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Empathy on Stage: Theatre as a Pedagogical Practice for Fostering a More Humanised Medicine

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Abstract

Research shows that, throughout medical school, students tend to experience a significant decline in empathy towards patients and peers. Faced with this challenge, we propose pedagogical strategies that use theatre as a means of exploring themes essential to professional training, creating a space for emotional learning and care. By employing reflection-in-action, the aim is to develop repertoires for dealing with situations that are difficult or far removed from ideals of care. After all, for health professionals to validate their patients' emotions, they must first recognise and legitimise their own. In this experience report, we discuss the Medical Education Empowered by Theatre (MEET) methodology, which is grounded in Paulo Freire's *Pedagogy of the Oppressed* and Augusto Boal's "theatre of the oppressed," and is implemented through two approaches: simulated medical consultations and theatre classes. Theatre classes focusing on communication skills foster the "de-mechanisation" of the body — working not only on physical expression but also on habits, dogmas, and deeply rooted certainties (Boal, 1998/2014). This practice broadens the existential repertoire, strengthening otherness and empathy. Students' testimonies highlight a gap in medical training: the lack of longitudinal humanist approaches, underscoring the urgency of curricular activities that sustain the learning environment as a creative, respectful, and vibrant space for reflection. In light of this, we advocate for the expansion of theatrical practices in medical education as a foundation for a more humanised medicine, committed ethically to the most vulnerable.

Keywords

theatre, empathy, humanised medicine, emotions in medical education, simulated medical consultations

Empatia em Cena: O Teatro Como Prática Pedagógica Para a Construção de uma Medicina Mais Humanizada

Resumo

Pesquisas mostram que, ao longo da graduação em medicina, os(as) estudantes tendem a sofrer uma perda significativa da empatia por pacientes e colegas. Diante desse desafio, propomos estratégias pedagógicas que fazem do teatro um meio para vivenciar temas essenciais à formação profissional, criando um espaço de acolhimento e aprendizagem emocional. Com

a utilização da reflexão em ação, o objetivo é desenvolver repertórios para lidar com situações difíceis ou distantes dos ideais de cuidado. Afinal, para que profissionais de saúde validem as emoções de seus pacientes, é preciso que antes reconheçam e legitimem suas próprias emoções. Neste artigo, em formato de relato de experiência, abordaremos a metodologia *Medical Education Empowered by Theater* (MEET), pautada na *Pedagogia do Oprimido* de Paulo Freire e no "teatro do oprimido" de Augusto Boal, em duas frentes: simulações de consultas médicas e aulas de teatro. As aulas de teatro com foco nas habilidades de comunicação, promovem a "desmecanização" dos corpos — trabalhando não apenas a musculatura, mas também hábitos, dogmas e certezas enraizadas (Boal, 1998/2014). Essa prática amplia o repertório existencial, fortalecendo a alteridade e a empatia. Depoimentos dos(as) estudantes reforçam uma lacuna na formação médica: a longitudinalidade das abordagens humanistas, evidenciando a urgência de atividades curriculares que mantenham o ambiente de aprendizagem como um espaço criativo, respeitoso e vivo de reflexão. Diante disso, defendemos a expansão de práticas teatrais na formação médica como alicerce para uma medicina mais humanizada, assumindo um compromisso ético com os mais vulneráveis.

Palavras-chave

teatro, empatia, medicina humanizada, emoções na formação médica, simulação de consultas médicas

1. Empathy on Stage

With the advancement of specialised sciences, divided by areas of knowledge, we observe both segregation and distinct valuation of these fields. This division not only generates a theoretical separation of disciplines but also fosters a fragmented view of natural and social phenomena, the individual, and their relationship with the environment and the sense of community.

Such segregation, more commonly manifested in Western culture, conveys the prevailing perspective that reason and emotion can be separated. However, based on the premise that human beings are composed of a physical body, mind (and perhaps spirit), we, as performing artists, approach the individual as a holistic being, considering them as a highly complex unity whose "parts" are inseparable.

In this article, we aim to problematise the assumption of a dichotomy between reason and emotion and, in particular, to reflect on empathy in the context of medical education. We focus specifically on actions involving theatre as a device for embodied, felt, and perceived reflection, emphasising the importance of affective communication for optimal patient care outcomes.

Furthermore, we discuss the necessity of self-knowledge and self-care among health professionals as fundamental factors in maintaining physical, emotional, and mental well-being. Recognising and legitimising the feelings and challenges inherent in medical practice — such as emotional fatigue, frustration, and vulnerability — is essential for delivering humanised care.

By integrating strategies of critical reflection on one's own emotions, as facilitated by theatre, professionals are expected to enhance their relationships with patients and

strengthen their resilience and well-being, in a process that values both care for others and self-care.

We argue that it is essential to focus on the emotions present in medical consultations — those of both patients and health professionals — as well as on the experiences of students throughout their medical training. This importance is underscored by the concerning state of mental health among students and professionals in the healthcare field.

