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Re-humanizing the Medical Gaze: Biography as a Critical Pedagogical Tool

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Abstract: Contemporary medical training is often dominated by a positivist epistemic gaze, prioritizing technical efficiency over the human dimension of care. This reductionist approach risks viewing the patient merely as a clinical case, ignoring the subjective lived experience. Drawing on Freire's (1996) critique of banking education, this contribution advocates for a shift towards a critical, dialogical pedagogy in the medical curriculum. We identify the biographical method as a privileged tool to challenge the current paradigm. By engaging with patients' life stories, future physicians can develop narrative competence (Charon, 2006) and empathy, moving from a disease-centered to a person-centered gaze. This pedagogical strategy aligns with the call for social justice in health (DasGupta & Charon, 2004), fostering professionals capable of active listening and interpreting the complex human needs in healthcare settings, thus balancing clinical skill with profound human sensitivity. The experience of the Attività Didattica Elettiva (ADE) in Medical Pedagogy at the University of Basilicata, delivered to first-year students in Medicine and Surgery, concretely illustrates this pedagogical proposal, demonstrating how biographical and narrative approaches can be integrated into medical training from its earliest stages.

Keywords: Medical Pedagogy, Biographical Method, Narrative Medicine, Epistemic Gaze, Paulo Freire

Sinossi: La formazione medica contemporanea è spesso dominata da uno "sguardo epistemico" positivista che privilegia l'efficienza tecnica rispetto alla dimensione umana della cura. Questo approccio riduzionista rischia di ridurre il paziente a un semplice caso clinico, ignorando l'esperienza vissuta soggettiva. A partire dalla critica di Freire (1996) all'educazione bancaria, questo contributo propone uno spostamento verso una pedagogia critica e dialogica nel curriculum medico. Si individua nel metodo biografico uno strumento privilegiato per sfidare il paradigma dominante. Attraverso il coinvolgimento con le storie di vita dei pazienti, i futuri medici possono sviluppare competenza narrativa (Charon, 2006) ed empatia, passando da uno sguardo centrato sulla malattia a uno centrato sulla persona. Questa strategia pedagogica si allinea con la giustizia sociale in sanità (DasGupta & Charon, 2004), formando professionisti capaci di ascolto attivo e di interpretazione dei complessi bisogni umani nei contesti di cura. L'esperienza dell'ADE di Pedagogia Medica all'Università degli Studi della Basilicata, erogata agli studenti del primo anno del corso di laurea in Medicina e Chirurgia, illustra concretamente questa proposta pedagogica, mostrando come approcci biografici e narrativi possano essere integrati nella formazione medica fin dalle sue fasi iniziali.

Parole chiave: Pedagogia Medica, Metodo Biografico, Medicina Narrativa, Sguardo Epistemico, Paulo Freire

Introduction

Contemporary medical education faces a profound tension between scientific rigour and humanistic sensitivity. The dominant paradigm in medical schools has long been shaped by what Foucault (1963) termed the "clinical gaze", a positivist, anatomoclinical mode of seeing the patient that prioritizes biomedical data over the lived experience of illness. This epistemic orientation, while essential for diagnostic precision, carries an inherent risk: the reduction of the patient to a collection of symptoms, laboratory values, and clinical findings, at the expense of their subjectivity, their story, and their humanity.

This article engages with a growing body of scholarly work that challenges this reductionist paradigm and calls for a more humanistic, relational, and critically oriented approach to medical education. Drawing on Freire's (1996) foundational critique of "banking education", we argue that contemporary medical curricula often reproduce an analogous dynamic: students receive, memorize, and reproduce biomedical knowledge without being invited to question its underlying assumptions, its epistemic structures, or its human implications.

Against this background, the present contribution advocates for the integration of the biographical method as a privileged pedagogical tool in medical education. By engaging with patients' life stories and their own biographical self-understanding, future physicians can develop what Charon (2006) calls "narrative competence": the capacity to recognize, absorb, interpret, and be moved by stories of suffering. This competence does not compete with clinical expertise; rather, it enriches and humanizes it.

