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The "human factor" and the phenomenological approach in the education of healthcare professionals

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ABSTRACT

The naturalistic paradigm in the medical sciences, based on the presumed "objectivity" of the body and its diseases, makes it difficult to grasp the subjective and intersubjective dimensions of illness and care. Nevertheless, professional healthcare often implies delicate - and yet essential - engagement of the emotional kind. Humanness is the cornerstone of an interpersonal care relationship that cannot be reduced to mere technical performance. Phenomenology provides theoretical concepts and practical tools for raising awareness of these "human" dimensions of care, making a key contribution to the epistemology, ontology and ethics of care. Bringing a phenomenological approach to bear within the continuing education of healthcare professionals can help to develop a professionalism in which behaving, thinking and feeling are not separated, and care of the other is continuously associated with self-care.

Keywords: *Phenomenology - Healthcare - Continuing education - Self-care - Ethics*

Il paradigma naturalistico delle scienze mediche, fondato sulla presunta 'oggettività' del corpo-cosa e dei suoi disturbi, impedisce di cogliere la dimensione soggettiva e intersoggettiva della malattia e della cura. Il lavoro nei contesti sanitari, tuttavia, implica spesso un coinvolgimento - delicato e nondimeno necessario - della vita emotiva, quale asse portante di una relazione interpersonale che non può ridursi a mera prestazione tecnica. La fenomenologia offre saperi e strumenti per assumere consapevolmente queste dimensioni "umane" del lavoro di cura, sia sul piano dell'epistemologia e della metodologia alla ricerca, sia su quello dell'ontologia e dell'etica professionale. L'approccio fenomenologico nella formazione dei professionisti contribuisce a delineare una professionalità terapeutica in cui l'agire non sia disgiunto dal pensare e dal sentire e in cui la cura di altri sia costantemente accompagnata dalla cura di sé.

Parole chiave: *Fenomenologia - Lavoro di cura - Formazione continua - Cura di sé - Etica*

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By far the most frequently used drug in

general practice is the doctor himself.

(Balint, 1957, p. 7)

Barcelona, Ciutat Vella. In Room 3 of the historic building that houses the Museu Picasso's permanent collection, visitors may contemplate a painting so large that takes up an entire wall: Picasso's *Ciència i caritat*, which he painted aged only sixteen, while employed in the workshop at no. 4, Carrer de la Plata in the quarter known as La Ribera. Although the work remained in the tradition of academic realism, it received honourable mention at the Madrid Fine Arts Exhibition in 1897.

The subject is of no little interest and displays evident symbolic value: a doctor and religious sister are attending at the bedside of a sick woman. To the left of the scene, the doctor is absorbed in taking the patient's pulse: he is holding her wrist but not speaking to her, his gaze fixed on the face of his watch. For that matter, the woman is not looking at him either: she is holding out her arm to him (signifying the abandonment of her body into the hands of a knowledge that she herself does not possess) but her attention is entirely directed elsewhere. From the other side of the bed, the sister is offering her a glass – the contents will not make the patient well, it goes without saying, but they will alleviate her suffering – and, more importantly, the nun is holding the woman's child in her arms, as the mother looks on worriedly. While the first person depicted (incarnation of Science) represents the coldness of de-humanized, albeit indispensable, *clinical care*, the second (personification of Charity) evokes the *existential care* due, for example, to one who though ill has not stopped being a mother. Taken as a whole, the scene could be interpreted as a warning, issued at the height of the positivist era, against allowing the world of science to lose its humanity; or even as an invitation to reunite these two complementary faces of care, which at the time had already become disassociated from one another to a perilous degree.

Technology and humanity

In an interview given in 1989, the psychiatrist Viktor Frankl shared the origins of his therapeutic calling, explaining that they went back to his childhood. "I wanted to be a good doctor, I hope I was not a bad doctor", he stated, "but definitly I wanted to *remain a human being*". Adding with engaging frankness: "I still try".[1] Thus did an 84-year-old neurologist, then world-famous, remind us that in exercising the medical profession it is possible to lose a part of one's humanity, or rather: vigilance is required so as not to lose it. This simple truth inspired all of Frankl's work, based on the firm conviction that "*homo patiens* demands of the *medicus humanus* [...] that he behave not only like a physician but also like a human" (Frankl, 2001, p. 121). We should not view this appeal to be human as a feel-good rhetorical outburst on the part of an old-fashioned professor, but rather as the assertion of a far deeper-lying principle: the caring professions are based on humanitarian motivation and on the development of specific human qualities that constitute the cornerstone of care. Only our humanity can "protect us from the inhumanity of technology, which has also made itself felt in the sphere of technical medicine" (*ibidem*).[2]

[1] "The Choice is Yours. The Life and Philosophy of Viktor Frankl". TV feature (PBS) produced by Ruth Yorkin Drazen, USA 2003.

