

Establishing contact: experiential workshops as tools for medical students to explore the patient perspective

Francesca Tusoni¹, Annalisa Iagnemma¹, Alessandro Franceschini², Riccardo Mastrantonio¹, Leila Fabiani¹

¹Department of Life, Health and Environmental Sciences, University of L'Aquila, 67100 L'Aquila, Italy

³SIpEM Italian Society for Medical Pedagogy, 67100 L'Aquila, Italy.

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Abstract

The asymmetry inherent in the care relationship can expose the patient to the phenomenon of reification, which induces patient alienation. Clinical procedures that require contact have a high alienating potential. Showing care and attention to the patient's reactions during contact procedures can improve the doctor-patient relationship. This requires the ability to identify the patient's feelings, known as cognitive empathy. Experiential training has proven to be effective in promoting perspective-taking ability in healthcare professionals. This paper presents 6 pilot experiential workshops aimed at enabling medical students to explore patient perspective-taking. It also outlines the results of a preliminary evaluation of the impact of these workshops on students.

Keywords: Medical Education; Clinical Contact; Perspective-taking; Cognitive Empathy; Experiential Workshops; Embodied Cognition.

1. Introduction

The caring relationship is characterised by a constitutive asymmetry that places the clinician in the condition of acting subject and the patient in the condition of action subject. This is because the patient does not know the principles, methods and objectives of the clinical procedures. In Italy and other countries, the law guarantees the patient right to be informed about the principles and effects of clinical procedures in a simple and clear manner, so that they can give informed consent. However, a patient's choice to undergo a medical procedure that he or she does not know deeply cannot be truly informed (Pietrzykowski & Smilowska, 2021). Moreover, although consent allows the patient to be an active part of the decision-making process, it does not make the patient an active part of the treatment process. Some medical procedures (especially those

requiring visual or physical contact) make the patient feel like being the object of the care relationship. This phenomenon, known as 'reification', is a highly debated bioethical issue (Taussig, 1980). Many clinical procedures are perceived by the patient as alienating because they require attentions and actions that invade the patient's intimate sphere. Such actions would be considered unacceptable in a non-medical context and are tolerated by the patient because of their purpose. However, the fact that patients consent to a medical procedure does not imply that they perceive it as pleasant. This may affect the clinician-patient relationship, inducing in the patient an attitude of closure, often unconscious. The patient's closed attitude may hinder the collection of anamnestic and clinical information, making it difficult to formulate a diagnosis. It can also hinder the success of treatment and reduce patient adherence to therapy.

The clinician's approach can affect the way patients perceive the procedure, influencing their attitude. Adopting a caring and reassuring approach contributes to making the patient feel at ease. This can increase patient compliance in the care relationship. It is therefore important to educate future clinicians to pay attention to the patient's feelings during all those contact actions that may put the patient in a state of awe. However, it is not easy to pay attention to the patient's reaction when the focus of action is clinical action. Knowing how to broaden the focus from the clinical action to the patient's reaction requires an attitude and training that many clinicians develop through experience. So, how can we educate students to pay more attention to the reactions of patients to contact actions?

The effectiveness of the experiential approach for empathic training of healthcare students and professionals has been proven (Bearman et al., 2015). This approach uses the perspective-taking modality to lead clinical to assume the patient's perspective, thus stimulating cognitive empathy. Despite its usefulness, this approach is quite uncommon in Italian medical training. At the University of L'Aquila, an integrated elective course in medical humanities for medical students has been activated since the academic year 2022-2023 (Tusoni et al., 2024). The course includes a module on Narrative Medicine (NM), aimed at promoting the development of an empathic attitude towards patients. However, the NM module does not focus on specific contact procedures and, although it is theoretical-practical, it is not based on an experiential approach.

We applied the experiential approach to a series of pilot workshops for medical students at the University of L'Aquila. The workshops aimed to make students explore the patient's perspective on contact actions, a critical but essential element of various clinical procedures. The objective of the present study was to assess the possible reaction of students to this type of workshops.

2. Methods

For our study, we sought medical students interested in ethical issues and open to experimenting with new types of workshops. Recruitment took place through the local branch of a student association, which forwarded our invitation to its members.