Recent studies (Schlittler et al., 2023) identify multiple contributing factors to psychological distress and suicide risk among medical students, including adverse working conditions such as long hours, challenges in the doctor–patient relationship, and excessive cognitive demands. Moreover, the study highlights the negative aspects of the hidden curriculum, in which humanistic skills are often neglected or considered less important than clinical abilities. Finally, another factor that exacerbates these issues is institutional violence, manifested through public humiliation, verbal and moral harassment, and gender and ethnic discrimination.

These problems are complex, structural, and institutional. Melanie Neumann et al. (2011) found that empathy declines during the training of medical students and residents. We recognise that a "cure" for this phenomenon cannot be achieved through a single approach. However, by envisioning joint action among professionals engaged in health, education, and the arts, we can collectively create a therapeutic plan and progressively effect significant changes; in addition, we can transform a deficient relational culture that perpetuates itself among professionals, teachers/students, and doctors/patients.

This research stems from our work as actresses and theatre lecturers within the Faculty of Medicine at the State University of Campinas (Unicamp). It has resulted in scientific articles, as well as master's and doctoral dissertations on topics related to this article's subject. It also engages with investigations conducted by colleagues at the same institution with whom we share teaching responsibilities, such as the studies by Gabrielle Silveira et al. (2019) and Marcelo Schweller et al. (2018), in which we actively participated as actresses in simulated medical consultations. Both studies referenced in this text (Silveira et al., 2019; Schweller et al., 2018) examined professional identity and the teaching of empathy in medicine, respectively, and they significantly informed our academic research.

Conventional assumptions about "being a doctor" are permeated by a stereotype that consolidates the figure of a professional who performs authority, indifference, and emotional shielding (Silveira et al., 2019). In contrast to this construction, theatre — as an artistic language — draws on the human being and their emotions as its raw material, exploring the dynamics of interpersonal and social relations. By engaging with different sociocultural contexts, theatre takes on a critical role, revealing normative structures and — through its aesthetic dimension — enabling reflection on new modes of existence and interaction.

Theatrologist Augusto Boal (1998/2014) observes that theatre emerges when a human being recognises that they can observe themselves in the moment of action — he does not refer to watching recordings, but to the act of performing theatre, to the capacity to observe what one does at the instant it is done.

In this sense, the actress or actor, in their performance, works directly with empathy, understood as the reverberation of another's emotion (a fictional being) through mirroring. By observing another, we recognise in our own body, through prior experiences, patterns of gestures and/or movements similar to those of the other. This enables the performer to feel for the first time or to access again feelings related to the other's experience.

> We access our own emotions, postures, and movements that we have previously experienced; we can also access states, postures, and movements observed in others (which are themselves experiences). This is facilitated when we are already familiar with these states, as Damasio (2011) notes, proposing that the process by which we experience another's state is what is termed empathy. (Santos, 2024, p. 226)

To experience the state of another is nothing more than to allow one's body and mind to release attachment to one's own habitual way of relating to the world, permitting oneself to be permeated by the narrative of the other. For this to occur, it is necessary to create conditions for something to happen to us, allowing a certain "action in passivity".

> Experience is what passes through us, what happens to us, what touches us. Not what merely occurs, happens, or touches. Many things happen every day, yet almost nothing truly occurs to us. One might say that everything that happens is organised so that nothing truly occurs to us. Walter Benjamin (...) already noted the poverty of experience characterising our world. Never have so many things happened, yet experience is increasingly rare. (Larrosa Bondía, 2002, p. 21)

How can theatre intervene and impact empathy during medical training? By experiencing the emotions of a fictional being — the dramatic action of theatre — we may regard this dynamic, by its very nature, as a rehearsal of empathy, since the student, while remaining themselves, allows themselves to become immersed in the motivations, feelings, and actions of another to perform their representation.

This question will be further explored throughout this article by presenting our actions and reflections as actresses — lecturers in simulated medical consultations and theatre classes.

The text is organised so that each subchapter presents "image excerpts", highlighted by the unconventional style of academic writing, that articulate reality and fiction. These compositions, derived from students' experiences and the authors' own

accounts, aim to create a unique reading atmosphere. This approach seeks to engage the senses, touching and affecting the reader.

2. Diagnosis: Empathy Suffocated by the Normalisation of Emotional Repression

> I went home deeply affected by the student's account. Her words reverberated through my body, sometimes manifesting in tears and muscular tension. The student shared her experience. She said that, on a particular day, she was faced with a stillbirth. She said she felt nothing. She felt nothing. The classroom seemed to condense, as if the particles of which we and all things are made had stopped spinning. Drawn into that reality, we stood motionless before that scene just brought into being. Moved, the student said that, in that instant, she realised she needed to seek help. Hope! (Excerpt image 1)

Emotions are constitutive of the human condition. Denying them as a form of self-protection does not eliminate them — it merely displaces them to an abstract plane, where they remain repressed. Feeling is like breathing: it can be held for a moment, but never completely suppressed. This raises a reflection: why do some health professionals feel they are the target of attacks or disrespect from patients who, in most cases, are in vulnerable situations and seeking help?

