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FEATURES

Toward an embodied pedagogy of care in specialist training in Chile: radical care and humanization in public health

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ABSTRACT

The training of health specialists is a strategic component for the operational, human, and territorial sustainability of the public health system. However, Chilean university training models—primarily oriented toward technical efficiency—have tended to marginalize the relational and ethical dimensions of care, weakening the experience of care and diminishing trust in health institutions. From a theoretical–reflective perspective, this article explores the possibilities and tensions that arise when transferring the principles of radical care and their performative version (Embodying Radical Care) to the field of specialist medical training in Chile, proposing that these approaches may contribute to reconfiguring medical training processes toward an embodied ethics of care. From this perspective, the article develops a comparative analysis of theoretical approaches that integrates care ethics, the politics of interdependence, and performative practice. Incorporating these perspectives could strengthen relational and affective competencies in clinical teaching, deepening the learning process through the ethics of radical care and recognizing bodily experience and ethical sensitivity as dimensions of professional formation. At the same time, these principles could improve the experience of care by fostering a culture that acknowledges interdependence among people, institutions, and territories, thereby consolidating a more humane and sustainable medical practice. Ultimately, this reflection seeks to offer conceptual foundations for public policies on training and humanization in health that understand care not merely as a technical act, but as an ethical, political, and aesthetic practice essential for the sustainability of the health system.

KEYWORDS Education, Medical, Graduate, Ethics, Humanism, Chile

INTRODUCTION

The sustainability of Chile's public health system depends largely on its ability to train and retain specialists who ensure equitable access to and continuity of care. However, current university training models, structured according to technocratic logic and focused on productivity, have tended to overlook fundamental dimensions of care: ethics, relationality, and the human experience of those who receive and provide care. This omission weakens the clinical bond, fragments communication, and impacts therapeutic adherence, user satisfaction, and trust in the system [1,2].

The movement for the humanisation of healthcare has emerged precisely in response to this relational crisis. In Chile, this approach has materialised in recent policies promoted by the Ministry of Health, such as the Strategy for Comprehensive Care Centred on People and their Environments and the Technical Guidelines on dignified treatment in healthcare with a rights and gender approach [3,4]. These initiatives seek to reinstate the human dimension as the core of healthcare, but their implementation faces structural difficulties. These include a lack of resources, protected time, and sustained support strategies for healthcare teams. Humanisation actions are often reduced to training or the dissemination of good practices, without achieving profound organisational change. This shows the need to move from awareness-raising to incorporating care as a cross-cutting principle of management and continuing education.

Despite regulatory advances, the distance between humanisation policies and the daily reality of clinical and teaching spaces reveals a deeper cultural divide. Dehumanisation is expressed both in relationships with patients and in links within teams and training environments. Abuse and harassment during medical training can be understood as a structural manifestation of this crisis in care. In Chile, 71.3% of residents surveyed reported having experienced intimidation

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MAIN MESSAGES

- Training models focused on technical efficiency have relegated the ethical and relational dimensions of care.
- This article is the first to transfer the principles of radical care and its performative version (Embodying Radical Care) to the field of specialist training in Chile.
- The analysis is theoretical and reflective and does not evaluate empirical interventions, although it establishes conceptual bases for future applications.

or contemptuous behaviour in the last year, mainly unjustified criticism or disparagement from their supervisors [5]. At the undergraduate level, students report public humiliation, discrimination, and verbal abuse as recurring experiences [6]. These practices violate the dignity of those in training, undermine the quality of learning, and erode patient confidence in the system. The Chilean Academy of Medicine has recognised this situation as a cultural problem that requires profound change [7], in line with Latin American studies that describe similar patterns of hierarchy and mistreatment in resident training [8].

The training of medical specialists in Chile takes place within the university system, accredited by the National Accreditation Commission and closely linked to the public health network. Clinical practice is mainly conducted in state hospitals and other establishments, where public health system officials actively participate in teaching. A Clinical Fields Bill (Bulletin No. 14088-11) is currently being debated in Congress, seeking to regulate access to these spaces and to recognise the teaching role of healthcare personnel [9]. This context highlights the need to rethink medical training as a shared responsibility between the education and health systems.

