MEDICAL ETHICS AND THE EROTETIC METHOD: AN EDUCATIONAL PERSPECTIVE

ETICA MEDICA E METODO EROTETICO: UNA PROSPETTIVA EDUCATIVA

Angela Magnanini
Università degli Studi di Roma Foro Italico
angela.magnaninini@ioma4.it

Emanuele Isidori
Università degli Studi di Roma Foro Italico
emanuele.isidori@uniroma4.it

Double Blind Peer Review

Magnanini A., Isidori E. (2025).
Medical Ethics and the erotetic method: an educational perspective
Italian Journal of Health Education, Sports and Inclusive Didactics, *9(4).*

Doi:
https://doi.org/10.32043/gsd.v9i4.1626

gsdjournal.it
ISSN: 2532-3296
ISBN: 978-88-6022-528-3

ABSTRACT

English
The article examines the erotetic method—teaching through structured questions and dialogue – as an operational framework for medical ethics. Shifting from transmitted rules to posed problems fosters critical thinking, value awareness, and well-reasoned decisions under uncertainty. Rooted in the Socratic tradition, the model can be applied to specific cases (end-of-life, transplantation, triage) to internalize values and strengthen argumentation, empathy, and professional accountability.

Italiano
L'articolo approfondisce il metodo erotetico – insegnare con domande strutturate e dialogo – come cornice operativa per l'etica medica. Il passaggio da regole trasmesse a problemi posti sviluppa il pensiero critico, la consapevolezza dei valori e decisioni motivate nell'incertezza. Radicato nella tradizione socratica, il modello si può applicare a casi specifici (fine vita, trapianto, triage) per interiorizzare valori e rafforzare argomentazione, empatia e responsabilità professionale.

KEYWORDS
medical ethics; erotetic method; dialogic pedagogy; case-based learning; ethical decision- bioethics education.

etica medica; metodo erotetico; pedagogia dialogica; apprendimento basato sui casi; decisione etica; educazione alla bioetica

Received 2025-10-05
Accepted 2026-01-07
Published 2026-01-12

1. Erotetic pedagogy: concepts and models

Medical ethics education is moving from lecture-based transmission to person-centred, dialogic learning that links ethical reflection with clinical competence and professional identity. Three currents support this shift and converge on an erotetic (question-centred) approach. First, principlism offers a shared grammar – autonomy, beneficence, non-maleficence, justice – but says little about how students learn to reason under uncertainty. The pedagogical task is to practise disciplined justification, defining the ethical problem, mapping stakeholders and values, generating options, and testing reasons and evidence before making a decision.

Second, humanistic and hermeneutic perspectives – such as narrative medicine and the biopsychosocial model – treat care as an interpretive and relational endeavour. They require better questions about persons and contexts, making dialogue the place where ethical relevance, options, and standards become explicit (Charon, 2006; Engel, 1977). Third, contemporary designs, such as problem-based learning and programmatic assessment, organise inquiry over time.

Based on these premises, by erotetic pedagogy we mean a structured, question-centred approach to teaching ethical reasoning in human and social sciences that treats the well-formed question as the basic pedagogical unit. Its first principle is problem-posing; learning begins not from a doctrine or rule to be applied, but from an articulated ethical problem situated in a concrete clinical context. The second principle is dialogical inquiry; knowledge and judgment emerge through conversation in which reasons are offered, challenged, and revised in the presence of others who are affected or accountable (Gadamer, 1975/2013). The third principle is reflexivity; learners monitor the assumptions, values, and interpretive frames that shape their judgments, and remain willing to modify them in light of counterarguments, new evidence, or patient narratives (Schön, 1983).

These principles extend the reach of principle-based bioethics by specifying how practical judgment is cultivated: through disciplined questioning that renders value conflicts explicit, makes options comparably assessable, and links decisions to publicly defensible reasons (Beauchamp & Childress, 2019). Contemporary accounts of Socratic questioning in health professions education corroborate this stance, demonstrating how guided questions promote intellectual humility,

justification, and the transfer of reasoning to novel cases (Ng, 2024; Oyler & Romanelli, 2014).

