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Beyond the checklist: Rebalancing structure and lived experience in community-based medical education to nurture compassionate clinicians

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Abstract

Contemporary medical education has increasingly prioritised structure, through competency frameworks, protocols and standardised assessment. These developments have strengthened consistency, transparency and patient safety, and they remain essential.[1,2] Yet, an over-reliance on what can be defined and measured risks displacing the lived, relational dimensions of clinical learning through which compassion, empathy and reflective awareness are cultivated. When structure becomes too rigid, these human capacities can be diminished or rendered merely performative.[2] Drawing on humanistic and experiential learning theory,[3,4] and on Neighbour's awareness-centred account of general practice training,[5] this viewpoint argues for rebalancing, rather than replacing, structured curricula with community-based learning environments that honour lived experience. General practice, with its continuity and relational depth, is uniquely placed to nurture reflective, compassionate practice alongside technical competence.

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Introduction

Consider a typical consultation in general practice. A medical student observes from the corner of the room. The patient hesitates, then falls silent, and the general practitioner (GP), far from rushing to fill the gap, waits. After a few moments the patient discloses a serious concern that had not surfaced earlier in the encounter. Afterwards the student asks why the GP said nothing during the silence. The reply is that the pause was deliberate and therapeutic: a space the patient needed in order to speak.

Moments such as these are seldom captured by competency frameworks, yet they sit close to the heart of clinical practice in the community. Neighbour, in his account of the consultation, describes precisely this kind of intuitive, relational skill, the capacity to connect with the patient, to attend to what is unsaid, and to use silence as a clinical instrument rather than a void to be filled.[1] Such capacities are real and consequential, but they resist easy definition.

In emphasising what can be specified and assessed, a competency-based approach risks allowing these more subtle relational aspects of care to be overlooked or reduced to behaviours performed for an assessor rather than offered to a patient.[2]

The rich and varied landscape of primary care offers an educational environment in which these less visible dimensions of learning can be brought to the foreground. Repeated encounters with the same patients, and the continuity that characterises general practice, allow learners to observe not only what experienced clinicians do, but how they are with the people in front of them. Learning from patients over time in this way is educationally valuable in its own right,[6] and continuity of care is also clinically important: it is associated with measurable improvements in patient outcomes, including reduced mortality.[7]

This article argues that, while competency frameworks remain essential, they risk overlooking the relational micro-skills that are everywhere visible in community-based settings. Making deliberate space for lived, experiential learning within general practice can help ensure that learners develop not only technical competence but also the capacity for genuine human connection.

Structure in medical education

There is good reason for the prominence of structure in contemporary medical education. By ‘structure’ we mean the competency frameworks, protocols and standardised assessments that specify what is to be learned and how it is to be demonstrated. Competency-based frameworks and structured assessment support patient safety, reduce unwarranted variability, and provide assurance that essential proficiencies have been demonstrated.[8] Outcome-based models give learners, teachers and regulators a shared and transparent account of what is to be achieved,[9] and in the United Kingdom the General Medical Council’s Outcomes for graduates sets out precisely such expectations.[10]

Structured learning is therefore both beneficial and necessary. But structure also has limits. In translating complex human behaviours into checklists and rating scales, it can inadvertently simplify the very relational learning it seeks to capture, and in doing so privilege what is measurable over what is meaningful.[2]

Assessment is central to this dynamic. Competency-based learning goes hand in hand with competency-based assessment, and there is substantial evidence that assessment shapes what and how students learn.[11,12] Van der Vleuten has long argued that professional competence is multifaceted and that authentic clinical performance involves integrated competencies rather than the isolated behaviours sampled in competency-based examinations,[13] and formats such as the objective structured clinical examination (OSCE) may over-emphasise observed performance at the expense of actual performance.[14]

One unintended consequence is that learners may begin to orient themselves towards completing checklists and reproducing well-rehearsed phrases in order to satisfy assessment criteria, an instrumental approach that can crowd out authentic engagement. Community-based placements offer a partial corrective. They frequently afford

the emotional and temporal space to watch consultations unfold in a less scripted way, allowing the learner to follow the patient's narrative rather than a predetermined structure, and so to prioritise connection over performance.

What is meant by 'experience'?