Faced with this scenario, it becomes necessary to expand the conceptual field to include new epistemologies of care that allow us to rethink both clinical practice and medical education. One of the emerging approaches in this line is the performative proposal Embodying Radical Care by Chilean artist Sergio Patricio Valenzuela, who reinterprets the concept of radical care (developed by authors such as Joan Tronto, María Puig de la Bellacasa, and the Care Collective) as an embodied, political, and situated practice [10–13]. Valenzuela does not formulate a theory of radical care, but rather embodies and actualises it in the field of living art, proposing an understanding of care as active presence, bodily resistance, and an act of political hospitality. From this framework, radical care can offer keys to revitalising the profound meaning of humanisation in healthcare. While institutional humanisation tends to standardise behaviours, radical care introduces the bodily and political practice of care, restoring agency to caregivers and recognising the interdependence among professionals, patients, and communities. Applied to medical training, this approach would allow us to conceive of specialist education not as a mere technical transmission of knowledge, but as an ethical and relational process that teaches how to care for others without losing the capacity to care for oneself and one's professional environment. Thus, caring for those who care ceases to be an end in itself and becomes a structural condition for providing better care to individuals and communities.

This article seeks to explore the theoretical and educational potential of the intersection between radical care, the Embodying Radical Care proposal, and health humanisation policies, with a special emphasis on specialist training as a strategic space for strengthening the human and territorial sustainability of the public health system. Through a theoretical-comparative analysis, convergences and tensions between these approaches are examined, proposing a conceptual framework that allows us to rethink medical practice as an act of hospitality and relational justice. The hypothesis guiding this work argues that integrating the principles of radical care into medical training would contribute to transforming the culture of mistreatment, strengthening the clinical relationship, and improving the care experience, moving towards a more equitable, sustainable, and humane public health model.

THEORETICAL FRAMEWORK: CARE AS AN ETHICAL, POLITICAL, AND PERFORMATIVE PRACTICE IN MEDICAL TRAINING

Care as ethics and politics

Care has traditionally been understood as a private or emotional practice, unrelated to political or institutional discussions. However, since the 1990s, feminisms in the Global North (particularly the work of Joan Tronto) have positioned care as a central political category. In Moral Boundaries (1993), Tronto [10] defines care as "a generic activity that includes everything we do to maintain, continue and repair our world, so that we can live in it as well as possible". This definition goes beyond the domestic sphere and brings care to the heart of public life, understanding that all social organisation depends on it. Tronto argues that liberal societies have made care invisible by privileging autonomy, merit and competition, values that structure both contemporary politics and institutions. The adjective radical, in this context, comes from care feminisms and refers not only to the depth or intensity of the act of caring, but also to its political power. It is a practice that questions power hierarchies, denaturalises the sexual division of labour and redefines sustainability as a collective responsibility.

In contrast, radical care proposes an ethic of interdependence, in which vulnerability is recognised as a shared human condition and, therefore, as the foundation of justice. Along these lines, María Puig de la Bellacasa [11] expands the notion

of care towards a more-than-human perspective, incorporating the affective, material and ecological dimensions that shape the worlds of living. In her proposal, caring is a situated and relational practice that involves responding attentively to the needs of others (human and non-human), but also sustaining the infrastructures that enable common life.

For its part, the Care Collective [12] introduces the concept of the politics of interdependence, arguing that contemporary crises (health, environmental, and economic) require the reorganisation of institutions from a care perspective. This approach redefines sustainability not as efficiency or productivity, but as the collective capacity to sustain life in conditions of dignity and reciprocity.

These contributions allow us to understand care not only as a moral or individual value, but as a political and cultural technology capable of reconfiguring institutions. In the field of health, this implies shifting the focus from resource management to relationship management, recognising that health systems are sustained, above all, by the human networks that comprise them.

The body as a place of care

The perspectives of David Nikkel and Maurice Hamington bring an ontological and performative dimension to the debate. Nikkel [13] proposes the notion of radical embodiment, an ontology that recognises that the body is not a means for thought or action, but the very form of being in the world. From this perspective, all ethical, political or spiritual experience originates in corporeality. Hamington [14], in Politics is not a Game: The Radical Potential of Care, argues that care has political potential precisely because it is embodied. His proposal of care-as-performance understands care as a performative theory of being, in which the body and everyday action are the vehicles through which ethics is practised. For Hamington, the ethics of care cannot be separated from praxis, since "only through the practice of care do the values of care come into existence".