Brought upstream into teaching, erotetic pedagogy makes ethical reasoning teachable, observable, and improvable across settings. In short, it translates principles into dialogic practice, embeds humanistic commitments into inquiry, and aligns with assessment-for-learning to form clinicians who can justify, communicate, and revise decisions in the context of objective clinical complexity.

To move from principles to practice, erotetic pedagogy is operationalized as a five-phase protocol that instructors can rehearse with learners across cases and simulations.

PROBLEM FRAMING → STAKEHOLDER–VALUE MAPPING → OPTION GENERATION → REASON–EVIDENCE TESTING → DELIBERATIVE REVISION

Figure 1. The five-phase protocol of the Erotetic Educational Approach (EEA).

Phase 1. Problem framing. Learners specify the ethical problem in precise terms, distinguishing it from clinical, legal, or logistical issues, and clarifying what is at stake and for whom. The aim is conceptual clarity that prevents premature closure or displacement of the ethical question.

Phase 2. Stakeholder–value mapping. Participants identify the relevant stakeholders (patients, families, clinicians, institutions, broader publics) and elicit the values involved (autonomy, beneficence, non-maleficence, justice, dignity). Here, narrative and communicative competences are central because understanding what matters requires interpretive attention to stories and meanings (Kurtz, Silverman, & Draper, 2016).

Phase 3. Option generation. The group articulates plausible courses of action, including creative or system-level alternatives that might have been overlooked, which prevents false dilemmas and widens the decisional field beyond default routines learned in purely biomedical Problem-Based Learning (PBL) contexts (Barrows & Tamblyn, 1980).

Phase 4. Reason–evidence testing. Each option is examined against articulated reasons and the best available evidence. What supports or undercuts this option? Which harms or benefits are foreseeable? What uncertainties remain, and how decision-relevant are they? Simulation-based enactments strengthen this phase by surfacing performance constraints and communicative demands that abstract discussion can miss (Issenberg et al., 2005).

Phase 5. Deliberative revision and decision. The group converges on a justified and communicable decision, states any residual uncertainties, and specifies conditions for revision should circumstances change. The decision is then translated into a communication plan suited to lay stakeholders. Programmatic assessment practices can document growth across repetitions of the protocol, aggregating low-stakes observations into a longitudinal picture of ethical competence (Schuwirth & Van der Vleuten, 2011; van der Vleuten et al., 2012).

1.1. Types of questions

Within the protocol, question types (clarifying, probing, counterfactual, consequentialist, and value-eliciting) are selected to address different moments of reasoning. Clarifying questions ("What exactly is the ethical problem here, and what is not?") help secure a shared understanding and bound the inquiry. Probing questions ("Which assumption makes this option attractive, and is it warranted?") bring tacit premises to the surface and test their legitimacy. Counterfactual questions ("If the patient's capacity were impaired, how would our reasoning change?") help learners examine their sensitivity to key uncertainties and avoid status quo bias. Consequentialist questions ("What foreseeable harms/benefits follow from this course, to whom, and on what time-horizon?") force explicit articulation of outcomes and trade-offs under uncertainty. Value-eliciting questions ("Which value takes priority here, and why would a reasonable stakeholder accept this priority ordering?") connect choices to justificatory frameworks, enabling accountability to both individuals and the public.
In practice, these question types are interleaved in dialogue; their sequencing is responsive to patient narratives and team interactions, consistent with a hermeneutic model of understanding as conversation and with communication-skills pedagogy that emphasizes listening, checking understanding, and shared decision-making.

1.2. Roles and responsibilities of instructors and students

Erotic pedagogy reconfigures the roles of classroom and clinical settings. The instructor, as facilitator, curates the case, scaffolds the inquiry with targeted question types, and models the virtues of ethical deliberation – clarity, fairness to alternative views, responsiveness to evidence, and humility in the face of

uncertainty. The facilitator also orchestrates briefing and debriefing, ensuring psychological safety while maintaining rigour in justification. In simulation settings, this includes aligning performance objectives with the phases of the protocol and capturing artefacts (audio, notes, rationales) for feedback.