The article is organized as follows. We begin by reviewing the theoretical landscape, examining the positivist epistemic gaze, Freire's critical pedagogy, the biographical method, narrative medicine, and person-centered care. We then describe the ADE (Attività Didattica Elettiva) in Medical Pedagogy designed and delivered at the University of Basilicata for first-year students in Medicine and Surgery. We proceed to narrate in detail the three pedagogical encounters that constitute the course, analysing their design, their theoretical underpinnings, and their pedagogical significance. Finally, we discuss the implications of this experience for the re-humanization of medical training and the development of a truly relational, critical, and person-centered medical gaze.

Theoretical Framework

The Positivist Epistemic Gaze and Its Discontents

The history of modern medicine is inextricably linked to the emergence of a specific epistemological posture: the clinical gaze. As Foucault (1963) argued in The Birth of the Clinic, the transformation of medicine in the late eighteenth century involved a fundamental reorganization of the medical gaze, from a symptom-based, narrative understanding of disease to an anatomoclinical, spatially-organized observation of the body. This shift produced a medicine capable of extraordinary diagnostic and therapeutic precision, but also one that systematically marginalized the patient's subjective experience, voice, and narrative.

In contemporary medical education, this positivist heritage manifests in what several scholars have identified as an "epistemic gaze" (Bastian, 2017; Kammerer et al., 2021): a mode of knowing that privileges measurable, evidence-based, and replicable data over interpretive, narrative, and experiential forms of knowledge. The implications of this epistemic orientation for medical training are significant. Students are socialized into a way of seeing patients as clinical cases rather than as persons; they learn to prioritize efficiency over relationality, diagnosis over dialogue, cure over care (Carel, 2016).

Fricker's (2007) concept of epistemic injustice offers a powerful analytical lens for understanding the consequences of this orientation in clinical encounters. Fricker identifies two forms of epistemic injustice particularly relevant to healthcare: testimonial injustice, which occurs when a patient's account of their illness is given less credibility than it deserves due to prejudice related to gender, race, class, or cultural background; and hermeneutical injustice, which occurs when patients lack the conceptual resources to articulate and communicate their experiences. Both forms of injustice are exacerbated by a

medical culture that devalues narrative knowledge and positions the physician as the sole epistemic authority in the clinical encounter.

Neumann et al.'s (2011) systematic review of empathy decline in medical students and residents provides troubling empirical evidence of what happens when medical education fails to cultivate humanistic dispositions alongside clinical competencies. Their findings show a consistent pattern of declining empathy over the course of medical training, particularly during clinical years, a period when students are most deeply immersed in the technical and procedural dimensions of medicine and least exposed to humanistic or critical reflection.

Freire's Critical Pedagogy and the Medical Curriculum

Paulo Freire's (1996) Pedagogy of the Oppressed provides a foundational critique of educational models that reproduce rather than challenge existing power structures. The "banking" model of education, as Freire describes it, treats students as passive receptacles of knowledge deposited by authoritative teachers, a model that stifles critical consciousness, autonomy, and dialogical engagement. The implications of Freire's critique for medical education are both powerful and underexplored.

In the medical curriculum, the banking model operates in multiple dimensions. It shapes the relationship between teachers and students, positioning medical knowledge as a fixed body of facts to be transmitted rather than as a set of practices and interpretations to be critically examined. It also shapes the relationship between physicians and patients: the physician as knower, the patient as object of knowledge. In both cases, the dialogical dimension of the encounter, the possibility of genuine mutual recognition, inquiry, and co-construction of understanding, is foreclosed.

Giroux's (2011) elaboration of critical pedagogy extends Freire's insights to the domain of higher education, arguing that educators must be understood as "transformative intellectuals" who challenge dominant ideologies, foster critical consciousness, and create conditions for emancipatory learning. Applied to medical education, this vision implies a pedagogy that invites students to question the assumptions embedded in their training about what counts as knowledge, whose stories matter, and what it means to care for another human being.

Kumagai and Lypson (2009) have developed this vision further in the context of medical education, proposing a model of "critical consciousness" as a core educational goal. Their framework goes beyond cultural competence, the acquisition of knowledge about different cultural groups, to cultivate in medical students the capacity for self-reflection, social analysis, and moral engagement with the complex realities of health and illness. Kumagai et al. (2018) subsequently developed the concept of "dialogical learning for humanism and justice", emphasizing the transformative potential of dialogical encounters across difference in medical education.