This bodily dimension of care becomes crucial in contexts such as medical training, where clinical learning takes place through direct contact with bodies, gestures and affections. In this sense, the caregiver's body is also a learning body, and the educational relationship becomes an ethical relationship. The teaching of care, therefore, cannot be reduced to cognitive content or technical skills, but requires spaces for embodied experience, where feeling, observing and sustaining are integrated as forms of knowledge.

Radical care as performative practice

From the performing arts, Chilean artist Sergio Patricio Valenzuela's Embodying Radical Care [15] transfers these philosophical foundations to the field of stage practice. Inspired by Hamington and Nikkel, Valenzuela conceives radical care as a bodily and political action, in which the act of caring is materialised in presence, movement and relationship. His work proposes that art can function as a laboratory of care, where modes of attention and support that challenge hierarchical logics of power are experimented with. Embodying Radical Care does not seek to formulate a theory of its own, but rather to embody and actualise the ethics of radical care through performative methodologies. In her proposal, the body becomes a space of hospitality, where the political and the affective meet. This perspective offers an interdisciplinary reading. Thus, care ceases to be a practice exclusive to the health sector and becomes an aesthetic and pedagogical principle capable of transforming the way we learn and relate to each other.

In the context of medical training, this performative translation of radical care can offer key insights for rethinking the teaching of clinical practice. Incorporating dynamics of bodily attention, embodied listening, and relational hospitality allows us to reframe the educational experience beyond technicality, favouring a comprehensive understanding of care as ethical presence.

Medical training in Chile: between education and healthcare

The training of medical specialists in Chile is part of the university system, regulated by the Ministry of Education and accredited by the National Accreditation Commission. The offer is mixed: public and private universities participate, designing their programmes according to academic standards, but whose purpose largely responds to the healthcare needs of the public health system. This dual dependence (academic and health) creates a structural tension between educational logic and healthcare demands. Most practical training takes place in hospitals and centres within the state healthcare network, where public health system officials conduct teaching activities. This hybrid model generates asymmetries in governance and in the recognition of the training function. These institutional tensions affect the educational climate and the culture of training. Various studies in Chile and Latin America [5–8] have documented the presence of vertical hierarchies, work overload and dynamics of devaluation that condition both learning and future relationships with patients. Consequently, medical training is a critical space where cultures of care or mistreatment are reproduced or transformed.

Towards an embodied pedagogy of care

The dialogue between ethics, body, and art allows us to think of medical training as a practice of care in itself. From the perspective of radical care, teaching medicine involves training bodies that care, not just professionals who perform. Integrating the embodied dimension of learning (as proposed by Embodying Radical Care) opens up the possibility of constructing sensitive pedagogies that recognise vulnerability as part of the training process. An embodied pedagogy of care does not replace scientific teaching, but rather expands it: it incorporates listening, mindfulness and co-presence as professional skills. In the Chilean context, moving towards this integration also

means recognising the teaching value of healthcare personnel and strengthening collaboration between universities and health services. Only in this way can the training of specialists contribute to the human sustainability of the healthcare system, making care not a complement to technique, but its structuring principle.

DISCUSSION AND ANALYSIS

The chilean training model as a field of ethical tensions

The medical training model in Chile operates at a complex intersection between the education and health systems. Although it formally falls under the university's purview, its main purpose is to meet the healthcare needs of the public system. This duality creates a vacuum of institutional responsibility. On the one hand, the Ministry of Education supervises the higher education system, while the National Accreditation Commission defines the criteria and standards of academic quality. For its part, the Ministry of Health depends on training outcomes to address gaps in the healthcare network. In this intermediate space, healthcare teaching (performed by public health system officials who are not part of the university staff) becomes the invisible backbone of the system. However, its institutional and academic recognition remains limited. From the perspective of radical care, this situation reflects a structural form of institutional neglect: institutions are required to educate and provide care, but without mechanisms to care for those who perform these functions. Care is fragmented across sectors, reproducing a logic where relationships are subordinated to productivity. This dissociation has a direct impact on the training culture and, ultimately, on the relationship with patients.