In any interaction, frustrations may initially be attributed to the other. However, it is essential to analyse: what, in fact, belongs to each person? Furthermore, what specifically emerges during that interaction? In an encounter, each participant may form expectations about the relationship, projecting onto the other feelings and perceptions that actually belong to themselves.

Beyond this challenging perception in the moment of encounter, we may consider that, more than feeling under attack, health professionals might feel threatened by the suffering that comes from facing situations that constantly place them before illness, ageing, and death — irrefutable conditions of any human being — which compel them to confront values and feelings experienced throughout their lives. Feelings of fear, shame, guilt, and helplessness when faced with what cannot be understood are often diagnosed during medical training and practice (Silveira et al., 2019).

Thus, in the absence of reflection and without knowing how to manage their own emotions, when such professionals become preceptors and teachers, they may convey the false idea that the "right" approach is to maintain emotional distance from patients, avoiding any involvement with their suffering. This posture reinforces a harmful cycle: new students are trained to believe that empathy and human bonds are signs of "bad professionals". The result is widespread disillusionment — affecting preceptors, lecturers, students, and, above all, patients, who receive cold and impersonal care.

For this reason, lecturers must teach their students to manage their own emotions and to embrace those of their patients. As Schweller et al. (2014) emphasise, lecturers can — and should — break this cycle by sharing their own difficulties during training, revealing vulnerability and, therefore, their humanity. It is necessary to make explicit the importance of becoming emotionally involved with patients effectively, remaining available to help, while still preserving one's own alterity and subjectivity.

Ignoring the suffering brought about by illness and death sustains the fantasy of medical omnipotence — the illusion of absolute control over vital processes. The patient's pain, combined with the limits of clinical practice, destabilises an idealised professional identity. The search for defence against these feelings seems legitimate when we understand how difficult it can be to deal with them. We know that an excess of any emotion or feeling — even of empathy — can trigger fatigue and emotional exhaustion, paralysing individuals when faced with the everyday situations of their professional lives. Thus, to avoid such prostration and remain "functional", doctors often resort to cynicism and/or indifference towards their patients' emotional demands.

Seeking balance between these opposing poles — an excess of empathy and complete apathy — constitutes a dynamic, non-linear process. The very notion of movement is fundamental here, as it reveals the processual nature of this emotional regulation. Far from being a static state that can be achieved or not, it is a continuous becoming: approaching and withdrawing, advancing and retreating, in response to the demands of each clinical encounter. It is precisely in relation to the other that this flexible and ever-unfinished movement is exercised — always in construction, never crystallised.

Rogers (1975, as cited in Amarante, 2019) explains that empathy is the ability to listen to another person's words, discern the emotional pattern that lies behind them, and somehow reflect to that person an understanding of what was being communicated, which is not always expressed through words, but also nonverbally.

Although the ability to read the other is grounded in psychology, it must be regarded as a fundamental element in the doctor–patient relationship. It should be embraced with the same importance as other disciplines in medical education. Training should cultivate what may be called "emotional literacy", enabling the reading and interpretation of speech, gestures, behaviours, and the subtleties of every human action.

Schmid (2001, as cited in Amarante, 2019) explores the philosophy and epistemology of empathy, viewing it as a fundamental human competence that involves the capacity to place oneself in another's position, experiencing their subjective frame of reference "as if" it were one's own. This "as if" is essential, for it distinguishes empathy from both identification and interpretation. While extreme identification dissolves the boundaries between self and other, causing one to lose oneself in the other's world, extreme interpretation leads to judgments based solely on one's own repertoire, disregarding the other's subjectivity. Empathy, therefore, occupies an intermediate space between these two extremes: it means "resonating with the other's melody" and being affected by it, without, however, becoming completely merged with it.

The step following this "emotional literacy" towards practising empathy would be to experience — without judgement and with respect for the other's singularity — something lived by another person. However, enacting empathy in medical practice comes up against a contradictory institutional reality: how can professionals be expected to cultivate such sensitivity when their training and work environments are marked by rigid hierarchies, dehumanising demands, and a culture that prioritises productivity over care? It is unrealistic to expect the valorisation of a humanistic medical practice when these spaces are inhospitable to the exercise of respect and empathy. They are culturally shaped by asymmetrical power relations and by superhuman performance demands (Silveira et al., 2019). At least two interrelated factors may sustain the perpetuation of this culture: first, by the productivist logic that permeates professional relations — in which value is tied to individual productivity; second, by the persistence of the meritocratic fantasy — which naturalises adversity and transforms individual achievements into universal standards ("if I managed, why can't others?").