[2] For background on the philosophical foundations and therapeutic and educational implications of Franklian existential analysis, see Bruzzone, 2012a.

This humanistic emphasis has been progressively overshadowed by the gradual "scientification" of medical knowledge and the ongoing upgrading of the professional qualifications of non-medical therapeutic figures.[3] The adoption of a positivist scientific model has underpinned the tendency to define professionality in terms of objective and impersonal requirements (a given body of knowledge and satisfactory operational skills) while overlooking the subjective and personal dimensions that nonetheless contribute significantly to the quality of care. In healthcare, *these personal dimensions* are not surplus or optional, but *represent equally indispensable professional requirements*.

Warren T. Reich, Professor Emeritus of Bioethics at the Georgetown University School of Medicine, has emphasized the risk of losing sight of the essence of care by reducing it to an exclusively technical matter: "The delicate link between the provision of care and medical *techne* is clearly under threat within contemporary medicine. In the world of ancient Greek medicine, the connection between *philanthropia and philotechnia* was taken seriously. We need to intensify our study of this link and suggest ways of reinforcing it, both in medical practice and in the training of doctors and nurses" (Reich, 2005, p. 31). In other words, it is time to restore the primacy of the human dimension, wherever it is at risk of being mortified by the instrumental logic of technology, specialization, bureaucratization and privatization within healthcare. A challenge that becomes all the more urgent when scientific advances fuel a notion of anonymous and ascetic care, entrusted "to arid exploratory and diagnostic technologies to which the logic of the heart is totally alien" (Borgna, 2013, p. 43).

The call to narrow the gap between the logic of *curing* and that of *caring*, sustained in recent decades by the increasing importance of the *medical humanities* (cfr. Little & Little, 2005; Zannini, 2008), reflects the need to oppose the positivist mentality that is widespread not only in the sphere of medical research but also in that of therapeutic practice. The doctor-patient relationship has evolved towards a contractualistic model, based on the functionalist principle of exchange: thus the doctor becomes the health professional, care the merchandise to be exchanged, the healthcare service a consumer industry, the vulnerable subject a passive and dis-habilitated client (cfr. Illich, 2004). In this context, the lived-through experience of those who turn to a system that is predominantly regulated by the cold logic of efficiency and technological excellence would often appear to feature a latent but widespread suffering:

> The ill person sees himself in a world of machines that analyze him without his being able to grasp the meaning of the procedures which go over his head. He finds himself in front of doctors, none of whom is *his* doctor. Thus even the doctor seems to have become a technician. (Jaspers, 1991, p. 51)

Objectification and its discontents

The roots of this depersonalization are to be found in the (typically positivist) process of *objectification*, that is applied to reality *a priori* in order to acquire as "precise" a knowledge of it as possible. In following this criterion, the modern sciences have become disciplines that aim to describe

[3] Even nursing training has become increasingly "medicalized" in recent years (perhaps as a consequence of the new requirement for nurses to hold a university degree, although this is a positive development in itself) with a corresponding impoverishment of its cultural heritage, which traditionally centered around the study of the humanistic and existential dimensions of care (cfr. Benner, 1984; Noddings, 1984; Watson, 1985; Kuhse, 1997).

rather than to understand phenomena, that is to say, they are "sciences of facts" (Husserl, 1987, p. 35) rather than of meanings. Excluding meaning implies marginalizing the subjective dimension of health and illness, or reducing it to the naturalistic domain of organic functioning. Thus the focus shifts from the subject to the problem, from the patient who is suffering to the pathological process that is underway, thereby stripping the person of his or her most intimate dimension. This shift is emblematic of the clinical paradox whereby

> the patient, in relation to that which he is suffering from, is only an external fact; the medical reading must take him into account only to place him in parentheses. (Foucault, 2003, p. 7)

This exclusion of the subject, which is typical of scientific rationalism, may be corrected by *recovering subjectivity within the boundaries of science itself*; for this to happen, it is essential that emotional competence be "re-habilitated" as a key professional requirement (cfr. Kanizsa, 1994; Iori, 2006; Bruzzone & Musi, 2007). Indeed, the de-sensitivization associated with a certain type of professionalism prevents carers from going beyond patients' illnesses to pick up on their existential hurt.