For the purposes of this article, 'experience' refers to the lived, felt and relational dimensions of learning. It encompasses:

- Emotional experience; noticing one's own responses, including discomfort, uncertainty and affective empathy.
- Relational experience; sensing the quality of connection between clinician and patient.

Kolb describes learning as a cyclical process that begins with concrete experience and proceeds through reflection, conceptualisation and active experimentation.[3] Without a genuine, affectively engaged experience to reflect upon, the cycle cannot fully turn. Rogers similarly emphasised that significant learning involves the whole person and is facilitated by authenticity, acceptance and empathy rather than by instruction alone.[4] Neighbour extends these ideas specifically to general practice training, arguing that effective teaching is awareness-centred: it cultivates the learner's capacity to notice, in the patient, in the clinical encounter, and in themselves.[5]

Community-based placements provide repeated opportunities for this cycle to occur. Students can follow patients over time, revisit earlier encounters and trace clinical journeys, reflecting on how relationships evolve. This continuity allows experience to accumulate and unfold naturally rather than in fragments, creating the conditions in which genuine empathy can develop.

Balancing structure with experience

The intention here is to encourage educators to make room alongside structure for lived experience, that of the learner, the patient and the educator, and to examine that experience through a reflective lens so that it yields deeper meaning. This can be approached in several complementary ways.

Clinical teaching often concentrates on what the learner did and how it might be improved. Inviting learners instead to attend to their own feelings, and to recognise their own responses, builds on the concrete experience of the encounter and, rather than defaulting to checklist-based debriefs, encourages relational, empathy-oriented learning.[3] This is consonant with Neighbour's awareness-centred model, in which the trainer's task is less to transmit information than to help the trainee become aware of what is already present in the encounter.[5]

General practice is unusually well suited to this work because it allows learners to follow patients over time and to use continuity itself as a teaching tool. Revisiting the same patient enables discussion to move beyond the isolated consultation towards an understanding of how clinical relationships develop. Asking a learner what has changed in their perception of a patient, or how an interaction felt different on a subsequent visit, can deepen insight into the relational dimensions of care.

Supporting educators to engage explicitly with emotional content, while promoting self-compassion as a core professional skill, can further strengthen this learning. Self-compassion is increasingly recognised as a protective factor against emotional exhaustion among healthcare professional and is amenable to deliberate cultivation.[15]

Crucially, community-based education offers a practical model because reflection of this kind is often already embedded in the working day, in the brief conversations that occur between consultations or during a home visit. These short, naturally occurring encounters can support meaningful learning without requiring additional formal infrastructure.

Discussion

Drawing on Bandura's observation that learning is shaped by observation of, and engagement with, the behaviour of others,[16] lived clinical experience can be seen as central rather than incidental to professional formation in primary care. To take lived experience seriously is to accept that not all valuable learning is immediately measurable.

Some of the most important capacities; compassion, empathy, the judicious use of silence, develop gradually, through repeated experience and reflection, and may be poorly served by frameworks designed to capture discrete competencies.

The evidence on how these capacities fare during training is instructive. Compassion and empathy are related but distinct constructs, and empathy has most often been measured as a proxy for compassionate care. Earlier systematic reviews reported a decline in empathy over the course of medical training,[17] whereas more recent longitudinal and multi-institutional studies suggest that this trend is neither universal nor inevitable and appears to vary with curriculum design and educational context.[18–20] Far from undermining the argument, this reinforces it: what we teach, and how, shapes whether these capacities are sustained, and so merits deliberate attention.

Community-based medical education is particularly well placed to support this gradual formation. Its continuity and relational depth create conditions in which learners can engage fully with the more human aspects of care, and in which the trainer–trainee relationship can itself become, as Neighbour suggests, a vehicle for awareness and growth.[5] Embracing lived experience does not entail abandoning competence or rigour. Rather, it invites us to expand our definition of competence so that genuine human connection sits alongside technical proficiency rather than beneath it.

Conclusion

Medical education continues to evolve in response to systems under sustained strain and the changing needs of an ageing population. Structure has brought welcome clarity and safety, but there remains a need to honour the less measurable dimensions of clinical learning. The challenge is to allow structure and experience to inform and enrich the other. By making deliberate space for lived experience, especially within the continuity and relational richness of general practice, we can support the formation of clinicians who are both competent and compassionate.

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