> The culture of "acceleration" has deprived students of the time and support needed to reflect on how to become the doctors they once envisioned. If that ideal proves impossible or even unreal, they need to consider how to come as close to it as possible. The undesirable result is the internalisation and repetition of attitudes and behaviours inconsistent with the students' moral values. When students finally recognise this process, they experience a psychological rupture accompanied by feelings of shame and guilt. (Silveira et al., 2019, p. 205)

The difficulty of reconciling one's beliefs with actions that contradict those values heightens feelings of frustration and alienation from the profession, calling professional identity into question. Below, we highlight some statements from medical students at Unicamp, taken from Silveira et al. (2019), which reveal this sense of incongruence:

> F4P3F: "In the end, what I would like to do is different from what I end up doing".
>
> F13P1M: "So, I think that, until the end of my degree, my strongest influences were related to the kind of doctor I didn't want to be".
>
> (...)
>
> F2P3M: "Sometimes you stop and ask yourself: 'What am I doing? No! I'm thinking exactly like that [teacher] I used to hate.' Then I stop, reflect, and start thinking my own way again. But we have to be alert". (p. 204)

In response to these problems reported by students, and drawing on the Brazilian educators Paulo Freire (1968/2005) and Augusto Boal (1998/2014), we have sought to

transform this reality. The Medical Education Empowered by Theatre (MEET) methodology was created to address these conflicts aesthetically, enabling medical students to practise theatre and rehearse their roles as doctors. By embodying characters with distinct attributes, they experience a range of perspectives while simultaneously engaging more consciously with their own subjectivities.

3. Care Plan: Theatre as a Means of Experiencing and Feeling

> It had been a long time since she had stopped — she was a task fulfiller. Wake up. Have coffee. Get dressed. Run to catch the bus... Classes... Classes... Lunch... Classes... Classes... Run to catch the bus. Take a shower. Have dinner. Study. Sleep. Dream? Who knows? But at that moment, she found herself sitting in a circle, even with her eyes closed. She felt her breathing and her bare feet touching the welcoming wooden floor. She breathed. She felt the warmth of the room. She felt the gift of simply being. Life is not [only] a series of tasks to be completed. (Excerpt image 2)

The active learning methodology MEET was created in 2012 collectively by a group[1] of lecturers–researchers, performing artists, pedagogues, and physicians, thus affirming its transdisciplinary approach.

Grounded in improvisations and theatre games, the methodology's primary goal is to enable medical students to develop communication skills by recognising their prior knowledge, identifying their difficulties, and acquiring new ways of improving them through aesthetic experience. To this end, it is necessary to practise a dialogical pedagogy and establish a horizontal power relationship; for this to occur, a welcoming and safe space must be created, where students feel encouraged and compelled to reflect and express themselves freely, without fear of judgment from lecturers or peers. The importance of such freedom and learning through experience is so central that we named the methodology MEET, as we believe in the transformative power of the "encounter".

The MEET methodology has proven to be an artistic, educational, and political practice capable of fostering dialogue and building knowledge among people from different fields. It also reveals emotions and power relations, thereby promoting the collective search for ways to address these aspects.

Since 2012, we have participated as actresses and lecturers in various curricular activities of the undergraduate and residency programmes in Medicine. In this article, we have chosen to focus on theatre classes and simulated medical consultations. The testimonies presented in the following sections were drawn respectively from the master's

[1] The MEET methodology was created in 2015, emerging from the work of lecturers and actors Nádia Morali, Letícia Frutuoso, and Adilson Ledubino in the undergraduate programme of the Faculty of Medical Sciences at the State University of Campinas (Unicamp), in collaboration with the art educator Márcia Strazzacappa and the physician–lecturer Marco Antônio Carvalho Filho. It is structured around four components: "simulated medical consultations," "theatre classes," "staging," and "clowning for health professionals".

and doctoral research of Barreira (2024) and Frutuoso (2024) and were analysed using a qualitative approach.

3.1 Theatre Classes: De-mechanisation of the Body and the Embrace of Emotions

In the MEET "theatre classes" strand, each student participates in five sessions throughout the medical programme, aimed at developing communication and self-awareness skills. Since 2015, this course has been a compulsory component for 120 students in the fourth semester, divided into groups of 40. To date, activities have engaged a total of 1,200 participants.

The testimonials in this section use fictitious names and are drawn from Frutuoso's doctoral study (2024), which collected data between 2021 and 2022, encompassing 231 students. Among the instruments used, the "final report" is notable: a document in which participants, after the five sessions, record their perceptions, emotions, and experiences in free-text format. The excerpts presented here were extracted from these reports, serving as evidence to corroborate and validate the study's hypotheses.

Each session is structured around five moments: (i) activation of prior knowledge and experiences, (ii) physical warm-up and games to construct the theme, (iii) immediate improvisation games, (iv) improvisation of thematic scenes, and (v) debriefing — sharing of ideas (Frutuoso, 2024).