The student, as a co-inquirer, bears responsibility for advancing the inquiry: articulating the problem, proposing options, offering and scrutinising reasons, and translating conclusions into communicable plans. Over time, learners demonstrate progress not only in outcome (reaching a defensible decision) but in process (how they justify, listen, and revise). Programmatic assessment provides the infrastructure for documenting this progress, combining multiple low-stakes observations with narrative feedback to support learning as development, rather than one-off certification (Schuwirth & Van der Vleuten, 2011; van der Vleuten et al., 2012). At the clinical interface, moral case deliberation offers a complementary institutional practice that aligns with these role expectations and demonstrates its feasibility in interprofessional teams (Seekles, Widdershoven, Robben, & Molewijk, 2016; Svantesson et al., 2014).

Erotetic pedagogy aligns the micro-practices of questioning with a culture of dialogic professionalism, in which ethical norms are internalized through repeated, facilitated acts of accountable reasoning embedded in the real conversations where care occurs (Jonsen & Toulmin, 1988). In practice, erotetic teaching stands on three complementary methods that any medical school or teaching hospital can use:

1) structured case discussions in small seminars to learn the questioning sequence without time pressure;

2) simulation or role-play to stress-test reasoning and communication under realistic constraints;

3) interprofessional case conferences (also in the style of moral case deliberation) to connect classroom habits with ward culture. Each method requires simple, reliable tools, a light yet fair way to assess progress, and a few safeguards to maintain high quality and comparability across settings.

For erotetic inquiry to transition from an appealing idea to everyday teaching practice, it requires a small, dependable set of tools that are easy to deploy and share. The aim is twofold: to guide ethical dialogue in a structured manner – so learners ask the right questions at the right time – and to make reasoning visible, allowing it to be observed, coached, and tracked over time. To this end, we propose a lean, adaptable toolkit that sustains the entire process, comprising didactic

materials that shape questions and cases, an assessment-for-learning spine that turns reflection into observable evidence, and a few quality safeguards that maintain high standards while allowing for local adaptation. Concretely, we outline the minimum elements for implementation: a Question Bank and brief scenarios to trigger inquiry; briefing/debriefing notes to orient and reflect; simple task/observer sheets to capture the “why” behind actions; a concise rubric, short feedback, and portfolio to support growth; and calibration, triangulation, and a fidelity checklist to ensure reliability and transferability. In this way, the erotetic method becomes a practical device – one that is teachable, observable, and coachable.

Materials and instruments. The core toolkit is intentionally lean and adaptable. A Question Bank links sample prompts to each phase of the erotetic protocol (from clarifying the problem to revising the decision) and to recurring themes, such as consent, confidentiality, end-of-life care, or distributive justice. Short scenario prompts – one page at most – offer information-rich vignettes with built-in ambiguities and brief "reveals" that the facilitator discloses only when learners ask the right questions. Briefing notes make aims, roles, timing, and psychological safety explicit; debriefing notes organise reflection around three anchors: the process (how we asked, listened, justified, and revised), the product (what decision and why), and the transfer (what we will reproduce next time). In simulation, simple task cards and observer sheets mirror the five erotetic phases, allowing observers to capture the reasons behind actions, not just the actions themselves. All files should be version-controlled and lightly annotated so that new faculty can reuse and adapt them without compromising the method's core principles.

Assessment for learning. To keep the focus on growth, evaluation is programmatic and evidence-based. A concise Ethical Reasoning Rubric transforms the method into observable behaviours across five domains: precise problem framing; stakeholder- and values-mapping with narrative attunement; generation of realistic options; testing reasons against evidence and counterarguments (including how uncertainty is handled); and a clear, lay-friendly justification, along with conditions for revision. After each session, the facilitator offers brief narrative feedback – one concrete strength and one priority for improvement – citing the questions asked, the reasons offered, and the clarity of the explanation to non-experts. Over a teaching block, multiple low-stakes observations from faculty, peers, and self-assessment are aggregated in a small portfolio with artefacts (reason maps, option tables, excerpts from debriefs), which provides a cumulative picture of progress and supports fair summative judgements without additional examinations.