The Biographical Method as Pedagogical Tool

The biographical method has a long and rich tradition in the social sciences and in educational research. Alheit and Dausien (2000) have conceptualized biographical learning as a fundamental mode of human self-constitution: the process through which individuals make meaning of their lives, construct their identities, and orient themselves toward the future. What makes the biographical method particularly significant for education is its capacity to reveal the complexity, singularity, and irreducibility of individual experience, qualities that resist reduction to categories, diagnoses, or statistical aggregates.

In the context of adult and professional education, Lichtner (2008, 2018) has explored the biographical method both as a sociological approach to understanding learning trajectories and as a formative tool for fostering self-awareness, reflexivity, and capacity for relational engagement. The biographical dimension of learning, Lichtner argues, is not a supplement to professional formation but its very substance: it is in and through their biographies that persons develop the relational dispositions, the ethical sensibilities, and the interpretive capacities that constitute genuine professional competence.

For medical education specifically, the biographical method offers several distinct pedagogical affordances. First, it cultivates in future physicians the habit of genuinely listening to patient stories attending not only to symptoms and timelines but to the meaning that illness holds in the context of a

particular life. Second, it develops what Charon (2006) calls "narrative competence": the capacity to recognize the multiple voices, framings, and perspectives present in a patient's account. Third, it fosters the reflexivity necessary for physicians to recognize how their own biographical experiences, assumptions, and values shape the way they hear and respond to their patients.

Ross and Hastie (2024) have documented these affordances in the context of nursing education, showing how engagement with biographical narratives can promote person-centredness by helping students move from abstract knowledge about patient populations to concrete understanding of individual patients in their full biographical complexity. Their work corroborates the central argument of this contribution: that the biographical method is not merely a pedagogical technique but a fundamental orientation toward the other, an orientation that medical education urgently needs to cultivate.

Narrative Medicine and Narrative Competence

The field of narrative medicine, pioneered by Rita Charon at Columbia University, provides perhaps the most developed theoretical and practical framework for integrating biographical and narrative approaches into medical education. Charon (2001) defines narrative medicine as "medicine practiced with the narrative competence to recognize, absorb, interpret, and be moved by the stories of illness". This definition is significant because it identifies narrative competence not as a supplementary skill but as a constitutive dimension of medical practice.

Greenhalgh and Hurwitz (1999) offer a compelling account of why narrative is so important in medicine. Stories perform cognitive and ethical functions that are irreplaceable by other forms of medical knowledge: they establish meaning, illuminate context, suggest causality, and make possible the kind of interpretive engagement that is essential for truly understanding a patient's situation. A diagnosis, however accurate, tells us what is wrong; only a story can tell us what it means to be this particular person living with this particular illness in this particular life.

Charon's (2006) conceptualization of narrative competence encompasses several interrelated capacities: close reading of complex texts (whether literary, visual, or verbal); reflective writing that cultivates self-awareness; attentive listening to the multilayered stories patients tell; and the interpretive skill to identify what is said, what is unsaid, and what cannot yet be said. These capacities are not innate; they are cultivated through practice, reflection, and pedagogically structured engagement with narrative, precisely the kind of engagement that the biographical method enables.

Halpern (2003) adds an important affective dimension to this picture by examining the nature of clinical empathy. She distinguishes between emotional contagion, which involves feeling what another feels and risks compromising clinical objectivity, and clinical empathy, which involves "resonant understanding": a form of engaged, imaginative understanding that enables physicians to grasp the emotional dimensions of their patients' experiences without losing their professional perspective. This distinction is crucial for medical education because it clarifies what we are asking of students when we invite them to develop empathic capacities: not unlimited emotional identification, but a disciplined, attentive responsiveness to the other's experience.

Montgomery (2006) adds that clinical judgment requires not only biomedical knowledge but also practical wisdom: the capacity to recognize what is morally and clinically salient in a particular situation and to respond appropriately. Narrative competence is essential to this form of phronesis because it cultivates attentiveness to particulars, sensitivity to context, and the interpretive skill that sound clinical judgment demands.

Person-Centered Care and Social Justice in Health

The biographical and narrative approaches to medical education are intimately connected to a broader shift in healthcare philosophy: the movement toward person-centered care. Mead and Bower (2000), in their influential conceptual review, identify five dimensions of person-centered practice: the biopsychosocial perspective, which attends to psychological and social as well as biomedical factors; the patient-as-person perspective, which engages with the individual's experience and understanding of illness; the sharing of power and responsibility in the therapeutic relationship; the therapeutic alliance;

and the doctor-as-person dimension, which recognizes the physician's own humanity and emotional engagement.