Initially, students are invited to reflect on the day's theme and are free to express themselves. The second moment, "physical warm-up and theme-building games", fosters an environment in which students participate in theatrical games to interact as a group, de-mechanising the body, moving, and exploring the day's theme in action. In a continuous flow, an immediate improvisation is proposed: without pausing to plan, students begin a scene derived from the game they are playing. Next, four groups are formed, each with fifteen minutes to create a new scene to present to the whole class. The session concludes with a dialogue where all participants share their perceptions, sensations, and reflections from performing and observing the scenes.

Drawing on *Pedagogy of the Oppressed* (Freire, 1968/2005) and "theatre of the oppressed" (Boal, 1998/2014), the goal is to create an environment that fosters personal freedom, respects students' prior knowledge, and provides a safe space for practical experimentation. The premise is that students experience situations (medical or otherwise) and portray characters, allowing them to access alternative modes of perception.

The course's pedagogical planning emphasises knowledge construction through aesthetic propositions. Teaching empathy can be approached by moving beyond the traditional expository model towards the practice of theatrical games that engage the affective dimension. This includes techniques from Boal's "theatre of the oppressed" repertoire, notably "image theatre" (Boal, 1998/2014), employed as a critical pedagogical methodology to materialise situations of oppression.

In this context, "de-mechanisation" refers to the possibility of "escaping the automatic" through bodily movement, constructing alternative knowledge (subjective and cultural). According to Boal (1998/2014), individuals must deconstruct their bodily patterns, allowing them to explore new postures and experiences. This process facilitates the reorganisation of a new corporeality — physical, mental, cultural, and emotional — relevant both for theatrical performance and daily life.

At times, experiencing the games makes some individuals aware of being subjected to various forms of oppression. From this awareness, we seek to understand the social mechanisms that foster such manifestations. Students frequently express visible oppressions they face during training, such as bullying, moral harassment, prejudices (sexism, racism, classism), unfair evaluations, and abuses of power by lecturers, as well as less tangible challenges, including excessive self-criticism, frustration, and helplessness in the face of illness.

Boal (2009) argues that aesthetic creation allows the oppressed to "question dogmas and certainties, habits, and customs that we endure in our lives" (p. 158). By engaging in games and creating theatrical scenes, students gain insight into mechanisms of oppression, recognise structural prejudices, and understand their impact on interpersonal relationships, effective communication, quality of care, and empathy toward socially vulnerable groups.

More important than the aesthetic of the game itself is the capacity to generate authenticity and construct alternative worlds that, even temporarily, suspend the logic of the State apparatus. Through play and aesthetic creation, participants can explore rupture, reinvention, and escape — a continuous movement of transformation. Their practice does not submit to structure; instead, it destabilises it from within, rejecting rigidity or mechanisation. This does not negate State power but rather deconstructs it, where the game becomes an aesthetic act and the player its agent. It is in this creative space that affective experience emerges, as in other forms of artistic production (Godoy & Scaglia, 2024).

Participants may identify both with the oppressed and the oppressor. In reality, we oscillate between these roles. Theatre classes allow reflection on, and rupture of, the binary of "good person" versus "bad person".

> During moments of tension, artistic and educational activities provide refuge, fostering amicable and supportive bonds — crucial for psychological survival and the maintenance of belonging and care. (Quilici, 2022, p. 6)

Despite being few in number, these sessions are highly valued by students, who report the importance of having a space to speak openly, be heard, and reflect on interpersonal relationships. After participating in theatre classes, Amanda reflected on the difficulty of maintaining a connection with her feelings. She described a class activity in

which participants collectively created an improvised scene to experience processes of illness and grief:

> [I would have preferred not to participate in] certain moments that were more personal and related to illness/death in the family. Since my uncle passed away a month ago, I have not felt like being there. These moments made me sad. It was a sadness I would not have time to process because the activity quickly moved on to lunch, afternoon class, and other evening activities. *I felt that feelings were being awakened that I had no time to process, so I ended up neglecting them*. The medical curriculum automatises studying under any circumstances but emphasises empathy towards others' feelings (future patients). I notice an incongruence. If, to become a doctor, I must neglect my own feelings to meet expectations, how can I remain sensitive to others' feelings if my own are desensitised for six years? (Amanda, as cited in Frutuoso, 2024, p. 163)

The student shows us how difficult it can be to step out of an "automatic mode" and come into contact with deeper feelings, since the course itself attempts to teach something that is often not practised in its own structure: it demands from students an empathetic and humanised attitude towards their future patients, yet does not allow these feelings to be expressed in the day-to-day life of the classes. We now present the account of a student who demonstrates how seemingly simple actions — such as looking at and actively listening to another person — can restore human relationships, fostering recognition, acceptance, and a sense of belonging within the group.