Quality and rigour. Three habits help maintain high standards while respecting local flexibility. First, inter-rater calibration involves short workshops where faculty use shared video or transcripts to align their application of the rubric; a quick recalibration mid-semester prevents drift. Second, triangulation, made in a way that combines sources (teacher, peer, self), methods (scores, comments, artefacts) and contexts (seminar, simulation, conference) so that claims of improvement rest on converging evidence, not on a single performance. Third, transferability with fidelity. Vary scenarios across specialities and care settings, and ask learners to write brief transfer statements ("Which erotetic move will you reuse in your next clinic or ward round, and how?"). A one-page fidelity checklist – for example, whether the five phases were followed, at least three options were considered, a counterargument was addressed, and a patient-facing note was produced – helps programmes preserve the method's essentials while allowing justified local adaptations. In this way, materials, assessment, and quality assurance form a coherent, lightweight system in which ethical reasoning is teachable, observable, coachable, and progressively internalized as a professional habit.

2. Case-based applications

The cases below are didactic constructions, distilled from study and teaching experience, and serve to show how erotetic pedagogy – learning through well-formed, structured questions – helps learners internalize values and act with clarity in ethically sensitive situations (end-of-life care, organ transplantation, emergency triage). Each case illustrates how asking, testing, and explaining (rather than merely "knowing the rule") turns principles into accountable practice.

Case A: End-of-life decision with divided family views. A 72-year-old, fully competent patient with end-stage heart failure refuses further invasive treatment and asks for comfort care. One child says, "Do everything," the other supports the patient; clinicians disagree about short-term reversibility. The erotetic move is to name the ethical question first: Are we honouring a competent refusal, checking capacity, or mediating a family conflict? Clarifying this boundary prevents a slide into purely prognostic debates. Next, the team maps stakeholders and values – patient autonomy and dignity; family hopes framed as beneficence; professional non-maleficence and integrity – and widens options beyond the false binary

"everything vs nothing." Reasonable options include a time-limited trial with stopping rules, a planned transition to comfort care, and a structured family meeting (possibly accompanied by an ethics consultation). These options are tested: capacity is documented; burdens and low probability of benefit weigh against escalation; a trial can address uncertainty without committing to unlimited treatment. The decision is then translated into plain-language communication that reconfirms the right to refuse, specifies what comfort care entails (symptom control and support), and invites a facilitated meeting to align goals. A brief decision and justification note records reasons and the conditions that would warrant revision (e.g., loss of capacity, new evidence). Debriefing asks: Did we frame the problem precisely? Which questions exposed hidden assumptions in "do everything"? How did we balance autonomy and beneficence under uncertainty? What erotetic moves will we reuse?

Case B: Organ allocation under scarcity. Two candidates qualify for one liver graft. Candidate 1 has better short-term survival odds; Candidate 2 has an acceptable prognosis but faces marked social vulnerability. Erotetic work begins by identifying the decision: is this an individual clinical choice or the application of a distributive rule on behalf of the entire wait-list? That reframes the reasoning around justice, policy, and public accountability. Stakeholders extend to the entire wait-list, the transplant centre, and the public, whose trust depends on transparent and consistent procedures. The team resists premature closure by articulating alternatives: follow the standard score, submit a justified exception, mobilize rapid social support for Candidate 2, escalate to an allocation committee, or defer briefly to gather discriminating data. Each path is weighed against justice principles – utility (benefit), equity (mitigating structural disadvantage), priority to the worst-off – within policy limits. Often, equity-oriented support for Candidate 2 is justified without altering the immediate allocation, which proceeds by the policy-concordant score unless clear exception criteria are met and approved. Public-facing communication explains the allocation aim, rules used, whether an exception was considered, and what was done to mitigate disadvantage. Debriefing examines how erotetic prompts broadened options, how utility and equity were balanced while maintaining fidelity to policy, and which elements are essential for a defensible, auditable justification.