> When sick people feels that they are being looked at with eyes that are indifferent, touched with gestures that are empty of meaning and lost in the abyss of extreme technical coldness, they cannot but experience themselves as useless 'objects'. (Borgna, 2013, p. 45)

Hence the need to re-educate the *gaze* that healthcare professionals bring to bear on clinical situations. A considerate and sensitive gaze

> has the power to transform patients' experience, from feeling objectified, because their subjectivity is cancelled out by the conceptual categories of clinical science, to feeling valued within a gaze that acknowledges their unique and original state of feeling. (Mortari, 2006, p. 88)

There is clearly a close link between this recovery of the emotional dimension of existence on the one hand, and the epistemological reframing of clinical science on the other: the rehabilitation of emotions and feelings not only implies the need "not to suppress" the unsaid within care, but also the need to redefine the essence of care itself. Thus Viktor von Weizsächer's call to "introduce the subject into medicine" (Weizsächer, 1951) does not evoke a purely ethical requirement: to allow doctors to be human, but above all an epistemological one: to give medical science back its true object, which is in fact a *subject* and, as such, resists all attempts to objectify it.

To do this, however, requires breaking what has long been considered a golden rule in all scientific procedures: the need to be neutral and detached. As pointed out by the psychiatrist Ludwig Binswanger in relation to the apparently alien nature of mental illness, which only becomes comprehensible when the barrier of incommunicability separating the "sane" from the "mad" is removed and a space of encounter created: indeed, we can "understand nothing of madness as long as we continue to behave towards the mad person as *disinterested subjects* [*unbeteiligtes Subjekt*], or,

which is the same thing, we view the mad person as a mere *object* [*Gegenstand*], or, in sum, we *represent* him or her as an object. On the contrary, we can only understand madness against the background of our shared human destiny, the background of the *condition humaine*, or, which is the same thing, we see the *other human being* [*Mitmensch*] in the mad person too" (Binswanger, 2013, p. 39).

Suppressing the emotional life

Subjective existence may therefore only be understood through subjectivity, while an objectifying approach only serves to denature it. What is valid for the scientific observation of nature may not necessarily hold for the human sciences. "If we wish to know what man is", wrote Edith Stein, "we must place ourselves, in the most vivid way possible, in the situation in which we experience man, that is to say, that which we experience within ourselves and that which we experience in our encounter with other humans" (Stein, 2000, p. 66). Furthermore, in the context of the care relationship, maintaining an impersonal approach means being inauthentic (Heidegger, 1997); and the same is true in reverse: authentic involvement in the relationship means accepting the need to be personally involved, with all that this implies in terms of vulnerability and risk. Above all, it implies running the risk of emotional exposure, given that in the therapeutic relationship "the emotions of both the carer and the one being cared for are strongly implicated" (Borgna, 2004, p. 187).

Nonetheless, *emotional life* (not only that of the patients, but also, and perhaps above all, that of healthcare professionals) is the first dimension to be affected by processes of denial and suppression, insofar as it unavoidably bears the irreducible imprint of subjectivity. Thus it happens that the places of care become places of indifference and lack of care. It is not uncommon for motivated and sensitive professionals, once they have entered into contact with the mechanisms of organization, lose their empathic approach and adopt a sort of rigid impassivity, as though this were the result of a latent and merciless "rite of initiation":

> On crossing the threshold of the hospital institution [...] the surgical removal of feeling becomes normality, 'normopathy', that is to say, the more sensitive human faculties, despite being those which make one *suited* to that world, are amputated. It is likely that those who aspire to becoming members of the community of 'technicians of life', accept the need to turn against themselves the resolution to change that as students they had harboured against the system. Ultimately it is easier to give up an ideal than to transfer it to a hostile context. The fidelity principle becomes modified along the way: it is no longer based on fidelity to oneself, but to the excessive power – hated in words and tolerated in deed – of an organization. (Musi, 2006, pp. 184-185)