Ekman et al. (2011) argue that person-centered care requires a fundamental reorientation of the clinical encounter, from a disease-centered to a person-centered framework. This reorientation involves listening to the patient's narrative as the starting point of the clinical encounter, rather than as background information to be extracted and translated into diagnostic categories. It requires understanding the patient's experience of illness in the context of their biography, their values, and their life goals. DasGupta and Charon (2004) have shown that engagement with personal illness narratives can significantly develop medical students' empathy and person-centered orientation. Their work with reflective writing in medical education demonstrates that when students are invited to write about their own experiences of illness and vulnerability, and to reflect on these experiences in relation to their clinical training, they develop deeper and more nuanced understandings of what patients experience in the clinical encounter.

Kumagai and Lipson's (2009) framework of critical consciousness places person-centered care within a broader framework of social justice. They argue that truly person-centered medicine must engage with the social, cultural, and structural dimensions of patients' lives, the ways in which race, class, gender, migration, and disability shape both the experience of illness and access to care. This social justice orientation extends the biographical method from the level of the individual encounter to the level of structural critique, inviting medical students to examine the social determinants of health and to develop a commitment to health equity.

The ADE in Medical Pedagogy: Context, Design, and Pedagogical Architecture

The experience described in this article is an Attività Didattica Elettiva (ADE), an elective educational activity, in Medical Pedagogy, designed and delivered at the University of Basilicata to first-year students enrolled in the degree course in Medicine and Surgery. The ADE is offered in the second semester of the first academic year, at a moment that is pedagogically significant: students have just begun their medical training, their professional identities are still being formed, and they have not yet been fully socialized into the technical and procedural dimensions of medicine that characterize clinical training.

This timing is not incidental. It reflects a deliberate pedagogical choice: to intervene at the moment when students are most open, most reflective, and most capable of integrating humanistic and relational orientations into their emerging professional identities. The ADE represents an attempt to establish, from the very beginning of medical training, a counter-discourse to the positivist epistemic gaze, to create a space where students are invited to experience medicine as, first and foremost, a relational practice founded on cognitive responsibility toward the other.

The overall arc of the ADE is organized around a progressive pedagogical movement that unfolds across five thematic nuclei: I encounter the other; I understand with the other; I explain to the other; I plan for the other; I find tolerable words for the other. This progression is not, however, a sequence of independent lessons. It is a single, continuous movement from student to professional, from the initial encounter with the dimension of relationality to the full assumption of professional responsibility for communication and care. Each encounter builds on the previous one, deepening students' understanding of what it means to be in relation with another person in a context of care.

The pedagogical architecture of the ADE is grounded in several foundational principles. The first is experiential learning: rather than transmitting concepts about empathy, listening, or communication, the ADE creates conditions in which students can experience these dimensions directly, reflect on their experience, and construct their understanding from within. The second principle is reflexivity: students are consistently invited to turn their attention toward their own responses, assumptions, and relational tendencies, developing the metacognitive awareness that is essential for professional growth. The third principle is transferability: each experience in the classroom is explicitly connected to the clinical

realities that students will encounter as physicians, so that the pedagogical work is never purely abstract but always oriented toward professional practice. The fourth principle is progressive complexity: the challenges presented to students in each encounter are calibrated to be neither too simple nor too demanding, but rather at the productive edge of their developing competencies.

Three Pedagogical Encounters: Narrating the Experience

First Encounter: Meeting the Other

The first topic of the ADE is structured around a deceptively simple question: what does it mean to encounter another person? This question is introduced not through a lecture or a theoretical presentation, but through an experiential activity "Raccontarsi" ("Telling about oneself") that invites students to experience the encounter with the other from the inside.

The activity is organized as follows. Students work in pairs, choosing a partner they know little or not at all a deliberate choice designed to prevent the comfortable shortcuts of established familiarity. Each person has approximately twenty minutes to tell their partner something about themselves. The themes suggested why they chose medicine, what they expect from the course, what worries them, what they think will help them through it are not incidental: they are chosen to surface precisely the biographical dimensions of students' relationship to their vocation and their emerging professional identities.