2.1. Structure of workshops

The workshops were designed as practical experiences, without theoretical preparation, but with a final discussion. The aim of the workshops was not to provide the students with pre-packaged answers, but to lead them to reflect independently on the situations they experienced and then to share their reflections with the other group members. Six workshops were conducted by two trainers/observers in three meetings over the course of a week. Each workshop addressed a different dimension of contact, proposing situations that may occur in clinical contexts.

2.1.1. Clinical observation (first day)

The first workshop aimed to simulate 3 general, prolonged clinical observation scenes (such as those occurring during a postural assessment). The workshop used the structure of role playing, with fixed roles, and tasks that varied during the various observations. The task of each participant was hidden from the others. Participants were divided into ‘clinicians’ and ‘patients’, randomly combined into clinician-patient pairs. The observations lasted 5 minutes each.

In the first observation, each ‘clinician’ was asked to take a close look at the patient he or she was paired with, with the aim of trying to find out what problem the ‘patient’ had. On the other hand, the ‘patients’ knew that they were visiting a doctor because they had an unspecified problem. We avoided mentioning a specific pathological situation to prevent participants from simulating specific symptoms. At the end of the observation, the ‘clinicians’ were asked to write on a piece of paper everything they had observed, while the ‘patients’ were asked to write how they had felt during the observation. In the second observation, each ‘clinician’ was asked to repeat the former task, supported by a real health professional, whose task was to ‘help the colleague’. It was explained to ‘patients’ that the ‘clinicians’ who had examined them during the first observation ‘had not been able to identify the problem and had asked for the support of a colleague’. Immediately after the observation, the ‘clinicians’ were required to write whether they had observed other details and what was their patient’s emotional state; the ‘patients’ were asked how they had felt and whether they had perceived something different from the first observation. For the third and final observation, each ‘patient’ was assigned another ‘clinician’, as the first one ‘had failed to understand his problem’. The ‘clinicians’, who had to visit a ‘new patient’, was explained that the ‘patient’ had already been seen by other colleagues without success; therefore, they were asked to try to put their ‘patient’ at ease and to observe him/her carefully to try to understand his/her problem. At the end of the observation, the ‘clinicians’ were asked whether they had succeeded in their task, while the ‘patients’ were asked how they had felt during the observation with the ‘new clinician’.

2.1.2. Proximity (second day)

The second workshop aimed to explore proximity distance and how it changes depending on the people involved in the spatial interaction. This exercise was also carried out in pairs, pairing

students according to various degrees of confidence: one pair consisted of two roommates, one of two boyfriends, 2 pairs consisted of two students who barely knew each other and 2 pairs consisted of a student and a trainer. In each pair, one participant (A) was asked to remain still, while the other (B) was asked to slowly walk towards their partner, observing any conscious or unconscious reactions of the still partner. Bs were instructed to stop at what they believed to be the maximum distance of proximity accepted by their partner. During the activity, As' heart rate (HR) was measured with an oximeter, with the initial and final HR being recorded and its trend monitored. At the end of the action, As were asked whether the distance at which Bs had stopped were appropriate for them, or whether they thought it should be shorter or longer. Then, if necessary, the distance between the two students was adjusted according to the indications of A and then measured. After all pairs had performed the first experiment, the workshop was repeated with the same pairs, with the task reversed.

2.1.3. Sensitivity mapping (second day)

The third workshop aimed to explore the potential invasiveness of the look, in relation to the parts of the body considered most sensitive to eye contact. Each participant was given a drawing of a mannequin and asked to colour in yellow the areas they considered slightly vulnerable to eye contact and in red those they considered most vulnerable. Ten sensitivity maps were thus created. The students were then randomly paired. Within each pair, one student (A) was asked to observe the other (B) for a few minutes, trying to identify the areas of their partner that were sensitive to eye contact. When all As felt they had identified the areas, they were asked to reconstruct their partner's sensitivity map. The experience was repeated with the task reversed. At the end of the workshop, the sensitivity maps were compared with the 'reconstructed' maps to verify the correspondence between the actual and the assumed sensitive areas.