> I discovered that there are many amazing people in my class and, extending this idea beyond the classroom, that there are probably many incredible and unknown people in our daily lives, which weakens the more hopeless views of the world. The difference between the classroom environment and our everyday life is that, very often, there is no favourable context for the skills we put into practice in this module — such as empathy, compassion, attentive listening, and care — to emerge more naturally. *The games, eye contact, and improvisation allowed us to remain open and let much of our creative potential come to the surface*. (Dalai, as cited in Frutuoso, 2024, p. 161)

Theatre thus becomes a driving force for bringing out this creative potential inherent in the human being. By exploring contexts of oppression, a sense of unity among group members can be observed — a condition essential to transforming the world. When a person recognises themselves as being in the role of the oppressed, a more empathetic view of other oppressed individuals emerges. There is a process of mirroring, of recognising oneself in the other. The other's pain is understood.

In this way, we highlight the complexity of the human being, enabling a deeper perception of emotions, socially created conventions, and our acquired habits as a society.

We are permeated by our values and beliefs, which result from social interactions, culture, and the strong influence of the media — factors that significantly shape our actions and choices, sometimes bringing them closer to our ethical principles and, at other times, distancing them. Accepting this movement and being open to critical reflection on our actions and the influences we face can be liberating in relation to feelings of guilt.

In the theatre classes, we emphasise becoming aware of one's own feelings and emotions — and accepting them. In the final course evaluation, conducted anonymously, we asked students about the feelings they experienced during the classes. The answers were presented in a multiple-choice format, allowing each participant to select more than one option and type in other feelings they considered relevant to record. Figure 1 shows a chart of the responses.

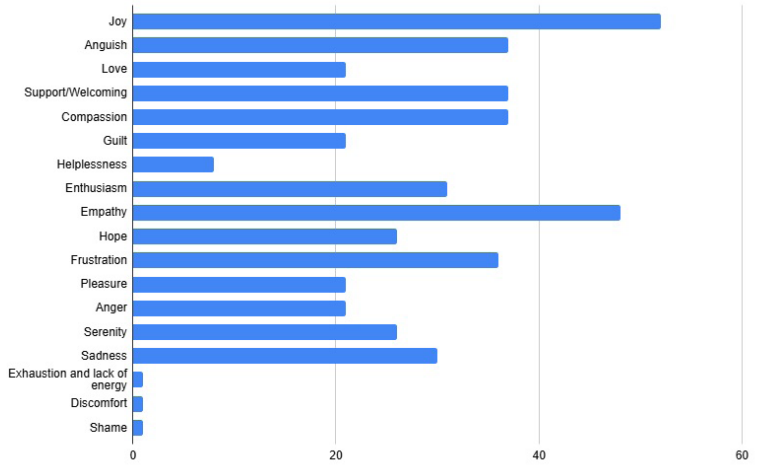

Figure 1. *Feelings experienced*

Source. Adapted from *O Teatro do Oprimido e a Metodologia MEET (Medical Education Empowered by Theatre): Caminhos Possíveis Para Identificar Opressões na Formação Médica* [The Theatre of the Oppressed and the MEET Methodology (Medical Education Empowered by Theatre): Possible Paths to Identifying Oppressions in Medical Training], by L. R. Frutuoso, 2024, p. 162

Joy was the most prevalent feeling, identified by 52 of the 55 respondents. The second most pervasive feeling was empathy, with 48 responses. Student Clarice describes how she became aware of the development of empathy:

> another essential aspect we worked on was empathy. During the classes, we reflected on and experienced circumstances through theatrical tools that allowed us to put ourselves in another person's place, recreating, through improvisation, situations from real life that we are likely to encounter throughout our lives — not only in our professional practice, but also in everyday contexts common to everyone. (Clarice, as cited in Frutuoso, 2024, p. 162)

Student Amora offers a reflection that goes beyond her experience with the themes of the classes themselves, looking instead at the role of these classes within her development as both a doctor and a person. She highlights feelings of empathy and acceptance,

as well as the establishment of genuine dialogue — practices we consider fundamental to our methodology:

> (...) trust was built; dialogue was truly a two-way street; the exchange was mutual (...); everyone left a little of themselves and took much back home. (...) *Besides testing our most primitive feelings* about sociability (shame, discomfort, belonging), it helps us develop skills we didn't even know we had or could take ownership of. (...) Moreover, going beyond medicine itself — because life is not "just that" — I feel like a different person (...), *as I feel more prepared to deal with people not only in the medical sphere, but also in life*. To treat someone as "a person like ourselves," to be empathetic, to be supportive, to transpose desires and needs from another's perspective to our own... such basic things, and yet so lacking nowadays. (Amora, as cited in Frutuoso, 2024, p. 163)

Finally, it is essential to emphasise that theatre is a collective practice — it is made together. Our proposals are rooted in Freirean pedagogy, that is, a "pedagogy that makes oppression and its causes objects of reflection by the oppressed," so that, through these activities, we can together create "the engagement necessary for the struggle for their liberation," a "ceaseless struggle to regain their humanity" (Freire, 1968/2005, p. 34). "Knowledge only exists through invention, through reinvention, through the restless, impatient, and persistent search that [people] undertake in the world, with the world and with others" (Freire, 1968/2005, pp. 66–67).