Debrief questions could be as follows: What exactly is the ethical problem here, and what is not? Is this an individual clinical choice or the application of a distributive

rule for the whole wait-list? Who are the stakeholders beyond the two candidates (other wait-listed patients, the centre, the public), and what matters to each? Which options did we genuinely weigh (apply score as-is, justified exception, rapid social-support for Candidate 2, allocation committee review, brief deferral for more data), and why? How did we balance utility, equity, and priority to the worst-off within policy limits? If an exception was discussed, which explicit criteria supported or ruled it out? What uncertainties most influenced ranking, and how were near-ties handled fairly? What mitigation measures for Candidate 2's social vulnerability have been activated, and what is the plan to document and follow up on them? What is our ≤200-word public-facing rationale that explains the decision and its trade-offs? Which erotetic moves improved transparency (framing, widening options, testing reasons), and what procedural refinement will we adopt next time?

Case C: Emergency triage with limited ventilators. In a surge, three hypoxic patients arrive; only two ventilators are available. Prognoses are close; information is incomplete; families are present; the team is under pressure. The erotetic protocol begins by establishing the aim of triage (maximising lives, maximising life-years, or ensuring fairness) and identifying which guidelines apply and where judgment must fill the gaps. Stakeholders include patients/families seeking transparency, staff facing safety and moral distress, and institutions/publics requiring accountability. The team structures options by allocating resources based on the best-supported prognosis, uses random tiebreakers when differences are truly marginal, adopts time-limited trials with predefined reassessments, or, when prognosis is clearly poor, pivots to comfort-focused care. Reasons and evidence are tested in real time: which data truly discriminate; how to use tiebreakers without eroding fairness; how to mitigate moral injury and perceived arbitrariness through documentation and clear explanations. A defensible plan typically combines prognosis-based allocation with time-limited trials and explicit review points, recorded in a contemporaneous justification note. Communication with families explains aims, criteria, and uncertainty in plain language, commits to reassessment, and affirms comfort measures regardless of allocation; team communication assigns roles, codifies documentation, and signals support resources. Debriefing asks which questions clarified aims and slowed impulsive choices, how tiebreakers and trials were applied, how effective language was under pressure, and what procedural refinements would improve fairness and resilience.

Debrief questions connected to the case could include: What is the primary aim of triage in this surge (maximizing lives, life-years, or fairness), and which guidelines apply? Which uncertainties truly matter for discrimination, and what additional data – if any – could reduce them in time? When prognoses are nearly equal, how will we use tiebreakers without undermining fairness? Which options did we consider (prognosis-based allocation, random tie-break, time-limited trials, comfort care), and why? What reassessment interval and criteria will trigger reallocation or de-escalation? How will we explain aims, criteria, and uncertainty to families in plain language while supporting staff and mitigating moral distress? What will our contemporaneous justification note include to document reasons, evidence, and review points? Which erotetic moves helped slow impulsive choices and improve transparency? What one procedural refinement will we adopt before the next surge? Each scenario opened by the three cases runs in a compact cycle:

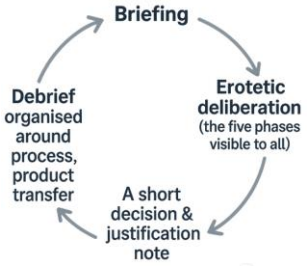

Figure 2. The cycle of the erotetic approach to case-based ethics education

Rotating roles (chair, scribe, sceptic, patient/family advocate) distributes responsibility for asking incisive questions, offering reasons, and converting decisions into accountable explanations. With repetition, these erotetic moves become habits: problems are precisely framed, stakeholders and values are mapped, options are expanded before being narrowed, reasons are tested against evidence and counter-reasons, and decisions are communicated in ways that patients, families, teams, and the public can understand and scrutinise. In this sense, the cases operationalize the abstract promise stated in the abstract itself. Grounded in Socratic traditions, the erotetic method helps learners internalise values and strengthen argumentation, empathy, and accountable practice in real conversations where care is present.

3. Educational outcomes and evidence of learning

When the erotetic protocol is consistently applied across seminars, simulations, and case conferences, the first noticeable change is in the texture of learners' reasoning. Students begin to name the ethical problem with greater precision, separating it from clinical differentials, legal compliance, or logistics. They learn to resist premature closure and to ask for the missing distinctions that keep an inquiry honest. Justification becomes more disciplined. Reasons are made explicit, counter-reasons are anticipated, uncertainties are stated rather than hidden, and conditions for revision are specified in advance. Such growth is best captured through programmatic assessment, which gathers numerous low-stakes observations over time and treats them as evidence of learning, rather than merely as grades.