Humanisation as discourse and radical care as practice

The humanisation policies promoted by the Ministry of Health have highlighted the ethical dimension of treatment, but their implementation is often limited to formal initiatives or awareness-raising courses. From the perspective of radical care, humanisation can be understood as institutional discourse, while radical care proposes a structural practice. Humanisation seeks to change attitudes; radical care requires transforming the conditions of relationships, time and power within institutions. In medical training, this difference is decisive. While the traditional model is based on rigid hierarchies, performance evaluation, and vertical transmission of knowledge, radical care proposes a paradigm in which the ethics of connection are as relevant as technical competence. Clinical teaching becomes a space where reciprocity, listening, and presence are learned, shaping a pedagogy of care that transcends mere content transmission.

Integration of three perspectives of care to reinterpret medical education

The theoretical-comparative analysis in this article does not start from pre-existing pedagogical theories, but rather transfers conceptual frameworks of care (ethical, political, and performative) to the field of medical training to explore their interpretive and transformative potential.

Drawing on the ethics of care (Tronto, Hamington), this paper proposes reinterpreting medical education as a morally situated relationship. Although these authors do not directly address the educational field, their approaches to responsibility and care suggest that the teacher-resident relationship is also an ethical space in which one learns to respond to others' vulnerability. In this sense, clinical teaching can be understood as an exercise in mutual care, in which teaching also supports, accompanies and recognises.

The politics of interdependence (Puig de la Bellacasa, Care Collective) offers a second level of analysis, focused on institutional structures. From this perspective, the Chilean training model is reinterpreted as a network in which educational and health institutions depend on each other, yet do not assume this interdependence as an organisational principle. This perspective makes it clear that institutional neglect (the lack of recognition of the teaching role in healthcare and the fragmentation between the Ministries of Education and Health) is not only a management problem, but also a structural manifestation of dehumanisation.

For its part, the performative practice of radical care (Embodying Radical Care, Valenzuela) introduces the possibility of rethinking clinical learning from the body and experience. Although this view comes from the field of the arts, it suggests that ethics can be taught and practised through bodily presence, attention, and co-experience. Transferred to medical training, this idea opens up the possibility of embodied methodologies that strengthen sensitivity, empathy and professional self-awareness.

Together, these three perspectives describe what training could become if it were reorganised in the light of radical care. The ethics of care illuminates the relational plane, the politics of interdependence reveals the institutional plane and performativity contributes the experiential plane.

Although they converge in the goal of revaluing care, they also reveal productive tensions. Ethics emphasises interpersonal encounter, politics questions the structures that condition it, and performativity invites us to embody the bond beyond discourse. This friction between levels allows for a comprehensive and critical reading of medical training, in which care is understood as a relational, structural, and bodily phenomenon.

This intersection between ethics, politics, and performativity constitutes the methodological core of the theoretical-comparative analysis of the present study.

Proposal from radical care

This article proposes understanding medical training not only as an academic process but also as a social practice of care that shapes how future specialists relate to people, institutions, and themselves. Accepting the radical nature of care implies recognising its feminist and political origins. This means shifting care from the private sphere to the centre of institutional

organisation, where teaching, learning and managing health are conceived as collective responsibilities rather than individual virtues. From the framework of radical care and its performative reading (Embodying Radical Care), five structural transformations are proposed that translate this embodied ethic into concrete actions for institutional, pedagogical and political change.

1. Reconceptualising medical pedagogy as a practice of care

Radical care, understood as a political and relational practice [10,12], invites clinical teaching to be a form of mutual care as well. This involves replacing the vertical and corrective logic of teaching with a relational pedagogy based on presence, listening and co-responsibility.

In practice, this can translate into:

- Redesigning clinical supervision spaces as bidirectional learning opportunities.
- Including modules on ethical and physical reflection on the pedagogical bond.
- Training clinical tutors in communication skills, empathetic feedback, and interpersonal conflict management.

These actions transfer the ethics of care from discourse into the daily practice of medical teaching, reinforcing the idea that teaching and caring are inseparable.