On close observation, we may identify a tendency from the outset of medical training to neglect (if not actually to hinder) the development of the affective-relational potential of the future care professionals, given that the goal of their training is to make them into competent technicians rather than sensitive therapists. "The only real solution" – an eminent oncologist has concluded – "is to completely revisit the curriculum for the medical training of future doctors: unfortunately this desirable ethical revolution is struggling to find acceptance in today's medical schools. Hardly anybody explains to medical students, whose training is becoming increasingly technical and specialized, that

their primary duty will be to care for human beings. Not for bodies, organs or masses of cells, but for the whole *human person*" (Veronesi & Pappagallo, 2004, p. 13). Furthermore, this gap in their formation places the young professionals themselves in a vulnerable situation, given that they are forced to learn for themselves and with difficulty to accept their own weakness, tolerate frustration, develop a sense of limit, listen even when it seems useless and instil hope.

For this reason, healthcare professionals whose daily work brings them into close contact with the most extreme situations of vulnerability and uncertainty (onco-haematology, intensive care, geriatrics, palliative care, hospices for the dying) become aware sooner than others that technical-scientific competence, while indispensable, is inadequate when it comes to dealing with suffering. Consequently they feel a strong need for places, times and tools for processing their emotional experience. These professionals cannot avoid becoming involved unless they are prepared to "betray" the helping relationship, and consequently they seek out (no longer as impassive and perfectly efficient automatons, but as vulnerable human beings caring for others who are even more fragile than they are) what, from the start of their training and in the name of an ice-cold and detached professionality, has always been denied to them: the opportunity to care for themselves, without which *care of the other* at any level, becomes unsustainable in the long run. It is therefore critical to provide healthcare workers with instruments for taking care of their own emotional health and for the ongoing regeneration of their professional motivation:

> Working on one's own resources and ability to communicate is an essential step towards learning how to constructively manage stressful psychosocial events and one's own emotions, such as anger, which are significantly associated with high levels of professional burnout. (Aragona, 2005, p. 195)

In the basic training of healthcare professionals, the traditional overlooking of biographical, affective and relational dimensions has been partly remedied thanks to the input of clinical and phenomenological pedagogical approaches with a focus on un-veiling the latent dimensions, ambivalences and paradoxes of care (Bertolini & Massa, 1998). However, caring for the emotional dimension of existence is not a capacity that can be acquired once and for all thanks to a short period of basic training: a more long-term formative input is required, and given the unpredictable nature of the job, ongoing "maintenance".

It is therefore of the utmost importance that healthcare professionals be given the opportunity, as part of their continuous education, to experiment, not with hypothetical strategies aimed at defending themselves from emotional involvement, but with spaces of dialogue and sharing, in which emotions and feelings can be allowed to step out of the shadows to which they have too long been relegated, and finally legitimized, expressed and put into a "form" that contains them without distorting them. This is only possible however in contexts in which the anaffective paradigm has already been challenged, if not in real terms at least in somebody's conscience. As Vanna Iori has observed:

> paying scientific and educational attention to feelings implies culturally transforming the social services by placing them in a '*relationship*' rather than a '*performance*' perspective. (Iori, 2003, p. 206)

Towards a phenomenologically-oriented training

The considerations outlined so far imply that phenomenology can contribute to the training of healthcare professionals at three levels: at the gnoseological level, it can rectify the distortions produced by the objectificaton of scientific thinking and encourage greater "epistemological responsibility" on the part of professionals (Caronia, 2011, p. 118); at the ontological and anthropological level, it can compensate for reductionistic and deterministic tendencies within science, helping to restore a holistic image of the human being (Bruzzone, 2012b); finally, at the ethical level, it can assist in rehabilitating the intuitive and affective dimensions that are an inherent part of the care experience, establishing them as valuable and legitimate professional tools.