The rules of the exercise are equally deliberate. The listener may ask only clarifying questions; they must not give advice, must not recount their own experience while the other is speaking. This is the crucial pedagogical constraint of the activity: it transforms listening from a passive to an active practice, from a mere absence of speech to a genuine form of engagement with the other. It also creates conditions in which the natural tendency toward projection interpreting the other through the lens of one's own experience can be made visible and examined.

After the pair work, students are invited to reflect individually in writing on their experience. Three questions orient this reflection: Did you feel listened to? At what moment did you sense that the other was understanding you? Did you feel the urge to give advice? These questions are carefully designed to draw students' attention to the affective and relational dimensions of the encounter to what it feels like to be heard, and to what it costs not to fill the space of the other's speaking with one's own voice.

The subsequent group debriefing is the pedagogical heart of the lesson. Here, through guided questions: When do we feel truly listened to? When was listening difficult? Is it harder to speak or to listen? Why do we spontaneously want to give advice? What happens when someone recounts something difficult? Students move from the raw experience of the encounter to a shared reflection on its meaning. They begin to articulate, in their own words, the difference between genuine listening and the appearance of listening; between empathy and projection; between understanding and advice-giving.

The concept of projection is introduced as a pedagogical tool rather than a diagnostic category: the mechanism by which we attribute to another person thoughts and meanings that actually belong to ourselves, a normal cognitive tendency that the activity makes visible. A concrete clinical illustration clarifies the distinction: a patient who says "I am afraid of the surgery" may elicit the projective response "It's normal, don't worry" which silences their specific fear. The empathic response "What specifically frightens you about the surgery?" opens space for the patient to be heard in their singularity. The difference seems small but changes the entire relational dynamic of the encounter. At the close of the lesson, empathy is defined not as "feeling what the other feels" but as "remaining sufficiently curious to discover what the other feels". The concept of reconstructive empathy is introduced, a form of understanding that seeks to reconstruct the horizon of meaning within which the other's experience takes form. The lesson closes with a reflection on the asymmetry inherent in the physician-patient relationship: an asymmetry that does not eliminate the need for empathy but makes it more urgent, clarifying that empathy in medicine is a disciplined form of understanding that enables the physician to grasp the patient's experience while retaining the professional responsibility their role requires.

Second Encounter: Explaining to Understand

The second encounter of the ADE builds directly on the first, moving from the emotional dimension of empathy to its cognitive dimension. If the first encounter revealed how difficult it is to listen genuinely to another person, the second reveals how difficult it is to make oneself understood and how much understanding what the other does not understand is itself a profound form of epistemic engagement with the other.

The lesson begins with a brief recall of the previous encounter and an introduction to the new focus: the capacity to explain something to another person. In medicine, the physician must not only listen to the patient's story; they must also make the patient understand their situation, their diagnosis, their treatment options. The capacity to explain to translate complex knowledge into forms that are accessible, meaningful, and actionable for a particular person is a fundamental professional competence, and one that is too rarely cultivated in medical training. The pedagogical activity of this lesson is peer tutoring. Students work in pairs deliberately with a partner different from the previous lesson, to continue the process of building the group with the following task: each person chooses an academic topic they feel confident about and explains it to their partner. The partners then exchange roles. This apparently simple activity conceals a profound pedagogical complexity: explaining requires not just knowing but rethinking one's knowledge from the other's perspective identifying what the other does not yet know, finding the right entry point, choosing the right words and examples.

During the pair work, the teacher observes rather than intervenes. This observational stance is not passive: it is a form of attentive presence that collects pedagogical material for the subsequent debriefing. The debriefing questions focus on the specific challenges of explanation: What was more difficult, listening or explaining? What helped the other to understand? What created confusion? Students typically report, with some surprise, that explaining is far more demanding than they expected, and that the difficulty lies not in knowing the content but in identifying and entering the other's cognitive frame.

This discovery is given a name: epistemic responsibility. To explain something to another person is not merely to transmit information; it is to assume responsibility for the other's understanding. This responsibility requires what Kumagai et al. (2018) describe as "dialogical learning", a mode of engagement genuinely responsive to the other's perspective, questions, and confusions, rather than simply delivering a predetermined account. One of the most important insights that the lesson makes possible is that we often discover the limits of our own understanding precisely when we try to explain something to another person.