2. Institutionalise care as a training principle

In the radical care paradigm, institutional sustainability depends on how those who sustain the system are cared for [13,14]. Therefore, care must be formally integrated into curricula, graduate profiles, and quality assurance mechanisms.

Possible actions include:

- Including learning outcomes related to dignified treatment, empathy, and collaboration in the profiles defined by the National Accreditation Commission.
- Developing "relational quality" indicators that measure the learning experience and student well-being.
- Incorporating qualitative assessments of the educational environment into accreditation processes.

With this, care ceases to be a soft skill and becomes a criterion for educational excellence, articulating ethics, technique, and educational policy.

3. Recognising and caring for those who teach

From the perspective of the ethics of care, patients cannot be cared for without caring for those who care for them. In Chile, public health system officials who teach healthcare are responsible for much of the practical learning, but without academic recognition or protected time.

In this regard, the following specific proposals are made:

- Move towards a framework of recognised healthcare teaching, with criteria for remuneration and evaluation shared between universities and health services.
- Formalise this principle in the Clinical Fields Act (Bulletin No. 14088-11), establishing teaching care as an essential component of the healthcare-teaching agreement.
- Create welfare and emotional support programmes for clinical tutors, recognising the emotional impact of the training role.

In this way, reciprocity is institutionalised: those who teach are also cared for, and the training system becomes more sustainable.

4. Incorporate embodied and interdisciplinary methodologies

Radical care, in its performative dimension [15], posits that the body is not only a means of action, but also a source of ethical and political knowledge. Applying this premise to medical training involves developing methodologies that integrate bodily reflection, mindfulness, and relational practice.

Possible applications:

- Include "body listening" workshops, clinical simulations with a focus on emotions and presence.
- Work with artists, therapists, and humanities teachers on transdisciplinary projects.
- Implement spaces for pause, silence, or conscious movement in the training routine as a strategy for self-regulation and empathy.

These practices promote an embodied pedagogy of care, where technical learning is complemented by the ability to feel, perceive, and support others.

5. Build an intersectoral policy of care

Radical care has a political dimension that directly challenges governance structures [10,12]. In the case of Chile, this requires a coordinated framework between the Ministries of Education and Health that recognises care as a common principle.

The following structural actions are proposed:

- Create a National Committee for Care and Medical Training, with the participation of both ministries, universities, and health services, to develop joint guidelines.
- Include care as a cross-cutting theme in the National Policy for Training and Retaining Specialists.
- Allocate competitive funds for pedagogical innovation projects related to the ethics and practice of care.

Together, these five proposals seek to translate the ethics of radical care into a concrete strategy for transformation. Their aim is not to replace technical knowledge, but to complement it with an embodied ethic that restores human meaning to medical training. Only in this way can we move towards a system in which caring (for patients, teachers, and institutions) is recognised as the deepest form of excellence.

Implications for governance and public policy

The parliamentary discussion of the Clinical Fields Bill [9] provides an opportunity to translate these principles into a

new governance of the training system. From the perspective of radical care, this law should not be limited to regulating access to clinical fields. However, it should recognise them as spaces of institutional care, where the State's educational, healthcare and human missions converge. An intersectoral policy that integrates teacher welfare, academic recognition and pedagogical support could transform healthcare agreements into reciprocal care alliances. Thus, the sustainability of medical training would no longer be measured solely by the number of scholarships or places, but also by the relational quality of the training process and its impact on clinical practice.

This horizon of institutional transformation aligns with other recent regulatory advances in Chile, such as Law No. 21,643, known as the Karin Law [16], which guarantees the right to a life free from harassment and abuse in the workplace. Its enactment reflects a deeper cultural change: the recognition of care as a legal and ethical principle for relations within the State. Integrating this approach into medical training would make it possible to anticipate and prevent the same dynamics of violence and dehumanisation that the law seeks to eradicate in the workplace.

In this sense, both the discussion on clinical fields and the implementation of the Karin Law [16] represent complementary opportunities to build a coherent institutional care framework, where training, work and healthcare are articulated around respect, hospitality and human sustainability.