The past several years have seen a number of attempts at the international level to apply the phenomenological paradigm to healthcare (among the more recent: Toombs, 2001; Carel, 2011) and to research methodology in the field of medicine and the human sciences (Tarozzi & Mortari, 2010; Chan, Bryczynsky, Malone & Benner, 2010); nonetheless, training experience[4] clearly shows that its richest pedagogical value relates to the "epistemology of reflective practice" (Schon, 2001; Kinsella, 2010), which the crisis of traditional models of thinking is making increasingly urgent and necessary. While in the past professional training applied, without leaving too much room for questioning, an "engineering" logic of building professional competence through the learning of ready-to-go techniques (assuming that any phenomenon whether technical in nature or not could be reduced to technical parameters), today there is increasing demand for more flexible instruments for coping with the uncertainty and unpredictable outcomes characterizing our historical era, that draw on the subject's unique and original identity rather than on his or her acquired abilities.

The answer lies in that "school of life" (Quaglino, 2011) whose contents are not learning objects but subjects themselves and their real-life experience. This means focusing not so much on events, as on the thoughts and emotions surrounding them; investigating not only facts, but their underlying meanings; drawing not only on the calculating logic of instrumental rationality, but also on the analogical languages of metaphor and image; and finally, preferring narrative modes over conceptual *dispositifs*, preparing and maintaining over time dedicated spaces (both external and internal) in which it is possible to narrate and rewrite one's lived-through experience in order to redeem it from fatalistic destiny and open up new possibilities.

These criteria already contain traces of a *phenomenologically-oriented training methodology* which could usefully inform self-care programmes for health-professionals. This methodology is underpinned by four key principles:

1) *The work is based on experience* (Iori, Augelli, Bruzzone & Musi, 2010) and not on preconstituted models and theories: it is only by remaining close to their own lived-through experience that professionals may be legitimated as generators – and not only as consumers – of an experiential knowledge that is nourished by life itself.

[4] The group εἶδος - *Fenomenologia & Formazione*, set up by Vanna Iori at the Piacenza campus of the Università Cattolica, has been conducting continuous training programmes for professionals from the socio-educational and healthcare services and other organizational contexts since 2004.

2) *It encourages the practice of reflectivity* in order to promote the self-appropriation of thoughts and feelings: because authentic self-care involves exploring the hidden life of our thinking and feeling (Mortari, 2009; Cunti, Lo Presti & Sabatano, 2010).

3) *It involves destructuring and restructuring*, through the practice of *epoché* or bracketing, any precomprehensions based on common sense, habit and routine, in order to dismantle reference frameworks that are too rigid and exclusive and to encourage doubt and questioning, which in turn stimulate the search for meaning.

4) *It includes broadening one's experiential field* (Bertolini, 1988), with a view to fostering cross-contamination among different spheres of knowledge (science, philosophy, figurative and performing arts, body-mind disciplines, etc.) and stimulating the sharing of experiences and languages: because acquisition of the deepest levels of understanding often occurs in conjunction with a broadening of one's horizons.

The phenomenological method also appears to hold promise for the area of transversal skills, also referred to (with a term that does not do justice to their importance nor to the complexity involved in constructing them) as "*soft skills*" (Caudron, 1999; Klaus, 2007). Communication ability, capacity for empathy, politeness, respect, intuition, attention, reflexivity, emotional balance, motivation, resilience, flexibility, spirit of cooperation and leadership qualities are but some of the "human" qualities that are required of a care professional, despite the fact that no specific training *dispositif* has been designed for the purpose of developing them.

The copious volume of popular literature and manuals on these topics conceal a deceptive illusion: that it is possible to mechanically (superficially) learn complex behavioural attitudes such as empathic understanding, effective communication or management of emotions, whereas these abilities are nothing more that the spontaneous reflex of a humanity that is constantly (and profoundly) cultivated. In other words, we need to return to that "introspective pedagogy" (Demetrio, 2000), long set aside in favour of more immediate and instrumental objectives, from which alone can issue the true remedy for all forms of loss of meaning, demotivation or *burnout*: namely, the possession of an *inner life*, from which our professional, intellectual, civic, ethical and even political commitment can flow with renewed vigour and freshness.