The lesson produces a concrete collective resource: a shared digital tool (a Padlet) in which each student records their name, a topic they feel confident about, and their availability to help others, making visible the heterogeneous competencies distributed across the group. An optional peer tutoring notebook invites students to record what they explained and what helped the other to understand. The connection to clinical practice is made explicit: explaining a diagnosis, a treatment plan, or a prognosis requires exactly the same capacity to enter the other's cognitive frame and construct understanding together.

Third Encounter: Telling Illness

The third and final encounter of the ADE described here represents the culmination of the pedagogical journey: the moment when the relational, empathic, and epistemic competencies cultivated in the previous lessons are brought to bear on one of the most challenging tasks in clinical practice, communicating about illness, suffering, loss, and death. The pedagogical device chosen for this encounter is unexpected and initially puzzling to the students: illustrated books for children dealing with themes of loss, grief, pain, fragility, diversity, and inclusion. Seven books are distributed across groups of approximately eight students, each tackling a different existential theme: *Il punto*, *Prova a dire Abbracadabra!*, *Il maglione della mamma*, *Pezzettino*, *Il buco*, and *Lupo, dove sei?* Each group is asked to read and discuss their assigned book in light of a set of guiding questions provided by the teacher. The choice of illustrated books is not arbitrary. It reflects a sophisticated pedagogical insight: the apparently simple language and imagery of children's literature can serve as a powerful translation

device for exploring the cognitive and emotional dimensions of clinical communication. Illustrated books deal with difficult themes, loss, death, illness, difference, loneliness, with a directness, a precision, and an emotional honesty that more "professional" texts often lack. They model, in compressed and accessible form, precisely the communicative capacities that physicians need to develop: the ability to name difficult realities without euphemism, to offer containment without denial, to find words that are simultaneously true and tolerable.

The guiding questions orient students'attention toward the communicative strategies, linguistic registers, and relational postures that the books employ. How does the author address a reader who may be experiencing loss or fear? What makes the language accessible without being banal? How does the imagery support and deepen the verbal content? What emotional responses does the reading elicit, and why? These questions invite students to develop a fine-grained awareness of how language, its rhythm, its metaphors, its silences, can either open or close the space for genuine encounter with difficult experience. The group discussions are followed by a plenary session in which a spokesperson for each group presents the key reflections that emerged. This creates a collective exploration of different communicative approaches to a terminal diagnosis, to a child, to a patient from a different cultural background to a person living with disability. In each case, the guiding question is the same: how do we find words that are not only accurate but sustainable, words the other can hear and use to orient themselves in their experience? The message that closes the lesson is one of the most important pedagogical formulations of the entire ADE: medical knowledge is a practice that will be used throughout a professional life always in the act of explaining it to someone. The quality of a physician's medicine depends, in large measure, on the quality of the words they are able to construct together with their patients. This formulation situates clinical communication not as a supplementary skill but as a constitutive dimension of clinical practice: the medium through which medical knowledge reaches, and can be received by, the persons who need it.

Discussion: Re-humanizing the Medical Gaze Through Critical Pedagogy

From Banking to Dialogical Education

The three pedagogical encounters described above can be read as a coherent, progressive attempt to re-humanize the medical gaze to cultivate in future physicians the relational, narrative, and communicative competencies that the dominant paradigm of medical education too often neglects. The ADE in Medical Pedagogy represents a concrete enactment of Freire's (1996) dialogical education in a medical curriculum context. Rather than transmitting fixed knowledge about communication, empathy, or clinical competence, the ADE creates conditions in which students can discover these dimensions through genuine encounter with each other, with literary texts, with their own experiences and assumptions. The banking model operates in medical education not only at the level of teaching methods but at the deeper level of epistemological assumptions: the assumption that medical knowledge is a fixed body of facts to be transmitted, rather than a set of interpretive practices to be critically examined. The ADE challenges this assumption by placing students in situations where they must engage with knowledge as a practice where understanding emerges not from memorization but from dialogue, explanation, reflection, and the encounter with complexity. In doing so, it takes seriously Freire's insistence that genuine education is always a dialogical process: it happens in the space between persons, through the reciprocal questioning and enriching of each other's perspectives.