2.1.4. Touch feeling (second day)

The fourth workshop was designed to let students experience how a subject being touched can perceive different modes of touch. Participants were randomly paired. In each pair, one student (A) had to stand behind his/her partner (B) without the latter being able to see him/her. As were asked to define and write on a sheet of paper 3 different intentions with which to touch their colleague's shoulder. For each intention, As had to make 3 attempts at touching, while Bs were asked to write down on a sheet how he had perceived the touch. The experience was repeated with reversed parts. At the end, students compared to each other to see how well touch perceptions matched touch intentions.

2.1.5. Touch negotiation (third day)

The fifth workshop aimed at making students pay attention to the possible reactions of the subject being touched. Again, students were paired randomly. In each pair, one student (A) was to touch first the upper limb of his colleague (B), proceeding from the hand toward the shoulder,

then the lower limb, proceeding from the foot toward the hip. B had no specific task except to freely express his feelings. During the touching exploration, A had to catch any embarrassment of B and immediately stop the action. Alternatively, As could stop when they felt embarrassed, if their embarrassment preceded that of Bs. The experience was repeated in reverse.

2.1.6. Contact lab (third day)

The last workshop was designed to give students the opportunity to use their gaze and gestures to negotiate a contact relationship. This workshop also aimed to return positive energy to participants. In this case, students were given the opportunity to choose a partner with whom they felt kinship. Basic exercises inspired by contact improvisation techniques were proposed.

2.2. Data collection

We collected workshop-related data and reflections emerged during the discussions. In addition, at the end of the course we sent the students a link to a google form, through which we anonymously collected their feedback and suggestions for improving the course.

3. Results

3.1. Sample characteristics

Thirteen medical students responded to our invitation. Of these, 10 (5 males and 5 females) were able to attend the workshops on the scheduled days and times. Two students were enrolled in the 1st year of the degree course, 3 were enrolled in 2nd year, 3 in 5th year, and 2 in 6th year.

3.2. Reflections from the workshops

Some reflections emerged from the discussions among students and trainers/observers.

3.2.1. Clinical observation

Students' reflections - 'Patients' reported feeling the weight of the 'clinicians' gaze in the first and, especially, the second observation (in which the clinician/patient ratio was 2:1). They also reported feeling judged, although some of them clarified that they rationalized the experience, considering being observed and judged as a necessary condition in a clinical setting. In the first two observations, the 'clinicians' focused mainly on details related to 'patients' appearance and posture. Only one of them paid attention to the 'patient's' mood and to his own. In the third observation, the change in the task led the 'clinicians' to focus more on the 'patient's' emotional state, trying to see if they had succeeded in making the patient feel comfortable. All 'patients' noticed the different attitude of the 'new clinician' in the third observation, reporting that they felt understood and comfortable. 'Patients' traced this feeling back to the change of 'clinician',

not being aware of the ‘clinicians’ new task assignment. *Observers’ reflections* - Some ‘patients’ showed a closed attitude from the first observation (crossed arms, low gaze, etc.), which became more pronounced in the second observation. In the third observation all patients were visibly more relaxed.

3.2.2. Proximity

Students’ reflections - The proximity distance was closely related to the relationship between the two subjects involved in the relationship, but it was not always symmetrical (the two did not perceive the relational proximity space as equal). Some students reported feeling uncomfortable while waiting for their partner to start moving. *Observers’ reflections* - Subjects in many cases correctly identified the partner’s preferred proximity distance. In only 2 cases was the distance preferred by the still subject a bit shorter or longer than that achieved by the approaching subject. In some cases, the HR of the still subject, as we expected, increased as the partner approached; in the other cases it increased as the partner started walking and then decreased as the partner approached.

3.2.3. Sensitivity mapping

Students’ reflections - In general, subjects correctly identified some areas of sensitivity, but only in some cases did the reconstructed map come close to the original one. Some students reported discomfort during the final discussion over sharing their areas of sensitivity. *Observers’ reflections* - In some cases, the observing subjects noticed sensitive areas that the observed subject had not coloured on the map (as initially was unaware of them) but which, after comparison, he or she recognized as sensitive.

3.2.4. Touch feeling

Students’ and observers’ reflections - The sensation perceived in many cases did not correspond to the intention of the gesture because, even if the physical dimensions of the touch were captured correctly (intensity, force, time and area of contact) nevertheless the gesture was received by the recipient with a different reaction than intended.