And to conclude: a film

Hanna, the main character in *The Secret Life of Words* [5], is a young factory worker who leads a solitary and obsessively ordered existence, governed by strange rituals and acoustically (she has a mysterious hearing problem) and emotionally isolated. During a forced leave of absence, she volunteers to provide nursing care to a stranger, bedridden with severe burns on an oilrig in the middle of the ocean (another emblem of solitude, shipwreck and the depths of desolation in which pain at times submerges our existence). The patient, Josef, is an exuberant and talkative man, intent on finding his way into the heart of the mysterious young woman who cares for him with such devotion, but never speaks about herself. Day after day, Hanna obstinately maintains the discipline of silence and anonymity: she carries out her duties correctly and efficiently, but does not want to establish real human contact. However, behind the apparent coldness with which she attempts to

[5] *The Secret Life of Words*, directed by Isabel Coixet. With Sarah Polley, Tim Robbins (Spain, 2005).

avoid becoming involved at any level, she is concealing untellable tragedy and hurt. Only Josef's (initial) perseverance and (later) love succeed in breaking down the barrier that Hanna has put up around herself to avoid suffering, allowing her to become open to life once more. Thus the designated roles of the two characters are reversed, illustrating a profound and paradoxical truth: it is *the carer* who *needs to receive care*. He or she is not necessarily the stronger or "healthier" of the two parties. Carers' own fragility allows them to recognize the suffering of others as an appeal for help, and therefore to give care: on condition that they also take care of themselves and their own hurt.

This film is underpinned by a radical reflection on the theme of care: concerning the fact that we are all (whether cared for or carers) simultaneously both providers and recipients of care; that the propensity to care for others indeed always corresponds to a need for (and sometimes expresses a desperate plea for) care; that while of course we give care through our actions, care can only come about (and ultimately can only be effective) in the context of an authentic encounter between one person and another. By extension, the movie may also be seen to imply that expertise in care does not solely draw on knowledge and practical experience, but also (or above all) on intuition and emotional capacity: that is to say, on the "human factors" that precede and transcend the limits of scientific knowledge and technical modes of intervention. This is the reason for the truly phenomenological requirement that we do not "cut out" humanity – either that of the carers or that of the cared for – but include and respect it, never tiring in our efforts to nourish it.

References

Aragona, M. (2005). Le emozioni nella relazione di cura in oncologia. In M. Gensabella Furnari (a cura di), *Il medico, il paziente e l'arte della cura* (189-211). Soveria Mannelli: Rubbettino.

Balint, M. (1957). *Medico, paziente e malattia*. Milano: Feltrinelli.

Benner, P. (1984). *From novice to expert. Excellence and power in clinical nursing practice.* Menlo Park: Addison-Wesley.

Bertolini, G. & Massa, R. (eds.) (1998). *Clinica della formazione medica*. Milano: Franco Angeli.

Bertolini, P. (1988). *L'esistere pedagogico. Ragioni e limiti di una pedagogia come scienza fenomenologicamente fondata*. Firenze: La Nuova Italia.

Binswanger, L. (2013). *La psichiatria come scienza dell'uomo*. Milano: Mimesis.

Borgna, E. (2004). *L'arcipelago delle emozioni*. Milano: Feltrinelli.

Borgna, E. (2013). *La dignità ferita,* Milano: Feltrinelli.

Bruzzone, D. (2012a). *Viktor Frankl. Fondamenti psicopedagogici dell'analisi esistenziale*. Roma: Carocci.

Bruzzone, D. (2012b). *Farsi persona. Lo sguardo fenomenologico e l'enigma della formazione*. Milano: Franco Angeli.

Bruzzone, D. & Musi E. (a cura di) (2007). *Vissuti di cura. Competenze emotive e formazione nelle professioni sanitarie*. Milano: Guerini.

Carel, H. (2011). Phenomenology and its application in medicine. *Theoretical Medicine and Bioethics*, 32, n. 1, 33-46.

Caronia, L. (2011). *Fenomenologia dell'educazione. Intenzionalità, cultura e conoscenza in pedagogia*. Milano: Franco Angeli.

Caudron, S. (1999). The hard case for soft skills. *Workforce,* 78(7), 60-66.

Chan, K.G., Brykczynski, K.A., Malone, R.E., & Benner P. (2010). *Interpretive phenomenology in health care research*. Indianapolis: Sigma Theta Tau International.