In short, radical care offers not only an ethical but also an organisational framework for rebuilding the relationship between education and health. Adopting this principle as the basis for Chilean training policy would align technical excellence with human sustainability, making care a cross-cutting theme of health governance.

CONCLUSIONS

Chilean medical training faces a structural challenge that transcends the gap between university supply and healthcare demand: relearning how to care. In a system strained by productivity and institutional fragmentation, training practices do not always manage to sustain the human dimension of learning or the reciprocity between those who teach and those who learn. This article has argued that the approach of radical care [10–12], articulated with the political ethics of care and its performative expression in Embodying Radical Care [15], can offer a way to rethink the very meaning of medical training. Radical care proposes an embodied ethic that recognises the interdependence between body, institution, and territory. Applied to medical education, it implies understanding clinical learning as a process of relationship and presence, where technical knowledge is intertwined with ethical sensitivity. From this perspective, teaching medicine is also caring, and training spaces must be configured as environments of hospitality: places where others are welcomed in their difference and vulnerability, and where teaching, accompanying, and learning become acts of relational justice.

The five proposals developed (reconceptualising medical pedagogy, institutionalising care, recognising healthcare teachers, incorporating embodied methodologies and promoting an intersectoral care policy) constitute a concrete framework for action. Together, they outline a project of cultural and institutional transformation in which the quality of training is measured not only in technical skills but also in the ability to build ethical and sustainable bonds.

This change requires political will, intersectorality, and a critical review of indicators of university and healthcare excellence. The Clinical Fields Bill [9], together with Law No. 21 643 (Karin Law) [16], represents opportunities to bring about this cultural shift towards an institutional framework that not only prevents mistreatment but also organises care as a principle of management and training.

The theoretical and analytical findings of this work confirm that integrating the principles of radical care into medical training can effectively help reverse cultures of abuse, strengthen clinical relationships, and improve the care experience for both patients and healthcare teams. In this sense, the radical nature of care does not refer to an excess of empathy, but rather to the will to transform the structures that sustain life, articulating a policy of care [10,12] that comes from feminism and is projected towards the institutional sustainability of the healthcare system. Ultimately, radical care allows us to understand medical practice (and its teaching) as an act of hospitality and relational justice, where caring means sustaining life also within those who sustain it.

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Hacia una pedagogía encarnada del cuidado en formación de especialistas en Chile: cuidado radical y humanización en salud pública

RESUMEN

La formación de especialistas en salud constituye un componente estratégico para la sostenibilidad operativa, humana y territorial del sistema público. Sin embargo, los modelos formativos universitarios chilenos, centrados en la eficiencia técnica, han tendido a relegar la dimensión relacional y ética del cuidado. Con ello se ha debilitado la experiencia de atención y la confianza en las instituciones sanitarias. Desde una perspectiva teórico–reflexiva, este artículo explora las posibilidades y tensiones que surgen al trasladar los principios del cuidado radical y su versión performativa, *Embodying Radical Care*, al campo de la formación de especialistas médicos en Chile. Además, se propone que estos enfoques pueden contribuir a reconfigurar los procesos de formación médica hacia una ética encarnada del cuidado. Desde esta aproximación, el artículo desarrolla un análisis comparativo de perspectivas teóricas que integra la ética del cuidado, la política de la interdependencia y la práctica performativa. Se plantea que la incorporación de estos enfoques permitiría fortalecer las competencias relacionales y afectivas en la enseñanza clínica, profundizando en ella desde la ética del cuidado radical y reconociendo la experiencia corporal y la sensibilidad ética como dimensiones del aprendizaje profesional. Al mismo tiempo, estos principios contribuirían a mejorar la experiencia de atención, al promover una cultura del cuidado que reconozca la interdependencia entre las personas, las instituciones y los territorios, consolidando así una práctica médica más humana y sostenible. En última instancia, esta reflexión busca aportar fundamentos para políticas públicas de formación y humanización en salud que conciban el cuidado no solo como acto técnico, sino como práctica ética, política y estética esencial para la sostenibilidad del sistema sanitario. En suma, se concluye que integrar el cuidado radical podría reconfigurar la formación hacia una ética encarnada del cuidado, fortaleciendo competencias relacionales y mejorando la experiencia de atención.