3.2.5. Touch negotiation

Students’ and observers’ reflections - In many cases, the subjects performing the task interrupted the action when they felt embarrassed or because they did not want to embarrass the subject undergoing the task. Participants reported perceiving embarrassment because the task was not associated with a clinical context, so they could not rationalise.

3.2.6. Contact

Observers' reflections - All participants got involved, without hesitation. At the end of the workshop, it seemed they did not want to stop experiencing contact. It would have been helpful to have more time to allow students to compare and fully understand the experience.

3.3. Participants' feedback and suggestions

We asked students to rate each workshop, indicating a score from 0 to 5. As Figure 1 shows, 4 workshops received an average rating above 3, including 1 with an average rating above 4.

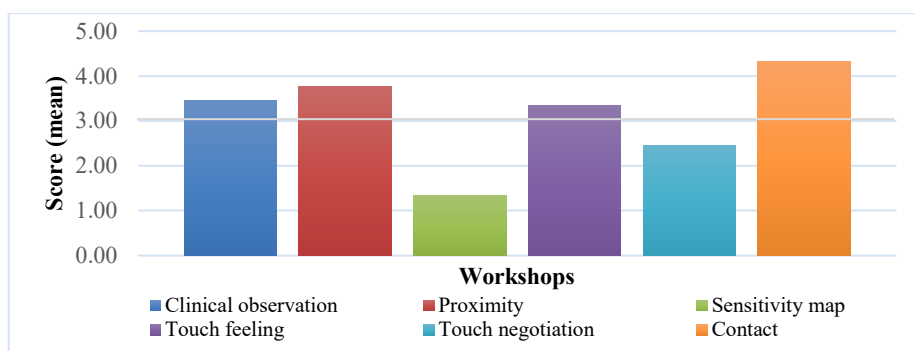


Figure 1. Students' evaluation of contact workshops

We asked students to provide us with suggestions for improving the course. Suggestions were about: increasing the number of meetings and expanding discussion times to allow for better assimilation of the experience; giving the opportunity to experience the workshops with different pairs and also making the first lab bilateral to broaden perspectives; delving into the various modalities of touch (fourth activity); providing a clinical context for the sensitivity map and touch negotiation activity as well to facilitate the approach; and reconsidering the structure of the sensitivity map activity because of the potential embarrassment that can be generated.

4. Discussion

The objective of our study was to investigate how experiential workshops aimed at exploring patients' perspectives could be received by medical students. Since these workshops were novel, we had no expectations. It became soon clear that participants found it difficult to experience contact, especially when they were given no explicit clinical context (2nd, 3rd and 5th workshops). As reported by the students, the absence of a clinical context prevented them from rationalising the experience (i.e. relating an emotional experience of the body to a logical abstraction). The need to rationalise is closely linked to the tendency for 'disembodiment' of understanding, which is rooted in Western culture and prevents the so called 'embodied cognition' (Johnson, 2015). In some cases, embarrassment was more related to the expectation of contact than to

contact itself (e.g. in the proximity workshop HR peaks often occurred before the walking student started to move) and sometimes anticipated actual discomfort (in the 5th workshop, some people performing the action stopped before they even felt uncomfortable or sensed the other person's discomfort). This could be explained by a certain tendency towards affective empathy, which, if unregulated, can interfere with cognitive empathy and perspective-taking ability (Ardenghi et al., 2023). Interestingly, it was not physical contact that had the greatest impact, but eye contact alone or eye contact combined with physical contact. The workshop on touch feeling, in which there was no eye contact, did not cause any embarrassment. The last workshop, in which both partners negotiated the motor action with glances and gestures, was most successful. This is probably because neither party played a passive role, but both played an active and collaborative role. It emerged from the discussions that the students expected the trainers to provide useful strategies for handling various contact situations. However, as one of the participants pointed out, the reaction of the clinician and the patient to a contact cannot be defined a priori but depends on contingent factors each time. When the participants told us that, at the end of the experience, they found themselves without precise answers but with further questions, we realised that the workshops had reached their goal. Of course, our study could have benefited from a bigger sample size and more time devoted to the workshops. Future research should address these limitations and explore how embodied cognition may impact the development of empathic perception in healthcare professionals.

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