Cunti, A., Lo Presti, F., & Sabatano, F. (2010). *Le competenze relazionali in ambito sanitario. Per una formazione all'agire riflessivo*. Roma: Carocci.

Demetrio, D. (2000). *L'educazione interiore. Introduzione alla pedagogia introspettiva*. Firenze: La Nuova Italia.

Foucault, M. (1969). *Nascita della clinica. Il ruolo della medicina nella costituzione delle scienze umane*. Torino: Einaudi.

Frankl, V.E. (2001). *Logoterapia medicina dell'anima*. Milano: Gribaudi.

Heidegger, M. (1997). *Essere e tempo*. Milano: Longanesi.

Husserl, E. (1987). *La crisi delle scienze europee e la fenomenologia trascendentale*. Milano: Il Saggiatore.

Illich, I. (2004). *Nemesi medica. L'espropriazione della salute*. Milano: Bruno Mondadori.

Iori, V. (2003). Il sapere dei sentimenti. In V. Iori (ed.), *Emozioni e sentimenti nel lavoro educativo e sociale* (193-209). Milano: Guerini.

Iori, V. (ed.) (2006). *Quando i sentimenti interrogano l'esistenza. Orientamenti fenomenologici nel lavoro educativo e di cura*, Milano: Guerini.

Iori, V., Augelli, A., Bruzzone, D. & Musi, E. (2010). *Ripartire dall'esperienza. Direzioni di senso nel lavoro sociale*. Milano: Franco Angeli.

Jaspers, K. (1991). *Il medico nell'età della tecnica*. Milano: Raffaello Cortina.

Kanizsa, S. (1994). *L'ascolto del malato. Problemi di pedagogia relazionale in ospedale*. Milano: Guerini.

Kinsella, E.A. (2010). Professional knowledge and the epistemology of reflective practice. *Nursing Philosophy*, 11(1), 3-14.

Klaus, P. (2007). *The hard truth about soft skills*. New York: HarperCollins.

Kuhse, H. (1997). *Prendersi cura. L'etica e la professione di infermiera*. Torino: Edizioni di Comunità.

Little, M. & Little, J.M. (2005). *Human medicine*. Cambridge: Cambridge University Press.

Mortari, L. (2006). *La pratica dell'aver cura*. Milano: Bruno Mondadori.

Mortari, L. (2009). *Aver cura di sé.* Milano: Bruno Mondadori.

Musi, E. (2006). La vita emotiva: risorsa delle professioni di cura. In V. Iori (ed.), *Quando i sentimenti interrogano l'esistenza. Orientamenti fenomenologici nel lavoro educativo e di cura* (163-221). Milano: Guerini.

Noddings, N. (1984). *Caring: A feminine approach to ethics and moral education*. Berkeley: University of California Press.

Quaglino, G.P. (2011). *La scuola della vita. Manifesto della terza formazione*. Milano: Raffaello Cortina.

Reich, W.T. (2005). L'idea di simpatia: la sua importanza per la pratica e l'etica della medicina. In M. Gensabella Furnari (ed.). *Il paziente, il medico e l'arte della cura* (13-31). Soveria Mannelli: Rubbettino.

Schon, D. (2001). The crisis of professional knowledge and the pursuit of an epistemology of practice. In J. Raven, J. Stephenson (eds.), *Competence in the Learning Society* (185-207). New York: Peter Lang.

Stein, E. (2000). *La struttura della persona umana*. Roma: Città Nuova.

Tarozzi, M. & Mortari, L. (eds.) (2010). *Phenomenology and human science research today*. Bucharest: Zeta Books.

Toombs, S.K. (ed.) (2001). *Handbook of phenomenology and medicine*. Dordrecht: Kluwer.

Veronesi, U. & Pappagallo, M. (2004). *Una carezza per guarire*. Milano: Sperling & Kupfer.

Watson, J. (1985). *Nursing: Human science and human care*. Norwalk: Appleton-Century-Crofts.

Weizsäcker, V. von (1951). *Der kranke Mensch. Eine Einführung in die medizinische Anthropologie.* Stuttgart: Koehler.

Zannini, L. (2008). *Medical humanities e medicina narrativa. Nuove prospettive nella formazione dei professionisti della cura.* Milano: Raffaello Cortina.

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