3.2 Simulated Medical Consultations: Experiencing the Relationship to Perceive the Other and the Self

In simulated medical consultations, the pedagogical objective is to experience a consultation within a controlled environment, free from the pressure and risks inherent in a real situation. Through this experience, the teaching and learning process unfolds in practice, fostering reflection in action. The simulations discussed in this article highlight the specificities of this methodology within our context of practice, without addressing other variations of its application. We use this methodology for student training rather than assessment. Thus, the clinical cases — and consequently the characters — are created to promote clinical, communicative, and emotional learning simultaneously. As in the other strands of the MEET methodology, our simulation activities begin with a pact of trust, respect, and non-judgement between students and lecturers. We emphasise that creating this atmosphere is essential for students to feel more comfortable and confident in exposing themselves before their peers and teachers.

In most cases, the design of clinical scenarios takes into account the realities of primary health centres, outpatient clinics, and hospitals that belong to the Brazilian Unified Health System (Sistema Único de Saúde), a government programme providing

free healthcare to the population. This approach influences the selection of the patient characters' characteristics, such as social class, financial condition, family structure, support networks, and the emotions that permeate the patient, among other aspects.

The practice of empathy begins in this very process of creation, as lecturers and actors must turn their attention towards others, considering their complexities, customs, values, and motivations. This exercise of empathy extends to the simulation itself, in the improvisational play. The actor, performing simultaneously as a simulated patient and lecturer, responds to the student's actions and intentionally introduces elements that highlight the relevance of the consultation. The objective is to lead the medical student to connect not only with the patient's feelings and experiences but also with their own emotions during the encounter.

> Even more important than creating a credible, realistic situation resembling an actual patient consultation is the forcefulness with which the existence of this fictional patient imposes itself on their interlocutor — the "fictional doctor", who is confused with the "real student". Even if my character is introspective, passive in the face of medical authority, the concrete development and detailing of their subjectivity represent alterity asserting itself before an oppressive system that tends to flatten the patient as a subject, transforming a person into a medical record, into symptoms, into a diagnosis. This, I believe, is a non-negotiable role of the simulation actress: to reveal to the student the existence of another being — complex, different from them, who must be seen and heard with openness. (Barreira, 2024, p. 77)

Revisiting the premise of a holistic view of what it means to be human, the actor or actress performing in simulated medical consultations must be aware that their performance is also pedagogical and, therefore, political. It is thus necessary to portray the patient character in all their complexity, expressing their emotions and indicating their motivations. The simulated consultation is not merely the provision of information about the patient, where the actor only responds to the students' questions. This could mistakenly convey the idea that communication is a standardised form of questioning and answering.

In our experience, we have often observed that students participate in simulated consultations without delving into the patient's life story, apparently lacking a genuine interest in understanding what is happening with that person beyond symptoms or clinical goals. Even when students fulfil all formal requirements during the consultation, it is evident that merely completing checklists — often regarded as indicators of "good consultations" — does not guarantee bonding or an understanding of the patient's emotions in their health–illness process.

The humanisation of the actor's work, both in character construction and in their performative and pedagogical practice, proves fundamental in revealing the more subtle layers of emotional complexity inherent in doctor–patient and lecturer–student

relationships. This approach, intentionally provocative and situated within the fictional interaction with students, allows for the exploration of nuances that frequently permeate these dynamics.

In the simulated medical consultation, the student engages with the fictional situation, exercising their autonomy in the teaching–learning process. Through their body, expression, and action, they reflect on how they are conducting the consultation and which aspects need further study and improvement during and after the simulation. It is common for students to report that, during the encounter, they realise that theory alone cannot encompass the complexity of a consultation.

Various strategies can be used in the learning process. According to Almeida et al. (2013), learning is understood as a process through which individuals assimilate new knowledge, develop skills, and modify behaviour. This transformation occurs through the creation of a social environment that fosters experiences both in interpersonal interactions and within the individual sphere, aligning with an epistemological perspective shared by authors such as Paulo Freire and Vygotsky. Becker (1993, as cited in Almeida, 2013) places the subject's action at the centre of learning, reinforcing the inseparable relationship between the body and the construction of knowledge.

In this way, by engaging their own body, the student can understand, beyond the rational, other forms of relating. According to all forty participants in Barreira's (2024) study, simulated medical consultations constitute a valid methodology for fostering meaningful learning. As part of the same study, conducted between 2021 and 2022, students were asked to explore the subject further by writing about how they assessed the simulation activities during their professional training. Among the responses, the following stand out:

> – The simulation activity consolidates the knowledge acquired through previous readings and increases confidence when attending to real patients.
>
> – It is more important than most of the classes we have throughout the course. The faculty prioritises a lot of technical information that is not very relevant in practice, but I have had little practical training. Dealing with human complexity is not easy, and so far, the simulations have been the most helpful.
>
> (...)
>
> – The activity is essential for professional training, as it provides a safe environment to practise, learn, and enhance consultation skills and interpersonal abilities, supporting future real-life applications. (Barreira, 2024, p. 46)

As part of the same research, students were also asked about their feelings after the simulation experience, with the question: "how did you feel during the activity?"

