rigour to what they were doing. This led, about two years ago, to the setting up of a writing workshop – to which we have already briefly referred – aimed at a small group of tumour patients and coordinated by two volunteers of the Associazione di Volontariato Oncologico Triangolo of Lugano. Begun in an exploratory manner, this has now reached its fifth edition. Patients’ reactions are certainly positive. They experienced this writing space also as a space for projectuality within their daily lives where they could “share time together”, as well as a life-experience, the disease, which brought them together, but on which the two volunteers did not dwell in what may be called an *a priori manner*.

We should also bear in mind that it is not easy to assess the results of a methodology that deals with subtle and wide-ranging dimensions of the “human being”. For scientific rigour, therefore, we refer to the studies of Bert (2008), Charon (2007) and Solano(2007), which emphasize that the benefits are physical as well as emotive.

We may conclude by adding that in the Italian context, in alignment with the findings of the literature of the sector, the narrative/autobiographical outlook in the education of medical/healthcare professionals and the use of the practice of writing with patients, where it is used at all, is limited to the areas of oncological diseases (Istituto Europeo di Oncologia of Milan; Ospedale S. Gerardo of Monza; Ospedale di Aviano, to mention a few), of diabetology types 1 and 2 (Marina Trento-Torino), home assistance to SLA patients (AnnaMaria Emolumento-Fondazione Maddalena Grassi-Milano) and terminal diseases.

We would like to close by describing an inter-university research project, of which the writer is scientific manager, to be set up by the University of Milano-Bicocca. Beginning in September

2013, its first exploratory phase, of a qualitative type, will aim to examine the real possibilities, already present or foreseeable, in medical/healthcare and care institutes, for narrative medicine and narrative/autobiographical care practices. At the same time the project will examine what is meant by “narrative paradigm” in help and care relationships, given that narration embraces all these practices in the healthcare context. This research programme also proposes to activate focus groups aimed at Department of Medicine tutors to sound out the margins, greater or lesser, for a collaboration with Departments of Educational Science for a possible inclusion of laboratory modules concerning the science and practice of narration in traditional curriculums. This with a view to possible collaboration in organizing post-graduate programmes such as Masters or Finishing Courses.

Starting from this investigation we will attempt to understand, in a second phase, which are the hospital situations, and in the presence of which variables, where writing devices might be set up aimed at patients, and in particular oncological, terminal, degenerative or chronic patients.

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<sup>1</sup>The author illustrates her point by breaking down the Italian words in a way that is impossible to translate. “*Incontro*” [meeting] is divided into “*in-contro*” [in-against], “*confronto*” [confrontation] is divided into “*con-fronto*” [with-front] – translator’s note.

<sup>1</sup> More divisions of words. “*Inter-sezione*” [intersection] is one case that works in English. “*Relazione*” [relation] is divided into “*rel-azione*” [real-action]- translator’s note

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