In this architecture, short "decision and justification notes," reason maps produced during deliberation, and brief facilitator comments become the currency of longitudinal feedback. The questions themselves do pedagogical work – Socratic prompts cultivate intellectual humility and the habit of testing assumptions openly – so that principlist content (autonomy, beneficence, non-maleficence, justice, and dignity) is not only recalled but also enacted in argument.

A second, parallel outcome concerns empathy and communication. Because erotetic dialogue requires learners to elicit what matters to each stakeholder and to translate ethical reasons into language that patients and families can understand, listening becomes purposeful, and value articulation becomes concrete. Narrative methods help: short patient stories anchor deliberation in lived experiences and train the capacity to recognise, absorb, interpret, and act on narratives, which is the core of narrative competence, as stressed by Charon (2006). Communication pedagogy provides the behavioural scaffolding—checking understanding, negotiating plans, and closing the loop—and simulation brings these skills under the pressure of time, emotion, and partial information, where they are most needed and most observable (Kurtz, Silverman, & Draper, 2016; Issenberg et al., 2005). In this way, empathy is not treated as an inner state to be declared but as a practice to be documented: How was the patient's perspective elicited? How were competing values named in the patient's terms? How was the final rationale explained in plain language?

Third, erotetic teaching normalises accountability in the face of uncertainty. Learners are asked to state the aim of the decision at hand (for example, fairness versus maximizing benefit), to articulate the criteria they will apply, to indicate what evidence counts now and what evidence might emerge later, and to commit

to review points when that evidence changes. Such practices reduce ad-hoc decision-making in crisis settings and create an auditable trail that patients, teams, and institutions can scrutinize. Simulation, followed by structured debriefs, is particularly fertile for this purpose: teams can replay how near-ties were handled, whether appropriate tiebreakers were chosen, and how the rationale was documented in real-time. Portfolios then preserve artefacts across weeks – a cumulative record of accountable judgment in formation.

Finally, the outcomes align cleanly with recognized competency frameworks and can therefore be embedded without curricular inflation. The capacity to frame problems, justify decisions, and make reasons public maps to Entrustable Professional Activities and entrustment decisions, providing assessable evidence for readiness to act with indirect supervision. Communication and professionalism outcomes align with all medical and health sciences professional roles, including the duty to engage in shared decision-making and to document decisions transparently for patients and colleagues (Frank, Snell, & Sherbino, 2015). Seen in this light, the erotetic protocol functions as a standard method that threads existing blocks, enabling educators to demonstrate – rather than merely declare – progress against institutional ethics objectives. By turning questions into the basic unit of ethical learning, the approach couples critical reasoning with empathic communication, binds accountability to explicit aims and criteria, and offers a tractable evidentiary base for assessment and improvement. In sum, the learning that matters in medical ethics becomes teachable, observable, coachable, and documentable.

4. Conclusions

Erotetic pedagogy is a human-centred method because it structures learning around what really matters to persons – patients, families, and professionals – while disciplining how reasons are formed, tested, communicated, and revised. It does not replace principle-based bioethics. It operationalizes it in the conversations where care actually happens. By making questioning the core professional habit – clarifying the problem, surfacing values, widening options, testing reasons, deciding, and revisiting – this approach aligns ethical formation with the realities of contemporary practice, namely, complexity, uncertainty, interprofessional teamwork, and public accountability. In short, erotetic pedagogy provides a

practical, research-ready, and standardizable approach for cultivating clinicians who can reason effectively, listen attentively, and respond to others with integrity. While this article primarily focuses on medical pedagogy and its teaching and research methodologies, the erotetic method addresses the shared ethics of care across the health professions. Because it is simple at its core – learning to ask well-formed questions, to listen for values, to justify decisions in clear language, and to revise when facts change – it can be introduced not only in medical curricula but also in Nursing, Midwifery, Physiotherapy, Occupational Therapy, Speech and Language Therapy, Psychology, and other allied programmes. Three practical choices make this expansion realistic: start with short, small-group case discussions; use brief, ready-to-teach materials (such as a question bank, one-page scenarios, and a two-minute decision note); and support teachers with light training and peer calibration. In this way, universities can promote a common pedagogical language for ethics and professionalism – one that is recognisable from the classroom to the clinic – without requiring significant structural changes.