> – I believe the simulation was very beneficial, and I felt comfortable because the lecturers managed the timing of questions well and respected students' personalities, such as those who are shy. So, I felt comfortable yet stimulated to understand the case.
>
> (...)
>
> – Especially in this activity, I felt challenged to think about how to apply what I had learned to "real life". It was an excellent opportunity to bring together the knowledge already acquired in the course.
>
> (...)
>
> – I could feel the emotions conveyed by the actress as if they were real, which prompted many reflections during the consultation. (Barreira, 2024, pp. 47–49)

From these responses, it becomes evident how difficult it can be to name one's own feelings. Schweller et al. (2018) showed that, through the use of simulated consultation methodology and subsequent guided reflection, it was possible to "discuss the role of emotions in clinical practice and their influence [on] the doctor–patient relationship" (p. 1). The authors also reported that "in the opinion of more than 95% of students, the [simulation] activity had a positive impact on their ability to listen to patients, and for more than 91%, this impact extended to their ability to listen to others in general" (p. 86). One student from this latter study stated:

> this activity was essential for my professional and personal development, as I learned to look at the patient from different perspectives. After this opportunity for reflection, I believe I can put myself in the patient's position and better understand the reasons for their anguish, their difficulties in dealing with illness, and their feelings of guilt and fear. (Schweller et al., 2018, pp. 86–87)

Acting allows us, when we perform in fictional situations, to come into contact with realities different from our own. When faced with otherness, we seek to understand the character's motivations and values, exercising empathy through our body and reaching deeper layers of perception. In this process, it becomes possible to comprehend the various logics that may drive people. Thus, we observe the potential of simulations for learning and emotional training. During improvisation, students act, live, and experience empathy in their own bodies, using their personal strategies of care or creating those they imagine to be ideal.

4. Prognosis: Hope for the Transformation of Healthcare

> As we walk, we carry within us our experiences, our foundational intensities. In the encounters along the way, with the tips of our fingers, we sift through our things, our dreams. Turning our hands into surgical instruments, we delicately grasp a gift to offer the other — someone different, unknown. A universe not to be unravelled, but navigated. Moreover, as we learn how to orbit around it, we enjoy the mystical dance we have invented together. A dance of eyes and ears. Subtly risky and ephemeral. A binding astonishment. Thus, in leaning over the bedside of care for another, we end up paying reverence to our own being, right there before us. (Excerpt image 3)

Theatre enables a displacement of the self, fostering a constant (re)creation of identity. This perspective justifies the relevance of theatrical practice — including acting and improvisation — in medical education. "To become an 'actor' therefore means to be able to 'act', that is, to free oneself from the reactive patterns and automatisms deeply rooted in the organism, thus achieving a true physiological revolution" (Quilici, 2002, p. 99). As the author observes, we believe that such a transformation of the self can bring about meaningful changes in the individual who engages in theatre, empowering them to deal with their own emotions and, consequently, improving their interpersonal relationships.

Moreover, as students experience their academic placements in hospitals and primary healthcare units, they are confronted with complex realities, where they are often exposed to authoritarian power dynamics and humiliation within the hierarchical relationships with medical professionals and lecturers — factors that impact their mental health. Hence, the opportunity to work on emotions through theatre emerges as a coping strategy capable of transforming this experience into a less solitary and exhausting process.

We recognise that the activities presented in this article represent a starting point, and that it is necessary to implement educational policies ensuring the longitudinal teaching of humanistic, communicative and emotional skills. At present, the medical curriculum at Unicamp offers only twenty hours of theatre and approximately forty hours of simulation with actors — a clearly insufficient workload. We, as lecturers and actresses, face daily an academic culture that persists in fragmenting knowledge, privileging technicism and a productivist logic.

As Freire (1968/2005) warns, the absence of critical consciousness condemns us to reproduce "already known models, even when we disagree" (p. 35). However, like the author, we continue to dream and to hope. We believe, as Boal (2009) affirms, that the process is essentially creative: "it requires the invention of alternatives. It is not enough to see what is, but above all what can come to be; to see what does not yet exist" (p. 160). This perspective sustains our practice and our pursuit of transformation in medical education.

Theatre offers us a space for rehearsal and creation of repertoires, allowing us to live, experience and connect with others. Creating aesthetically reconnects us with who we are, restoring the recognition of our humanity — with all its imperfections, values and emotions. This practice invites us to dream collectively of a fairer society, one grounded in freedom and equity.

To understand and listen actively to others sets us in motion and into action. As we teach, we also learn; as we welcome, we are also welcomed; as we care for others, we also care for ourselves. Furthermore, through this exchange, we discover that we are not alone.

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