The Biographical Method and the Epistemic Gaze

The biographical dimension of the ADE, the invitation to tell one's own story, to listen to another's story, to engage with the stories of illness told in illustrated books, functions as a counter-practice to the positivist epistemic gaze. Where the epistemic gaze reduces the patient to a set of clinical signs and symptoms, the biographical orientation insists on the irreducible singularity of each person's experience. Where the clinical gaze prioritizes efficiency and precision, the biographical orientation prioritizes attention, curiosity, and time.

As Alheit and Dausien (2000) suggest, biographical learning is a fundamental mode of human self-constitution the process through which persons make meaning of their experiences and construct their identities over time. When medical students are invited to engage with biographical narratives, their own and those of others, they are being invited into a mode of knowing that is qualitatively different from the biomedical mode: more interpretive, more attentive to context and meaning, more responsive to the complexity and ambiguity of human experience. This counter-practice has implications not only for clinical communication but for the entire epistemological orientation of medical training.

Narrative Competence as Professional Competence

The experience of the ADE supports and enriches Charon's (2006) claim that narrative competence is not an add-on to medical expertise but a constitutive dimension of it. The three encounters of the ADE are all, in different ways, exercises in narrative competence: learning to listen to another's story (first encounter); learning to construct an account that can be understood by a specific other (second encounter); learning to find words adequate to the weight of difficult realities (third encounter). These are not three separate competencies but three dimensions of a single underlying capacity, the capacity to be genuinely present to the other, to receive what they bring, and to respond in ways that are both truthful and sustaining. If narrative competence is genuinely integral to clinical practice, shaping not only how physicians communicate but how they think, perceive, and judge, its cultivation cannot be relegated to elective activities. It must be integrated into the core curriculum from the earliest stages of medical training. The ADE described here represents a concrete example of how this integration can begin, even within an elective format.

Social Justice and the Humanistic Physician

The ADE also contributes to the project of social justice in health (DasGupta & Charon, 2004; Kumagai & Lypson, 2009) by cultivating in students the critical consciousness necessary to recognize and respond to the social dimensions of illness. The third encounter, in particular with its focus on communication with children, migrants, persons with disabilities, and other vulnerable patients extends the biographical and narrative orientation from the individual clinical encounter to the structural dimensions of healthcare.

This social justice dimension of the ADE aligns with Fricker's (2007) analysis of epistemic injustice: the recognition that marginalized patients are systematically disadvantaged not only in terms of access to care but in terms of their capacity to be heard, believed, and understood by medical professionals. Cultivating the capacity for genuinely attentive, non-projective listening which is the core pedagogical aim of the first encounter is thus not merely a relational but a political practice: an exercise in epistemic justice. The physician who has learned to listen without projecting, to explain without presuming, and to find words adequate to the other's experience is not only a more humane practitioner, they are also a more just one (Roex, Huysken & Gijbels, 2017).

Conclusions

This article has described and analysed an educational experience, the ADE in Medical Pedagogy at the University of Basilicata that represents a concrete attempt to re-humanize medical training through the integration of biographical, narrative, and critically pedagogical approaches. The three encounters described, Meeting the Other, Explaining to Understand, and Telling Illness, constitute a coherent and progressive pedagogical journey from the discovery of relationality to the assumption of communicative responsibility. The experience supports and enriches a growing body of scholarship that argues for the integration of humanistic, narrative, and critically reflexive approaches into medical curricula. Against the dominant paradigm of positivist technical rationality, it proposes a different vision of the physician: not as the master of a body of biomedical knowledge, but as a relational, communicative, and critically reflective practitioner, one who is capable of genuinely encountering the other, of listening to their story, of finding words adequate to their experience, and of accompanying them with both competence and humanity through the experience of illness.

The biographical method, as the ADE demonstrates, offers a particularly powerful pedagogical tool for cultivating these competencies. By engaging students with their own and others'biographical narratives, it cultivates the attentiveness, the curiosity, the interpretive skill, and the emotional responsiveness that are the foundations of narrative competence and, we argue, of genuinely person-centered, socially just, and humanistically informed medical practice. The re-humanization of the medical gaze is a rigorous, theoretically grounded, and practically urgent educational endeavour, one that responds to the documented decline of empathy in medical training, the persistent epistemic injustices of clinical encounters, and the growing call for a medicine that is not only scientifically excellent but genuinely worthy of the human beings it serves.

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