Building on this, an erotetic approach can anchor a truly "medical pedagogy" based on curricula structured around well-posed questions, iterative diagnostic inquiry, and Socratic dialogue that make reasoning visible. By turning questioning into the engine of learning and assessment – across cases, simulations, and bedside teaching – programs can develop a scalable model that links knowledge to action, integrates ethics with evidence at the point of care, and forms clinicians who think with and for their patients.

Author contributions

The article is the result of a joint effort by the two authors. However, the specific contributions are as follows….. authored Sections 1 and 4; …. authored Sections 2 and 3.

References

Barrows, H. S., & Tamblyn, R. M. (1980). *Problem-based learning: An approach to medical education*. Springer.

Beauchamp, T. L., & Childress, J. F. (2019). *Principles of biomedical ethics* (8th ed.). Oxford University Press.

Charon, R. (2006). *Narrative medicine: Honoring the stories of illness*. Oxford University Press.

Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science, 196*(4286), 129–136. https://doi.org/10.1126/science.847460

Frank, J. R., Snell, L., & Sherbino, J. (Eds.). (2015). *CanMEDS 2015 physician competency framework*. Royal College of Physicians and Surgeons of Canada.

Gadamer, H.-G. (2013). *Truth and method* (J. Weinsheimer & D. G. Marshall, Trans.; rev. ed.). Bloomsbury Academic. (Original work published 1975).

Issenberg, S. B., McGaghie, W. C., Petrusa, E. R., Gordon, D. L., & Scalese, R. J. (2005). Features and uses of high-fidelity medical simulations that lead to effective learning: A BEME systematic review. *Medical Teacher, 27*(1), 10–28. https://doi.org/10.1080/01421590500046924

Jonsen, A. R., & Toulmin, S. (1988). *The abuse of casuistry: A history of moral reasoning*. University of California Press.

Kurtz, S., Silverman, J., & Draper, J. (2016). *Teaching and learning communication skills in medicine* (3rd ed.). CRC Press.

Ng, I. K. S. (2024). When I say … Socratic questioning. *Medical Education, 58*(5), 475–477. https://doi.org/10.1111/medu.15397

Oyler, D. R., & Romanelli, F. (2014). The fact of ignorance: Revisiting the Socratic method as a tool for teaching critical thinking. *American Journal of Pharmaceutical Education, 78*(7), 144. https://doi.org/10.5688/ajpe787144

Schön, D. A. (1983). *The reflective practitioner: How professionals think in action*. Basic Books.

Schuwirth, L. W. T., & van der Vleuten, C. P. M. (2011). Programmatic assessment: From assessment of learning to assessment for learning. *Medical Teacher, 33*(6), 478–485. https://doi.org/10.3109/0142159X.2011.565828

Seekles, W., Widdershoven, G. A. M., Robben, P. B. M., & Molewijk, B. (2016). Evaluation of moral case deliberation at the Dutch Health Care Inspectorate: A pilot study. *BMC Medical Ethics, 17*, 49. https://doi.org/10.1186/s12910-016-0114-4

Svantesson, M., Karlsson, J., Boitte, P., Schildmann, J., Dauwerse, L., & Widdershoven, G. (2014). Outcomes of moral case deliberation—The development of an evaluation instrument. *BMC Medical Ethics, 15*, 30. https://doi.org/10.1186/1472-6939-15-30

van der Vleuten, C. P. M., Schuwirth, L. W. T., Driessen, E., Dijkstra, J., Tigelaar, D., Baartman, L. K. J., & van Tartwijk, J. (2012). A model for programmatic assessment

fit for purpose. *Medical Teacher, 34*(3), 205–214. https://doi.org/10.3109/0142159X.2012.652239